REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

CORRECTED

At Macquarie Room, Parliament House, Sydney on Friday, 10 December 2021

The Committee met at 8:45 am

PRESENT

The Hon. Wes Fang (Chair)

The Hon. Anthony D'Adam
The Hon. Greg Donnelly (Deputy Chair)
The Hon. Scott Farlow
The Hon. Trevor Khan
The Hon. Taylor Martin
The Hon. Rod Roberts
Mr David Shoebridge

* Please note:
[inaudible] is used when audio words cannot be deciphered
[audio malfunction] is used when words are lost due to a technical malfunction
[disorder] is used when members or witnesses speak over one another

The CHAIR: Welcome to the second day of public hearings for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021. Before I commence, I would like to acknowledge the Gadigal people, who are the traditional custodians of the land on which the Parliament sits. I would also like to pay respects to Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginals present. Today we will be hearing from opponents of the bill. We will hear from religious groups and organisations, in addition to academics in the legal, medical and bioethics fields. We will also be hearing from a number of other peak bodies, as well as palliative care physicians. Before we commence, I would like to make some brief comments about the procedures for today's hearing. I note that the hearing room is closed to the general public for this hearing and the hearing on 13 December. This is due to the room capacity restrictions under the New South Wales Parliament's COVID-safe arrangements. However, the hearing will be broadcast live on the Parliament's website.

While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses may say outside of their evidence at virtual hearings. Therefore, I urge witnesses to be careful about comments you may make to the media or others after you complete your evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In these circumstances, witnesses are advised that they can take the question on notice and provide an answer by 28 January 2022.

As I mentioned, today's proceedings are being streamed live and a transcript will be placed on the Committee's website when it becomes available. In terms of audibility for today's hearing, we have witnesses in person and via the videoconference system. I ask that Committee members clearly identify who questions are directed to, and I ask everyone appearing remotely to please state their name when they begin speaking. Could everyone appearing via the videoconference please mute their microphones when they are not speaking. Members and witnesses should avoid speaking over each other, so that we can all be heard clearly. To assist Hansard, I remind members and witnesses to speak directly into the microphones and avoid making comments when your head is turned away.

MARGARET ANNE SOMERVILLE, AM, Professor of Bioethics, Affiliate of the Institute for Ethics and Society, University of Notre Dame Australia, sworn and examined

DAVID ALBERT JONES, Director, The Anscombe Bioethics Centre, before the Committee via videoconference, sworn and examined

The CHAIR: I will now welcome our first witnesses. Professor Somerville, could you please state your name and position title?

Professor SOMERVILLE: My name is Margaret Anne Somerville. I am Professor of Bioethics at the University of Notre Dame Australia. I am also Samuel Gale Professor of Law Emerita, a Professor Emerita in the Faculty of Medicine and Founding Director of the McGill Centre for Medicine, Ethics and Law Emerita at McGill University in Montreal.

Mr DAVID SHOEBRIDGE: Chair, I have a small conflict of interest to note. For a number of years now, on an annual basis, I have done a bioethics seminar with Professor Somerville at Notre Dame university.

The Hon. TREVOR KHAN: As have I, but not for the last couple. I haven't been invited back.

The CHAIR: Thank you. Professor Jones, could you state your name and position title?

Professor JONES: Yes. My name is David Albert Jones. I am Director of The Anscombe Bioethics Centre, which is an independent research centre in Oxford. I am also a research fellow at Blackfriars Hall, which is part of the University of Oxford, and Professor of Bioethics at St Mary's University in Twickenham, London.

The CHAIR: Thank you very much, Professor Jones. I will invite opening statements. Can we keep them short, please? Professor Somerville, if you have an opening statement I invite you to do it now.

Professor SOMERVILLE: Thank you, Mr Chair. Firstly I would like to thank you, Mr Chair, and the honourable members for your kind invitation to address you today. I have researched, written, spoken and consulted on euthanasia and physician-assisted suicide—that is, voluntary assisted dying [VAD]—for over 40 years. What I have learned has led me to conclude that legalising it is a very bad and dangerous idea. I will try to explain why I have come to this conclusion in the very short time I have.

But first—and I think this is really important to note—there are some things that we all agree on. None of us wants to see people suffer and all of us recognise that we have fundamental ethical obligations to relieve suffering. Where we disagree is as to some of the means of relieving that suffering and whether or not they are ethical and legitimate.

Advocates of VAD want doctors and nurse practitioners to be allowed to intentionally inflict death—to be blunt, be allowed to kill a suffering person—to relieve a person's suffering. Anti-VAD proponents reject it as unwise, unethical and dangerous. The pro-VAD case is straightforward and easy to make; it focuses only on the suffering individual and only in the present. The anti-VAD case is much broader and harder to make not because it is weak—it is not—but because it is much more complex. As well as looking to the present and an individual person's needs, important as those are, it also looks to collective human memory, history, for lessons from the past and collective human imagination for likely future consequences of legalising VAD. It looks to protecting vulnerable people and the common good, not just the individual. That much broader perspective will give us the knowledge we need to make a wise decision about legalising VAD.

The arguments against legalising VAD include the unavoidable logical and practical slippery slopes; my colleague Professor Jones will speak to some of that. The logical slippery slope is the major expansion of who may have access, on what conditions and in which circumstances; the practical slippery slope, failure to comply with the law. These are unavoidable. The logical slippery slope is dramatically evidenced in the implementation of medical assistance in dying [MAID], which is VAD in Canada, and the practical slippery slope in the Flanders region of Belgium. In less than four years Canada has moved from relatively restrictive initial limitations on VAD to having some people considering going to court to argue that there is a right to euthanasia on demand. The need for death to be reasonably foreseeable has been abandoned and euthanasia by advanced directive for people with dementia and for children is under consideration. Euthanasia will be available for people with only mental illness—no physical illness—in early 2023.

Dr Yves Robert, the head of the College of Physicians and Surgeons of Quebec, whom I debated on many occasions, was a big advocate of legalising VAD. When he saw the results of what happened in the first year of implementation in Quebec, he was absolutely shocked because he had believed it would be a rare procedure and that it was a medical procedure. What he concluded—it was in French that it was given—was that it was "la mort a la carte"; that is, we now have a menu and you can choose the death you want from the menu. He went on to say that this was not a medical treatment and it should not be carried out by doctors; it was State-authorised suicide and medical doctors should have no role in it. The official death toll from MAID in Canada up to the end of 2020 was 21,589. That is the official figure, and that is almost certainly an underestimate. In Canada 2.5 per cent of deaths were by MAID and the number of deaths increased by 34.2 per cent between 2019 and 2020. What this demonstrates is that VAD cannot be contained once it is legalised because once we step over the clear line that we must not intentionally kill another human being, there is no logical stopping point.

What are some of the arguments that we have to deal with? First of all the base of the pro-VAD case is the right to autonomy: my body, my life, my choice. Again, we all agree that respect for autonomy is important, but, like freedom, it has to have limits on it. So what we have looked to—this has become very prominent with our trying to deal with COVID and some of the objections to mandatory measures there—is that our individual flourishing is bound up in collective wellbeing, and VAD will seriously harm our collective wellbeing. What about the concept of autonomy? Are we just atomistic beings, where just what I want is what I should be able to have? Or do we have to also look to our relationships, what is called by the feminists "relational autonomy"? What that requires is protecting those relationships because they are important. In the context of VAD some of the things that happen are a breakdown in those relationships. One of the three most common reasons for asking for euthanasia or VAD is that people feel a burden on others, particularly their carers and those that they love.

So there is much a larger picture that we have to look at to decide whether this is a wise and safe idea, to legalise VAD. I would like to just give you some thoughts about what that larger picture is. I believe that VAD will harm both the common good and what is called social capital: society's store of goodwill, generosity, helping others, caring for those in need et cetera. Politics both follows and creates culture. So what has happened in our society that after millennia of strict prohibition of, in both society and medicine, intentionally killing, we suddenly think that allowing doctors to kill their patients is a wise idea?

Moreover, what future culture will we create in New South Wales if we allow this? Might it be a society with a damaged or even no ethos of caring for others, a damaged value of respect for life, which operates at both the individual level and the societal level and is particularly important in medicine and law in a secular society? Because medicine and law carry that value. VAD contravenes that capacity of both of them, because the law is changed to allow this intentional killing and it is carried out by doctors. So they are not able to carry that value of respect for life in the way that it needs to be carried.

This raises the question: What are our obligations to future generations? This question is common to our deliberations about euthanasia and climate change. Climate change threatens our physical ecosystem. VAD threatens our sociocultural or what is called our metaphysical ecosystem: the collection of values, beliefs, attitudes, stories and so on that we buy into and share to create the glue that binds us as a society. Neither system is indestructible, as we know so well with our physical ecosystem; both can be irremediably damaged. Most MPs in Parliament will not live long enough to experience the worst effects of climate change, but their children will. Likewise for VAD.

Therefore, the question that you as legislators must address is not only "Will legalising VAD affect individuals and our present society?" but also "What kind of a world will you have left to future generations?" Here are some of the things I think we could anticipate about our future world: vulnerable people, what risks and harms to them, those who have disabilities or are fragile elderly people? That is our neighbours who are living in the same life circumstances as those who VAD supporters believe are making the right decision in wanting assisted dying. We would be messaging them and establishing as part of our revised cultural values that they have lives not worth living and, even more reprehensibly, that they themselves have no worth. This is particularly concerning when we recall that feelings of loss of dignity are another of the three main reasons that people request euthanasia—

The CHAIR: Professor Somerville, can I just inquire as to how much more you have got of your opening statement?

Professor SOMERVILLE: Yes, okay. I know. So I will skip some of this. I invite you to read it. I believe you have got a copy of this.

The Hon. SCOTT FARLOW: If it is your opening statement, you could table that to Hansard, and Hansard could incorporate it.

Mr DAVID SHOEBRIDGE: It is largely the submission, I think.

The Hon. SCOTT FARLOW: It is largely the submission?

Professor SOMERVILLE: Sorry. I am having trouble hearing this.

The Hon. SCOTT FARLOW: I was just saying, if it is your opening submission, you can hand it to Hansard and have that incorporated into *Hansard*.

Professor SOMERVILLE: I have already handed it in.

The Hon. SCOTT FARLOW: You have? Good. Thank you.

Professor SOMERVILLE: Yes, I have handed it in. I want to give you two things: first, VAD and organ transplants. I decided to write an article on this because when I first realised that euthanised people were being used as a source of transplants, I first of all thought it was fake. I did not believe that that was happening. The earliest article on it was on Belgium and they were doing that. So I wrote an article about it, asking: If we thought it was okay to take organs after the person had been killed with euthanasia, why not carry out euthanasia by removal of organs? That is, give the person a general anaesthetic and then take out a beating heart, breathing lungs and so on. The organs would be much more viable. They will not have been affected by waiting for the person to die et cetera. Most people were absolutely appalled that that would even be suggested. In fact, my medical school asked me not to speak to the students about it, because they thought it might upset them about participating in organ transplantation.

So what we have to ask is: Why would that be? Why would we not think it was okay to do euthanasia by removal of the organs rather than after death? I think one of the answers is—there are many answers, but one of them is that it makes us face up to the reality of what we are doing, that we are intentionally inflicting death, and we are appalled by that. So what I would ask is: Will future generations look back in horror and say "How could they"—that is we and especially you—"have allowed the intentional infliction of death by medical professionals? How could society have allowed this to happen?" I think what we have to do there is learn from the past about unethical, human rights breaching laws. The one that comes most prominently to mind are the laws that allowed the Stolen Generations. Our grandparents and great-grandparents authorised legislation that we now are appalled at. It is human rights breaching that you would take children from their families and put them in institutions.

When you look at the Acts that allowed this, which I have done—I have looked at the Victorian and New South Wales Acts—there is very close analogy to the VAD legislation, analogies in that it started in Victoria, it had a euphemistic title, they were called the Aboriginal Protection Acts, they set up a board that was supposed to guide their implementation. We assumed that the people who did this thought it was ethical. And yet we look now and see what we think about it and we are appalled, and we say, "Well, this was terrible. How could they have done it?" My prediction is, if we do this, future generations will look back on us and say, "How could they have done it?" And I think that is what you have to think about, important as the individual person and the immediate present are, is not just them. So, for—

The CHAIR: Professor Somerville, can I just inquire, do you have much more to go because I am just—

Professor SOMERVILLE: No, one paragraph. For all our sakes, both those who are dying now and those who are not yet dying, and for our descendants and their future societies, we must kill the pain and suffering of dying people, not the dying people with the pain and suffering. I urge you in the strongest possible terms to advise the New South Wales Parliament against the enacting the Voluntary Assisted Dying Bill 2021. Thank you, Mr Chair.

The CHAIR: Thank you, Professor Somerville. Professor Jones, do you have an opening statement and if so could you please keep it to no more than a couple of minutes?

Professor JONES: I will do my best. There is a problem, as Professor Somerville has said, that there are so many different parts of the evidence, so what I really want to do is not try to be diverse but just look at one thing—just look at one feature of one country with which I am familiar so that we can illustrate some of the problems, and therefore I hope to be succinct. I want to look at Belgium and I want to look at the way that in Belgium doctors intentionally end the lives of patients both with and without their consent. Belgian legalised VAD in 2002 and they have almost 20 years of experience and so we can see how that change in the law has changed the practice of medicine.

For example, it has changed the way they use sedatives. I think this is really important. Now they use sedatives not only for symptom control but also as an alternative to VAD. Now there is "euthanasia lite" or slow euthanasia. They sedate people who do not need it for symptom control, or outside what is needed for symptom control, to deep unconsciousness and then withdraw or withhold hydration so that the patient dies in a few days. It is not called euthanasia and that means they do not need to do the paperwork but they think it is reasonable because they have euthanasia—because they have already crossed that line.

What I want to focus on is not the in-principle question of whether doctors should ever end the lives of their patients but the reality—the danger—that if you implement any kind of system then there will be people who do not fulfil the criteria who will have their lives ended. And that is what I want to focus on: the inevitability of deaths outside the criteria. And that is what is happening in Belgium. How many deaths are we talking about? Data from Flanders indicates that in 2013 there were roughly 1,000 life-terminating acts without explicit request of the patient. And this is not counting the far higher number of deaths involving intentional terminal sedation, mostly without consent. So the number of lives ended intentionally without consent in Flanders in one year is closer to 5,000. This is a region which is roughly 80 per cent of the size of New South Wales—5,000 people.

A group of researchers in Belgium who were in favour of VAD tried to say that these figures were not as bad as they seemed and they looked deeply not at the 5,000 but at the 1,000 unrequested deaths. And they said, of these, in about a third of the cases the patients had "at some point expressed a wish for life to be ended implicitly or explicitly but not as a formal euthanasia request". So of these third of 1,000 people whose lives were ended without consent, a third at some point implicitly could have asked but did not ask, and that is the point. It moves from an explicit request to a vague expression of a wish to no expression at all of a wish in two-thirds of cases but a view of the doctor that they would be better off dead.

A final example, just because it was very striking to me, concerns cases of VAD for mental suffering in Belgium. So these were patients with psychiatric conditions who were not physically ill and not near the end of life. They had an average age of 47. Of these hundred people who were seeking VAD, five years later 43 of them were dead—35 by VAD, of which 31 was by lethal injection and four by taking the drugs themselves, six by non-assisted suicide, so non-assisted suicide is still an issue and I think an important issue. One died by anorexia nervosa and one died, according to this report, "after palliative sedation in a psychiatric hospital"—so death by sedation in a psychiatric hospital of someone who was not physically ill and it was not euthanasia because it was palliative sedation. So there was no paperwork. VAD for mental health impairment is excluded from the VAD Bill—part 2, clause 16 (2) (c)—and I am glad to see, but it should be noted that a similar exclusion did exist in the Canadian C7 bill that has since been amended. Laws get amended and one should expect permissive laws to be amended in a permissive direction.

The CHAIR: Professor Jones, I am just noting that we have only got—

Professor JONES: I have got one paragraph.

The Hon. TREVOR KHAN: One paragraph—let him.

The CHAIR: One paragraph, okay.

Professor JONES: The logic of the bill—the logic of VAD—will push doctors to find ways to help patients who do not fulfil the criteria. This is what happens. This is what is happening in Belgium. It is real. There are hundreds of people who die in this way without consent and I think it would be naive for you to believe that, if you pass this law, New South Wales would not be vulnerable to a similar thing happening.

The Hon. SCOTT FARLOW: Thank you both for your appearance today. I am just very interested in terms of—we were presented by the proponents of the bill that the arguments put forward by opponents of the bill are the slippery slope, effectively, and I think both of you have pointed to examples both in Canada and also in Belgium of how these laws can be changed and how they start at a certain level where there are certain protections that are involved in the legislation but then those get amended. Do you want to just outline perhaps how those happened in both Canada and Belgium to date, or any other jurisdictions you would like to point out?

Professor SOMERVILLE: I will do Canada and Professor Jones you can speak to Belgium. In Canada the original law required that death was reasonably foreseeable, the person had to have extreme suffering, it was not available for people who were mentally ill but not physically ill, it was not available for children and it was not available to anybody who could not give fully informed consent at the time of administration of the death. I cannot think of all the other things. But, anyway, all of those things have now either been abandoned or amended or are under consideration for change.

In Canada a court held that it was discrimination to require that death be reasonably foreseeable in that it discriminated against non-terminally ill people who wanted euthanasia. So the Federal Government passed a law to take that out of the legislation. They have recently looked at pure mental illness and they have passed an Act to say that this will be allowed in early 2023. They gave a waiting period. But as Dr Mark Komrad said, who is an American psychiatrist on the American Psychiatric Association board, what it does is it converts the role of psychiatrist from having their role as needing to prevent suicide to having their role as providing suicide.

There has also been a big problem in the Netherlands with people who are just mentally ill and not physically ill and they set up a special clinic called—translated it means the End of Life Choices Clinic, and mentally ill people who have not been able to persuade their own doctors to give them euthanasia are going to that clinic. Some of the evidence is that on several occasions the doctor has never met the person before but they do provide euthanasia. And also children is a big issue. In the Netherlands, there is the Groningen Protocol which allows babies to be euthanised and there is now a request for not just babies but—I have lost my train of thought there, sorry—

Professor JONES: Can I jump in with Belgium?

Professor SOMERVILLE: —babies and children and that is under consideration in Canada.

The Hon. SCOTT FARLOW: I think Professor Jones wanted to add in there perhaps.

Professor JONES: Yes, just that the examples from Canada that Professor Somerville has pointed to are changes in legislation, and those happen so that you have amendments, so people want to extend the law. But I think that the primary problem in Belgium is not changes due to legislation, it is changes in the culture of medicine, because what happens is once you allow this practice then it has an effect on other types of practice. What happens with terminal sedation—and I can give you, on notice, evidence that it is different the way they practice terminal sedation in Belgium than it is in the UK.

The Hon. SCOTT FARLOW: That would be helpful, thank you.

Professor JONES: What happens in Belgium is that people have started to use other things for euthanasia. For terminal sedation, they will say things like, "We do not do euthanasia at a weekend, we can do you terminal sedation." They started using other parts of medicine intentionally to end the lives of patients. Things like withdrawal of treatment or terminal sedation or use of analgesia, which were simply about symptom control, are now being extended as ways to have euthanasia lite and euthanasia outside of the bounds of the legislation, and that is a real concern I think, not just what the law says but what this will do to medicine.

Professor SOMERVILLE: I could just add too there that Quebec has a separate Act allowing euthanasia and that includes what they call continuous terminal sedation. That is exactly what Professor Jones is saying where they use the sedation as a means of carrying out euthanasia. What is really, I think, very questionable in the Quebec Act is that it does not have to be the person who consents to that. A surrogate decision-maker can actually consent to that type of what they call "slow euthanasia".

The Hon. SCOTT FARLOW: I have just one last question before I hand over to other members. Professor Jones, you talk about the suicide contagion in your submission as well with respect to the introduction of VAD and I think refer to the study of "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" Could you tell us what the findings of that are?

Professor JONES: This is work that I did with Professor David Paton, who is an economist in Nottingham, and we looked at suicide rates in the United States, and because different States in the United States have legalised at different times, it is possible to use different States as controls for other States. You can look at year effect and State effect and then you can also look at other kinds of regression. What we found was the number of people who took their own lives either by suicide or by assisted suicide certainly increases. It is not the case that you have a kind of substitute and you are saving people who would otherwise be committing suicide.

There was no evidence at all of a diminishment of non-assisted suicide. There was some evidence—it was not as strong, but there was some evidence of an increase in non-assisted suicide. There was strong evidence of an increase in overall death and some evidence of an increase in non-assisted suicide and no evidence of a decrease in non-assisted suicide. Since then, there have been other studies by other people and I have other studies myself in at the moment submitted for publication, but I know of no study which has shown evidence of a reduction in non-assisted suicide as a result of VAD. There are no studies that say there is a reduction.

The CHAIR: Professor Jones, I am just noting we have only got about five minutes left because I want to start the next panel on exactly 9.30 a.m. and we have to change over and do the COVID-safe cleaning.

The Hon. TAYLOR MARTIN: I will be as direct as possible to leave time for other members. Professor Somerville, in your opening statement you talked about organ donation, or harvesting rather. Which provisions of this bill give you concern for that happening in New South Wales in the future?

Professor SOMERVILLE: I am sorry, I am having trouble.

The Hon. TAYLOR MARTIN: In your opening statement you mentioned organ donation, or organ harvesting rather. What provisions of this bill give you concern that that might happen in New South Wales going forward?

Professor SOMERVILLE: It was not considered at all in Canada before the legislation was passed, and the practice arose of simply taking organs from people after they had been euthanised. For example, in Ontario, there is an organisation called Trillium. It is a government organisation which organises organ transplants. I was really surprised by this, but apparently they contact the person if they are competent—the person who is going to be euthanised—or their relatives if they are not competent and seek consent to donation after the person has been euthanised. I know that in the Benelux countries there has been discussion about people who want to die at home but want to give their organs and how can that be organised because they need to be in the hospital so that the organs can be taken in a relatively short time. There has been suggestions that maybe they could be actually given a sedative and taken to the hospital and then euthanised and then the organs taken. There is nobody at the moment carrying out organ harvesting by removing organs from a living donor, and that is prohibited as it stands at the moment by what is called the dead-donor rule. You have to have a donor for organs dead.

The Hon. TAYLOR MARTIN: I am very conscious of time. If you are able, would you mind taking my question on notice and are you able to provide any evidence of what you have just raised there? Is that possible?

Professor SOMERVILLE: About donating organs after—

The Hon. TAYLOR MARTIN: You said there was an experience in Canada with this. If you can, that would be handy.

Professor SOMERVILLE: Sure. Okay.

Mr DAVID SHOEBRIDGE: Thank you both for your assistance today. Professor Somerville, you would recognise that there are already instances where medical practitioners provide medication, often pain treatment, to patients that have untreatable pain and terminal illness knowing full well that that will hasten their death. That is already occurring.

Professor SOMERVILLE: Yes.

Mr DAVID SHOEBRIDGE: I think the standard direction to juries in those situations are that where it is proper and necessary to relieve pain and suffering even if the measures may shorten life, that is permissible.

Professor SOMERVILLE: Yes.

Mr DAVID SHOEBRIDGE: You acknowledge then I suppose that it is happening in a largely unregulated space without checks and balances. Are you comfortable with the current law?

Professor SOMERVILLE: What that raises is the doctrine of double effect, and that there is a vast difference between giving pain management that is necessary and that runs a risk of shortening life as compared with giving a lethal injection that has a singular purpose of ending human life. People who use that as an example to say, "Well, VAD is no different," as you are claiming here, I am sure—

The Hon. TREVOR KHAN: Actually he is not. He is asking a question.

Professor SOMERVILLE: I think the answer to that is that intention matters, and where can we see that? We see it in criminal cases where what the crime is or even whether a crime has been committed depends on the intention. The claim then is: How can you tell what the doctor's intention is? Judges make that decision in criminal cases thousands of times a year, and you can tell the doctor's intention by the circumstances and by the treatment and what is done.

The CHAIR: Professor Somerville, I am terribly—

Mr DAVID SHOEBRIDGE: But, Professor, to be clear, I am not saying they are the same.

The CHAIR: Mr Shoebridge—

Mr DAVID SHOEBRIDGE: I am asking you if you are comfortable with the unregulated situation we currently have.

The CHAIR: Mr Shoebridge, apologies, we have reached time. I thank both witnesses for appearing today. For any questions that have been taken on notice, please liaise with the secretariat. They will arrange for you to table those responses. Again, we thank you for your time and submissions.

(The witnesses withdrew.)

(Short adjournment)

IBRAHIM ABU MOHAMED, His Eminence the Grand Mufti of Australia, before the Committee via an interpreter, affirmed and examined

ABDULRAZAK MOHAMAD, Senior Consultant Physician, Medical and Scientific Advisor to His Eminence the Grand Mufti of Australia, affirmed and examined

ANTHONY FISHER, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Christian Apostolic Churches, sworn and examined

The CHAIR: We welcome our next set of witnesses. I will invite opening statements now. Archbishop Fisher.

Archbishop FISHER: Thank you for the opportunity to address the Committee this morning. I appear on behalf of the Catholic Bishops of New South Wales and also the Bishops of the Australasian-Middle East Christian Apostolic Churches. The faithful of our communities make up about a quarter of the population of this State. The Catholic Church in New South Wales operates 11 hospitals and 59 nursing and aged-care facilities, each of which is directly affected by this bill. The Catholic faithful also provide a significant proportion of the State's healthcare workforce. Catholic health and aged-care institutions are founded on the belief in the sanctity of human life and the inalienable dignity of the person. The proposition that human life is inviolable has been part of the common morality of the great civilisations, the best secular philosophies, the common law tradition, international human rights documents, the pre-Christian Hippocratic oath, the codes of the World Medical Association and the Australian Medical Association, and the world's great religions.

Unsurprisingly then, we oppose any attempt to legalise euthanasia or assisted suicide in this State. Our position is based not only on religious beliefs but also upon the desire to protect the most vulnerable in our society. Legalising euthanasia and assisted suicide will be a radical departure from one of the foundational principles of our society. It confirms in law that some people are regarded as better off dead and that our legal system, health professionals and care institutions will help to make them dead. These laws separate us into two classes of people: those whose lives are considered sacred and whose deaths we invest heavily in preventing, and those who are considered dispensable and whose deaths we invest in assisting.

As time goes on and assisted suicide is normalised, this latter class of people expands. In Canada, for instance, euthanasia was legalised in 2016. Within five years, the class of those eligible expanded from the terminally ill to the chronically sick or disabled who are not dying, and the requirement of natural death being reasonably foreseeable was repealed. In less than 18 months from now, eligibility will also extend to those suffering mental illness alone. In due course we can expect provision for the unconscious and for children. Many of those who have made submissions to this Committee have spoken from their own personal experience and I would like to speak briefly of my own.

In 2015 a sudden attack of Guillain-Barré syndrome left me close to death, paralysed from the neck down, in extreme pain and reliant on others for every aspect of my existence for the next five months in hospital. My recovery was very slow and painful. I was embedded amongst patients suffering multiple sclerosis, motor neurone disease and other degenerative and ultimately fatal illnesses. Although I recovered, I had an experience of the kind of suffering that makes people want to end it all. Both my parents are in nursing care and my mother is presently dying of bone marrow cancer. In addition to my own illness and that of people I love, I have more than 30 years experience as a pastor, walking with the sick and their fatigued carers, sitting by the dying and offering love and hope, prayer and sacrament, and commending the dead to God while comforting their grieving families. As difficult as these times have been, I have also witnessed the reconciliation and peace that comes with letting things work themselves through.

So I approach these questions not just from theory or dogma but personal experience. Indeed, religious believers cannot approach this issue from a sanitised distance, as care of the sick and dying is core to our mission. It is the reason why the church is the oldest and largest provider of health care, aged care and palliative care in the world. Those who seek to exclude religious voices from this discussion, or minimise the weight given them, are not only demonstrating an anti-religious bias but also rejecting the views of one of the chief providers of end-of-life care. I appreciate the terms of reference of this Committee do not address the fundamental question of whether New South Wales should cross this precipice of allowing some of its citizens to be killed or assisted to kill themselves. Instead, we are asked to focus on the provisions of the bill before us. These provisions are addressed in our submission in detail.

However, it is worth noting that the bill lacks many of the safeguards in the bill presented to the Legislative Council just four years ago. It also represents a serious attack on the freedom of religious hospitals and aged-care facilities to operate in accordance with their ethos, which the previous bill did not. I ask this

Committee to consider seriously the amendments we have proposed. Finally, it would be remiss of me not to record that this inquiry is the shortest in duration of any inquiry before this Committee, and perhaps any committee, in the history of the New South Wales Parliament. It is the shortest inquiry into euthanasia and assisted suicide held in any Australian jurisdiction. It has allowed fewer submissions than any other State inquiry. It is also being held at a time when our health professionals are fully occupied, even overstretched, by the COVID pandemic and so have been unable to contribute as they might to an inquiry like this and broader debate. Notwithstanding that incredibly short time frame, I ask the Committee to consider carefully the many submissions before it and to ensure the law does not put the already vulnerable even more at risk. Thank you.

The ACTING CHAIR (The Hon. Rod Roberts): Thank you. Dr Mohamad, an opening statement?

Dr ABDULRAZAK MOHAMAD: I would like to give that priority to His Eminence the Mufti, then I will follow, if that is okay, Mr Chairman.

The ACTING CHAIR: Certainly.

Dr IBRAHIM ABU MOHAMED: His Eminence the Grand Mufti of Australia commenced by acknowledging and extending appreciation for being here at this Committee to be able to speak to this most important matter. It is noble that in Australia he says we are able to engage in dialogue on matters to do with life and death. And in relation to the subject of what is proposed in the Voluntary Assisted Dying Bill, we respect all opinions and positions on the matter even if we do not subscribe to such positions. We also believe that our position is the honourable truth on the matter and is in accordance to our common humane values, our character values, our religious values, despite some not subscribing to the same belief.

Our human life is comprised of two essential stages. The first is during our time in this world. This is the preliminary stage to another life, the afterlife, a life which is higher, more noble, more valuable and eternal. This second stage commences after death. In the afterlife there shall be ultimate justice with each human being brought to account for their good and bad deeds, and their life from thereon in will be the eternal bliss or eternal damnation. Another matter is that life and death is not under the choice of any human being. Life and death is not left to an individual to choose when they were born nor when they die. No human being in history has ever chosen the day or circumstances surrounding their birth, when they were born, or the circumstances in and around that. No person chose how compassionate or dignified their birth could have ever been. Therefore, it is understood that life is a gift given by God to human beings and none can withdraw it from the human, save God alone. Similarly, death is a defined decree, with no human being able to intervene to determine its when.

Life is also a time for trials, tribulations, tests and suffering. We are tested as human beings in our good nature and in our bad nature, in our health and in our illness, in our wealth and in our poverty, in our ease and in our difficulty. Ultimate success lies in persevering throughout life with everything that comes our way, showing contentment in every situation that is placed before us, whether it is to our liking or not. We would also like to point out, His Eminence said, that there is a great confusion in the use of basic terms in relation to the newly proposed law, or bill, of voluntary assisted dying. There are clear and distinct differences between three terms—which include "dying", "suicide" and "homicide"—based on linguistic, scientific and medical definitions. Dying is a natural and spontaneous process. "Suicide" means that someone terminated their own life. "Homicide" means that someone terminated the life of another. When we look at the title of the proposed law, the Voluntary Assisted Dying Bill, we find two major contradictions. Dying is natural and spontaneous with no room for choice by someone for themselves to die; otherwise it becomes suicide. Also, dying cannot be assisted by someone else; otherwise it becomes akin to homicide. So the name of the proposed law is misleading for many.

In another two concluding points, when we talk about dying with dignity, the Oxford dictionary states that dignity is the "state or quality of being worthy of honour or respect", coming from the Latin "dignitas", meaning "worthy". Therefore, we need to have discussions about what dignity actually means. When people talk about how the passing of this bill will allow them, if they are terminally ill, to talk about death in a more comforting, easy and facilitated manner with their loved ones, the issue arises: Why is it that we need to wait for such a bill to pass to facilitate the conversation about death when death itself is a part of life, and we should be prepared for it no matter our circumstances, health or illness? Thank you.

The ACTING CHAIR: Dr Abdulrazak Mohamad, would you like to make an opening statement?

Dr ABDULRAZAK MOHAMAD: Thank you very much, Mr Chairman, and honourable Committee members. I thank you for giving me the chance to voice our thoughts. I come from a medical background. I am still a working clinician with more than 40 years of experience in this profession. I live this on a daily basis. On top of that, I am a member of four international bodies, in addition to the Australian college of physicians. One of them is the American College of Physicians, which represents more than 160,000 members, and, again, the royal college of physicians of Glasgow, the Royal College of Physicians of London and the Royal Australasian College of Physicians. I am not representing them but I know their opinion.

The main two justifications that VAD is based on are compassion and dignity. I would not waste your time talking about dignity again but, number one, we do share, as the opponents of this bill, in caring for our patients and in making them have dignity all their life, not just when they approach dying. We share the same passion. What made me be against this bill is, number one, it is not something we have been trained to do. We have been historically trained to look after our patients, their life, make them comfortable and live longer. I think the medical profession, in my view at least, should not be part of this procedure, should it be passed. We are trained to look after our patients and we are comfortably doing that. Number two, in Australia we have one of the most excellent health services globally, and I am proud whenever I go somewhere that I refer to our Medicare and the service we have been offering to our patients and their families—holistic care, looking after the patients and their family, not only from a pure clinical point of view but we look after their safety, we look after their house, we do occupational therapy, we do physiotherapy, and we have psychologists and psychiatrists. That is happening in Australia. I think that is one of the things we should continue doing and even improve, if there is room for improvement.

The other very risky aspect of this law, already being referred to by some of the speakers, is this is a very slippery pathway. We can indicate the beginning but we will never be able to stop it. We do have an example in the narcotics, which were introduced in the 1990s as a way of comfort and helping people to relieve pain, but now we live in a narcotic pandemic; it is not only endemic. It is costing tens of thousands of lives annually. In America they estimate it is something like 70,000 deaths from narcotics. This might be another sad example, should it be passed. Again, there is a bit of vagueness around which patients are eligible. If you go to the definition of "terminally ill patient"—well, depression can be a terminal illness. A bad leg ulcer in a diabetic patient can be nearly terminal. An amputation is terminal. So that is a very vague definition. Saying six months or 12 months—again, that is one of the things very well known to every clinician. We can give a rough idea of when the death might happen but that often comes not true. I have seen many patients; they come and talk to me. Someone has told him that he is going to die in a month but he is living after a year or two years. So that never comes true all the time. There are scales—there is a way we can assess the possibility of longevity—but there is no guarantee that is right. Even the six or 12 months might not be what represents the reality.

There are a few studies that have shown that most of the people who make the decision to end their life do it under social or psychological circumstances. They might often change their opinion. Just last month in my own practice I faced two cases. One of them was a 74-year-old lady, who used to be a case manager. The case managers in the hospital circumstances are the people who handle those complicated cases. She came in with a pain and she voiced that she does not want to live longer. We controlled the pain. With assisted physiotherapy she went home and I requested psychiatry consultation. I just received the report a few days ago. She is a very happy lady and she is now writing a book. So turning from somebody who would like to end their life, now they are writing books. Another lady, she had been designed not to have life prolongation procedures three years ago. But when we met her with the family we explained to her things, we offered her the palliative team, we offered her home service. She changed her mind. She wanted to live longer. Again, with a good explanation of palliative care, the service available, the patient can choose a different goal than to die. Actually, that has been again shown that a lot of people who choose to die do not have an idea about palliative care, and when it was explained to them they choose palliative care for themselves and their family.

I will not go through the legal part of it. I am sure you are more informed than me, but just commenting on the alternative—as I said, the alternative is palliative care. We do have palliative care. What we need probably is to have more palliative care aspects, including the option to die at home. Many, many people like to die at home, but because of the lack of facility, sometimes we keep them in the hospital to give them the comfort and dignity until the natural death happens. I am sure there is plenty of room in Australian medical services we can expand on and improve on rather than to incline to—I am sorry to say this—kill somebody so we can get rid of their suffering, rather than kill the suffering and keep the patient alive. I think I will stop here for the sake of time. Just a couple of comments on the bill—again, I hope that this bill will not be passed—but about the right of the clinician or the health service worker. Again there is a bit of vagueness around the definition of "health service worker". I think we need it to be a bit more clear and avoid duplication.

The other thing is the right of the health service worker to say "no". I would also like to include not to be obliged to refer that patient to another clinician. So yes, say "no", but also "I am not obliged to refer you because I do not believe in it". I am saying this out of our experience with the abortion law. In some States, even if you do not believe in termination or abortion, you have to refer the patient to someone who can do it. I think that is part of practice, it is a part of involvement. And I would very much be keen not to include that, should this bill be passed. I thank you again for giving me this chance, and I am happy to receive questions. If an honourable member would like to send them to me, I am more than happy to answer them later on. Thank you again.

The ACTING CHAIR: Thank you, Doctor. I am going to open it up for questioning from Committee members now. Would anybody like to commence?

The Hon. ANTHONY D'ADAM: I am happy to start. I am not sure whether the panel members have been following the proceedings of the inquiry. On Wednesday we heard from witnesses. One particular witness, Cathy Barry, spoke about the situation of her brother Tom. It was pretty harrowing testimony. She described in quite graphic detail the end of Tom's life, his pleading with them to assist him to end his life and put him out of his misery, his terrible suffering. The question that I want to pose to the panel is how can it be moral for us, as a society, to ignore the pleadings of people in Tom's situation, who are dying, are in terrible pain and suffering terribly? They want it to end. How can it be moral to just allow that to proceed unassisted, unsupported?

The ACTING CHAIR: Are any of the witnesses able to answer that?

Archbishop FISHER: If I might speak briefly to it?

The ACTING CHAIR: Certainly, Archbishop.

Archbishop FISHER: I am in complete agreement that we should never let anyone in that situation be unassisted and unsupported. That is exactly why the great faiths devote so much of their energy to caring for suffering people, to doing everything possible to relieve their suffering—at least everything that is morally and practically possible to relieve their suffering. So it is not the case that any of us would be saying, "Suffering is good for you, and we want it to continue, and we will bring about more suffering if we can." Quite the opposite, we do everything that is morally and practically available to stop the suffering. We are getting better and better at that—physicians, such as this one, learning the science of pain management—and it is improving all the time. So often, sadly, people do not have access to that kind of relief from their pain. In fact, we know that in large parts of this State there is very little access to palliative care. Even within this city, there are parts of the city where you have to go a long way or where the local physicians know very little about it. So until we are quite confident that we have made sure every possible way of relieving people's suffering has been offered to them and delivered to them if they want it, I do not think we should be considering going the route of killing them.

Mr DAVID SHOEBRIDGE: But this was a case with world-class palliative care, every available pain management option being provided, and nevertheless untreatable pain and suffering. So all of those options were available in the case that Mr D'Adam put to you, and you have not addressed that fact.

The Hon. GREG DONNELLY: Point of order: I have read the transcript very closely with respect to the evidence here of Ms Cathy Barry about the circumstances of her father's passing.

The Hon. TREVOR KHAN: No, it was not her father, for a start; it was her brother.

The Hon. GREG DONNELLY: Sorry, her brother. I contest clearly this statement that every available possible pain relief—using your words, Mr Shoebridge—was provided to him. I think, in all fairness, that is a complexion you are putting on the evidence. A fair reading of the evidence does not in fact make that absolutely clear, so I think that is an important point to make before the witness answers that question. If the witness needs to read the transcript to make an assessment about the evidence, that should be allowed to happen. But to make that statement and then say, therefore—

The Hon. TREVOR KHAN: To the point of order: This is taking too long. There is very limited time.

The Hon. GREG DONNELLY: Okay.

Dr ABDULRAZAK MOHAMAD: Can I just add—

Mr DAVID SHOEBRIDGE: I think the witness can answer my question. World-class pain treatment, world-class palliative care, intense and untreatable suffering—that is the scenario you did not address, Archbishop. I ask you to address it.

Archbishop FISHER: Thank you, Mr Shoebridge. I said that we would do everything that was morally and practically available. We know that in some of those cases we effectively induce coma. People are put out of their pain by being rendered unconscious and they are perhaps periodically brought back to consciousness so they can say goodbye to their family or make some decisions for themselves or whatever, but then they are slowly again put back to sleep. That is in extreme cases but that, I know, is one of the options available to palliative care professionals.

The ACTING CHAIR: Do you want to address that, Dr Mohamad?

Dr ABDULRAZAK MOHAMAD: Yes, I would like to. Thank you very much, Mr Chairman, and thanks to the honourable members. To make a statement like that, I think it entails more details than just simply to make the statement, with due respect to the witness. I am not doubting that witness but, again, suffering is part of our daily life. It depends on what degree of suffering. I suffer from bad traffic, you suffer from headache, so there is no way we can end the suffering, but I am with you: We should do our best to end that suffering. Number two, stating that VAD will end their suffering I think is too optimistic—that is, by itself. I work on a daily basis with my patients. I am happy with their happiness; I am sad with their sadness. As a clinician, when I see somebody is being killed, that is a big trauma. That actually steers the relationship between the doctor and his patient, and the doctor and the community at large from a state of doing our best to palliate, to give comfort. Now we are ending the life. Now, this VAD itself I do not think it is a very colourful way to end life. I am sure there will be emotion; I am sure there will be pain; I am sure there will be pain of waiting. So this is not the simple step forward.

Number two, I am a general physician. I palliate people, I look after them, and I discuss all those aspects. Yesterday, a time like now, I was talking to one of my patients about the death, despite he is on palliative. We did everything we could to comfort him; we offered him the best care we could. Now, with a terminally ill patient admitted, I can imagine only few patients where I failed to comfort them—and even when I say I failed, probably for the first six hours. They can always increase their dose, add new medication, add new ways of comforting the patient. The other important point—people might suffer not from the terminally ill but with a terminally ill. Someone who has a depression, now he has a cancer—his depression will worsen. So we cannot always add that suffering to the terminal illness, and there are always more aspects. Human complain, human feeling is very complex. It [inaudible] organic, cultural, religious, theological, and all this culminate into giving that feeling of suffering, or comfort on the other side. Thank you, Mr Chairman.

The Hon. TREVOR KHAN: I do not want to misquote in any way the evidence that was given by a witness the other day, so I will read it directly. It was the evidence of Ms Abbey Egan. This young woman, I think when she gave her evidence, she was 32. She spoke of the suffering of her partner, Jayde. I will read you part of the evidence of the suffering that she was experiencing:

> I want you to remember that we are talking about a 32-year-old woman at this point. We are not talking about someone who is 80, not that that is any better. But at 32 years of age, this is not something that she should have gone through. She had a permanent catheter in to help her go to the toilet. Because of the pain medication she was on and because of the tumours, it was impacting her bowels so much that she was unable to go to the toilet that way, so she would end up vomiting her own faeces on the regular. The way that her tumour was positioned in her body—when I would have to change her, parts of her tumour would fall out from her, which was horrendous for everyone involved, especially Jayde, obviously. The tumour was so large in her back that it cracked her vertebrae. In terms of her being in bed, when we would have to move her so she wouldn't get bedsores, trying to roll her over—she would scream in absolute agony because of the cracked vertebrae. You could only imagine.

I read that out because I do not want there to be any doubt but, in terms of that and other stories, that is the nature of the pain and suffering that some of the people are experiencing. It is not just pain management; it is gross suffering in the most profound ways. So I invite you again to explain how we deny young women like Jayde—and, indeed, Abbey—this bill.

Archbishop FISHER: Thank you, Mr Khan. I can only say, once again, I would do everything possible to help her. Certainly my church, and I know the other great faiths, invest an enormous amount of our energy in doing exactly that—in trying to relieve the suffering of such people.

The Hon. TREVOR KHAN: I accept that.

Archbishop FISHER: I also recognise that sometimes people are in such a bad way that we have got to go to the extreme of basically knocking them out, keeping them unconscious. That is a very extreme measure. Really, does it have to go to that extreme? I would point out though that these awful cases—and I do not want to diminish them for a moment—are not all this bill is allowing euthanasia for; it is allowing it for a much broader class of people. If we go this way, we can expect then in the years to come it will be a larger and larger group of people. While we do not for a moment diminish the suffering of these extreme cases, let's be frank about what will be the normal case. If you look, say, at the Victorian experience so far, it would not be all of the cases like that or even the majority. It is other kinds of cancers and the like that people have been seeking euthanasia for.

The Hon. SCOTT FARLOW: To return again to the evidence we heard on Wednesday, I direct this question to all panellists but, Your Grace, I might start with you. Many of the witnesses came before the Committee, as you have heard the stories of Mr Khan and Mr D'Adam in their telling of that inquiry, but said that effectively religion should not get in the way of peoples' choice. I just want to see if you could expand why, from your perspective, this is more than just religion and why this bill has a broader impact.

Archbishop FISHER: I said in my opening remarks that this is not just a religious view; this is actually common to all the great civilisations, the great philosophies, the common law tradition, international human rights instruments, the Hippocratic Oath, the World Medical Association code of ethics, the Australian Medical Association Code of Ethics, and on we could go. Now, those are not Catholic or Christian or religious organisations, but what they all hold in common is an ethic of "Save and care for your patients. Don't ever kill or harm your patients." That has been what has defined medicine as opposed to other activities in all the great civilisations. Certainly in the one that most of us are part of, it has been the story for 2,500 years. That has been definitional of what is health care: You save and you care, but you do not hurt and you do not kill your patients.

So this is not just a religious argument. I think you are very right to point that out—that the religions have extra reasons because we also believe it is God's will that we not kill people, that we have extra reasons because we believe God has told us we have to care for people that are suffering. That is true, but we also share with all humanity that common concern for ethical health care and for proper respect for the dignity of every elderly, sick and dying person.

Dr ABDULRAZAK MOHAMAD: Mr Chairman, can I just add a couple of things?

The ACTING CHAIR: Certainly.

Dr ABDULRAZAK MOHAMAD: Thank you very much. I do not understand why religion should be secluded from life. We listen to everyone. Why should we not listen to people of faith? I am not encroaching that on this bill, but I consider myself a practising Muslim and I have seen that my religion goes very well with the best practice in medicine. Historically, that has been with Christianity and other faith. That is why there is always a link between religion and hospitals, religion and doctors. I think everyone should be listened to, give his opinion and leave it up to the honourable Committee to make the judgement. Thank you.

Dr IBRAHIM ABU MOHAMED: I am amazed how religion at times can be sidelined from the progression of humanity in furthering their civilisation when it is religion that upholds the principles of truth, the principles of justice, the principles of freedom, the principles of human dignity. The existence of religion has been since the dawn of human beings on the surface of this earth. It is the presence of religion that speaks to human character, to human ethics and to human morals. If those that propose religion not stand in the way of the VAD Bill, then let us also cast religion aside from the conversations on truth, justice, freedom, human dignity and honour. It is religion that talks also to that quality of the human conscience, that quality that prevents and curbs the human being from committing injustices and evils within society.

The ACTING CHAIR: Sorry, Your Eminence. At this point in time, I must call the session to a close. We have our next witnesses that we have to get in. We have a very strict timetable to stick to. I apologise for interrupting you, but we must stick to our schedule. I would like to thank all witnesses for their attendance. I do not believe any of you have taken any questions on notice but, if you have, the secretariat will be in contact with you in due course. On behalf of the Committee I thank you all for your attendance today.

Archbishop FISHER: Thank you, Chair, and God bless your deliberations.

(The witnesses withdrew.)

NOCHUM SCHAPIRO, President, Rabbinical Council of NSW, sworn and examined

ANDREW SLOANE, Associate Professor of Old Testament and Christian Thought, Director of Research at Morling College, Baptist Churches of NSW and ACT, affirmed and examined

JOHN McCLEAN, Convenor, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in New South Wales, sworn and examined

JOANNA BARLOW, Member, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in New South Wales, sworn and examined

The ACTING CHAIR: I would like to welcome our next witnesses.

Rabbi SCHAPIRO: I am a rabbi at Chabad North Shore and President of the Rabbinical Council of NSW, so I represent the Orthodox Jewish community, which is basically 80 per cent, you could say, of the Jewish synagogues that I belong to.

The ACTING CHAIR: Thank you very much. Just before we start, I ask all witnesses to keep the microphone nice and close to them for the purpose of not only us hearing but also those that are viewing via the webcast and also for Hansard, so we can get accurate reporting. Do any of the witnesses have an opening statement that they would like to provide?

Reverend Dr McCLEAN: Yes.

Mr SLOANE: Yes.

The ACTING CHAIR: Who would like to go first?

Mr SLOANE: I will lead off. I am the Associate Professor of Old Testament and Christian Thought at Morling College and am here on behalf of the Baptists. I would like to note from the start that our opposition to voluntary assisted dying and the concerns we have arise out of our Christian commitment and what that allows us to see about people in the world. It is also informed by the costly service of vulnerable people that our churches are committed to. That prompts us to see particular things in particular ways, but many others who do not share our faith share those concerns. We have a number of concerns. We are concerned that introducing voluntary assisted dying into the practice of medicine will profoundly distort its fundamental nature and its chief ends. We are concerned about abuses of this law and what we think is almost inevitable bracket creep of the gradual loosening of the current restrictions and the widening of provisions, as has happened in a number of other jurisdictions.

We are deeply concerned about the risks of coercive control and elder abuse, and the abuse and neglect of people with disabilities, all of which are very significant issues in our society at the moment, as recent royal commissions have demonstrated. That is notwithstanding some of the comments made by proponents of this legislation. We are concerned that, while unintentional, this legislation might send deeply problematic messages at a time when mental health resources are under significant strain and veteran suicide is rife. We also perceive deep ironies of resources being directed towards dying in a context where we are dealing with a global pandemic. It seems as though those resources would be much better directed towards community mental health programs and palliative care services, all of which have clear and demonstrable benefits and many of which are not accessible to people who need them the most. With respect, we urge the House to reject the legislation or, if it must take this unwise step, amend it to improve its safeguards. Thank you.

The ACTING CHAIR: Thank you, Mr Sloane. Dr Barlow, do you have an opening statement at all?

Dr BARLOW: Yes. I am very much in agreement with what Mr Sloane was just saying. As a Christian, I do believe in the sanctity of life but I do understand that not everybody has that perspective. My perspectives as a psychiatrist are that I am hoping that this would largely be unnecessary because of good palliative care. Also, my concern is about the danger of abuse. In terms of palliative care, I did work with a palliative care service in Melbourne and found that the majority of patients who requested euthanasia—and I do appreciate that it was hypothetical at the time because they were not able to access it—were able to be helped by actually sitting down with them and going through the concerns that they had, some of which were the potential for ongoing pain. A lot of them were family issues that could well be dealt with. Some of them had significant depression that did benefit from treatment. I think, significantly, a number of those patients said to me afterwards that they were glad that their life had not been taken at that point because, having treated their depression, improved their quality of life, it actually allowed them to enjoy their last weeks of life.

Like Mr Sloane, I am concerned about the danger of abuses. Firstly, we are not very good, as doctors, at predicting the outcomes of terminal illnesses. I can think of one of my friends, who had motor neurone disease and lived for many years past what was predicted—not quite as long as Stephen Hawking, but six years or so. We are concerned about vulnerable people. People with psychiatric disorders are vulnerable people. There is no question about that. Perhaps there is not going to be slippage, as per Oregon. I think there has not been obvious slippage there. But I think there has been a great broadening of criteria overseas. We have seen people with psychiatric problems being given the option of euthanasia there. I think that is a very significant concern for me. As a doctor, I am dedicated to preserving life and relieving suffering. It is a very fundamental, different kind of way of looking at things, to be going down this path.

The ACTING CHAIR: Thank you. Reverend McClean?

Reverend Dr McCLEAN: Thank you. Thanks for the opportunity to speak to the Committee. Thank you to each of the MPs who invest in time, thinking about this important topic. Like the previous two witnesses, I am also speaking out of the Christian tradition, which has had a commitment to the value of human life and is really the origin of the hospice movement, which led to contemporary palliative care treatment. So it is obviously speaking from that perspective. In our society we are committed to preserving human life and caring for those in pain. In most cases, when someone says they wish to end their life, we resist that—and we should. Family and friends, the health professionals, the wider community put our resources into easing their pain, supporting them, helping them to find meaning in life. We do that, in particular cases, with good mental health. We do that more generally with suicide prevention. We recognise that, when someone wants to take their own life, that is a tragedy.

The irony is that voluntary assisted dying legislation would flip that for one set of cases and say that when someone faces terminal illness and their illness causes a suffering that they consider cannot be sufficiently relieved in any other way, at that point and that point alone in our society, we would say we agree with someone's assessment, that ending their life is the best outcome. We would never say that in any other circumstances. But, in this circumstance, we would. Ethically, it would be far better, more caring of us, to commit ourselves to providing all the support and care that we can to help them through that process and to die with dignity. That is, of course, what palliative care does do and has been doing, with greater and greater effect, over the last few decades.

I know that, when you put that position, there is, basically, two responses that people will make. One is that we should recognise people's autonomy and allow them to make their own choices and that, secondly, we are considering people who are facing intolerable pain and discomfort. In reply to those objections, I make two comments: first, that we do not consider that individual autonomy should be the sole deciding factor when anyone else wishes to bring their life to an end. We resist that preference, and we seek to help them cope in other ways. People find life intolerable and they find they are facing unbearable psychic suffering, and we assure them that we will stand with them in their pain, that we will help them through that. The fact that someone is facing a terminal illness does not mean we should offer them something less than that. That would be my in-principle objection to this legislation.

I think legalising voluntary assisted dying will also have two other deleterious effects. One is—this is the point that Mr Sloane has already made—that is distorts medical care, that health care has been committed to the principle of non-malfeasance, expressed in some versions of the Hippocratic oath as abstaining from doing harm. Ending life, even if it is a way of limiting suffering, is not consistent with avoiding harm. Secondly, this legislation helps to normalise and sanction suicide. It says there are circumstances in which it is better to end your own life. That actually subverts our efforts in suicide prevention. I know the legislation is clear that voluntary assisted dying is not counted as suicide at law. But still the message of the legislation conflicts with what we want to say in every other circumstance and risks sending the wrong message to people who are at risk. Thank you for the chance to address the Committee.

The ACTING CHAIR: Thank you. Rabbi?

Rabbi SCHAPIRO: Thank you for having me here today. I agree with a lot of what was said here, most of what was said here. This is certainly a very vexing issue, when we try to consider the pain of a terminally ill patient versus the sanctity of life. There are compelling arguments on both sides. I do not doubt the sincerity and the empathy of the other side of what I will argue. I myself personally experienced a subarachnoid haemorrhage 12 years ago. It was incredibly painful. I was told it is like the greatest pain you could have. Whilst lying in hospital with this incredible pain, I just wanted it to end. Thank God, I was able to overcome the weeks of pain and live what I hope is a productive life for the 12 years since.

Today I am here to present the Jewish position, the Jewish viewpoint. Why is that important? Why is the Jewish viewpoint significant to, let's say, a secular body, such as this esteemed upper House? Two thousand years ago, cradle of civilisation, the Greek, the Roman perspectives on life. In many ways the Greek theories are present within society today in a huge way. Infanticide was the norm. You were criticised if you did not consider it. The Coliseum, where there were gladiator matches to the death. A parent takes their child to a football game today.

There is where they took their children, glorifying murder of people. What changed? How did society become what it is today, where we respect life and where we respect the value of every life? It is not utilitarian. It is not because a society with murder is a society you cannot live in, because that is true 90 per cent of the time, but there are those at the edges of society who the general society might think we can live without.

What changed is the fact that the vision of the *Bible* spread throughout the world. That vision is that man is created in the image of God. Every human being is a part of God on earth and is given a mission: to bring godliness and goodness and light into this world. This has slowly, through the other great religions, taken on—the whole society has begun to see the value of every life. Because of that, we changed in a very positive way and we, society as a whole, value every life. In the same way, we must value every moment of life. There are those who say, "I have gotten everything I could out of life. Life has nothing more to give to me." That is what people say. "And I'm in pain, and I want to end it." That comes from a perspective, that life is about what life gives to me. We view life as a mission.

It is about what I give to life, not what it gives to me. To paraphrase JFK, ask not what your country can do for you; ask what you can do for your country. It is not about what life gives us; it is about what we are here to do and achieve in life. So here our esteemed members in Parliament are achieving a tremendous amount. You are fulfilling one of the seven Noahide Laws—the laws that God gave Noah—for all of humanity, to have a just system of government, to make laws and to treat everyone equally. That is what you are achieving now—a great calling. But this calling does not end when you retire or leave Parliament. It continues as part of the community, as parents, as children and as spouses. It continues in the way you do any other business. We still have a mission and that mission of goodness into the world still exists and continues. And when one is on their deathbed, that mission does not end. It continues with the kind words you say to the nurses or the doctors or your family members, or in putting a coin in a charity box, or ultimately the mission continues in how other people treat you in the palliative care they give. That continues our mission.

And so giving this message is so important. We have youngsters who are suffering mental health issues, especially after this pandemic, because they view life as, "What is in it for me? What am I getting out of life?" And if I am not getting out of life what I think I should, it brings depression and it brings too the terrible suicidal thoughts that we see people have. Having this bill, in a sense, strengthens that attitude. What are we getting out of life? We should give a mission; we should give a perspective and a message. It is not what we get out of life; it is what we are given to do in life. My rabbi, Rabbi Schneerson, would say, "A birthday is God saying to you, you matter." And you matter regardless of your faults, of hardship, of anything that—God created me the way I am and, with all my faults and with all my negatives, I am still here on his mission. And when a youngster thinks in those terms, then, regardless of what happens, he will endeavour to continue that mission. So, in summary, we are each created in the divine image. We each have a mission to bring goodness and godliness into the world and that mission continues until we take our last breath. Thank you.

The Hon. TREVOR KHAN: I will just start with a bit of a quote.

Rabbi SCHAPIRO: A bit of a what, sorry?

The Hon. TREVOR KHAN: A quote, and it is this:

> For those suffering unbearably and coming to the end of their lives, merely knowing that an assisted death is open to them can provide immeasurable comfort.
>
> In refusing dying people the right to die with dignity, we fail to demonstrate the compassion that lies at the heart of Christian values. I pray that politicians, lawmakers and religious leaders have the courage to support the choices terminally ill citizens make in departing Mother Earth. The time to act is now.

That is a quote from Desmond Tutu, which was supported by Lord Carey, the former Anglican Archbishop of Westminster. I understand that you have a different position, but I will ask why are Lord Carey and Desmond Tutu wrong and you are right?

Mr SLOANE: So first a point of language, if you like—compassion speaks not of the content of an action but of the motivation. So saying that something is compassionate speaks of the motives of those who engage in it. Compassion can be well directed or it can be poorly directed. In my view the motivations are honourable motivations to care for suffering people. Those motivations can be misdirected and I would simply say, with respect, that they have mistaken what compassion ought to lead them to do. Compassion—and I think Dr Barlow can speak very clearly to this—directs us to walk with people and sit with people in all the discomfort that that might bring to us as we face our own mortality in their faces rather than, I think, abandoning them, which is, I would suggest, another way of thinking about what voluntary assisted dying is. It is abandoning them to death rather than walking with them through the valley of the shadow of death, if I can put it that way.

Mr DAVID SHOEBRIDGE: So the choice is abandoning them to their pain. That is the choice you have at this point. You cast it the other way, but Desmond Tutu and others, people of faith, say that abandoning people to unbearable pain is not an act of compassion and is misdirected.

Mr SLOANE: I think they are mistaken in that. I think it is also deeply problematic to speak of that as abandoning them to that pain and suffering. Anyone who has ever worked in medical care or palliative care knows that those who walk with people through these last phases of life are doing anything but abandoning them. What they are doing is everything that they can reasonably do to support people to deal with their suffering—yes, their pain but also their suffering—and to do what we can to manage that, recognising that the human condition is such that we cannot escape, it is just impossible to escape, all that we might find unwelcome. Compassion prompts us to be with people in those circumstances and to do what we can to care and support them in that. Abandonment is precisely what it is not.

Reverend Dr McCLEAN: Can I just add briefly in response to the quote. Obviously there are varieties of views of people within—

The Hon. TREVOR KHAN: Of faith.

Reverend Dr McCLEAN: —faith traditions and even in the same faith tradition. But I don't think those quotes, I am confident those quotes don't reflect the classic Judeo-Christian view, which the Rabbi articulated so beautifully. And so really those expressions are minority views within the broad Judeo-Christian tradition, which has been committed to the sanctity of life and the preservation of life. And that has, again as the Rabbi was saying, led to really significant developments within our culture over a long time, as well as the more recent developments of the hospice movement and palliative care, which have sprung from a commitment to wanting to preserve life and comfort people through death.

The Hon. TREVOR KHAN: I suppose what I am left with is this—and I will accept that Desmond Tutu and Lord Carey's position is not the mainstream view but it is a view of people of faith, and indeed, if one looks at polling, for what it is worth, people of all faiths in the Australian context, who identify themselves as of faith, are actually part of a group who are in favour of a law such as this. So in a sense, whilst Desmond Tutu and Lord Carey are in the minority in the way you describe it, actually the majority of people of faith in Australia are in favour of a bill such as this.

How do you deal with that conundrum? Aren't they, in a sense, coming to a reality that we can talk about fighting it through to the end and that people are compassionate around them—and I have no doubt that people are. I watched my own father die badly. But to say as I did, as my father asked me to assist him, "No, I cannot help you. You just have to lie there", leaves me, quite frankly, profoundly conflicted to this day, profoundly conflicted when I saw what he went through. And the evidence that we received on Wednesday was the same. People are—and I do not want to use the term "pain"—suffering extraordinary indignities, whether it be pain, incontinence, inability to walk or inability to lie down without discomfort. Those people are the ones who feel abandoned—abandoned by life.

Reverend Dr McCLEAN: I think there are two questions there. One is how would I respond to the fact that surveys suggest a wide number of people who profess faith would also want to support this kind of legislation?

Mr DAVID SHOEBRIDGE: The majority. The surveys almost uniformly show the majority.

Reverend Dr McCLEAN: Yes.

The ACTING CHAIR: Mr Shoebridge, do not interrupt, please. You will have your turn.

Reverend Dr McCLEAN: Obviously these are the issues that everyone has to arrive at their own conclusions on. I think when we look at the Australian population and those who profess faith, something like 50 per cent of Australians say that they are Christians on the census and about 15 per cent attend a congregation. To think about what are the views of people who have an active faith formed in the Christian tradition, you would really need to look at those who are participating. Certainly, my experience is the vast majority of people in our congregations want me to be here today to say this, but there is obviously a wider spectrum of people with a variety of—the extent to which they have formed in faith. As Dr Sloane said, I think we are all motivated by compassion.

The Hon. TREVOR KHAN: And I am not doubting that.

Reverend Dr McCLEAN: The debate is: What is most compassionate? I desperately hope that nobody is talking about saying to people, "Just lie there and suffer." Palliative care is all about seeking to alleviate that suffering.

The Hon. TREVOR KHAN: Agreed.

Rabbi SCHAPIRO: Can I just first off say something? It is not the first time I will disagree with Desmond Tutu.

The Hon. SCOTT FARLOW: It might not be the last.

The Hon. TREVOR KHAN: Many have.

Rabbi SCHAPIRO: His stance on Israel is one that we vehemently disagree with. I would just echo what was said. Yes, certainly people who claim to be of faith but do not necessarily think through the issues fully, sometimes you just take a superficial view of things. But those who are dealing with it regularly and on a deep level would have, I think, the position that all of us here have presented. I am not a doctor, but my understanding from doctors is that in today's day and age there should be no reason that people should have intense pain. With the palliative care that is available; people should be able to be kept comfortable throughout the end time of their life.

We do not believe that you must do heroic measures to elongate death, but the natural course of life should be played out. We do believe that do not resuscitate [DNR] is possible and things of that nature, although we do not agree to withhold hydration or food or oxygen, but other heroic measures do not necessarily have to be done. We also believe that we can alleviate pain if the intent is to alleviate pain and not to shorten life. Morphine and things of that nature if necessary to alleviate the pain and to keep the patient comfortable is something that we are comfortable with and something that is necessary and something that we should be focusing on. If all this energy was focused on keeping patients at the end of their life comfortable and having meaning and purpose even in those times, we would alleviate a lot of the stress and the difficult statements that others have thought about and made.

The Hon. SCOTT FARLOW: I think Dr Barlow wanted to address—

The ACTING CHAIR: I think Dr Barlow wanted to make a contribution. Please go ahead, Dr Barlow.

Dr BARLOW: I am feeling very sad about your experience, Mr Khan, with your father because that is very sad. Obviously the aim of palliative care is that that is not going to happen. I think where good palliative care is given, it really does, as the Rabbi was saying, minimise almost all pain. I understand that suffering is broader than just pain. People who are short of breath or who are distressed in other ways can be managed with medication, and it may shorten their life but we accept that as a side effect of relieving suffering. I must say, in the vast majority of palliative care patients who I have been involved with, we have been able to alleviate 99 per cent of their pain and most of their suffering. But I take the point that it needs good palliative care and good palliative care is not available in a lot of places in Australia. I commend Mr Perrottet's aims to make that more widely available, particularly in regional areas.

The Hon. TREVOR KHAN: I think we all do, Dr Barlow.

The Hon. ANTHONY D'ADAM: I wanted to draw the panel's attention to the evidence that was provided on Wednesday, particularly by Ms Cathy Barry about her brother Tom, and I do that because for me this is the central conundrum of the debate around this bill. How do we deal with circumstances that were described by Ms Barry? I will read from her evidence about the final weeks. She said:

> He only was able to utter two words that week, one was "help" and the other one was "inhumane".

She describes in graphic detail the end of Mr Barry's life. He had said he wanted them to assist him to end his life. Rabbi Schapiro, you talked about the mission being the mission of life right to the end. I put it to you, and I invite you to respond, what mission was Mr Barry serving at that point in time? He was in a state of inconceivable suffering, pleading for his life to be ended. How can that be judged to be an appropriate mission still being served?

Rabbi SCHAPIRO: As I mentioned earlier, and I will add one more point, the mission then is how he is treated by others. The mission then is the kindness and the palliative care, frankly, that is presented to the suffering patient. That is the mission then—the kindness of all those around us. What is the mission of a child who is born who has no ability to walk and talk and see, as my nephew? My sister has a son who is now in his twenties. He has never been able to walk or talk or see. He has to be fed special foods. She and her husband and her family take care of this young boy. He has no mission of his own, but the love and the care they have for him is incredible, and it is in their greatness in how they cared for him or how they care for him is the purpose of his soul being here.

Then there is one last point. King Solomon says, "The candle of God is the soul of man." The very fact that a part of God is here in this world in the form of a soul in a body brings light to the world, and we cannot snuff that out. That is a divine light in the world greater than any other creature or creation. The human being is the crown jewel of God's creation, and he is part of God on Earth. That light, regardless of what we do or do not do, is always there. That is the mission. Life is full of suffering in all different variations. People who suffer with mental illness have excruciating pain, and they could depict their pain in the most tragic ways that we would all feel empathy and sympathy for them to want to end it. We do not understand all the challenges and difficulties of life; we do not get it. What we do know is that we can make it meaningful regardless.

The Hon. ANTHONY D'ADAM: What of Mr Barry's choice? Does he have no choice in this matter?

Rabbi SCHAPIRO: Giving you the Jewish perspective, the Jewish laws say that if I tell someone to destroy my home or my car or my clothes and they do, they have no responsibility because I gave them permission. But if I tell someone to injure my body and they do, they are not allowed to because I am not in control of my being; I am a custodian of God's soul in my body. I do not have a right to commit suicide and so I just have to utilise my time on earth in the best possible way. But I am not the one who controls my physical body; I am a custodian and I have to make sure that I take care of it to the best of my ability, to make sure it is healthy and taken care of in all kinds of ways, but I do not have a right to hurt it.

The ACTING CHAIR: Mr Farlow, I believe you have some questions.

The Hon. SCOTT FARLOW: I do, thank you, Mr Chair, and thanks to the witnesses. I just wanted to pick up I think it was comments that Reverend McClean made, and, Dr Barlow, I think you commented on it as well, and to take you to comments from Wednesday as well, and this was in response to a question from the Hon. Greg Donnelly by Dr Leaf, who outlined:

> … the international evidence is that pain is about the third or fourth symptom which is responsible for patients in the surveys accessing assisted dying around the world. It is not in the top two or three; in fact, in Oregon it is number four.

I think you both made mention of some of those concerns and challenges. Then Dr Leaf goes on to say:

> In front of that is existential crisis and losing autonomy.

And I think you both made comments about that. Just in terms of the legislation that is before us and the requirements, how do you think that that is addressed in the legislation? If you can speak to that specifically and also perhaps, Dr Barlow, from your medical perspective, your experience with working with patients at the end of life who do have those concerns, particularly about existential crisis and losing autonomy.

Reverend Dr McCLEAN: Thanks for the question. I am trying to think about the specific connections with the legislation; I am not sure how detailed that can be. I understand that the second printing still has there would be a five-day gap between someone indicating—they would need to indicate twice in the space of five days. I am not sure that even five days gives sufficient time for either treatment of possible mental illness, depression and things, but also to come to terms with the existential realities of facing your own death. There is no doubt there is existential angst about that, and we live in a culture where we often live our lives very sheltered from the reality of death and dying, and I think for many of us our own death, that the prospect of our own death when we receive, say, a terminal diagnosis may be the first time that we really have to come to terms with our mortality, and five days is hardly long enough to work that through.

Mr DAVID SHOEBRIDGE: But that is ignoring the long process before that. It is not as though the five days just comes out of the blue; there is a very long process, detailed process, multiple steps before that. If you just look at the five days you are ignoring all of the process before then in the legislation.

Reverend Dr McCLEAN: In the legislation.

Mr DAVID SHOEBRIDGE: I am asking you to address that because you have missed that in your response.

The Hon. GREG DONNELLY: Can I just indicate, through you, Chair, that the issue of what has just been said about the provisions of the bill in terms of what has just been discussed, if you are not familiar with it there is a capacity to take a question on notice and familiarise yourself with the provisions of the bill before you answer.

Mr DAVID SHOEBRIDGE: But I was asking this witness, not you, Greg.

The ACTING CHAIR: Please feel free to answer in your own way.

Reverend Dr McCLEAN: I think the principle of what I am saying I still want to assert. Granted there is a longer process that extends for several more days, Mr Farlow mentioned about those existential issues being primary issues that might lead someone to seek voluntary assisted dying, I still do not think that the legislation is particularly allowing for the time that might be taken for someone to work through that.

Mr SLOANE: Correct me if I am wrong, I do not believe the legislation makes specific mention of providing people with opportunities to deal with those existential issues. That is not something that is always in the forefront of a busy doctor's mind. In fact, if you look at the pressures particularly on general practice, dealing with fundamental personal and social questions is something that often GPs would like to do and they do not have the time to do it. So the very notion that just giving someone time will allow them to deal with those existential issues I think is naive when there is no provision in the legislation to specifically prompt those kinds of questions. If the legislation is seeking to deal with questions of suffering of an existential nature then it seems worthwhile specifically identifying those existential needs as being addressed in that period of decision-making.

Dr BARLOW: I am not sure that either the coordinating physician or the consulting physician necessarily would be addressing those issues because I do not think there is a requirement in the bill, that I have read, to do that. Obviously, doctors vary in terms of their degree of competence and their degree of interest, and particularly looking at mental health sort of things, and I think it is very important to tease out those existential issues. I do not put my Christian views to patients, saying that that is how they have to think. I want to find out where they are coming from and what their background is and what they think is important, what their values are and so on. That is a concern that I have, that it is not part of the legislation, that there is no opportunity for that necessarily to happen. Thank you for that question.

The ACTING CHAIR: Thank you. I note the time, but for one last question I will give the call to Mr Shoebridge.

Mr DAVID SHOEBRIDGE: Thanks, Chair. In two of the submissions that you have put today, and multiple other submissions and in your presentation, the argument is there is some binary between voluntary assisted dying and palliative care. But I would ask you to reflect upon, and if you have any views about, the core principles in this legislation, one of which is in 4 (1) (d), which says, "a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life", and it is then reflected in multiple provisions in the bill, the primacy of palliative care, not least 28 (1) (c) that gives an unambiguous obligation on the coordinating practitioner to advise patients of the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment. Why do you say that they are inadequate, those repeated assertions of the benefits of palliative care and the palliative care provisions in the bill?

The ACTING CHAIR: Just before you answer, I draw your attention to the fact that the question was quite specific in relation to technical parts of the bill and certain sections and I assume you do not have the bill in front of you. You are more than welcome, and I invite you, to answer if you feel competent enough, but if you wish to take the question on notice so you can examine the bill closely and provide an answer at a later time please avail yourself of that as well.

Reverend Dr McCLEAN: Whereas the people around me might want to take the question on notice, I am happy to say something.

The ACTING CHAIR: Certainly. Go ahead.

Reverend Dr McCLEAN: First of all to say I am not and the Presbyterian Church is not critical of those elements of the bill. In terms of a bill that, in principle, we are opposed to, those specific provisions I think are commendable. One of the good things, I think, about this debate is that it has led to a greater recognition within the wider community and more discussion about the importance of palliative care and, as an outcome from that, that is a good outcome. I think lots of us in the room can agree around that. So my comment would be not on those particular provisions, of which, as I say, I am not critical, but the broader ethical framework that informs the whole decision, and that goes back to what I was saying earlier, that in every other case in our culture and in our society we want to persuade people that seeking the end of their own life is not the best outcome. And yet here, at the point where the thing that has changed is people have a terminal illness and have suffering related to that, we are saying that could be a good outcome, whereas for any other form of suffering we would say, "No, there are other solutions. There are other ways of getting through this." So I think there are two different ethical frameworks that inform that, but I am not critical of those particular provisions in the bill.

The ACTING CHAIR: I note the time. On behalf of the rest of the Committee, I thank all four of you for your attendance today and for your evidence. I do not believe you took any questions.

Reverend Dr McCLEAN: I do not think anyone did, no.

The ACTING CHAIR: But if you did, the secretariat will be in contact with you in due course.

(The witnesses withdrew.)

(Short adjournment)

GREG SMITH, Former New South Wales Attorney General, Minister for Justice and member for Epping, sworn and examined

PAUL SANTAMARIA, Barrister, Owen Dixon Chambers, before the Committee via videoconference, sworn and examined

The ACTING CHAIR: I welcome everybody back to the Standing Committee on Law and Justice inquiry into the provisions of the Voluntary Assisted Dying Bill 2021. I welcome our next witnesses. Mr Smith, do you have an opening statement that you would like to give to us?

Mr SMITH: Yes, I do. I should have also said I am still a practising barrister.

The ACTING CHAIR: That is fine.

The Hon. SCOTT FARLOW: Before Mr Smith starts, I should declare a conflict of interest. For the record, I formerly worked for Mr Smith some years ago.

Mr SMITH: At Epping, yes. Thank you—and he worked well.

The ACTING CHAIR: That is duly noted.

Mr SMITH: I support the right to life for the fit and unfit, vulnerable, unborn and aged, demented and clear minded. I refer to Justice Brennan's statement in Marion's case, which is mentioned in my submission:

> The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled.

Those are matters that drive me and have always driven me. It gives my opposition to this bill more force having those beliefs. Also that opposition has been reinforced by personal tragedies of suicide that affected me and my family. Firstly, a young man—I managed him as part of the cricket team. He was a good mate of my son's. He had a major depression—this was a few years later—and family members had to keep a watch on him all the time. He escaped and sneaked out, went to the local railway station and jumped in front of a train, which killed him. That had an enormous impact on the family who were involved, and the train driver and his family, and other people who were on the train as well. What a tragedy that a young man, otherwise brilliant scholastically and healthy, had this problem with depression, which seemed to be hard to cure.

Another young man who was a friend of my daughter's had a promising career ahead of him as a podiatrist. But it took him time to get established. It was hard. Like when everyone starts, it is hard. He disappeared one day in the family car. They thought he had gone shopping at the Macquarie Centre. A whole lot of us went round that area looking for his car—the family car—which was not found. It was found outside a motel up at Terrigal, where he had booked a room. With a large quantity of poisonous material and whiskey he had killed himself because he was depressed about his business not going well. I went to both the requiem masses for those two young men and they were very sad affairs, I can tell you.

I have been present at beautiful deaths, if you can call them that, where the family have been all around in the hospital, praying with the patient who was dying and on painkillers, morphine and other things as part of the palliative process. We were praying for him as he left this world. That was a beautiful occasion. He was very happy about it. That keeps the family together. The family know that that man died honourably. Imagine a family who are not even religious and who do not even know, as this bill would allow, that one of their loved ones had been killed by a doctor who he did not know before as well. The grief that they must feel because they were not given a chance to grieve with him before his death—he or she just took their life away thanks to this legislation. They are things that I have seen and experienced, and many other people who I know have had similar experiences and want to change things.

We have currently got a royal commission into soldiers and other military who have killed themselves. Why are they doing this? We are saying this is a terrible problem. We have had the same situation with the deaths by suicide of young people with depression, and we are trying to work out ways to stop it. Yet here we are passing legislation—it has passed one House and, please God, will not pass the other—looking at a bill that will allow people to be killed or to kill themselves. What impact will that have on other people they know and other people who are in similar positions who want to hang on but feel guilty because they are spending the money—the family treasure, as it were—and others are keen to get it?

I gave evidence on behalf of the Australian Right to Life federation at Darwin at the Parliament House on 29 March 1995 against the Rights of the Terminally Bill, which was passed by one vote. I opposed that bill because, among other reasons, it was poorly drafted and dangerous. There is a report in *The Lancet* that was attached to my submission by Dr Kissane and Dr Nitschke reporting seven deaths in Darwin, four of whom were people who had undetected depression and so would not have been eligible to use the powers of that Act. But because they were not properly screened by Dr Philip Nitschke—who was then very much on his bandwagon pushing euthanasia everywhere, including the Northern Territory—they died invalidly, in a sense. They were not following the law. That is a paper I suggest you read because it suggests that in this bill there does not have to be any analysis of the person's mental state. There may be but it is not necessary that you be shown as not having depression. Even if you have depression, they might say, "That's all right."

In a case this century involving Dr Nitschke as a witness, which is referred to in my submission as well, the de facto wife and a friend helped the victim kill himself. He was found by Dr Nitschke to be confused in his mind but he still recommended Dignitas, the Swiss euthanasia group, and that he should get euthanasia. They knocked him back because they said, "If he has got this mental illness and he has got dementia, we will not do it." But the family still went ahead. They knew that. They made the decision to kill him, and they benefited. The wife and two daughters benefited from his estate, and his death was hurried up because of that. That is part of the problem with euthanasia. When you give people the power, it might be a relative who is pushing, coercing, as it were, undetectably this thing, and it is not covered by the safeguards. When the draftsman of this bill or the sponsor of it, the main sponsor, says it has got lots of safeguards, it has not got any really.

I was present at a protest against Dr Philip Nitschke at the Sydney YMCA when he demonstrated his so-called COGen machine, which was killing people by carbon monoxide poisoning. That was one of his ideas. Mr Kep Enderby, former judge of the Supreme Court, former Federal Attorney-General, was there and came out to try to quieten us down. He was also president of the Voluntary Euthanasia Society of NSW, as I understand it. He was very much involved in all this. He was entitled to have that view, but I happened to be there in the Deputy DPP's office, which I occupied when Nicholas Cowdery, a witness for the bill, was away. I had a call from Mr Kep Enderby, and when I told him who I was and that I had been the president of the Right to Life association, he did not want to talk to me about the matter that he wanted to talk to Nick about. I was in charge but he did not want to talk to me now.

People use friends in high places to influence decisions. There were cases at that time where a husband had been charged with assisting the suicide of his wife and got quite a light penalty, and the Crown did not appeal. So that is Dr Nitschke again haunting society and, in effect, he put back your cause—the euthanasia cause I mean—for some years because he came across as such a crazy man. There are other reasons—many reasons—why I oppose the legislation. I do not believe the consent provisions are satisfactory. This statement the other day by the president of Dying With Dignity NSW that the clause there on consent was okay, where it shifted the onus onto people saying this person was not able to consent, who was not suited, physically or mentally able to give the consent, and making out that is the general situation—well, is it the general situation with young women who are sexually assaulted or who complain to the police about lack of consent and all that? Because they are changing the law to tighten all that up.

Why should the law be loosened to cover people who want assisted dying when it is a life you are dealing with and the right to life is being interfered with? I say the consent provisions should have requirements that the person be of clear mind and have had full discussion and understanding of the decision, and satisfy the doctors, including their own doctor, who should be involved in any such decision, before they get the procedure. That is all I have to say. I have gone for long enough probably.

The ACTING CHAIR: Thank you. Mr Santamaria, do you have an opening statement?

Mr SANTAMARIA: Yes, thanks very much, Mr Chairman. I am in my chambers in Melbourne. It is another beautiful sunny day in Melbourne, as always. Of my 40 years in active legal practice, I have been a member of Victorian and New South Wales bars for about 38-odd years. I am not an academic lawyer and I am not a lawyer who is an academic. My practice as a lawyer does not allow me to theorise or speculate. I am at the coalface of engagement in the resolution of real disputes and, on an almost daily basis, I see the best and the worst of human conduct, and much in between. Much of that is in the area of probate and administration. I have a pretty extensive practice as a mediator of both commercial and non-commercial disputes, particularly involving disputes within families about entitlements, distributions under wills, disputes about what the best arrangements are for the care of elderly parents and so on.

I have been involved in several community activities away from the law, for several years as chair of the National Archives Advisory Council. I sat on the board of a community-based palliative care service in Melbourne known as Eastern Palliative Care. In fact, for a time I sat on the ethics committee of that body and so became, in that involvement, quite interested in matters of end-of-life care and decent palliative care successfully introduced into Melbourne—a palliative care option for those sick and dying who wish to be cared for at home in their family surroundings of home-based palliative care. Because of that involvement, I have given advice to healthcare bodies, aged-care services about all manner of things which arise, particularly as legislation develops in this area, as it will as the population continues to age. Those involvements give me some insight into the very real challenges which are encountered on a daily basis in these institutions.

I want to add how fortunate we are in Australia to have such an excellent health system, wonderful dedicated GPs, specialists and, most importantly, a nursing profession that sometimes gets less gratitude and recognition than is deserved. I can say from my involvement in home-based palliative care, I want those nurses looking after me. Why does a Victorian have any interest in what is happening in New South Wales? I should explain that my interest arose when I read a piece that was circulated to parliamentarians by Nick Cowdery, QC. Nick is a distinguished New South Wales prosecutor, as I acknowledge in my paper. His opinion is certainly not to be dismissed. But what I did was address the remarks that Nick Cowdery made in his paper, and I attached his paper to my own submission. So I would like you, if you have the opportunity, to read my remarks about Nick's paper.

But I think if I can suggest one point of principle which is shared by both proponents and opponents of this bill, it is that a bill of this nature must ensure that, amongst other qualifications, a person apparently requesting access to VAD is both acting voluntarily and not acting because of pressure or duress. It is implicit in the drafting of this bill that a VAD death, in circumstances where a person may be shown to be acting involuntarily or is acting because of pressure or duress, will be unacceptable to the Parliament of New South Wales and indeed to the wider community. None of the proponents of the bill would advocate, I am sure, or indeed could advocate that these fundamental principles are not needed. That is because, without them, there is likely to be the unlawful taking of life, which is what we used to call homicide. I think we all agree about those principles. The bill is unambiguously clear about that—so far, so good.

The question then becomes: How does the bill serve to implement these fundamental principles? The lower House has told us, and the proponents advocate, that the bill is replete with safeguards. In Victoria the recently retired chair of the review board, Betty King—another highly regarded lawyer and member of the Victorian bar— speaks proudly of the 68 safeguards in the Victorian bill, if you read the reports produced by the review board. So I would ask the Committee to question whether the safeguards are satisfactory and to see how they stand up. I do not think they do, and this is because no safeguard is effective unless the circumstances can be empirically tested. There is no point having road laws unless a driver's breach of them would be detected. There is no point telling our young members of the community not to use their mobile phones when driving unless there is a real possibility of detection and that the penalties for breach are onerous.

The risk scenarios identified in this bill, unsurprisingly, principally involve members of the patient's own family. In some other VAD Acts in other States they also identify aged-care service providers as being people that one has to make special provision for. The third category are medical practitioners who are of the family or practitioners who are outside the patient's family who believe they will benefit under the will et cetera, et cetera. When you look at the bill, it is replete with these disqualifications. For example, the patient's declaration of an intention to proceed has got to be witnessed, members of the family cannot do that, so on and so on, if they are a beneficiary under the will.

Throughout this bill, it does look like the most likely source of abuse and exploitation has been addressed, but one has to evaluate whether that is so and whether these safeguards can be worked around. Of course, they can be worked around. The workarounds by the unscrupulous are obvious. In all of those situations where the bill drives the need for someone out of the family to witness, to give consent—the status of a lawful consent—you just get someone else. You get someone outside the family. You get a friend, a neighbour. You can drive a truck through the safeguards. There is nothing that the review board will ever know which will ever appear on a form submitted to the review board which draws the board's attention to an unlawful consent. That, to me, is a fundamental problem with this bill as drafted. Whether a different bill can be drafted, I do not know; one always has to see the bill and not theorise or speculate. But this bill does not do the trick.

The proponents of the bill will likely say that someone will get caught; they are liable to criminal prosecution. The prospects of detection under this bill as drafted, I would suggest, are zilch. Even if some hapless member of the family was prosecuted, the get-out-of-jail card is, "Look, I acted in good faith. I just wanted to put mum or dad out of their pain and misery. I acted out of the best motives." What Nick Cowdery would have to do as prosecutor is to prove that that declaration is false. Acting for a defendant, an accused, in that situation would, I would suggest, be an easy brief. I wanted to touch upon a point that was raised about Desmond Tutu, Archbishop of Cape Town, which I picked up just as I tuned in this morning. I do not know whether there is time to do that, but can I just say this about that scenario of Desmond Tutu?

The fear about this bill is that it actually is discriminatory and unintentionally so. The way in which it discriminates, I think, is this—and this is not an ideological or religious objection; that is not my bag. My bag is a forensic legal analysis of the bill. But I do distinguish between ideological, religious on the one hand, and philosophical objections on the other hand; they are not always the same. Here, proponents of the bill have said, "Look, this slippery slope argument, it is rubbish," et cetera. But the eligibility criteria under this bill are discriminatory, because on what philosophical basis can the community refuse a voluntary assisted death to a person who has had dementia for many years, otherwise physically healthy but who cannot recognise their own children? How distressing it is for the family to go to the relative and see this? It is so sad. It is distressing. But they are not eligible for VAD because they are not dying and they are not in pain; they have to stick it out, so to speak.

In fact, I think Mr Khan used the expression this morning, "I cannot help you. You just have to lie there. You might think I'm abandoning you, but I'm not." Of course, no-one is abandoning them at all, but they are not entitled to VAD and I do not see how, if I were a legislator, I could actually defend this bill, defend the entitlement for the sick and dying to access the bill but deny it to the person who is suffering from dementia. If the Committee is able to explain a philosophical basis of the distinction, my hat goes off to you.

The Hon. TREVOR KHAN: Happy to, Mr Santamaria.

Mr SANTAMARIA: Very good. One of the younger members of the community, paralysed as a result of a sporting engagement—a friend of my daughter, a quadriplegic as a result of falling off a horse; those who are involved in industrial or car accidents—if for them life was intolerable, and that is a frequently expressed view, on what philosophical basis as a community can we tell them, "Sorry, we feel for you but you will have to stick it out because you don't qualify for VAD. We understand that your life is, in your eyes, worth less—not in our eyes but your eyes—and it is your right, so it is said, to determine your own future."? I am very interested to hear how the Committee justifies the different approach for those people because I cannot see how, ultimately, we can say no to those people.

The ACTING CHAIR: Thank you, Mr Santamaria. I will now open it up for questions.

The Hon. SCOTT FARLOW: Thank you, Mr Smith and Mr Santamaria, for both your submissions and your attendance here today. I put this question to the Bar Association in the last inquiry, which was with respect to proposed section 41C in the bill—and it is one of the amendments; I think it is in schedule 1, actually, and it is an amendment in the Crimes Act, I believe—as to inducing another person to request to access voluntary assisted dying. This goes to the heart of duress and coercion. I asked them the question and I will ask you the same: Do you believe that that covers the total gambit of areas where duress could effectively be placed upon an individual and that that provision is sufficient to protect individuals from duress or coercion under this bill?

Mr SMITH: What provision was it again?

The Hon. SCOTT FARLOW: Section 41C. Apologies; I think it is on page 111 of the bill. I am quite wrong on that. It is on page 77 if you have the second print. This was one of the amendments made in the Legislative Assembly in the debate.

Mr SMITH: And it was an amendment to 41—

Mr SANTAMARIA: Yes, I have that in front of me.

The Hon. SCOTT FARLOW: Mr Santamaria, did you want to perhaps start? I might provide Mr Smith with a copy of that to assist him.

Mr DAVID SHOEBRIDGE: Which section was it, Scott?

The Hon. SCOTT FARLOW: Section 41C on page 77.

Mr SANTAMARIA: Are you waiting for me?

The Hon. SCOTT FARLOW: Yes, Mr Santamaria. If you wanted to start, you are welcome to.

Mr SANTAMARIA: Yes, okay. Well, my immediate response to that is: How will the person who has, by dishonesty, pressure or duress, induced another person to make that request ever be detected?

Mr DAVID SHOEBRIDGE: How is any dishonesty offence detected? Why is that different to a whole raft of dishonesty offences in the Crimes Act?

Mr SANTAMARIA: No, not at all. Not at all.

Mr DAVID SHOEBRIDGE: "Not at all" is not an answer.

Mr SMITH: Usually there is money lost and the money trail is traced, and it points to someone doing something dishonest in putting in a document claim for money or something like that. So far as this is concerned, you can prove things if you have telephone intercepts or something like that, which is highly unlikely—

The Hon. TREVOR KHAN: Or the patient actually discloses to their doctor in the course of the process that one of their relatives or somebody else has leant on them. That is the obvious way in which it is disclosed.

Mr SMITH: Yes.

The Hon. TREVOR KHAN: And that is the risk that any perpetrator would be exposed to, would they not?

Mr SMITH: Do you think that the doctor is likely to report that person, particularly if the doctor does a lot of euthanasia or voluntary assisted dying work?

The Hon. TREVOR KHAN: Is that your answer?

Mr SMITH: Yes.

Mr DAVID SHOEBRIDGE: So the assumption is an unethical medical profession dealing with this? That is the assumption in your evidence?

Mr SMITH: There are cases where there are unethical doctors that carry on medical procedures such as abortion and such as euthanasia where they are beneficiaries under the will themselves. There is that famous English case where somebody killed 214 patients and he was a beneficiary of the will in about 150 of them. I have had a case like that here in Sydney where a doctor gave a patient a large dose of a drug—insulin, it was. She was not on insulin, but he gave it to her. He stood to gain about $200,000 out of her will. He was charged with that offence and he ultimately beat it at committal, but it was very suspicious that that is why he did it. He was going to get a lot of money.

Mr DAVID SHOEBRIDGE: You talk about document trails; I cannot think of a clearer document trail than the one you have just put in front of us. I ask again: Is your opposition in this regard based upon an assumption that the medical profession, or a significant proportion of it, will operate with self-interested lack of integrity?

Mr SMITH: For a start, it is against medical ethics for someone to kill their patient currently. There is no proposal amongst the World Health Organization or the Australian Medical Association to change that. Someone that goes over the bridge and starts acting professionally as a euthanasia giver is, prima facie, a suspicious person. If they are doing that they are not that honest, because they are not following their own medical ethics. That is an issue as to why, in this bill and all the other bills, it has to be a doctor that kills the patient. Why pervert the medical profession?

Mr DAVID SHOEBRIDGE: So I take it the answer is "yes" to my question?

Mr SMITH: No, you can take it as much as you like. That is not the answer. The answer is what I gave.

The Hon. SCOTT FARLOW: Mr Smith, just following on from your comments, I note that on page 14 of your submission you talk about coercion being hard to detect.

Mr SMITH: It is very hard to detect.

The Hon. SCOTT FARLOW: You talk about some of the—based on the New Zealand legislation. I quote:

> The Royal College of Anaesthetists, too, highlights the subtle coercion that may be placed on a patient, in pain, confused and vulnerable. And it worries how a doctor can spot that coercion.

Do you think that section 41C as it is enacted there could actually spot that subtle coercion that the Royal College of Anaesthetists, in the New Zealand experience, had concerns about?

Mr SMITH: I very much doubt it.

The Hon. SCOTT FARLOW: Thank you. Mr Santamaria, did you have any further comment on that? I think you were talking about that subtle coercion as well.

Mr SANTAMARIA: There is no prospect of the subtle coercion being seen, and that was really the thrust of my submission. But I think one of the Committee asked Mr Smith a question about the medical profession and whether one was casting aspersions about the medical profession; I thought I had made it clear that that was the opposite of what I was saying. But in the same way as I would like to think that most barristers are ethical at all times, the record shows that they are not. I would like to think that most parliamentarians are ethical, but ICAC proceedings in New South Wales would suggest, unfortunately, that they are not. There are a small number of practitioners who, I regret to say, are driven by either ideological reasons or financial reasons. That is why this bill focuses upon medical practitioners, with family members, as being the most obvious risk category. It is the Parliament which has recognised that—not me, not Mr Smith, but the Parliament. That is why special provision is made to exclude medical practitioners.

If there were no issue about medical practitioners, there would be no need for that provision in the bill. But, like it or not, the bill must make special provision for those who are involved in the active engagement of the death. The difficulty with the bill and other VAD legislation is that it sort of privatises death so that the opportunities of detecting breach—which, after all, are going to result in the death of a patient; no small thing—are unlikely to be detected. When you talk about form filling, the function of the review board under this bill is the same as in Victoria. It has no investigative role; it just checks the paperwork. If you look at the data in Victoria about the number of people who have been assessed as eligible and compare it to those assessed as ineligible, the paperwork shows that less than 1 per cent are ineligible. What does that say? So I go back to that 41C and say to you, if I may—sorry to delay you. I had that page. Did you say it was page 77?

The Hon. SCOTT FARLOW: Page 77, yes.

Mr SANTAMARIA: Can I just have a quick glance at that? I think it is a point well worth making. This amendment is designed to bolster the safeguards, clearly, and the Parliament, in my view, is to be commended whenever it bolsters safeguards. But when you are involved in the practice of law applied in this context, I think you will see that the prospects of detection of a crime are actually quite remote. It would require—was it Mr Khan, I do not know who said it—the witness speaking up.

The Hon. TREVOR KHAN: It was probably me.

Mr SANTAMARIA: I'm sorry. It's hard for me to see.

The Hon. TREVOR KHAN: No, that's alright. I'm a good culprit to identify.

Mr SANTAMARIA: I was about to say "who's who in the zoo?" and I thought, "That may not be appropriate." The truth is that the doctor who comes to the first assessment, the consultative, and then the coordinating—sorry, the first consultative. They arrive at the bedside. They may never have seen this patient before. They know nothing of the family dynamic. They are not required to consult the patient's own GP. They are not even required to notify the patient's GP of the process being undertaken. I think all of us know that the role of the GP in patient care is absolutely at the top of the tree. What this legislation does not do and, I think, at the very least ought to do is to mandate that the consulting and coordinating doctors have engaged with the patient's own GP. That is a real safeguard because they are likely to find out whether in fact it is a situation of potential duress, dishonesty or pressure. Section 41C, in my view, looks great. But it is essentially cosmetic.

The ACTING CHAIR: Thank you. At that juncture I might draw everybody's attention to the time. I would like to thank our witnesses for their attendance today and their submissions. I do not believe you have taken anything on notice. But, if you have, the secretariat will be in contact with you in due course. Once again on behalf of the Committee I thank you for your attendance today.

Mr SANTAMARIA: Mr Chair, I would like to ask for the ability to provide the data from Victoria, if I could, just by way of supplementary submission, because I think it is useful to see.

Mr DAVID SHOEBRIDGE: I will tell you what. I will ask if you could, on notice, provide the data from Victoria. You can take that on notice.

Mr SANTAMARIA: Thank you very much.

(The witnesses withdrew.)

MICHAEL McAULEY, President, St Thomas More Society, sworn and examined

JOHN OBEID, Consultant Physician and Geriatrician, affirmed and examined

FRANK BRENNAN, Palliative Care Physician, St George and Calvary Hospitals Sydney, and Senior Lecturer, University of NSW, sworn and examined

EUGENE MOYLAN, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, affirmed and examined

The ACTING CHAIR: Thank you, gentlemen. Just for the record and before we start, I would just like to make a disclosure that Mr McAuley represented me some 20 years. He probably does not remember me as a particular client.

Mr McAULEY: Cannot say. And I suggest you do not tell anyone why I was representing you, because I cannot remember.

The ACTING CHAIR: Suffice to say we were not in the criminal jurisdiction. That is all we need to make—just for the purpose of the record I would like to disclose that. That is all.

The Hon. TREVOR KHAN: You protested too much.

Dr BRENNAN: But thanks for confirming that, Chair.

The ACTING CHAIR: Gentlemen, I assume you have an opening statement. I might start with you first, Dr Moylan.

Dr MOYLAN: Thank you for the opportunity to participate in this inquiry. I am a senior staff specialist in medical oncology and the director of the cancer therapy centre at Liverpool Hospital. I have been a medical oncologist for the last 35 years. In my experience, most people do not want to die and requests for euthanasia are infrequent. Requests for euthanasia, in my experience, most often occur at a time when symptom control and suffering are at a peak. They are seldom voiced or repeated when triggering symptoms have been controlled. Requests for euthanasia are also more likely to occur when life appears to have lost its meaning and also in people who feel socially isolated or a burden on others. The request for euthanasia mostly occurs within the last few weeks of life. However, when the patient is compassionately made aware that their life expectancy is short, the desire for euthanasia diminishes. Providing good symptom control, psychological and spiritual support meaningfully addresses the desire for euthanasia in patients that are socially isolated or suffering existential angst.

In my submission I indicate two major causes for concern with the proposed legislation: errors in diagnosis and errors in prognosis. It is clear that, despite their best intentions, doctors make mistakes and thus euthanasia could be performed under a false premise. Once or twice each year during my career, I have been referred patients that have been told that they have metastatic cancer, based on diagnostic reports from experienced doctors. Further investigations have revealed that these changes have been due to the presence of treatable conditions masquerading as metastatic cancer. This can occur in patients previously diagnosed with malignancy but also in individuals with no prior history of cancer.

The Voluntary Assisted Dying Bill 2021 presupposes that two experienced doctors will always get the diagnosis correct. There is no onus placed on the coordinating practitioner to accept the opinion of a dissenting specialist regarding either the diagnosis or prognosis. Of concern, a coordinating doctor does not need to have been the patient's treating doctor. In my experience, it is not uncommon for medical error to occur when anchoring bias leads doctors to accept clinical diagnoses and diagnostic reports indicating the presence of advanced cancer. There is no clause within the proposed legislation—that a post-mortem examination be performed following the patient's death. This assumes that doctors will get the diagnosis right every time and there is nothing to be learned from a person's death.

The Voluntary Assisted Dying Bill 2021 assumes that doctors can reliably and accurately predict life expectancy for cancer patients within a six-month time frame. That is patently incorrect. As an experienced cancer specialist, I can almost always predict when someone is within the last few days of life and usually identify when someone is within the last three to six weeks of life. It is, however, very difficult to accurately predict who is likely to die within the next six months. It is my belief that, if the bill is passed, incorrect prognostication will ultimately mean that people will be assisted to die that may have lived significantly longer than might have been anticipated. I believe that our laws need to protect the vulnerable for the benefit of society as a whole even when they go against popular opinion. Medical professionals need to adhere to the dictum "first do no harm". We need to substantially increase our palliative care services to ease the burden on individuals with terminal illness and their families. We need to maintain the role of medical practitioners as healers, not as agents of voluntary assisted dying.

The ACTING CHAIR: Thank you. Dr Brennan.

Dr BRENNAN: Thank you, Chair, and I appreciate the invitation to speak here. I am a palliative care physician based in Sydney and I shall commence by quoting clause 4 (1) (d) of the second print of the bill. The subclause states:

> … a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life …

Precisely. This debate commences with the response to the suffering of people with serious illnesses. Both those who agree and disagree with this bill start at this point of departure. One clear and obvious point of entry into that response to what I have just said are the following lines of inquiry. What happens now in palliative care, geriatric medicine and elsewhere in the response to the suffering of patients and, second, how can this be improved? At a public policy level, how can they best be funded? At a professional level, how can we within medicine better educate our medical students and junior doctors in these skills? Respectfully, members of the Committee, I feel we are having the wrong debate. Let us return at another time to have the VAD debate when we have secured improved, funded and universal access to palliative care. There is not enough of us and not enough settings. Before the legal debate, we should be having a medical debate.

A 68-year-old woman with metastatic breast cancer asks you, her doctor, that she has had enough and wants to end it all. What will you do? Let me tell the Committee what I do now. I sit and ask the most basic questions. Why? What troubles you most? What do you fear—pain now or later, fear of being a burden to my family, loss of dignity, seeing grief in their eyes. I do not rush to answers for there are no easy answers. I allow that river of suffering to flow to a point of calm. I sit with that patient in that suffering. What follows in that calm is my reassurance about what may be possible in terms of care, not only for his or her body but for their spirit as well. In palliative care this is a moment of revelation—an opening up, a beginning but not an end. In my experience, once genuinely heard and reassured, the request to finish life is rarely repeated. That response is completely different to the VAD Bill.

So while both sides of the VAD debate start at this point of departure, their destinations are completely different. The response is different and it cannot help but be. At least in part this comes to the difference between law and medicine. Law—including this bill—aims for precision. Medicine, on the other hand, operates in a landscape of uncertainty. The VAD Bill strains to achieve certainty in language and effect. The bill seeks, but medicine cannot guarantee or provide, such precision. There are inherent uncertainties in each of the major elements of eligibility—prognostication, the assessment of decision-making capacity, including screening for depression, and the possibility of pressure or duress. As physicians we know that we cannot be certain about these issues.

There is therefore an inherent tension at the centre of any VAD bill. For statutory law is entering a domain that is already challenging and mysterious—the profoundly human experience of becoming seriously ill, balancing hope and realism, enduring and hopefully overcoming symptoms, facing one's own mortality, gazing with penetrating eyes at the meaning of your life, comforting and being comforted. No law can use this language and yet that is the reality of our work as physicians—discussion, negotiation, compromise. And there lies the rub. Law grapples earnestly with this area and seeks to marshal multiple safeguards in the bill but, by having as its destination the planned premature death of a person, the law ventures into uncertain medical terrain—the vagaries of human nature and the extraordinarily complex nature of interpersonal relationships. No law can perfectly capture this reality—of minds made up and then changed, of the ebb and flow of the human spirit, despairing now, content a day or so later, of a selfless impulse in some to ease the burden on one's family, of a lifetime habit in others of acquiescing to the suggestion, even unspoken, of a dominant relative.

I wish to turn briefly to the specific provisions in the bill stating that the VAD decision is ineligible if it is made on the basis of pressure or duress. In reality there is a spectrum from one end to the other, where there is one end where there is absolutely no pressure, all the way through to where there is an unequivocally clear pressure or duress. But between these points there are shades of subtle pressures or influences that do not meet the statutory bar—sub-statutory, if you like—but nevertheless influence people's decision-making. These influences may be overt—an adult child saying to her mother of VAD, "Perhaps, Mum, it would be for the best"—to covert influences, like sensing that your family feel that you are living too long, fearing you are becoming a burden to your family, seeing others choosing VAD so perhaps I should use the same and also choosing VAD because of a lack of adequate medical or palliative care.

Each of these influences or subtle pressures may exist in the context of a vulnerable person. It is the combination of these influences on a vulnerable person that is concerning. "I am frail. I am a burden to others.

I am not worthy." And what a tragedy—what a failure of public policy—if patients choose VAD because of a lack of a palliative care service. This is where the medicine and law intersect. In the bill, one of the criteria of eligibility is the "disease, illness or medical condition … is causing suffering to the person that cannot be relieved in a way the person considers tolerable".

In reality, this is often the precise point that palliative care enters, or should enter, the scene now. And it does so to bring hopefully a powerful and forensic approach to these issues and their management, attentive to an understanding of the rhythms of both the disease and the human heart. Instead, under the bill the eligible person embarks on an altogether different journey. Process dominates. Seeing a palliative care physician is optional. The patient decides on the point when things are intolerable but that decision may never have been informed by any actual experience of receiving palliative care. The bill places into the patient's hands the ability to commence a process that may lead them to a premature death where that patient has not engaged with the very medical experts who could deal with, or try to assuage or comfort, the reasons they sought this process in the first place.

One of the myths in this debate is that palliative care is powerless to assist patients who are intractably burdened by symptoms or anguish. Although all disciplines have their limitations, palliative care possesses several critical strengths—firstly, a forensic interest in symptoms and a tireless creative pursuit of treatment that may work in any individual patient and, secondly, a belief in an application of the principle of non-abandonment. At precisely the moment medicine may say, "I am sorry. There is nothing more I can do," palliative care steps in, engages intensely with the person who is suffering and aims to support them throughout their illness until their death. Loss, despair, loneliness, feeling one is a burden—the profound and complex communication skills of a clinician in the face of this suffering broadens medicine from the purely technical to the deeply personal.

Let us talk about process. Some years ago I was in Canada. It was months after the Supreme Court judgement and there was a series of provincial legislations coming through on this topic. I was with a group of palliative care physicians; we met some of our colleagues in Canada. One told a story. Recently, she said, a junior doctor was asked to see an elderly woman with cancer. In pain, she said to the junior doctor, "I am not sure how long I can keep going on like this." "Oh," he said immediately, "the law has changed. You do not need to. I will go and get the papers. We can start the process now."

Soon after, the nurses rang the senior palliative care doctor about the pain and she advised a change in the patient's regimen of analgesia. Both the senior and junior doctor came to the patient's bed the next day. Her pain had gone with the treatment. The junior doctor reminded the patient of her statement the previous day and was flummoxed when she said, "No, I don't want that. I'm so much better now." Rather than conscientiously responding to the pain of the treatment, the junior doctor reached for forms. Suddenly, in the twinkling of an eye, a shadow came over two millennia at least of health care, and process superseded and trumped medical response.

I fear the same would occur year because under the bill an eligible person could decline to see a palliative care physician, and the patient, family and doctors are all caught up in a process rather than a genuine and conscientious intent to look at precisely why the patient wishes to embark on this course. One of the major reasons people request VAD is feeling they are, or become, a burden to others, loss of dignity or loss of the ability to enjoy life. If so, let us go to those problems and deal with them. As a society, are we so lacking in wit that we run from that place to death by our own hands. Surely we can do better. Let us be more creative in the pursuit of not only better management of symptoms but also to think about deeply, care for and lighten the loss, the sadness, the change in self and the dying. Surely we have more wit.

The ACTING CHAIR: Thank you. Dr Obeid?

Dr OBEID: Thank you for the invitation. I am a consultant geriatrician with 23 years of specialist experience. I specialise in the care of older people with complex problems, especially neurodegenerative diseases, cancer, frailty, Parkinson's disease and stroke. I also served on the federal council of the Australian and New Zealand Society for Geriatric Medicine for 21 years. Medical practitioners have a reasonable expectation that legislators will make laws based on rational scientific principles, taking into account advice from medical experts. For example, when Parliament makes laws about climate change, we expect them to seek advice from the very best climate scientists. When making laws about fiscal and monetary policy, we expect they will consult the best economic minds. End of life care should be no different. Parliaments do well to seek advice and guidance from experts in the field—in this case, palliative care physicians, geriatricians and oncologists. Being guided by anecdotal reports of emotive case studies or the opinions of trade union leaders or retired comedians and TV hosts, whilst interesting, is unlikely to form the best healthcare policy.

As far as my role as a geriatrician is concerned, I and, in my experience, the majority of my colleagues do not see VAD as a tool that we require to best serve the needs of our patients. If we lacked some important tool to do our work, we would ask lawmakers and healthcare funders to provide us with that tool. In the case of VAD, we geriatricians and palliative care physicians are not asking for it nor do we need it to care for our patients and address their symptoms. On the other hand, many of the things that we do ask for are not provided—more beds, better access to rehabilitation and palliative care, enhanced community care funding, better nurse-to-patient ratios. It pains us that Parliament is yet again debating a supposed healthcare provision yet seems to be doing little to provide the things we are asking for. I say "supposed" because the medical profession has repeatedly emphasised that VAD does not form part of medical practice.

Reading through the *Hansard* transcripts from Wednesday's proceedings, I was dismayed to hear of stories from people who could have been helped by proper access to palliative care. Even the doctors who spoke to this Committee seemed to lack a basic understanding of what palliative and geriatric medical care offers. One GP said that he was stuck in a country town and that palliative care services would not allow him to increase morphine dosages, resulting in unbearable suffering to his patient. This is just not borne out in the reality of day-to-day medical practice.

If anything, the case that he highlighted speaks volumes about the much more important task of enhancing palliative care services, not introducing VAD. To further enlighten this Committee, I would just like to point out that there was absolutely nothing stopping that GP as a registered medical practitioner from increasing the morphine dose himself if he thought it was required. I found the use of that case as a supposed justification to bring in VAD to be appalling and misleading. The case is a good example of how VAD will be misused by doctors who lack basic skills or understanding of palliative care or geriatric medicine if the legislation were to come into force.

Perhaps the most disappointing aspect of this bill is the false hope that it provides to many people with chronic illnesses in New South Wales. As experts in medicine, we know that very many people suffering from severe pain, existential crises and feelings of powerlessness will not be covered by this bill. Illnesses such as arthritis, chronic obstructive pulmonary disease, chronic renal failure, diabetes and even many cancers have prognoses well over six months and hence they will not be covered by this bill. The so-called safeguards of the proposed VAD Bill are not only weak but they can be done away with very easily by a later amendment or Act of Parliament.

As examples, I draw your attention to the following. The bill does not guarantee that a person has capacity. It assumes capacity to be present unless proven otherwise. Doctors who have very little training or understanding of capacity will be able to rubberstamp the voluntary assisted suicide of vulnerable patients. The bill purports to exclude dementia as a qualifying diagnosis, yet makes no provision for expert assessment of cognition. The bill supposedly outlaws coercion or undue influence but, as Dr Brennan pointed out, has no real ability to detect subtle or even overt forms of coercion. The doctor merely has to provide a statement confirming that he or she acted in accordance with guidelines in determining whether the patient has experienced duress. The bill even allows others to suggest VAD to patients.

In conclusion, the VAD Bill has many deeply concerning aspects. It does absolutely nothing for the bulk of people who are suffering from the problems the bill purports to address. It relies on populist ideas and exploits people's fear of death rather than taking a scientific and expert analysis. It is not something that the majority of those who actually work in the field are even asking for. In my opinion, Parliament would do well to spend its valuable time addressing the true healthcare needs of the people of New South Wales guided by experts in the field. Thank you for listening to me.

The CHAIR: Thank you, Dr Obeid. The Chair just got a little bit younger but a lot less articulate. I thank the Hon. Rod Roberts for covering for me while I had to attend to something. Mr McAuley, you have the call for an opening statement.

Mr McAULEY: Thank you, Mr Chair. Thank you for inviting me to address the community, and I thank the administrative staff who have very efficiently and very courteously organised this obviously under great pressure. Rather than take up too much time and given that there has been a significant change in the legislation as a result of amendments in the Legislative Assembly, I have reduced my thoughts to writing and I have a far shorter submission, which I make available to the Committee rather than the rather prolix submission that I originally made. There are just a couple of points I would make and then I will leave it to others. It seems to me that the area of scientific discipline which is most relevant to this is medicine not law. Lawyers only have a subsidiary role to play. Modern contemporary medical science is going to throw far more light on this than the waffle of lawyers.

Secondly, my experience over the past 40 or more years as a lawyer has been as a personal injury lawyer and there are three things that have impressed me: firstly, the very wide differences in the abilities and experience and knowledge of medical practitioners. That is one thing. Secondly, the variability of medical opinions; it is possible to obtain a medical opinion as to just about anything, whatever one wants. And thirdly, the reality is that in Australian hospitals something like 9 per cent of admissions end up in some adverse event. So any concept that doctors are infallible, any concept that doctors will always get it right, any concept that all medical opinion is the same, is entirely, in my submission, false. That said, the best medical opinion, which in this area is the opinion of palliative care specialists, palliaticians, oncologists, neurologists, neuropsychologists, that is the opinion which should inform the Committee. That is my opening statement.

The CHAIR: Thank you very much, Mr McAuley. We will now open for questions.

The Hon. TREVOR KHAN: I am happy to go first.

The CHAIR: Mr Khan, you have got the call.

The Hon. TREVOR KHAN: There has been reference to the transcript of the hearing by Dr Obeid so I will just read part of it. Page 44.

The Hon. GREG DONNELLY: Can we give the doctor a copy of that?

The Hon. TREVOR KHAN: No, I will read it, thank you.

The Hon. GREG DONNELLY: He might like to see a copy of it.

The CHAIR: Order!

The Hon. TREVOR KHAN: Don't start running interference, Greg.

The Hon. GREG DONNELLY: I am not running interference. If you are quoting from *Hansard* he is entitled to have it in front of him.

The CHAIR: Order! Dr Obeid, are you happy if Mr Khan reads you the transcript, and while we are doing that we will see if we can get you a copy?

The Hon. TREVOR KHAN: If anyone thinks that what I am reading is a misquote of the transcript, then they will be in a position to take that point.

The Hon. GREG DONNELLY: I have got a copy of *Hansard*.

Dr OBEID: I have actually brought it up myself.

The CHAIR: Thank you, Dr Obeid.

Dr OBEID: Page 44 was it?

The Hon. TREVOR KHAN: Page 44, and I will read it:

> Venessa was an amazing human being. I have never met anybody like her—the smartest person I have ever met. She already had a worldwide reputation in her field. We all thought she was going to be a professor of medicine one day. You could not get anything past her. She had worked most of her life in a hospital; she had seen everything. She had worked on palliative care wards, she knew what palliative care wards were about, and I think that is a really key message when you have got someone like Venessa—super smart, super compassionate, super caring. She chose to die alone without saying goodbye to her loved ones, and that was for a really, really good reason: She knew what the alternatives were. She did not want to die in a hospital; she knew what it would be like.

I am just picking up on the words that Mr McAuley last used. Venessa Pattullo was a doctor, apparently of some capacity, who took her own life when suffering from leukaemia. I have heard the concept of wit used in terms of this, but it struck me that the evidence of Dr Pattullo in describing his wife and her decision to prematurely end her life was not a story of a lack of wit, it was not a story of a lack of understanding of palliative care; it was, in a sense, that she did not see an alternative, I think could be the conclusion—that she was going to die and she was going to do it on her own terms. I give that to you because there has been so much made of understanding and medical expertise. Venessa, it would seem, knew it. Dr Pattullo, who gave evidence before us, knew it—a specialist anaesthetist. So how do I take all your evidence about lack of wit and lack of doing things with a statement like Dr Pattullo did and of the actions of Venessa? How do you rationalise those two positions?

Dr OBEID: Sorry, what do you mean by "a lack of wit"? What is that all about?

The Hon. TREVOR KHAN: That was a term that Dr Frank Brennan used in the concept of VAD.

Dr MOYLAN: Perhaps I could start by saying that Venessa herself is not here to give evidence. Your impression of the events is as they were described by her husband. What triggered her taking her own life is not clear. You might just think, "I've got all of the answers: She had cancer, she killed herself," that that is the answer. Whether she had depression, whether she had had an argument with her husband that morning about issues that are not documented—there are so many things, but you think that the whole story is there. I would contest that; in fact, the whole story is not there, and that is part of the problem. We see all of these arguments about people wanting to end their own life from the view of those that were observing; we are not seeing it from the side of the people who were suffering. The Voluntary Assisted Dying Bill is about stopping people from observing suffering as much as it is about trying to alleviate suffering.

Dr OBEID: I would also like to add that leukaemia is a very diverse disease; it does not necessarily just progress to the one way that has been painted here or the way that you suggest. I see this as a terribly sad case that this person—

The Hon. TREVOR KHAN: This doctor.

Dr OBEID: —the doctor understood all about palliative care wards. But palliative care does not need to be delivered on a ward; it can be delivered at home, and the expertise of a palliative care team that would be coming out to see the doctor who passed away, who took her own life, it is really sad that the palliative care specialists were not given the opportunity to assist her. I see this as a really tragic case and it is very painful to read because of the way that it panned out when it did not need to pan out that way. I do not see how this suggests that we should be bringing in VAD.

The CHAIR: Mr Khan, do you mind if I ask—

The Hon. TREVOR KHAN: Please, please, go your hardest.

The CHAIR: I will not do that, I will just seek some elucidations. Mr McAuley, I will start with you because I was fortunate to be here when you made your opening statement. I note that you were talking about the quality of doctors, that we have a range of doctors and that doctors are fallible—I think that was the word that you used.

Mr McAULEY: That is right.

The CHAIR: In that instance, given that we cannot have the best doctor in every hospital all the time, that there are a range of those views, if the doctors that are available to a patient are perhaps not of the standard which you are talking about and that they are not able to alleviate the pain with the level of experience and training that they have, is it perhaps not a more humane and more kind thing to actually not force somebody to go through suffering because, like I said, we cannot have a professor of medicine in every hospital across the State?

Mr McAULEY: I understand that. That is what human life is about; we are all different and there are different qualities. Nevertheless, the very impressive submission from Dr Sarah Wenham from Broken Hill highlighted the absence of palliative care in the Far West of New South Wales but also commented on the absence of palliative care to people in large and major metropolitan centres in New South Wales. That says to me that we are a society with enormous resources and we need to ensure that persons who are sick, who are dying and who are severely disabled have reasonable quality of care. The difficulty with this bill is that it leaves the decision-making in the hands of two general practitioners who simply, in the general run of situations, will not have specialist qualifications in geriatrics and palliative care, oncology, neurology et cetera or psychiatry.

It is not a situation where—this bill seems to envisage that neither of the doctors will necessarily be treating doctors. There is no requirement in the bill that the doctors have regard to the person's medical history. There is no requirement in the bill that the doctors who are approving the proposed voluntary assisted dying provide a detailed written report explaining their decision.

The CHAIR: Mr McCauley, can I interject?

Mr McAULEY: It is a Socratic dialogue.

The CHAIR: It is more of an elucidation that I am seeking, but I am very mindful that you have all come here and I do not want to be rude in interjecting.

Mr McAULEY: Sure. I am looking forward to Mr Khan's interjections.

The Hon. TREVOR KHAN: I can do my own thanks very much, Mr McCauley.

The Hon. ROD ROBERTS: Don't invite. Invitation not necessary.

The CHAIR: Mr McCauley, I think you do a disservice to doctors to suggest that because the bill does not say they must take into account a history or the like that any GP who is making a decision such as this would do so. I think any doctor, even a medical trainee, would have the sense to understand—

The Hon. TREVOR KHAN: Or wit, in fact.

The CHAIR: The wit—thank you, Mr Khan—

The Hon. GREG DONNELLY: Is this a statement or a question?

The CHAIR: —to factor that in. I struggle with the concept, given that we can expect that doctors are going to be professional in that but also that we cannot always have, as I said, a medical professor of palliative care in every hospital around the State. We know from the testimony from the last hearing that even a palliative care specialist cannot always alleviate pain. Is it not a more humane, kinder thing to allow somebody of their own choosing to alleviate that pain than to force them to go through that until they pass away of whatever has afflicted them?

Mr McAULEY: Parliament should make laws for the generality of cases. The generality is that it would seem about 50 per cent of patients in major metropolitan centres in New South Wales do not have access to palliative care. The way palliative care units, like any other medical units, are set up is that at the top of those units you have highly experienced people and then you have a gradation of people. There is no reason why this bill should not make clear the seriousness of the whole process of voluntary assisted dying, and the doctors who are effectively making decisions should have regard to the person's history, particularly any psychiatric history, and their medical records. There is no reason why this bill should not require the doctors who are providing the certification to express their opinion in a reasoned and detailed fashion. That can easily happen. I understand the concern behind what you say. I think this bill needs to be looked at very carefully.

The CHAIR: I note the time. The Deputy Chair has a question but we will have to wrap up shortly so we can bring the next witnesses in.

The Hon. GREG DONNELLY: That is fine. We can take our time. I want to direct this opportunity for Dr Brennan to respond to the point—I am not sure I clearly understand the point, but the reference to the term "wit" in your statement.

Dr BRENNAN: Yes.

The Hon. GREG DONNELLY: I did not quite understand exactly the way in which the honourable member was presenting the word and perhaps its meaning—more to the point, your intention of the use of that word in your statement. For the record, I want to enable you to clarify that so there can be no doubt whatsoever what you meant by that and what led up to that word. That would be helpful.

Dr BRENNAN: My apologies, Mr Khan, if I have misspoken or misled you in what I was speaking about. I certainly was not speaking about the wit of an individual person, Dr Pattullo's wife or any individual. I am not going to be making judgement. The wit I am talking about is the collective wit, the wit of a society. How can society—and, indeed, the legislature in that society and the medical profession—respond to the suffering of an individual? That is where I was thinking of the collective wit of us all. I guess that dovetails into the previous discussion about "Okay, you cannot have professors of medicine and palliative care in every hospital". That is true. There are so few of us in so few settings, as I said in my statement.

There is a story where medicine is really reaping a bitter harvest. How much education of palliative care has there been for undergraduates and postgraduates over decades? Things are changing quickly but for a long time there was very little, if any, palliative care education. There are many senior clinicians, including general practitioners, who are really not sure what to do. It would be a great shame if in a suffering person their sense is that because there is no palliative care on the ground, we need to leap all the way through to VAD rather than sit, be with that person, talk it through with that person, and then engage with senior colleagues on the phone and start to think through what can we do, what is possible here? That is hopefully what is happening now, that the opening up of that possibility that I, as Dr A, do not know this sufficiently well enough. I do not have those communications or the symptom-management skills but I had best find that information. I think it would be very sad if clinicians say, "Because we don't have palliative care here, this is what we're going to offer you."

The CHAIR: Thank you very much for that testimony. Mr D'Adam, did you have something very quickly?

The Hon. ANTHONY D'ADAM: I want to ask one question. You are all very eminent members of your professions. In a palliative care sense you are, I suppose, in control of the administration of the care. I suppose for someone who is contemplating voluntary assisted dying, they may look at a situation where they do not want to submit to a system where they cease to have agency, where they become powerless, where they move from being subject to object and, ultimately, in the palliative care system towards the end of life, they lack agency. I want to put to you the notion of: What of the capacity or the right of someone to choose not to enter that system? Shouldn't they have the right not to have to submit, to remain a subject rather than to accept that they are on a pathway to become the object of care?

Dr BRENNAN: Thank you for your question. Perhaps there are two parts to the answer. I hope I am speaking on behalf of all of my colleagues. I would never see a patient who is now very weary, spending more and more time in bed or sleeping virtually all the time ever as an object; I would see them as a human being.

I would have a great sense of their dignity. I hope patients never feel that they are turning into something different to who they are: human beings, with that inherent dignity.

The CHAIR: Dr Brennan, I am sorry to interrupt. I will ask Mr D'Adam to put that question on notice. Given it is time to change panel, I will invite you to provide that answer on notice. Thank you very much for your appearance today. If there have been any questions taken on notice, the secretariat will liaise with you to table them.

(The witnesses withdrew.)

LEEROY WILLIAM, Immediate Past President, Australian and New Zealand Society of Palliative Medicine, before the Committee via videoconference, sworn and examined

DAVID KISSANE, Professor and Chair of Palliative Medicine Research, University of Notre Dame Australia, and The Cunningham Centre for Palliative Care, St Vincent's Hospital Sydney, before the Committee via videoconference, sworn and examined

RODERICK MacLEOD, HammondCare Associate and Honorary Professor, University of Auckland, before the Committee via videoconference, sworn and examined

The CHAIR: I invite the three of you to make an opening statement, starting with Adjunct Clinical Professor William.

Adjunct Clinical Professor WILLIAM: Thanks very much. I would like to acknowledge the traditional owners of the lands upon which we are all meeting and pay my respects to Elders past, present and emerging. Thank you for the opportunity to speak on behalf of the Australian and New Zealand Society of Palliative Medicine, ANZSPM. We are a trans-Tasman Society for medical practitioners working in palliative care, including specialists, non-specialists and trainees. We have 579 members in total, with 444 based in Australia. As the immediate past president of ANZSPM, I have been privy to the concerns of palliative care doctors and other healthcare professionals regarding voluntary assisted dying legislation. As palliative medicine practitioners, we are skilled in dealing with difficult conversations, including wish-to-die statements and addressing the reasons they are made. They are often due to unresolved psychosocial and existential symptoms, fears, perceptions about their future and what palliative care can offer.

In Victoria, cases of coercion, reduced quality of care and difficulties with conscientious objection have been witnessed. Many patients have been fearful of being put into residential aged care and have been inquiring about voluntary assisted dying as an alternative. However, the provision of holistic care in a safe environment has often negated the need for voluntary assisted dying and enabled transition into aged care with ongoing palliative care support. It seems incongruent to be introducing voluntary assisted dying at a time when health care needs to be better supported to deliver holistic care and palliative care to all those who need it. The Victorian legislation [audio malfunction] clinicians about end-of-life care and contributed to moral distress at a time when those who need such care require a cohesive, inter-professional approach.

The CHAIR: Thank you very much for that succinct opening statement. Professor Kissane, I invite you to make one now.

Professor KISSANE: Thank you for this opportunity. I have six dot points. Number one—quality of care. In my written submission I presented four patients' stories to illustrate how VAD in Victoria had failed to protect the vulnerable. These were examples of poor -quality medical care. The standard of medical care under the Rights of the Terminally Ill legislation in the Northern Territory was also very poor. VAD in New South Wales will similarly lower the standard of medical care. Point two—depression. Depressed and demoralised patients will receive VAD without their medical assessors recognising the mental illness. Indeed, VAD distracts from comprehensive assessment because it focuses on legalistic forms, rather than holistic care. If New South Wales passes this bill, legislators in the future will be invited to legalise VAD for the suffering of the mentally ill. Point three—decision-making. When patients become depressed or demoralised with terminal illness, about half lose decision-making capacity. Because the depression may pass undiagnosed, a significant subgroup emerges who are vulnerable and need protection.

Point four—suicide. Euthanasia and VAD create a cultural acceptance of suicide. Societies that normalise suicide for any form of suffering will increase the rate of unassisted suicide in that society. Point five—destroying palliative care. There is an incompatibility between palliative care and VAD. They are drawn from different philosophies. Palliative care promotes quality of life; VAD gives up on life. VAD creates a danger that palliative care will be weakened and rendered futile. Finally, point six—protect the vulnerable. As John Stuart Mill argued, the foremost duty of legislators is to prevent harm to others in society. Sanctioning medically assisted suicide will not achieve this. Legislators must make a difficult choice between two imperfect systems: one in which some suffering may be difficult to ameliorate; and the other in which the regulation of State-sanctioned killing will be difficult to control. I submit that legislators ought to protect the vulnerable and focus on improving the delivery of palliative care across New South Wales.

The CHAIR: Thank you, Professor Kissane, for another concise opening statement. Professor MacLeod, I offer you the opportunity to make an opening statement.

Professor MacLEOD: Thank you very much. I am speaking as a [audio malfunction]. HammondCare opposes all legalisation of VAD and endorses palliative care as the appropriate service for people who are nearing the end of life. Fundamentally, [audio malfunction] law suggests that some lives are not worth living. When the option for hastened death becomes—

The CHAIR: Professor MacLeod, sorry to interrupt you, but you are dropping in and out. I can see the quality of your camera is not great. Maybe if you turn the vision off but leave the audio on, it may improve the audio for us.

Professor MacLEOD: Sorry.

The CHAIR: Would you have somebody there who might be able to assist you, by any chance? Actually, we can do it from this end apparently.

Professor MacLEOD: Yes, you have done it, thank you.

The CHAIR: Please continue your opening statement now.

Professor MacLEOD: We believe the creation of VAD law suggests that some lives are not worth living. When the option for hastened death becomes available, it can have a small but significant effect on public consciousness. Rather than being off limits, killing [audio malfunction] becomes a possibility. VAD is then [audio malfunction].

The CHAIR: Professor MacLeod, my apologies, we just lost you again. Is it possible we could try—

Professor MacLEOD: I could move my position and go to a different room.

The Hon. TREVOR KHAN: I reckon we have got to give him the chance.

The CHAIR: Yes. The secretariat is going to make contact with you and see how we can better have your evidence heard.

Professor MacLEOD: Okay.

The CHAIR: Is your opening statement written?

Professor MacLEOD: Yes.

The CHAIR: If possible, I will get the secretariat to also liaise with you to arrange for it to be sent in and we can table it as your opening statement.

Professor MacLEOD: I [audio malfunction] as well and see if that helps. Excuse me a minute.

The CHAIR: Thank you very much. While we are sorting out the issues with—

The Hon. TREVOR KHAN: No, I think people have to give their opening statements first before we do anything else. Can I suggest we—

The CHAIR: They are all done.

The Hon. TREVOR KHAN: Well, no, they are not all done.

Professor MacLEOD: Is that any better?

The Hon. TREVOR KHAN: Yes, it is. It does sound better.

The CHAIR: Yes. If you want to continue with your opening statement, thank you.

Professor MacLEOD: Okay. Sorry about that. HammondCare opposes all legalisation of VAD and endorses palliative care as the appropriate service for people who are nearing the end of life. Fundamentally, the creation of VAD law suggests that some lives are not worth living. When the option for hastened death becomes available it can have a small but significant effect on public consciousness. Rather than being off limits, killing suddenly becomes a possibility. VAD is antithetical to the goals of medicine, which are concerned with care and enhancing patients' quality of life, not assisting in the end of life. Making a prognosis is a professional opinion based on medical experience that only produces a forecast of the likely outcome of a medical condition - we know from many studies that prognosis can be and often is, wrong. It is incredibly hard to detect coercion when people want to end their own life because there is no real test to know if, in fact, they are seeking death of their own free will.

What we do know is that many people still do not know what palliative care is, what it can do, how it can minimise symptoms and, importantly, that the very worst suffering it addresses, in our clinical experience, is often not physical but existential. Given that most medical students will have only a few weeks at most to learn about palliative care, it is not surprising that some in the profession of medicine are unaware of exactly what palliative care is and what it can do. My final point is that the majority of people living in rural and regional

Australia may have difficulty accessing palliative care. In residential aged care where many people will spend their last months and years of life, the capacity for services to provide appropriate care at the end of life is limited by the skills and availability of the workforce and the resources available to provide the necessary supports and services.

The CHAIR: Thank you very much, Professor MacLeod. The audio does seem to have been improved in the location you are in now. I will now invite questions from the Committee.

The Hon. ANTHONY D'ADAM: I will perhaps direct my first question to Professor Kissane, who talked about palliative care offering quality of life. I wanted to ask initially about whether you see deep sedation as one element of palliative care. Is deep sedation one of the options that you would consider in the toolbox of palliative care?

Professor KISSANE: Yes, I would use the word "proportionate sedation". One, of course, can use tranquilising medications to enhance sleep, to reduce anxiety. I think your concept of deep sedation—you are alluding to the idea of somebody who has very extreme symptomatology and is struggling without some sedation, which can give them comfort and peace—is a very unusual activity that occurs once or twice a year in the palliative care units that I go into but one which is very helpful to give people that good sleep and rest. If then they wake and they are more comfortable and their symptoms are better controlled, then they are able to communicate it again with their families.

The Hon. ANTHONY D'ADAM: Is it the case that sometimes that is not how it pans out—that, in fact, the sedation continues until death?

Professor KISSANE: That can be the case, as you know. That is consistent with palliative care where the goal is to relieve the symptoms, relieve the distress and allow for a peaceful dying if that follows. But the ethical principle is that the goal of care is the relief of distress, not the shortening of life.

The Hon. ANTHONY D'ADAM: But that is not quality of life, is it? Would you agree?

Professor KISSANE: Well, I think palliative care, the vast majority of times, works to enhance quality of life. The Temel study is a very good example of that, where they treated patients with lung cancer in Boston and randomised people to either early palliative care, with good symptom control, or conventional cancer care. The outstanding finding from that study was that palliative care extended survival and that the patients that received palliative care lived longer than those that received conventional anti-cancer care—a very good study indicating how quality of life is enhanced by palliative care. That is very much what we are about in the palliative care that we deliver.

The Hon. ANTHONY D'ADAM: I might take the opportunity to put the question that I attempted to put to Professor Brennan in the previous session about, I suppose, the operation of the palliative care as a system where those entering it progressively lose agency. They submit to the control of medical professionals in palliative care specialists, and as they progress towards the end of life, their agency and their capacity to exercise control over their own life declines and, really, transfers into the control of others. I wanted to put this question about those who want to choose not to enter that system and whether that choice should be respected.

Professor KISSANE: If that is addressed to me, sir, then I would wonder about your choice of words where you convey the sense that palliative care seeks to take over control from people. That is not part of the ethos of palliative care. Palliative care is very respectful of the wishes and needs of a person and seeks to work in a shared decision-making process to support them and help them to achieve their wishes as they approach the end of their life, and to allow a natural death to then intervene.

The CHAIR: Thank you very much. I will now pass the questioning to the Hon. Trevor Khan.

The Hon. TREVOR KHAN: My question is directed to Professor William, I think, at this stage. Professor, you would have quite commonly come across advance care directives, would you not?

Adjunct Clinical Professor WILLIAM: Not necessarily.

The Hon. TREVOR KHAN: How do you mean "not necessarily"?

Adjunct Clinical Professor WILLIAM: Well, advance care planning in the healthcare system should be done much earlier than when I meet people. However, it is not done because those conversations are not carried out as often as they should be so that people can express their wishes about what matters most to them and marry that with what medically is appropriate for that person. Often when I look in the record and I am seeing someone, there is not an advance care directive that has been made. If there has been one, say, for example, in an aged-care facility where they have someone on admission, it is a very cursory and incomplete and outdated document.

The Hon. TREVOR KHAN: Sure. Professor, you are probably presuming where my question is going and your assumption may be wrong. So let me just work it through a little bit. You have come across advance care directives. That is correct, is it not?

Adjunct Clinical Professor WILLIAM: Correct.

The Hon. TREVOR KHAN: And you know that an advance care directive can be a very simple document that only needs to be executed by the patient—that is correct, isn't it?

Adjunct Clinical Professor WILLIAM: Correct.

The Hon. TREVOR KHAN: And indeed they are established under common law. In New South Wales there is no legislative framework around them—you know that?

Adjunct Clinical Professor WILLIAM: Yes.

The Hon. TREVOR KHAN: And do you know that at common law, when dealing with an advance care directive, there is a presumption of capacity? Did you know that?

Adjunct Clinical Professor WILLIAM: Yes.

The Hon. TREVOR KHAN: And there is no requirement for a patient, prior to executing an advance care directive, for instance, to have consulted their doctor with regards to the treatment options that are available. Did you know that?

Adjunct Clinical Professor WILLIAM: Yes.

The Hon. TREVOR KHAN: And did you know also that there is no requirement for an advance care directive that a patient has received advice with regards to palliative care? Did you know that?

Adjunct Clinical Professor WILLIAM: Yes.

The Hon. TREVOR KHAN: And there is no framework in any way with regards to advance care directives to, for instance, penalise a relative who may have convinced a patient to execute an advance care directive. Did you know that?

Adjunct Clinical Professor WILLIAM: Yes.

The Hon. TREVOR KHAN: And did you know that an advance care directive can extend to such things as not only DNRs but, for instance, in the case of a loss of capacity, to the patient not being hydrated or fed in any way? Did you know that?

Adjunct Clinical Professor WILLIAM: Well, I think there are a couple of issues to consider here. Much like a birthing plan, when someone who is going to deliver will have wishes about what they would like, that needs to be taken into consideration. But when that person comes into hospital in a certain clinical situation, the doctrine of necessity might mean that we would have to act in a certain way which would be against the wishes of that person because of the risk to the baby. In a similar circumstance, I have seen people with advance care directives that have been very well put together and very clear, but the doctor has not considered them and acted in the interest of the doctrine of necessity to treat that person because of the information they had with them.

The Hon. TREVOR KHAN: Putting aside the doctrine of necessity, do you understand that to act contrary to an advance care directive—for instance, with regards to issues of feeding and hydration—would be to commit an assault upon the patient?

Adjunct Clinical Professor WILLIAM: Well, I have never seen any advance care directives that have had that detail in them, because often they are more vague—

The Hon. TREVOR KHAN: Professor, please do not avoid the exercise.

The Hon. GREG DONNELLY: Order!

The CHAIR: That's my job.

The Hon. GREG DONNELLY: Sorry, I won't nudge you out yet. Point of order: The issue of avoiding the question—that was quite pointed, I have to say.

The Hon. TREVOR KHAN: Indeed it was.

The Hon. GREG DONNELLY: It is a very strong allegation that the witness is avoiding answering the question.

The Hon. TREVOR KHAN: That is what I am suggesting, Greg.

The Hon. GREG DONNELLY: It may well be that he is not giving you the answer you want. As we know—

The CHAIR: I can rule on the point of order now.

The Hon. TAYLOR MARTIN: He hasn't finished, Wes.

The Hon. GREG DONNELLY: I haven't finished.

The CHAIR: Alright.

The Hon. GREG DONNELLY: What I am saying is: We know how these are conducted. You ask the question, you receive the answer and it goes back and forth. If you do not get the answer you want, that is just the way it is.

The Hon. TREVOR KHAN: Well, Greg, a specific question has been put to the witness. I am entitled for the witness to actually direct his mind to the question that is being asked, not give an answer which is non-responsive.

The Hon. GREG DONNELLY: Or he may take the question on notice.

The Hon. TREVOR KHAN: Chair?

The CHAIR: I am going to rule now. Thank you for the points on that point of order. I believe that the witness is able to answer the question however he wants. Mr Khan, I would ask you to let him finish his answer, and then you can make whatever elucidations you need to afterwards. I uphold the point of order, but I am also going to remind members of this Committee that when they are chairing I may well call the same points of order.

The Hon. GREG DONNELLY: More than happy, and I will deal with it at the time.

The Hon. TREVOR KHAN: Go your hardest, Professor.

Adjunct Clinical Professor WILLIAM: I would say that with any advanced care directive, whenever it was made, the approach of shared decision-making would occur because we do not know what that person has said in the interim and we also do not know when necessarily the advance care directive was made and whether it was an inappropriate time and needed to be reviewed as other circumstances have come about. The shared decision-making process that Professor Kissane discussed previously is something that exists, where we talk about what the trajectory of the illness is and how the wishes of the patient are married with what the clinical management will be going forward.

The Hon. TREVOR KHAN: I will just end by saying this: Professor, can I invite you to look at such cases as *Hunter and New England Area Health Service v A*, a 2009 decision dealing with a schizophrenic patient who sought to refuse care. The Supreme Court there made pretty clear what the law is in regards to this matter, and I suggest it is not consistent with your description.

Adjunct Clinical Professor WILLIAM: I will take that question on notice, then.

The Hon. TREVOR KHAN: Yes.

The CHAIR: Thank you, Mr Khan. Does any other member seek to question the witnesses? Mr Donnelly?

The Hon. GREG DONNELLY: No, I'm okay.

The CHAIR: In that case, I will conclude this session of the hearing. Thank you very much for appearing today. For the questions you have taken on notice, the secretariat will liaise with you to have those tabled. As a bit of a gift, we have an extended lunch break now until two o'clock. Thank you.

(The witnesses withdrew.)

(Luncheon adjournment)

SARAH WENHAM, Specialist Palliative Care Physician, Far West Local Health District, before the Committee via videoconference, sworn and examined

MEGAN BEST, Associate Professor of Bioethics, Institute for Ethics and Society, The University of Notre Dame Australia, sworn and examined

MARIA CIGOLINI, Clinical Associate Professor and Lecturer in Medicine, University of Sydney, and Administrator, Health Professionals Say No, affirmed and examined

The CHAIR: Thank you very much. We will now move to opening statements. I will give each member the opportunity to make one. If you could, keep it short, please. Professor Cigolini, if you could start, please.

Clinical Associate Professor CIGOLINI: Thank you. Health Professionals Say No is an independent, secular network of over 880 healthcare professionals dedicated to the care of the seriously ill, aged and dying, with 430 being represented from New South Wales. Our experience ranges across healthcare sectors and regions inclusive of psychosocial care. Many of us have been or are still in coalface and leadership positions associated with NSW Health and other significant care institutions, including community services. Between us, we have cared for hundreds and hundreds of thousands of individuals with life-limiting, mental health and aged conditions.

As a group, we are at times incredulous of how our knowledge and experience is often brushed aside by some of the media, proponent lobby groups and those in the political sphere when we try to rationally explain, with hard and true evidence, that euthanasia and physician assisted suicide legislation represents a minority world view and sociopolitical agenda that should not be imposed onto health care and psychosocial services or institutions due to the harms it would create. We are also concerned by the rapidity of the uptake of such bills in Australia, despite it being a minority view and, for Australia, an untested trend that already demonstrates distress and ambiguity created in healthcare environments, fears of or confusion around what constitutes palliative care, and even a wrongful death due to coercion.

There are only 16 worldwide jurisdictions with such legislation, five of which are in Australia. If one examines the USA alone, where the Oregon model exists—88 bills have been rejected in the last four years, with legislation reversed in New York City the same year the Victorian bill was passed because of concerns around safety and the negative impacts toward those in need of health care and social services, as well as the resultant degradation of services.

There have been or are many reasons demonstrable for why New South Wales should not follow this trend. We have this opportunity for discernment here today in New South Wales, and it should not be wasted. We add to this also the scaremongering created by misrepresentation of coronial statistics on suicide in the seriously ill, which do not serve to inform New South Wales citizens of what can be availed and what should occur instead. The claims—that VAD will eliminate suffering—are illusory only, as dissection of this information demonstrates that most of these assumed bad deaths as claimed in Victoria and now in New South Wales would not have been prevented by VAD legislation and, in fact, they may have not occurred if referred to appropriate psychosocial or palliative care services. We also see emotive or subjective interpretation of what the legislation represents above true representative opinion polls and majority world view, which shows that Australians would actually want access to general service provision and palliative care addressed ahead of VAD legislation, as we do. Australians also harbour concerns about the lack of safety inherent in VAD bills for the vast majority of vulnerable individuals in need of that care.

The bill also is contrary to what is actually recommended by major Australian and New South Wales inquiries toward self-provision of that care. Our written submission has also provided evidence for this. Specifically, the New South Wales bill has far-reaching implications and requires major legislative changes in criminal, coronial and healthcare regulatory Acts that make mistakes, abuse and coercion more likely. Significantly, there are inadequacies in the process with regards to patient assessment, provision of a poison, lack of detailed medication safety processes and record keeping, assumptions in the witnessing process, brief turnover period prior to suicide, and the allowing for a patient to be euthanised, all creating potential for abuse and errors, not to name problems for investigations of wrongful practices or breaches by the health secretary and also erosion of the Coroner's ability for investigation.

Euthanasia and physician-assisted suicide are not part of evidenced good end-of-life practices or palliative care. Nor are they medical treatments and not made so through an individual's assertion of autonomy, which is then described as choice and care. Healthcare professionals, institutions and care workers are not agents of State for sociopolitical agendas, which this bill is. The practices within this bill and expected of clinicians, healthcare workers and institutions are contrary to the standards of safe and ethical clinical practice, conduct and guidelines. The approaches to process in the bill is devoid of the usual rigour of history taking, clinical investigation and/or management and referral necessary for best practice approach, patients' safety and quality assurance.

Examples of this are in the presumptions made and lack of adequate process around the determination of competence, mental health and coercive influences in decision-making. This would be compounded further by the inaccuracies inherent in allowing telehealth assessments to be utilised and the subjective measures of what is tolerable or intolerable for a given individual and their relatives. Another example is in the doctor being able to endorse or suggest suicide, even if that doctor's attitude or behaviour creates undue influence towards suicide by their action or demonstrable attitude and even from a doctor with no expertise, experience or qualifications to serve that patient's needs. These circumstances are also contrary of the preamble claims in the bill around undue influence. We also provided evidence for what it means in our submission to a patient's decision-making, including the fostering of fears that may never eventuate or can be managed and prevented—

The CHAIR: I apologise for interrupting but I am just wondering if there is much more to go because—

Clinical Associate Professor CIGOLINI: No.

The Hon. TREVOR KHAN: No, I reckon she is entitled to bowl her arm over.

The CHAIR: I understand. I am just making sure we have time for questioning and there are also two other witnesses to make opening statements. Thank you.

Clinical Associate Professor CIGOLINI: As I said, it may foster fears that never eventuate or can be managed or prevented, reinforcement of a sense of burden or hopelessness or by leaving depression, which is common, untreated. This replaces good practice and care with inaccurate assumptions and a bureaucratic tick box of expectations in conduct, which give preference to euthanasia and assisted suicide. It creates upward coercive influences, which is void of the rigor and care expected of clinicians and healthcare and care workers when faced with requests or expressed desires. It is also contrary to evidence and our almost universal experience that when the reason for the request for hastening is made, explored, appropriately managed, compassionately so, and referred for appropriate management, with symptom control and advance care planning, that most patients' fears and desire diminish and distress dissipates. People usually change their minds and their sense of suffering is relieved. Quality of life, hope, outlook, meaning and sense dignity is usually restored with the medical and psychosocial care and accompaniment they receive.

Just to cut myself shorter then, just for your own sake, the bill is not neutral and is not just about choice. There are, for example, no safeguards for the majority of patients vulnerable to this legislation and their doctors or institutions of care. Protections and sanctions are illusory and unenforceable. The limited mention of conscience, without any true rights around the expression of sound professional objections, is another example here. Institutions, doctors and care staff would be expected to be complicit in actions against their professional ethics and usual standards of knowledge and approaches to patient safety and care, creating workspaces filled with tensions or conflicts, imposed often in already challenging normal circumstances and compounding further the degree of conflicts and certain stresses that we are receiving in pandemic conditions.

The only real protections offered in this bill are for the narrow reference group and doctors it was designed for. Priority in New South Wales should be given to the majority health, aged and psychosocial agendas ahead of VAD legislation. This includes access and delivery of quality and specialist palliative care, through better funding and modelling arrangements of aged care. This bill does not serve to educate or inform the general public of the real and appropriate advocacy for those in challenging life circumstances or under duress, nor does it provide true choice for the vast majority of these citizens for their care. The bill should not be imposed on healthcare workers or healthcare institutions, inclusive of community services. The bill does not serve the healthcare needs and interests of New South Wales citizens in need of or under our care and would create a two-tiered system, which favours a small reference group for which it was written above the larger communal rights and good healthcare practices. Thank you.

The Hon. GREG DONNELLY: Mr Chair, could I ask please through you to the witness for the whole statement to be incorporated into *Hansard*. I noted from her comments, unless I misunderstood her, that there was a chunk cut out to effectively meet what was an indication of shortening it.

Mr DAVID SHOEBRIDGE: I would object to that process. It is novel and I have not heard it done in a committee.

The Hon. GREG DONNELLY: If that is the case, I would like to hear the difference to the opening statement that was cut out because it is important, it was prepared, the witnesses were asked to prepare an opening statement and, with the greatest respect, they are entitled to complete their opening statement without cutting a chunk out.

The Hon. TREVOR KHAN: I support Mr Donnelly. Let's get it done.

Mr DAVID SHOEBRIDGE: I have no difficulty with the statement being tabled and then being tabled as an addendum to the submission. But I think it is a bad precedent to allow witnesses to incorporate material into *Hansard*.

The Hon. TREVOR KHAN: I am not suggesting that. I am suggesting if she wants to—let's just let her finish her statement.

The CHAIR: I am prepared to rule. If you feel that it is important to have your opening statement read in completeness, then I will allow that. However, I do note that we do have other witnesses who also have to have the opportunity to do so. I am happy to allow you to complete your opening statement and read the sections, if you believe it is important for the debate.

Clinical Associate Professor CIGOLINI: I am happy to table it for the sake of proceeding with the time that we have and hopefully questions will raise my ability to answer those sections for you.

The CHAIR: And that is obviously the challenge we have got—the longer opening statements go, the less time we have got to interrogate any evidence.

The Hon. TREVOR KHAN: No doubt Greg can ask a simple question like, "What did you miss?"

The CHAIR: It is over to you Associate Professor Best. Can I invite you to make an opening statement, please.

Associate Professor BEST: Thank you, Chair, for the opportunity to attend the hearing. I am an Associate Professor of Bioethics. I have worked as a palliative care physician and in State and Federal government palliative care policy. I would like to express my concerns about the risks of euthanasia laws in general and the New South Wales VAD law in particular. The bill should not be made law in New South Wales. It represents a significant danger to the sick and vulnerable members of our community and disrupts the normal provision of health care. It appears designed to ensure that the maximum number of citizens die from VAD without ensuring that adequate healthcare provisions, which may deflect a desire to die through VAD, are universally available. As such, it does not represent a pathway to relieve suffering so much as a pathway to eliminate the sufferers. Furthermore the content of the bill reflects a lack of understanding of the research on requests for hastened death and as such represents a significant risk to citizens.

I do not deny the reality of suffering but would like to suggest as an expert in the field that what we are hearing at times is the distress of those witnessing the end of life rather than those whose life is drawing to a close. Furthermore we know that, even in the midst of suffering, the overwhelming majority of those dying retain a strong will to live and would not choose VAD for themselves. They may, however, choose it on behalf of their suffering relatives. Proponents of the bill suggest that the legislation is required in view of high public support and evidence of safety of legislation in other jurisdictions. I have provided evidence in my submission that single question polls using emotive language artificially raise the support rates and that more extensive questionnaires performed in Australia in the last year have shown that public support for VAD falls to less than 50 per cent as respondents are given more information and that there is more public support for universal access to palliative care than to VAD.

Safety of legislation is usually claimed by reference to Oregon, USA. This is because there is such dreadful evidence of abuse in countries such as the Netherlands, Belgium and, more recently, Canada that proponents try to pretend it is not relevant to Australia. For example, there are persistent reports from the Dutch Government that approximately 1,000 patients per year are killed each year without their knowledge or consent—1,000. We do not have sufficient evidence to know how the Australian experience is playing out, although anecdotal evidence suggests there are problems in Victoria already with an exponential rise in the number of deaths and our bill has less safeguards than their law. The reason there is little evidence of abuse in Oregon is because there is little evidence collected by that government. Government reports admit that they rely entirely on self-report of the physicians administering physician-assisted suicide, and it has been likened to enforcing the speed limit by relying on drivers to report their own infractions. They admit they may not know the full story, and non-government research has shown evidence of abuse, which I have listed in my submission.

It is surprising that proponents rely on the Oregon experience to reassure members of Parliament in that our bill is not based on the Oregon model at all. There are significant differences, such as the fact that Oregon's law specifically prohibits euthanasia and allows only physician-assisted suicide and it requires the patient to have a six-month prognosis with no 12-month exceptions. It also has a longer cooling-off period and if a diagnosis of depression is suspected, the patient needs to be referred for counselling. In Oregon, physical symptoms are not a prominent reason for requesting assisted suicide anyway. Officials from Sweden recently decided against pursuing VAD after investigating the problems with the Oregon model.

For instance, they discovered that the short prognosis can be avoided by saying that a non-terminal illness such as diabetes, which is eminently treatable, can be terminal if you never take the treatment. Therefore, the legislation is used by non-terminal patients, which was not the original intention of the Parliament. Again and again, parliaments across the world reject euthanasia legislation because it is not safe. I can elaborate on that if you wish. Proponents of the bill, on the one hand, suggest there is no difference between VAD and giving sedation at the end of life. However, a person with a 12-month prognosis is not actively dying. They are still living and who knows what treatments can become available in that remaining time. I have personally discharged people from palliative care when new treatments completely turn their disease around.

The bill is designed to ensure the maximum number of people die through VAD. Proponents are reframing traditional safeguards as barriers to access so that the opportunity to avoid death for those whose wish to die is transient or due to lack of mental capacity or illness, are led directly down the VAD pathway without the standard medical treatments they would currently be offered to investigate the cause of their distress. Research in Melbourne this year found that less than 5 per cent of patients who initially expressed a desire for hastened death actually proceeded to access VAD. This bill would make unsafe legislation and bad medicine. Up until now, patients expressing suicidal intent are treated as a psychiatric emergency. Why is this group of patients being treated so differently? It is simply not possible to write a safe VAD bill.

Parliamentarians have to decide if they want to support State-sanctioned killing for the small number who would avail themselves of this legislation or if they want to fulfil their role of providing security for the majority. I would suggest that it is not the role of Parliament to fulfil the wishes of the few for autonomy at the end of life. The role of this Committee is to decide what is in the best interests of our community and whether this Parliament should endorse the view of this small group who say that there are some lives that are not worth living and that, if you do decide to endorse this view, whether you are going to make it a restricted service for those in extremis or the fast track to premature death.

The CHAIR: Dr Wenham, can I invite you to make an opening statement.

Dr WENHAM: Mr Chair and Committee members I would like to thank you for this inquiry and the opportunity to appear before you today. I am Dr [audio malfunction] I have worked in the specialty of palliative medicine for 19 years. I moved to the outback mining town of Broken Hill nine years ago when I was appointed as the first and only specialist palliative care physician employed by the Far West Local Health District. I am the elected co-chair of the Agency for Clinical Innovation End of Life and Palliative Care Network executive, however I am appearing today to in my personal capacity only.

I am passionate about providing high-quality, patient-centred palliative and end-of-life care for the rural and remote community within which I live. As the only specialist palliative care physician working in rural and remote New South Wales, I desire to see everyone across New South Wales have equitable access to high-quality, holistic palliative care at home and in their own community, which will allow them to live as well as they can for as long as they can, to achieve their goals and, as their disease progresses, to die a natural death in the place they want to be. Therefore, I cannot support the legalisation of physician-assisted suicide and euthanasia in New South Wales.

Palliative care is an approach that improves the quality of life for patients and their families facing the problems associated with life-limiting illness. Palliative care addresses suffering and enhances quality of life. Palliative care is not just for those in the last weeks and days of life but occurs from diagnosis through to death and supports families in their bereavement. Generalist palliative care should be accessible by any clinician in any care setting, by any GP, hospital doctor and nurse or aged-care facility nurse. This is basic care which is delivered with variable results and must not be confused with specialist care.

Specialist palliative care is a distinct specialty like cardiology, oncology or neurosurgery. Central to the provision of best practice, specialist palliative care is the meticulous assessment and the early identification, treatment and support of the physical, psychological, emotional, spiritual, cultural and social needs of patients and their families. For this to occur, patients need access to highly trained and skilled multidisciplinary specialist clinicians. People who are dying and their families require care and support 24 hours a day, seven days a week.

I trained to become a specialist in palliative care for 10 years. I am trained to practise safe, high-quality, evidence-based palliative medicine and this is what I do every day. The research consistently shows that when compared to standard care, including palliative care provided by non-specialists, the early introduction of specialist palliative care leads to significant improvements in patient's pain control, symptom management, quality of life, mood, care in their place of choosing and, contrary to public popular opinion, longer survival. For patients who are admitted to our Far West service, we are consistently providing high-quality palliative care that supports and enables 98 per cent of patients to be cared for and to die with their symptoms controlled in their place of choice surrounded by those they love.

However, we know that only 50 per cent of people who are living in New South Wales who would benefit from palliative care are able to access it, whether that be generalist or specialist, and only half of those who are accessing are accessing specialist support. We also note that for Australians living in regional, rural and remote New South Wales, these numbers are even fewer. It is vital to ensure that everyone in New South Wales who has uncontrollable suffering due to advanced progressive illness can access and be seen by highly skilled specialists who are trained to help them. It is also vital to ensure that patients are provided with information about treatment options and likely outcomes for their advanced progressive illness and palliative care by the specialists who are trained in that field.

This bill assumes that all doctors understand what care is available for any patient, and that is simply false. That is why we specialise to gain knowledge that others do not have. The NSW Health department provides clinicians with guidance to ensure compliance with New South Wales law on attaining consent for medical treatment from patients. This guideline states that the clinician gaining valid informed consent must have the necessary skills and experience to undertake the treatment in order to ensure that the patient has sufficient relevant information to enable them to make their own decision about the proposed treatment.

I am not a neurosurgeon and so I do not have the training, up-to-date knowledge or clinical experience to provide cancer patients, for example, with sufficient relevant information regarding all possible treatment options and likely outcomes for the management of a brain tumour. Therefore, how can a single clinician who is discussing VAD with a patient provide them with sufficient relevant information regarding all the possible treatment options for their illness or palliative care to allow them to make an informed choice when that clinician is not trained in the specialty of the patient's disease nor is trained in specialist palliative care? I cannot or would not speak on behalf of another specialist in another field. That would be medical negligence. Therefore, how can a non-palliative care specialist speak [audio malfunction]?

In addition, [audio malfunction] a treatment is ineffective until we have trialled it for a sufficient time. Therefore, how can we say that a patient has unrelieved suffering when we have only provided them with information about treatment options and not actually implemented the treatment itself? There is not a week that goes by where the patient, or more frequently the family members, ask me about assisted suicide or euthanasia. When this occurs I take time to explore that request. For patients, it is usually due to fear of what may happen, fear of loss of concern, fear of symptoms or fear of being a burden. In my submission I provided an example of how patients change their mind when they actually experience the care they need. I am sure every specialist palliative care clinician will be able to tell you multiple similar stories. For patients, their requests are usually due to their own distress at watching their loved one die and the grief that accompanies death. I often hear relatives express their belief that their loved one is experiencing extreme pain and suffering. However, my independent and objective clinical assessment identifies that the patient is settled, comfortable and has good symptom control, whilst it is the grieving relative who translates their own emotional distress and pain onto the patient, their own suffering on seeing their loved one. This is why the Medical Board of Australia code of conduct for doctors states that doctors should avoid providing medical care to anyone with whom they have a close personal relationship. The code acknowledges that in doing so it is inappropriate because of the lack of objectivity. It is the same loss of objective perspective that clouds the opinions of loved ones as they transfer their own emotional distress, pain and suffering on what they believe that dying family member is experiencing.

I certainly do not seek to minimise the immense distress of family members and loved ones in any way, but I do ask that you consider the emotional stories you have read and heard in this process, supported by adding this context. The emotional distress associated with physician-assisted suicide or euthanasia, it is vital to ensure that equitable access to highly trained and resourced services are able to provide emotional support and grief counselling to carers, relatives and families both during the illness as well as after death. Palliative care is a privileged journey we share with our patients and their families. We walk alongside them to relieve pain and other symptoms, to provide holistic support and to offer hope and quality of life. On the contrary, VAD seeks to alleviate the trials associated with lack of ability and illness with premature death.

Despite the Canadian Government's commitment to approve access to personal end-of-life care, there is, in fact, evidence to demonstrate the profoundly negative impact that medical assistance in dying legislation has had on Canadian palliative care services, including palliative care resources and funding being diverted to assisted dying, particularly in rural areas. Therefore, I cannot support this bill. To pass it prior to ensuring specialist palliative care is accessible across New South Wales will create further inequity and, rather than creating choice for a few, will ensure further segregation for the majority. Instead, I believe we have the unique opportunity to impact every single New South Wales resident by positively investing in equitable and sustainable specialist palliative care services, ensuring we develop comprehensive highly trained 24/7 access to inpatient services in [inaudible] hospice and community palliative care services in every city, town and community across our State. Thank you.

The CHAIR: Thank you, Dr Wenham. Noting the time—we have only about six minutes for questions—I am going to invite questions from the panel.

The Hon. ANTHONY D'ADAM: I will kick off. I just wanted to raise a question with Professor Cigolini about her opening statement. You said that euthanasia and physician-assisted suicide are not part of evidenced good end-of-life practices or palliative care. Then you go on to say, "Nor are they medical treatments, and not made so through an individual's assertion of autonomy, which is then described as choice", which you put in inverted commas in your statement. I wanted to put to you a question about whether you think individual choice is an essential component of the practice of good end-of-life care.

Clinical Associate Professor CIGOLINI: Yes, we do. We practise patient-centred care and family-centred care. That is our principle. However, what you are describing is not usually our experience of what we actually need to provide and also what patients request from us. We experience people coming and talking about hastening or desire to die as usually a cry for help and/or an exploration of what their choices actually are at that time of life. Similar to Dr Wenham and to Associate Professor Best, what you will find, as someone like myself who has got nearly 40 years of experience, invariably people usually adjust and also then seek appropriate medical care as we provide. If you are considering this a choice issue only, however, the issue is that you are imposing a non-medical intervention onto health care.

The Hon. ANTHONY D'ADAM: No-one is imposing anything, are they? The individual, all other considerations aside—

Clinical Associate Professor CIGOLINI: I am not questioning the individual. I am questioning this bill. This is the issue that is here today; we are discussing this particular bill.

The Hon. ANTHONY D'ADAM: But assuming an individual seeking to exercise their rights, in full command of their faculties and their eyes wide open, wants to exercise the choice to end their life, is that not ultimately control over your life, control over your body? That is at the core of a human right, is it not?

Associate Professor BEST: Can I suggest that even though autonomy is highly respected within health care, medical practitioners are not tradesmen who are there to do whatever the patient wants. We are expected to exert our professional expertise to work out what is in the best interests of the individual, and that is how we decide. We do not necessarily do whatever the patient wants. What we are saying is that if you want to impose VAD on the healthcare system, using doctors to assess eligibility and giving it a mask of legitimacy by pretending it is a valid end-of-life care option, you are confusing issues of liberty with the traditional practice of medicine, which is first to do no harm. And if it is going to be a liberty issue, by all means legalise VAD, but do not put it in the healthcare system, do not tell people who have trained to preserve life to start killing them. So what I think you should do is introduce VAD as a non-healthcare service, with a government office where people can go and express their autonomous wishes and receive VAD without this false cloak of legitimacy by putting it within the hospital.

The CHAIR: I believe the Hon. Trevor Khan had a follow-up question.

The Hon. TREVOR KHAN: The follow-up question is this, Dr Best—

Associate Professor BEST: Professor Best.

The Hon. TREVOR KHAN: I am sorry, Associate Professor. My question is this: Accepting what you say, if a patient arrives at a facility with an advanced care directive that specifies that certain treatments are not to be received or, indeed, hydration or food, you would respect that expression of autonomy, would you not?

Associate Professor BEST: We express wishes for autonomy within the bounds of what is legal and what we believe is in the best interests of the patient.

The Hon. TREVOR KHAN: Associate Professor, I will again ask: If the patient turns up with an advanced care directive that says no hydration, no food, not to receive particular treatments, you would respect that wish, would you not?

Associate Professor BEST: We are not talking about whether autonomy is something we respect. Of course we respect autonomy. What I am saying is that the choice to be killed by a doctor or ask them to prescribe a poison to allow them to kill themselves is not a legitimate medical act.

Clinical Associate Professor CIGOLINI: And also the rigour involved in assessing such a request as well, this bill takes away and creates an upward coercion towards suicide in the processes that we would have to follow in regards to this bill. So it is actually not good medical practice to accept such a thing on face value.

The Hon. TREVOR KHAN: Professor, again I will just put to you, in terms of an advanced care directive, the patient turns up with it, it is signed by the patient. Supposing you accept that it has been signed by the patient, there is not a requirement that the patient has received any medical advice before executing that advanced care directive, is there?

Clinical Associate Professor CIGOLINI: In terms of the advanced care directive, a doctor has a right to examine the validity of the advanced care directive. That is the first thing.

The Hon. TREVOR KHAN: How, Professor?

Clinical Associate Professor CIGOLINI: Usually you, as I said, find out the history, you find out the person's motivations, whether they may have had a coercive influence or a past history of abuse or whether they have got other agendas that are deciding things. We make sure that they are not depressed, which is a treatable condition. We ensure that they have not been given misinformation about what is available for them as well. The advance care directive should be a guide to when a patient would not get better—what the options for their treatment would be.

The Hon. TREVOR KHAN: Professor, I invite you to look at Hunter New England area health service and A, and you will see there a circumstance of a patient with, I think, schizophrenia who expressed desires as to how their treatment was. That case says it is valid. Your inquiry with regard—

Clinical Associate Professor CIGOLINI: What is valid? What was valid? I am sorry.

The Hon. TREVOR KHAN: Let me finish. Your inquiries that you referred to are not criteria, I suggest, that are binding in respect of that advance care directive.

Clinical Associate Professor CIGOLINI: But you have not pointed out to us what was valid in that advance care directive.

Mr DAVID SHOEBRIDGE: The directive itself.

The Hon. TREVOR KHAN: The advance care directive was valid because it was made by a capable patient.

Associate Professor BEST: But advance care directives are not legally enforceable in New South Wales.

The Hon. TREVOR KHAN: Really?

Associate Professor BEST: Yes.

The Hon. TREVOR KHAN: Is that what you say?

Associate Professor BEST: Yes.

The Hon. TREVOR KHAN: All right.

Clinical Associate Professor CIGOLINI: The other issue there, I am sorry, Trevor—is it okay if I call you Trevor?

The Hon. TREVOR KHAN: We have met before.

Clinical Associate Professor CIGOLINI: The other issue there, Trevor, is that the advance care directive is usually meant to guide a management when a person is no longer capable of expressing their views and it was made in a situation where they were competent. Usually in an end-of-life situation it is not—any patient has the right to refuse treatment well before that end-of-life period. That does not require an advance care directive. However, when you are talking about an advance care directive in an end-of-life period, that is trying to guide management. Some patients would like trials of treatment in that period, some patients would not. Whatever their concerns are, and whatever their wishes are at that time, if they are dying we try to fulfil their wishes in providing a peaceful death, hopefully within their place of care which they have chosen, if possible. But that does not require us to compromise standards and compromise our own management of people to include creating death.

The CHAIR: I note the time. We only have two minutes left. I should have the next witnesses already seated. Mr Shoebridge has a pressing question.

Associate Professor BEST: Can I provide on notice the advice we were given from the NSW Health department regarding the legality of advance directives?

The CHAIR: I was actually going to ask that from you.

The Hon. TREVOR KHAN: Absolutely.

Mr DAVID SHOEBRIDGE: Associate Professor Best, are you saying it is legitimate for a medical practitioner to ignore the wishes in an advance care directive if the advance care directive has been validly given? Are you saying that it is quite—

Associate Professor BEST: Yes, in some circumstances.

Mr DAVID SHOEBRIDGE: Let me finish the question please, Associate Professor. Are you saying that it is the role of the medical profession to ignore those wishes and assert their values over the patient they are treating even when it is a validly given directive?

Associate Professor BEST: Yes. If a patient comes and says, "I want you to do everything. I am in extremis and I want you to do everything," we are not obliged to do everything.

Clinical Associate Professor CIGOLINI: We are not—

Mr DAVID SHOEBRIDGE: I am clearly asking in circumstances—

Clinical Associate Professor CIGOLINI: You are not—

Mr DAVID SHOEBRIDGE: Let me finish. I am clearly asking in circumstances in the context of someone asking for things not to be done.

Associate Professor BEST: Yes.

Mr DAVID SHOEBRIDGE: I put to you that your answer was disingenuous, Associate Professor. You misunderstood—

The Hon. GREG DONNELLY: Point of order—

The CHAIR: I will hear the point of order.

The Hon. GREG DONNELLY: The member has directly confronted the witness—

Mr DAVID SHOEBRIDGE: Which is what I am entitled to do.

The Hon. GREG DONNELLY: Yes—and said that her answer was disingenuous.

Mr DAVID SHOEBRIDGE: I am allowing her to—

The CHAIR: Well, no—

The Hon. GREG DONNELLY: No, hang on. We conduct these inquiries with an understanding of respect around the table, particularly to witnesses and—

The CHAIR: I understand, Greg.

The Hon. GREG DONNELLY: I have not finished my point of order.

The CHAIR: I am ready to rule.

The Hon. GREG DONNELLY: I have not finished.

The CHAIR: I am ready to rule.

The Hon. ANTHONY D'ADAM: The Chair can rule at any time.

The CHAIR: I am prepared to rule.

The Hon. GREG DONNELLY: I will keep talking because I have not finished.

Mr DAVID SHOEBRIDGE: No, you won't.

The CHAIR: You can, Greg, but that is rude and I would ask you not to. The question was in order.

The Hon. GREG DONNELLY: I think it is rude the member saying to the witness it is disingenuous.

The CHAIR: The question was in order and I will allow Mr Shoebridge to continue.

The Hon. GREG DONNELLY: I believe it is unfair and unreasonable to not let me complete my point of order.

The CHAIR: You can cavil my ruling, if you want to do that.

The Hon. GREG DONNELLY: I might do that.

The CHAIR: By all means.

The Hon. GREG DONNELLY: The point is we do not insult members—

The CHAIR: You can challenge my ruling; you know the procedure.

The Hon. GREG DONNELLY: We know—

The CHAIR: I dare you to challenge my ruling, Greg.

The Hon. GREG DONNELLY: We know we act respectfully.

The CHAIR: Do not talk over me. I will ask you—

The Hon. GREG DONNELLY: We know we act respectfully.

The CHAIR: Greg.

The Hon. GREG DONNELLY: We know that you do not accuse a witness of being disingenuous.

The CHAIR: The question was in order. Mr Shoebridge was allowed to do that.

The Hon. GREG DONNELLY: That is not the question.

The CHAIR: Then I guess you challenge my ruling. Deputy Chair, challenge my ruling then.

The Hon. GREG DONNELLY: It is the calling of the witness "disingenuous".

The CHAIR: By all means, challenge the ruling or be quiet.

The Hon. GREG DONNELLY: No. I do not accept a member—

The CHAIR: Okay, then challenge the ruling.

The Hon. GREG DONNELLY: I do not accept—

The CHAIR: If you do not believe it, challenge the ruling. I am not going to sit here and be interrupted like this. Challenge the ruling and do it properly or be quiet.

The Hon. GREG DONNELLY: You do not—

The CHAIR: Challenge the ruling or be quiet.

The Hon. GREG DONNELLY: You do not—

The CHAIR: Challenge the ruling or be quiet.

The Hon. TAYLOR MARTIN: Wes.

The Hon. GREG DONNELLY: Wes, it is not acceptable for a member around this table—

The CHAIR: Greg, they are there two options open to you now.

The Hon. GREG DONNELLY: No, it is not acceptable—

The CHAIR: They are the two options open to you: challenge the ruling or be quiet.

The Hon. GREG DONNELLY: I will keep repeating it: it is not acceptable for a member—

The Hon. TREVOR KHAN: Could I ask that we go into a deliberative session?

Mr DAVID SHOEBRIDGE: I propose we go into a deliberative session.

The Hon. TAYLOR MARTIN: It is probably for the best at this point.

(Short adjournment)

The CHAIR: Welcome back to the broadcast. Our deliberative has finished. I have ruled the question in order. Before I allow Mr David Shoebridge to complete his question, the Deputy Chair wants to make a statement.

The Hon. GREG DONNELLY: I would like to make a personal explanation on behalf of myself. My behaviour in terms of challenging and cavilling with the Chair's clear ruling on the matter was unacceptable. I have accepted that that was wrong and I ought not to have done that. I have apologised to the Chair and the whole Committee for the embarrassment that has visited upon him, this Committee and the Parliament. I am sincerely sorry for that. I also wish to offer that apology to all three of the witnesses, anyone who is here today in the general public and anyone who may be watching the inquiry.

The CHAIR: Thank you, Deputy Chair.

Associate Professor BEST: Thank you.

Clinical Associate Professor CIGOLINI: Thank you.

The CHAIR: Mr Shoebridge, please continue your question.

Mr DAVID SHOEBRIDGE: I will restate it and then ask you to take it on notice given the time, Associate Professor Best.

Associate Professor BEST: Very well.

Mr DAVID SHOEBRIDGE: I put the proposition to you that your answer setting out the circumstances in which a practitioner may refuse to follow an advance care direction was disingenuous because you were referring to circumstances where a patient had asked for additional care. Indeed, the proposition that was put to you was about circumstances where a patient wanted reduced care or indeed no care or sustenance. I ask you to respond to that on notice and provide a response to circumstances in which a practitioner may refuse an advance care direction where the request was for limited or no care.

Associate Professor BEST: Very well.

The CHAIR: That concludes this session of the hearing. For the witnesses, the secretariat will be in contact to arrange the tabling of questions you have taken on notice. I thank you very much for your appearance today.

(The witnesses withdrew.)

(Short adjournment)

RACHEL HUGHES, Director of Palliative Care, Calvary Mater Newcastle, Little Company of Mary Health Care (Calvary) Ltd, before the Committee via videoconference, affirmed and examined

ANDREW COLE, Chief Medical Officer, HammondCare, sworn and examined

GRANT MILLARD, Chief Executive Officer, Anglicare Sydney and Anglicare Northern Inland, sworn and examined

JULIA ABRAHAMS, Chief Legal Counsel, Catholic Healthcare and member of Catholic Health Australia, sworn and examined

RICHARD CHYE, Director, Sacred Heart Supportive & Palliative Care, St Vincent's Hospital, Sydney, affirmed and examined

MARK GREEN, National Director of Mission, Little Company of Mary Health Care (Calvary) Ltd, affirmed and examined

ANDREW MONTAGUE, General Manager, Health and Palliative Care, HammondCare, sworn and examined

The CHAIR: Welcome back to this afternoon's session. I now invite opening statements. I am not sure whether each member has their own opening statement. If they do, please keep it to no more than a couple of minutes. Because of our reduced time, we have got only about five minutes per person.

Dr MONTAGUE: Professor Andrew Cole and I are doing a shared joint statement, so Professor Cole will commence if that is okay, Chair.

The CHAIR: Excellent, thank you very much.

Associate Professor COLE: We would like to thank you for the opportunity to appear before this Committee. Thank you for your diligence. Dr Andrew Montague and I shall each present a few further points beyond what is in the content of HammondCare's submission in relation to this bill. I am the Chief Medical Officer for HammondCare and I have been granted life fellowship of the college of physicians. HammondCare provides home care, residential care and healthcare services, both in hospital and community settings, in aged care and palliative care, and operates Dementia Support Australia. Though most of our work is in New South Wales, we are at work in Victoria, and we have adjusted our operations there to reflect their VAD legislation. HammondCare nevertheless endorses palliative care as the most appropriate service and approach to supporting and caring for people who are nearing the end of their lives. Our organisational concerns relate to capacity, equity, conscience, accreditation and bereavement.

The New South Wales Bar Association submission says that a person wishing to access VAD needs to have the capacity, in their words, "to waive their right to life". The standard for mental capacity, we believe, should match that applying in similar circumstances—for example, making or changing a will, donating a power of attorney. Unlike in younger people, it is our experience that assessing capacity in older people is not always straightforward, even with capacity toolkits. Capacity is often variable. It may be affected by illness and medications taken. Lengthy discussions with older people and family members are often needed to clarify both the wish to act and the capacity to decide, even in matters that many of us would think were less consequential—for example, transition to aged care. Frequently, our experience is that we spend a lot of time speaking with both family, the individual person and the members of their family about the decision-making in that situation.

Our concern is that more specialist input, including by mental health professionals, is required at multiple stages in the VAD process proposed, both to assess and verify capacity early on, and we support that a mental health professional should be a member of the proposed VAD board.

Dr MONTAGUE: Access to the VAD scheme must be truly voluntary, with people having had prior full opportunity to discuss and understand their conditions, then access and receive good state-of-the-art palliative care services. The reality on the ground, though, with health services in a lot of parts of our community is that both of these steps cannot be taken for granted, and there is actually quite a lot of inequity when you look at rural and regional provision of palliative care services and also, from nearly 25 years experience, in the degree of discussion that medical practitioners will have with patients in hospitals. Further, given the significant real limitations of telehealth, we acknowledge that telehealth does have a place in the healthcare system, but we believe that use of this as a communication method to have discussions around VAD should be reconsidered. It really is something that would need to happen in person.

The other thing we would like to emphasise is that the conscientious objection by HammondCare staff in our community settings will not, if the bill comes into legislation, change the care that we provide to people, and we will not neglect them as a result. Our Victorian nursing home residents may choose to access VAD provided by outside practitioners, even though our nurses, doctors and care assistants will not at all be involved with the process. Our chaplains, however, do continue to provide support, both to the individual, their families and the staff. One of the issues that we do have concern around is having adequate services to provide support to those people when someone has passed away.

Associate Professor COLE: Two more, sorry. Having discussed capacity, equity and conscience, with the issue of accreditation of staff, it is unclear how VAD might operate in hospitals, whether public or private, where accreditation of senior specialist medical staff to provide services is a central plank of assurance of quality health care. Given evidence that the overwhelming majority of people at the end of their life prefer to die at home, the best practice might seem to be that a person wishing to access VAD is supported to return home to end their life there if that is at all possible. There are strong cultural preferences that will govern that in many different situations. In a previous life, I worked in East Asia. I went there thinking to establish a palliative care service in a hospital and discovered in the first couple of months that 100 per cent of my patients wanted to go home to die, so we established a palliative care service at home.

Certainly, one of the shortcomings of palliative care in the present situation in New South Wales is that many people wish still to go home to die and for a variety of reasons cannot. Finally, the bill makes no specific mention of the need for special provision of bereavement support to families after VAD. We believe this should be addressed. We do not think that the existing bereavement service resources are adequate. It is likely that there will be special bereavement needs after a VAD instance, particularly if you have a situation where you have some family members who agree and some family members who disagree.

The CHAIR: Thank you, Associate Professor Cole and Dr Montague.

Mr GREEN: Good afternoon, Mr Chair and members of the Committee. Calvary acknowledges the Gadigal people of the Eora nation and pays its respects to the Elders, traditional custodians and First Nations people who live on these lands. We also acknowledge you, the members of the Legislative Council who constitute this Committee, and we thank you for this invitation to appear. Dr Rachel Hughes, who joins me via video link this afternoon, is our Director of Palliative Care at Calvary Mater Newcastle. Rachel is a palliative medicine specialist with a background in rural and remote primary care in aeromedical retrieval. Rachel is currently working in partnership across a number of co-designed projects, locally and regionally, to improve access of patients and carers to needs-based palliative care. Dr Hughes will assist by addressing some particular clinical questions members may have. I will provide our opening submission.

Calvary, I think, is well known to you, and our credentials are set out in our submission. Suffice to say that our focus since 4 November 1885 has been on the care of the dying. Calvary is concerned that the legalisation of voluntary assisted dying in New South Wales, while ostensibly benefiting a small percentage of people—perhaps one in 200 of those who die—who want the option of euthanasia available to them, nevertheless poses a greater unintended but foreseeable risk to people living with significant vulnerability.

In addition, as has been previously stated, I think our capacity as a State to provide palliative and end-of-life care, particularly in regional, rural and remote areas, is at best inconsistent. People cannot be said to have equitable access to quality needs-based care as they approach and reach the end of their lives. Despite experiencing higher levels of morbidity and mortality, people living in rural and remote areas have poorer access to health care, including, as we have heard, palliative care services. Pain management, medication management, staff knowledge and training are essential and critical ingredients of effective care as a person comes to the end of their life.

By legalising VAD, do we really address this inequity for 199 out of 200 people who will die and who will not want to access or seek VAD? If we do not address this existing inequity, are we offering any semblance of real choice to people who are living with a serious and potentially very frightening disease to find a way to live as fully as possible until they die? In our statement, you will see reference to something Dr Natasha Moore said—and while I will not quote the entire statement, she does suggest that the elements that we need to look at as a State are "the resources available for palliative care; the patient-doctor relationship; family dynamics at the end; our understanding of dementia, disability, suffering in general." As is so often the case, it is the already vulnerable who have most fear.

Uncertainty and fear mandate comprehensive information provision and symptom management. The unmet need in distress is highly complex and VAD legislation simply does not, and cannot, address this. Of course, few would disagree with the general thrust of the principles in clause 4 that a person exercising a power or a function under the bill must have regard to. But it is in the operation of the Act, particularly the role of the coordinating practitioner in division 3, that it would seem to Calvary that little attention is paid to ensuring that those principles in clause 4 are evident and operationalised in the process. Clause 28 speaks about the information to be provided, but the clause does not address the greater questions of solidarity, accompaniment and the preparation for the journey which is each of our deaths. We risk selling many people short. It is Calvary's submission that we may also open the door to new kinds of failure, missed opportunities, suffering and abuse—unintended but, Calvary submits, not unforeseen.

Yesterday one of our patients wrote to Dr Hughes, "I am dying. I have never done it before. I have no idea what I'm going to face and this unknown is very daunting. Where do I turn to for help? Who can help me with the unique experience of having to face my own death, fully knowing it is imminent? Mentally and emotionally, I am dealing with an enormous amount. My wife and family are also going through this experience and they need help dealing with it as well. Where do I go for information to help demystify the great unknown of facing my own death? This is where I hope palliative care can help me—help me with all of this and the things I haven't even thought of yet. I hope palliative care can ensure I am comfortable as I can be, as informed as I can be. My loved ones are also considered in this situation, and they make the whole process as easy as possible and reduce the stress of the whole issue."

Our organisation is reviewing our entire end-of-life care strategy, and Dr Hughes and I are both involved. Our challenges are not unique. They affect and reflect all those that we all face collectively together, and we will face these challenges regardless of the outcome of these deliberations. In our consultation processes, a wide range of stakeholders have suggested that these are the things we need to attend to in our models of end-of-life care design: public awareness and death literacy; training and education; ambulatory specialist multi-disciplinary support, particularly in rural areas; workforce fragmentation and funding—major barriers; critically, we need to know the whole person—holistic care requires holistic data; welcoming and accommodating care environments; care that respects dignity, identity and choices; and recognising that death and dying is hard on our people too—who cares for the carer?

I conclude on behalf of Calvary with a simple word about people in residential care, a particularly important group to consider and already vulnerable precisely because they are in this form of care. The operation of clause 97 (2) is particularly problematic for Calvary. In the same environment, and indeed in the same room, may reside a person or people who do not want to be associated with any form of euthanasia. As we stand aside to allow their fellow resident to take the VAD substance, how do we deal with that person's rights, their beliefs, fears, anxiety and even anger that we have allowed this to happen in their home without their consent? How do we explain to them that we are upholding principle 4 (k) of this legislation—"all persons … have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics"? This person might say, "This Act has violated my sanctuary and left me with grief and suffering I did not expect to have at this point in my life." And so we end where we began: Assisted dying legislation takes one kind of death and aims to make it easier. It is a deeply sympathetic goal. It also opens the door to new kinds of suffering and abuse—unintended but not unforeseeable.

Clinical Professor CHYE: Thank you very much for the opportunity. I wish to acknowledge the Gadigal people. I live on their land and I work on their land, like you do. I do respect what they have done for this land, and I wish them to continue what they have done for our lands for these countless generations. I am a palliative care specialist and I have worked in palliative care for 30 years. I am here on behalf of St Vincent's Health Australia and also Catholic Health Australia. I worked at St Vincent's Hospital since 1995 but also at Prince of Wales Hospital as well. So, yes, I work for a Catholic institution but my views, my ethics, my morals are my own and are not reflective necessarily of the Catholic ethos that I also acknowledge, but these views are my own. Therefore, I am not a conservative. I am actually a progressive doctor—and some would say I am actually an aggressive doctor in the way I look after my patients. To give you an example, at one stage in the early days of the cannabinoid therapies, I held 20 per cent—20 per cent—of all of New South Wales' authority to prescribe cannabis. So I am not a conservative; I am progressive.

I am appalled at the many stories that you have heard and the many stories you have been told. It is an indictment on the health system. It is an indictment that the health system lacks courage to confront dying. Because of that, you hear many stories of how poor the dying experience has been for many, many people. This health system and the attitudes I endure every day, they actually see palliative care as a failure. Whilst I acknowledge the principles in clause 4, that does not necessarily happen in our health system. It does not happen every day. My colleagues come across me and see me as a failure—a failure because I am looking after their failures.

They rely on me to tell patients they are dying. They are not trained and they are not confident to do it themselves, even though they may have been looking after these patients for many, many years and I have only had 15 minutes with them. That is the health system that we encourage. That is the health system that you and I have created. We do not look after our dying. No wonder the stories you hear—how poorly our dying are looked after. My experience with my father's poor care—and, yes, I have put that in my submission—has led me on my path to provide care and compassion for those I look after now. My father's death has led to many receiving compassionate care. His death was not a failure; his death led me to make sure that lots of other patients are well looked after.

I am worried about this process and this legislation. I am worried about the calls for the swiftness of assessments, for example. It does not need the expertise to ensure patients are not written off prematurely. Yes, it does not need that assessment. It does not need an expert of the patient's medical illness. I just looked after a lady with multiple system atrophy, but what does that mean to a doctor? Not much, because it is a very rare disease. How would you expect a lot of doctors to know how to look after patients like these, but also even to know whether they have reached the end of their treatment? I came across a man with lung cancer and I was told, "There is nothing left for him; therefore he needs palliative care." It was only out of my curiosity that I actually asked for a test to be done on his lung cancer, which found an epidermal growth factor receptor mutation which could be treated. No-one else looked for it.

That meant, because of my curiosity and because of my expertise in looking after lung cancer patients, this man lived for another five years. Are we saying that anyone can look after anyone and decide—who may not have the expertise in that individual disease—that they have the knowledge to write off a patient, and that they are at the end? I am saying that part of the assessment needs to be "Is the disease at the end?" before going on to the next step. It does not need expert palliative care to be involved. Being given the option of palliative care by someone who may not understand palliative care is different from experiencing what palliative care can provide in terms of benefits. There was a patient who had VAD in the Northern Territory right from the beginning. Her experience of palliative care was a 15-minute consultation in a hospital, and that was all the tick box required.

Palliative care is not 15 minutes. It takes help from a palliative care doctor. It takes help from a palliative care nurse. It takes help from a palliative care social worker, physiotherapist, occupational therapist and psychologist. Are you expecting us to cram all of that into 15 minutes for a tick-box exercise? Can I pose that question to you? Palliative care is not a 15-minute exercise. If you think it is then it reduces my seven years of training and my 26 years of experience as a practitioner in palliative care to a tick-box exercise. It demeans me and my specialty. It demeans me as a palliative care doctor to think that all that time comes down to a tick box. I am worried that it does not need a psychiatrist to ensure depression is not present. I am worried that the psychiatrist is not even asked if the treatment that a patient is on is actually working or if other treatments are available before we decide, on a say-so, that depression is not present.

A psychiatrist takes many, many years to diagnose depression. Can VAD navigators have the same experience? It does not need a proper assessment to ensure that there is no coercion to pay off debts. I cannot do that; I do not know how to detect coercion in my practice of so many years. Are you expecting a VAD doctor or assessor to be able to do that? I am also worried that all of the above can be done via telephone call for patients in remote New South Wales. Yes, I know your legislation has to apply in metropolitan Sydney, but it also has to apply in the most remote parts of New South Wales. I do a lot of telehealth conversations, even with video consultations, and I miss a lot of things because I am not there face to face. I am not there laying my hands on a patient to find out more about the patient's condition. You are asking us to do this via telephone call. I am worried that is a tick-box exercise.

I am worried about the lack of documentation of the assessments that need to be done, other than a say-so in a letter. Depression cannot be diagnosed on a say-so. It needs a lot of experience. It needs the tools to do that. Trying to assess cognition—remembering we have a high bar, a legal bar, a judicial bar as to what is a valid will. This is a bar that is much, much lower for someone deciding on their life's end. Do we not equate them at least the same? Coercion cannot be excluded on a say-so. There is lots of background information and lots of background conversations that assessors may not be aware of. How do we bring that out? I cannot detect coercion, even in my experience. What hope do we have that a doctor can learn how to detect coercion in a 15-minute training video, as happens in Victoria now?

I am worried about the lack of authority of the review board that you are planning. If there is no formal assessment being presented to this review board other than a say-so, is that enough? If we are not careful and we are not systematic in terms of looking for problems then we will never find them. You have asked the health system to be systematic. You have asked the health system to be systematic in the way we deal with problems. You have asked the health system to be systematic in the way we treat patients. Why not this as well? If I practise medicine—

The CHAIR: Professor Chye, my apologies for interrupting you. I am noting that we only have about five minutes left of this session and I have two more witnesses who have opening statements to make.

Clinical Professor CHYE: I will finish with one last paragraph.

The CHAIR: Thank you.

Clinical Professor CHYE: Yes, you have heard many, many terrible, heart-wrenching stories; that is the reason why people are asking for assisted dying, no doubt. We want to be compassionate. All of us practice—and you have asked us who practice—by solving the root cause of problems. The lack of palliative care is the root cause, so I ask you a question to take away: Does assisted dying solve the root cause of our problems, or does assisted dying solve the result of that root cause? Thank you.

The CHAIR: Thank you, Professor Chye. Just before I ask the other two witnesses to make opening statements, Hansard have asked if those who have read their opening statement could provide copies of those opening statements so that it makes transcribing easier. Ms Abrahams, can I invite you to make an opening statement, please?

Ms ABRAHAMS: I thank the Committee and the Parliament for giving us this opportunity to provide evidence. I would like to acknowledge the traditional custodians of the land on which we are gathered and show my respect for Elders past, present and emerging. I am here today on behalf of Catholic Health Australia [CHA]. Nationally its members constitute Australia's largest non-government grouping of health and aged-care services. In New South Wales, CHA members provide about 8,000 residential aged-care beds, 1,800 public and private hospital beds, and care for about 14,000 home care consumers. I am from one of CHA's members, called Catholic Healthcare, where I have worked as the chief legal counsel for over 12 years. Catholic Healthcare provides aged-care services, residential, retirement, community, and most of our 40 homes and services are provided in New South Wales.

I want to draw your attention to some of the things that I have observed, in my legal practice, that cause concern in light of the potential of this bill. I am talking about the intersection of a bill such as this with coercion and abuse and capacity. I know that there has been evidence given about this before. But what I would like to just draw your attention to is a number of cases in which I have been involved. I have seen cases where the assets of older people have been stripped, where people have been taken out of aged-care homes to solicitors to have their wills redrafted, earlier this year I came across a forged guardianship tribunal, which a person had photoshopped to give themselves more powers than the tribunal ever intended, and also cases of abuse. One case concerned an older client living in a fairly isolated area with his carer and the son. The attending community nursing team observed constant issues in relation to the delivery of morphine. It just ran out. It disappeared. Six months later, the client turned up in the emergency department [ED], covered in scabies, monstrously undernourished. Blood tests showed that he had not had any morphine. As the evidence unfolded, it became apparent that the carer, a morphine user, was stealing the morphine for their own purposes.

In reading *Hansard* last night, I was struck about some comments made about, almost—it was fanciful to think that a bill like this could in some way interplay with abuse of older persons. But the cases that I have been involved in are really quite shocking in some ways. It is astounding what people will do. The other thing that is very pertinent about this case to the inquiry here is that there were so many people that were going through the house of that elderly person. There was a community nursing team. There was a GP. There were social workers. There were police doing police checks. There were all sorts of people. In the course of the proceeding, I kept on wondering, how is it that none of these people has picked up what was going on? The only conclusion I could come to is that this style of abuse—

The CHAIR: Ms Abrahams—

The Hon. TREVOR KHAN: I think we have got to allow Catholic Health this. It is a significant—

The CHAIR: I am just seeking how much longer the opening statement is, because we are—

The Hon. TREVOR KHAN: I think we have just got to roll with it, just at this stage.

The CHAIR: If the Committee is happy to allow it, we go over time.

Mr DAVID SHOEBRIDGE: I do not think we have any other option and we just get into it. We just are very short of time. That is all.

The CHAIR: The session is due to finish now. So I will allow you to finish and ask Mr Millard to make a brief statement too. But, unfortunately, we are not able to get to questions.

Ms ABRAHAMS: Would you like me to table my statement?

The CHAIR: I am happy to allow you to have a bit more time. But I just wanted to be fair to Mr Millard as well, to make sure that he has an opportunity to have a say before we call this session to a close. If there is something pertinent that you feel needs to be addressed, I am happy to provide you time for that.

The Hon. TREVOR KHAN: I just think the witness is entitled to give a statement at the very least. Whatever other things we have done wrong today—

The CHAIR: I am happy to do that. I am just noting that it will impact. Please continue.

Ms ABRAHAMS: I will try and be brief. And the things that I miss out—I will table the statement, and they can go into evidence in that way.

The CHAIR: Thank you.

Ms ABRAHAMS: I have lost my train of thought now. The point I am making is that the things that can happen are really quite shocking. This is just one inquest that I have been involved in. I can recall a case a number of years ago. I was called in to assist with the settlement of a claim. It was a person, non-English-speaking, who had come into a hospital. They had come in. Their husband had spoken to the gynaecologist. The patient had had a tubal ligation. The patient thought that she was having an appendectomy. The thing was that the husband did not want the children. The wife could not speak English. That was the outcome of that situation. Here we are facing a bill which will say things like, "Well, you can have consultations over the phone. You can have documents signed remotely." I have already said earlier this year I came across a forged guardianship order. The interesting thing about that is that the clinical staff had been using that order as authoritative for years. It was only that it came to somebody like myself, who said, "That language is odd," that you picked up that there was something really not right with the particular type of order.

I can tell you about inquests that I have been in, where persons had been determined to have capacity, by GPs or by other people, and on the basis of that determination of capacity they have engaged in conduct that brought about the end of their life. Then in the course of the inquest, and I am talking about older people here, the expert psychogeriatrician has come on—I am thinking of two or three cases where this has happened—that said that the assessment of capacity in an older person is a very specialised area and that the capacity assessments of the GP and the staff at the nursing home were completely wrong.

I know that we have got a presumption in favour of capacity in the bill, and I know that this is a common feature of the law, the presumption of capacity. But given what I have seen and the number of cases and the issues and the disputes between learned practitioners, when we are dealing with something as terminal as the end of life I am wondering whether this is the right place to just allow that presumption to stand. Also, as I have said, I worry about coercion and abuse. The last thing I would say, as many people have said, palliative care—we want to have an equal playing field for everybody. But manifestly that is not the case in relation to services such as palliative care. One of the things I worry is something like, "If the only option is VAD, is that a subtle coercion towards VAD, when another viable option, if we were prepared to fund it, would be excellent, accessible palliative care for everybody?" I am sorry. I have taken a bit long. But I will table the statement.

The CHAIR: Thank you. Mr Millard, you have got the opportunity.

Mr GRANT MILLARD: Thank you. Good afternoon. My organisation, Anglicare Sydney, is a large provider of residential aged-care services in New South Wales and one of the largest providers of retirement living in Australia. Our residential aged-care homes are intimately familiar with the end of life and dying. Yet it is a wonder that staff and residents are not immune to the grief of loss for friends that they have shared life with over months or years. Residential aged-care homes celebrate life. It is particularly precious when it is short and measured in days and sometimes hours. Good residential aged-care homes are communities of people doing life together. They are not a random association of autonomous individuals housed in an institution. They are a home where residents have chosen to live together in community.

This bill under consideration will fundamentally change the confidence and trust that residents place in staff and management of homes. This bill will compel residential aged-care operators to allow VAD in their homes, which will be against their objects, their mission and their calling. While supporting my colleagues here today, my primary focus will draw the attention of this Committee to the fundamental lack of balance in this legislation. It is flawed because, although the bill in clause 89 expresses a form of conscientious objection for residential aged-care homes, the operative provisions of part 5 override any home's objection to VAD by absolutely prioritising the decision of one resident against the interests of their community who fundamentally disagree with the unnatural termination of human life. This result is untenable. It goes further than many of the proponents of VAD suggest in their own submissions. In support of this claim, I draw your attention to submission 43, of the NSW Nurses and Midwives' Association, where at paragraph 10 the position statement reads:

> Legislative reform must ensure that no individual, group or organisation shall be compelled against their will to either participate or not participate in an assisted or supported death of a person.

The bill before this committee contravenes this principle by compelling residential aged-care homes to participate in VAD. It will be impossible for the property, resources and staff of homes not to be involved. The amendments proposed in the Anglicare submission No. 55 focus on correcting this imbalance and seek to insert a modest rebalancing of interests. And in formulating our suggested amendments, we have pursued the middle ground or the reasonable accommodation model, which has been documented again by proponents of the bill in submission No. 97 by Professors White, Willmott and others. Standard 1 of the Commonwealth aged care standards requires that an aged care recipient must be treated with dignity and respect and must be able to maintain their identity. They must be able to make informed choices about their care and services and live the life they choose. Our proposed amendments reinforce choice. Clause 98 of the bill as drafted supports informed choice by requiring advertising about the non-availability of VAD, and we support this. On the other hand, clause 89 of the bill as drafted pretends there is choice but currently there will be no choice for residents, staff and owners who do not want VAD to be practised in their homes—their home where they have chosen to live well until the end and to experience life-affirming care.

Proponents of the bill note that people should not be restricted from lawful choices in their home. Affirming and enabling individuals' choice drives this bill. The amendments proposed by Anglicare will not constrain choice for those who want to make use of the provisions under the bill. Our amendments proceed on the basis of informed choice by an individual to select a residential aged care home that provides VAD services should they choose. Standard 2 of the Commonwealth aged care standards requires assessments, planning and regular reviews of care and services, including advanced care planning and end-of-life planning. To maintain compliance, a residential aged care home must facilitate review of residents' plans for end of life. Pursuant to clause 2 of this bill, there will be at least 18 months for any current resident to consider or reconsider a future choice for VAD and to make plans with a home support for any relocation that they may need to pursue. There is adequate time for informed choice and community education. I urge this Committee to support the Anglicare amendments proposed in submission No. 55, which will promote dignity, choice and freedom of conscience.

The CHAIR: Thank you, Mr Millard, and thank you to all the witnesses who have provided their statements today. Unfortunately, we are out of time.

Mr DAVID SHOEBRIDGE: Could I ask for one question to be taken on notice?

The CHAIR: Yes, Mr Shoebridge.

Mr DAVID SHOEBRIDGE: It is really to Mr Green and Mr Montague. In both of your submissions, you state the adverse potential consequences for people in the palliative care system. The only rigorous evidence we have had in relation to that is reference in submission No. 1a and a very recent Canadian journal which found quite the opposite: A study of hospice palliative care providers found a very positive response and a very positive outcome for palliative care providers in the last four to five years of the Canadian experience. So I just give you the opportunity, if you choose, on notice to persuade us why that evidence is not compelling.

The CHAIR: With that, I will draw this session to a close.

(The witnesses withdrew.)

PETER KURTI, Director, Culture, Prosperity & Civil Society program, Centre for Independent Studies and Adjunct Associate Professor of Law, University of Notre Dame, affirmed and examined

CHRISTINE CAMPBELL, Chair, Australian Care Alliance, sworn and examined

BERNADETTE TOBIN, Director, Plunkett Centre for Ethics, sworn and examined

JOHN DAFFY, Treasurer and Medical Spokesperson, Australian Care Alliance, before the Committee via videoconference, sworn and examined

The CHAIR: Thank you very much to the witnesses who have joined us now for the next session. I will now invite opening statements. Associate Professor Kurti?

Adjunct Associate Professor KURTI: Chair, thank you very much for giving me the opportunity to give evidence at this inquiry. Much of what I have written about on this issue, including my submission to this inquiry, has been in the course of my work at the Centre for Independent Studies [CIS]. However, I appear here today in my own capacity and not to represent the views of the CIS, which are quite divergent, in fact, on this matter. It is my view that the legalisation of voluntary assisted dying calls into question fundamental principles concerning the wellbeing of others and challenges some of our key moral principles about the deliberate taking of human life. Therefore, in my remarks I would like to sketch the broader impact that I believe VAD will have on our society.

Advocates for the legislation tend to build their case upon a series of individual experiences, which are often tragic, and then they move from the specific to the general, although it has to be noted they tend to discount individual situations where abuse occurs. Those situations do not count against their argument. While I certainly have great compassion for those who do suffer, this inductive approach to lawmaking, where a law with general application is argued for on the basis of specific observations, is, in my view, misguided. Rather, I believe we ought to adopt a deductive approach to lawmaking, which begins from the articulation of general principles and proceeds from there to address specific situations. The law which prohibits the deliberate taking of human life—a law informed by general principles regarding the value of every human life—is the same law that currently prevents the practice of voluntary assisted dying. It is my view that we tamper with this law at our peril and, in doing so, threaten great harm to our culture and to the fabric of our civil society. Certainly the medical profession ought to strive for the palliative relief of suffering. No-one should ever have to die a bad death. Disagreement arises over how to bring about that relief, however.

I recognise that some struggle to access high-quality palliative care services in New South Wales, particularly those who live in rural and regional areas of our State. This is an issue clearly on which the Committee has already heard from palliative care specialists. However, it is my view that for us to turn to voluntary assisted dying as the source of relief from suffering is to overlook the fundamental role palliative care needs to play in the provision of health services. I should add that while compassion is often cited as a principal reason for sanctioning euthanasia, data from other jurisdictions suggests that inadequate pain control is seldom the main reason people seek assistance with ending their lives.

I also think we must attend to the possible impact of legalised voluntary assisted dying on the medical profession itself, which is a matter on which the Committee has already heard a good deal of evidence. Licensing doctors to end the lives of their patients, I believe, threatens the trust a patient has in that doctor's professional commitment to her wellbeing. Damage to the relationship between doctor and patient will also damage the standing of the profession of medicine. By changing the law, we not only threaten the social, legal and cultural norms underlying civil society, we threaten to change society itself. It is already apparent from jurisdictions such as Belgium and the Netherlands that the categories of those eligible for VAD inevitably expand. Indeed, imposition of any categories of eligibility is inconsistent with arguments about autonomy of the individual.

The testimonies of those who have watched the anguished deaths of family members are, of course, deeply moving. However, I believe that the legalisation of euthanasia and physician-assisted suicide is, ultimately, an issue of public policy. In considering the proposed legislation, I believe that we need to act in such a way as to advance the common good and to uphold the fundamental principles of our society. In formulating legislation, we also need to adopt an appropriate form of reasoning which adheres to those fundamental principles rather than subverts them. In conclusion, Chair, my view is that the legalisation of voluntary assisted dying in New South Wales will enshrine in law what amounts to a subversion of those principles, a rejection of the duties we owe to others and a rejection of the claims others have upon us.

The CHAIR: Ms Campbell, would you like to make an opening statement?

Ms CAMPBELL: Thank you, Chair. Dr Daffy was intending to be up here but due to medical necessity down in Melbourne and his work, he has had to remain there. Could he do the opening statement? I will supplement it, thank you.

The CHAIR: Absolutely. Dr Daffy?

Dr DAFFY: Thanks very much to the Committee for the opportunity to present evidence today on this most difficult of subjects. To introduce myself, I am a general infectious disease physician with 30 years of experience and I have particular skills in diagnosis, diagnostic error and indeed errors within medical systems. The desire to bring forward and debate this legislation is prompted by a very real and profound suffering that can occur to some at the end of life. I am also moved by some of the personal stories people bring to this debate. Very often, such stories are actually illustrative of poor medical care and indeed in some circumstances there has been actual medical neglect. It is particularly troubling that large numbers of people in New South Wales and Australia do not have access to specialist palliative care. Indeed, this legislation proposes doctors facilitate suicide and deliver lethal injections under a circumstance for some where specialist palliative care is not even available, thus creating the circumstance where your Government will help you take your own life but will not provide the care you need to relieve your suffering.

The clear issue with this bill, despite its well-meaning drafting, is the certain wrongful deaths that it will bring. The Care Alliance submission fully explains why wrongful deaths will occur due to wrong diagnosis, wrong prognosis, failure of access to the specialist palliative care, subtle and even innocent coercion and rarely even elder abuse. Of particular note, doctors are clearly shown in literature to very often miss treatable depression and demoralisation, which are major drivers of suicide. No assisted suicide or euthanasia bill can avoid wrongful deaths, but the particular issue with this bill is that it does not require a specialist medical practitioner to be involved in the process when medicine and treatment options are becoming more and more sub-specialised and indeed beyond any one individual general practitioner.

The bill allows for doctors to raise the topic, which is of itself a form of subtle coercion. This bill does not mandate a psychiatric assessment from a specialist psychiatrist to reduce the risk of wrongful death due to unrecognised depression and demoralisation. This bill does not mandate access and indeed assessment by a specialist palliative care physician to outline the medical treatment options other than suicide. What were lauded as safeguards against wrongful deaths in previous debates have within a few short years now become described as impediments to access. The bill has claimed to be able to avoid violent suicides, but the violent suicide rate in Victoria has been unaltered by the introduction of such legislation. In addition, a review of 118 Victorians with cancer who died of violent suicide by O'Dwyer et al. over a four-year period in Victoria showed that only 13 per cent were receiving palliative care and 43 per cent actually had pre-existing mental illness, illustrating that we should be providing much better palliative and psychiatric support at the end of life. I will pass to Ms Campbell for a quick comment.

Ms CAMPBELL: Chair and members, ultimately I see this hearing as an opportunity to converse about whether you as lawmakers would administer a lethal injection based upon this legislation or you would help a person mix the schedule 4 and schedule 8 prohibited drugs that will allow them to suicide. After the evidence you have heard—and I have sat through it since 12 o'clock—and all the submissions you have read, do you know that doctors are infallible? Do you know that there will not be an error in diagnosis or prognosis which could be lethal? A 1 per cent error in diagnosis or prognosis is 100 per cent irreversible. Then I think again, as lawmakers in the time you have sat in this Parliament, have you had the opportunity to hear family and friends comment upon how tired they are of caring for a person, how frustrated they are, how tormented they are as they watch someone who they love get sicker and sicker and sicker?

After what I have listened to today and as a palliative care volunteer, I know that when palliative care steps in, the whole community surrounding that dying process—the individual, the family, the loved ones—are better equipped with facing dying, which for most people is not something they are practised at. When you are giving birth, you go to plenty of training sessions on how to introduce life, but at the other end of life, until palliative care gets involved, most of us never have opportunities to do that. I am asking you, as you are fully aware of individuals that come into your electorate office and the people you talk to and the emotional stories you have heard both for VAD and against assisted dying and suicide, when you have examined the evidence, can you guarantee if you were administering the schedule 4 and schedule 8 drugs, would the person have a quicker death?

If you look at the submission from the Australian Care Alliance, you will see that there are no guarantees of a quick death or a painless death when this system is put in place. So if it is based on the relief of pain and you have to be 100 per cent guaranteed that if you believe this is the only way that pain can be relieved that you would actually administer that lethal injection, I cannot see how you could come to that conclusion after hearing the evidence that has been presented here today with what palliative care has to offer. The other point I would like to make is, as lawmakers, you must consider both the consequences of detection and the ability to convict somebody who may not have followed this legislation. In evidence you have had earlier today and in submissions that I know have been put before you, with all the goodwill in the world, I cannot see how you could look any constituent in the eye and say, "We know for sure that there will not be duress, coercion, that there will never, ever be medical errors."

I cannot see how you could pass such legislation without having that guarantee. So, as lawmakers, you must consider both the consequences of being able to detect a breach of this law and the likelihood of a conviction, and all of that so often depends on what occurs behind closed doors and the subtle comments that are made when people come to visit their loved ones—"It took me an hour to get a parking spot", "I'm worn out", "Haven't you had enough?", "This is going to cost a lot." There are all kinds of comments that can be dropped that can never be proven because they are behind closed doors. That is from a citizen point of view, but the best example I have got is from a hospital in Melbourne where I begged this couple to lodge a formal complaint, where a couple have gone in to the oncologist but once they had a vast array of treatment options, it diminished, diminished, diminished, diminished, and the oncologist has said, "There is not much left in the way of options for treatment, but in Victoria you have got one other option, and that is voluntary assisted dying." That is in a State that prohibits it being raised. The reality is people will be pressured and, knowing that, do you know intellectually that you have got foolproof legislation that will never, ever have a wrongful death? Thank you.

The CHAIR: Thank you very much. Dr Tobin, can I invite you now to make an opening statement?

Dr TOBIN: Thanks very much. I will be as brief as I can. I sat down the back here putting lines through quite a lot of what I had prepared to say because of the pressure of time.

The CHAIR: I cannot tell you how much I thank you.

Dr TOBIN: I could give it to you and you could see all the lines. Doctors are trained to help us look after health and our health-related wellbeing. That goal shapes good practice, even as someone dies, for there it means doing what a doctor can to assist the patient to die in comfort and with dignity—thus withdrawing and withholding futile and overly burdensome treatment; thus relieving physical symptoms of frailty, disease, even if that hastens death; thus the empathy of a doctor as a fellow human being to someone who feels ashamed of their dependence on others, anxious about the burdens they impose on others, lonely, bored, demoralised. Today, some people die well and some people die badly. Understandably, we all want assurance, comfort, so-called insurance that we will not suffer physically as we die.

Whether we will be lonely or feel we are a burden on others or feel we have wasted our lives or we will feel sad or frightened, those are matters that go beyond the remit of doctors to resolve. Relieving them is not something that doctors are trained to do, though of course a good doctor is sensitive to the presence of any of these forms of suffering and does what she can, as a fellow human being, to respond to them. But this bill is about something entirely different. Suicide is always a tragedy. It is very bad that doctors will be free to assist suicide, worse that they will be free sometimes to administer the lethal substance themselves. And yes, there is a binary between good end-of-life care and assisted suicide: one belongs to the practice of medicine, the other corrupts the profession, as this bill most certainly will.

I have two other points. One goes to the way it is drafted. The eligibility criteria do not protect those who need our protection through you. It recognises that there is a need to protect people who may be subject to pressure or duress, so it recognises that some people are very independent, unusually independent, and some people are ordinarily susceptible to the widespread devaluation of the lives of the elderly. Protecting them is as much a matter for you as it is advantaging those who are free of pressure and duress. The bill says in 16 (1) (d), (c) and (e) that the person has to have decision-making capacity, must be acting voluntarily and not be acting because of pressure or duress. I reckon it fails, as currently drafted, on all three of those standards. It does not require that the patient demonstrates decision-making capacity.

This is very important. This is not a health-restoring intervention to which the capacity for decision-making may be presumed. This is not an instrument for advance care planning in which people can make known in advance what life-prolonging treatments they would want and they would not want, what they accept. This is something entirely different. It is a death-dealing intervention for which evidence of capacity for decision-making should be positively required. The bill does not effectively ensure the patient is acting voluntarily. If the drafters were serious about voluntariness, the bill would say that a person ceases to be eligible for VAD if he or she loses decision-making capacity at any time—that is, they would exclude the extension of eligibility to people with dementia. The bill should expressly prohibit the writing of an order for VAD in advance care directives, for once eligibility is extended to those who seek VAD if they come to suffer from dementia, then genuine voluntariness is gone. And the bill does not ensure that the patient is not acting because of pressure or duress. That is not something doctors are competent to assess, as Dr Chye said just before, for it is not a medical judgement.

The bill requires that the doctor makes this assessment of the patient, the two doctors independently of each other, but it provides no mechanism for detecting whether that independence is the case. Failure to act independently would never be capable of detection, and on this matter there is no comfort to be gained from Victoria, despite the claim that there is no evidence of pressure or duress there, because the review board offers no opportunity for that to be recorded. So even if it were possible to draft a platonic set of safeguards, they, I submit, would be ineffective. So-called safeguards cannot be effective because there is no way of enforcing them, no way of policing them. The bill will rely on self-reporting. It will be as safe as would be enforcing the payment of taxes by relying solely on individuals to report their own infringements. And I must add that the addition of 41 (c) does not help because, again, there is no prospect of it being detected.

One last thing: Over the last couple of days there has been a kind of implication that legalising assisted suicide will reduce unassisted suicide. There has been a kind of thought in the air that assisted suicide is a kind of suicide prevention. We have heard very sad, terrible stories of people who have thought they have had to suicide on their own without saying goodbye to the family in order to avoid a terrible dying. No-one can be unmoved by those stories. But the evidence does not support the claim that legalising assisted suicide diminishes the number of unassisted suicides. Legalising physician-assisted suicide in Oregon has led to an increase in the rate of total suicides and not a decrease in unassisted suicide. The same is true of Switzerland. I would be very happy to supply the references for that data if anyone asked me to do so.

To conclude, legalising VAD will not change the fundamental facts. There are factors that make people vulnerable to suicide and there are factors that are protective against suicide. I submit that even if you pass this bill, a fundamental question will remain: How can we help people with serious disease and disability find hope in life and cope with the challenges that human life inevitably brings?

The CHAIR: Thank you very much for that.

Mr DAVID SHOEBRIDGE: Thank you for your submissions. Ms Campbell, until I read your submission I had never heard of the Australian Care Alliance. I do not know what your organisation is and what its membership base is comprised of. I am wondering with what authority you come here. What is the Australian Care Alliance?

Ms CAMPBELL: The Australian Care Alliance originally began after the Victorian voluntary assisted dying legislation. It has since become national. It is composed of people who are current or past legislators, who are doctors, and who are lawyers, researchers and people interested in this topic in the community.

Mr DAVID SHOEBRIDGE: Is it member-funded or does it receive its funding from other organisations?

Ms CAMPBELL: It is member-funded but all of us operate as volunteers. There is no secretariat; there is no office.

Mr DAVID SHOEBRIDGE: Can you indicate how many members it has? Because if we just see an alliance, I really do not know what it stands for. Is it five members or 10 members?

Ms CAMPBELL: It is members who are—it is not hundreds and thousands of people who are members; it is members in all the States who are interested in this topic. I do not have the numbers in front of me.

The Hon. ANTHONY D'ADAM: You can take the question about how many members on notice.

Ms CAMPBELL: Okay.

Mr DAVID SHOEBRIDGE: But its primary purpose is to advocate against law changes like this.

Ms CAMPBELL: Its primary purpose is to educate the public on good end-of-life care and to alert legislators about the dangers of this type of legislation.

The Hon. ANTHONY D'ADAM: Maybe Dr Daffy can provide some information about the funding of the Australian Care Alliance. He is the treasurer.

The Hon. GREG DONNELLY: Point of order—

The CHAIR: I will hear the point of order.

The Hon. GREG DONNELLY: I think it is reasonable to ask questions about an organisation that comes before the inquiry.

The Hon. ANTHONY D'ADAM: Indeed, you did it yesterday

The Hon. GREG DONNELLY: Yes. But pursuing a line of questioning into the financing of an organisation is going somewhat beyond what is reasonable. Those matters can be researched by the individual member, who has got access to the internet. I do not believe the question falls within the remit of the terms of reference of this inquiry, which is an inquiry into the provisions of the bill.

The Hon. TREVOR KHAN: Indeed, I took this point of order on Wednesday, Greg. I support you with this proposition.

The Hon. GREG DONNELLY: No, this is going into the finances.

The CHAIR: Order!

The Hon. ANTHONY D'ADAM: The shoe is on the other foot now.

The Hon. TREVOR KHAN: I think it is outrageous.

The CHAIR: Order!

The Hon. GREG DONNELLY: I did not talk about the numbers, just the finances.

The CHAIR: Order!

Mr DAVID SHOEBRIDGE: They took it and lost.

The CHAIR: Order! I am going to rule on the point of order. I note the ruling that I made when Mr Khan took the same point of order. I ruled the question in order but I warned members that this was potentially going to open Pandora's box and that it may come full circle.

The Hon. TREVOR KHAN: No, I think I said that.

The CHAIR: No, it is in the transcript.

The Hon. SCOTT FARLOW: No, Wes did.

The CHAIR: I did mention Pandora's box.

Ms CAMPBELL: I have already answered that, Chair, in that I said we are not funded by any other organisation. We are not aligned—

The CHAIR: Ms Campbell, I accept that. However, I am making a ruling at the moment.

The Hon. TREVOR KHAN: Ms Campbell knows how it works.

The Hon. GREG DONNELLY: Take it on notice.

The CHAIR: I am making a ruling. The question is in order. I note that Dr Daffy's title is treasurer of the Australian Care Alliance. I rule the question in order. Mr D'Adam has the call.

The Hon. GREG DONNELLY: That is a note given to you by him, so that is the reason for that.

The CHAIR: What note?

The Hon. GREG DONNELLY: The notes.

The CHAIR: Order! The note is from Mr Shoebridge saying that—

The Hon. GREG DONNELLY: That is right; the notes came round. I watched it.

The CHAIR: No, the note says, "We will propose that we have a break at 10 minutes instead of 15."

Mr DAVID SHOEBRIDGE: To give these witnesses more time.

The Hon. GREG DONNELLY: Yeah, right.

Mr DAVID SHOEBRIDGE: That is what it says: "give the witnesses more time".

The CHAIR: That is the note. It is right here; you can read it.

The Hon. TAYLOR MARTIN: All right, let's get on with it.

The CHAIR: No, I am really starting to tire of this, Deputy Chair.

The Hon. TAYLOR MARTIN: Either which way, let's get on with it.

The Hon. GREG DONNELLY: Well, there are notes being passed around, so—

The CHAIR: I am telling you that is the note and I have it right here.

Mr DAVID SHOEBRIDGE: Proposing to give your witnesses five minutes more time. The conspiracy theories need to cease.

The CHAIR: I have just about had enough of my integrity in the chair being questioned.

The Hon. TAYLOR MARTIN: If people don't mind, I would prefer to hear from the witnesses rather than Committee members.

The CHAIR: I am going to ask you to withdraw that.

The Hon. GREG DONNELLY: I withdraw.

The CHAIR: Thank you. Mr D'Adam, you have the call.

The Hon. ANTHONY D'ADAM: Dr Daffy, what is the current annual budget of the Australian Care Alliance?

The Hon. GREG DONNELLY: Point of order—

The CHAIR: I will hear the point of order.

The Hon. GREG DONNELLY: My point of order is that the terms of reference for this inquiry are into the provisions of the bill. To be opening up a line of questions to—

The CHAIR: I am prepared to rule on this already.

The Hon. GREG DONNELLY: Well, no—

The CHAIR: Don't do it again!

The Hon. GREG DONNELLY: I—

The CHAIR: Don't do it again or I will—

The Hon. GREG DONNELLY: Don't pressure me.

The Hon. TAYLOR MARTIN: Wes, sit down.

The Hon. GREG DONNELLY: Sit down, mate.

The CHAIR: I have already ruled on this issue.

The Hon. GREG DONNELLY: I was taking another point of order; it wasn't the same one.

The CHAIR: I know. I have ruled, however, that the question is in order. I also mentioned on Wednesday that I was allowing a level of latitude with your questioning—

The Hon. GREG DONNELLY: On membership, not finances.

The CHAIR: —and it would be extended to the other hearings. Mr D'Adam, you have the call.

The Hon. ANTHONY D'ADAM: I have asked my question.

The Hon. GREG DONNELLY: Point of order—

The CHAIR: I will hear the point of order.

The Hon. GREG DONNELLY: The point of order is that this inquiry is into the provisions of the legislation—

The CHAIR: I have already ruled on this point of order. Mr D'Adam has the call.

The Hon. GREG DONNELLY: —and that with respect to this question—

The CHAIR: If you want to cavil with my ruling, you know the procedure. You can challenge it or you can be quiet, Mr Deputy Chair. Mr D'Adam, you have the call.

The Hon. ANTHONY D'ADAM: I have asked my question. I am happy for it to be answered.

Mr DAVID SHOEBRIDGE: To Dr Daffy.

Ms CAMPBELL: Excuse me, Chair. As chair of Care Alliance, am I allowed to ask have other organisations been requested to provide their financial details?

The Hon. GREG DONNELLY: The answer is no.

The Hon. TAYLOR MARTIN: You are the only one.

The Hon. GREG DONNELLY: You are the only one.

The CHAIR: The question is in order given the latitude that I provided to other members in previous hearings, noting that I did specify that it would open Pandora's box and it would be open to other members to pursue similar lines of inquiry.

The Hon. GREG DONNELLY: Point of order—

The Hon. TAYLOR MARTIN: To be frank—

The Hon. GREG DONNELLY: —that is not true.

The Hon. SCOTT FARLOW: Point of order: We are getting close to time. Can the witnesses at least take the question on notice and we have the 10-minute break that we were going to have.

The Hon. TREVOR KHAN: They can decide whether they want to answer it or not.

The Hon. SCOTT FARLOW: It is a matter for them.

The CHAIR: I will allow the question to be taken on notice. Noting the time, I am going to ask that any of the questions taken on notice will be provided to—the secretariat will liaise with the witnesses and provide the opportunity to table them within the specified time. I thank the witnesses for appearing today.

(The witnesses withdrew.)

(Short adjournment)

CHRISTOPHER BROHIER, Legal Counsel, Australian Christian Lobby, before the Committee via videoconference, sworn and examined

ALEXANDER MILLARD, Solicitor, Human Rights Law Alliance, before the Committee via videoconference, sworn and examined

GREGORY PIKE, Director, Adelaide Centre for Bioethics and Culture, before the Committee via videoconference, sworn and examined

BRENDAN LONG, Chief Executive Officer, Right to Life NSW, sworn and examined

The CHAIR: Thank you very much to the witnesses who are joining us today for the final session. I note that we are trying to bring up one more witness on the Webex system. In the meantime, Dr Long, I invite you to make an opening statement.

Dr LONG: I thank the Committee for the opportunity to present a brief statement. As will be known to many, Right to Life NSW is an organisation that has existed for many decades presenting, on one hand, a values proposition that we are an organisation that does believe in the value of human life, and we would emphasise the role of the State, as its primary obligation, to defend human life from its start to its natural end, as a fundamental duty of the Government in New South Wales and of the Parliament in New South Wales. Besides having it being a value-based organisation of wide membership—20,000 people on our email list in New South Wales alone—we are also an evidence-based organisation, and we like to present strong policy arguments and concerns for our position. I am a professional social science researcher and professional public policy specialist, so it is actually more in relation to the latter issues that I would like to draw the Committee's attention.

While there has been many a debate on the bill and we have presented a substantial submission, which I am sure many of you have had the opportunity to read—some of you might even have heard us as we were rallying outside when the Parliament was sitting in the Parliament's session briefly one afternoon——our concerns in relation to the public policy concerns in relation to this bill focus on a number of issues but, in particular, the question of the risk to the vulnerable persons, especially those with mental illness. One of the key issues that I think needs further consideration, in the consideration of the issue around the country, is in relation to the Victorian legislation—the only legislation of which we have had any attempt to have any sort of serious analysis. It is only in the last report of the Voluntary Assisted Dying Board that there has been any discussion of how many psychological assessments were actually taken in relation to the large number of cases that have occurred. That number is 17—17 assessments. Of course, there have been 250-odd deaths.

Of those 17 assessments, we do not know how many were rejected—how many people who were called for a psychological assessment to determine their mental capacity. We do not know. We only know there were 17 undertaken. We do not know. Maybe all were accepted, and we just do not know. It is that paucity of data that worries me. Something that should be considered in the passage of this bill is whether it would not be better to have the benefit of greater experience from Victoria and from Western Australia before proceeding down this bill and have a greater evidence base, particularly in relation to the impact of psychological assessment. That also would be an issue which could be raised in terms of creating greater data that might flow from the bill if it does become law. I would also briefly like to point to a couple of other issues.

The first issue is that, as you would have been aware from the debate, there is considerable argument about not meeting palliative care benchmarks in New South Wales. As you know, the national benchmark is the international benchmark: two full-time equivalent palliative care specialists per 100,000 of the population—basically at 91 FTE. At the moment we are about 1.1, but we should be two. So we are about 60 per cent of where we should be, and that remains a concern. It seems to be difficult to countenance how a person could be really given a choice when the services that they need to be able to make an effective choice are simply not funded at a level that is accurate. It seems as if the choice is not really an adequate choice.

I do want to respond briefly to another quick issue on palliative care. I would draw attention to the University of Wollongong study, which considered the pain control effectiveness, in particular, of palliative medical programs. It was debated by some that the figure of 6 per cent was the failure rate. In fact, the data shows—and it is in our submission; I have the graph before me—that after the palliative care plan is activated and allowed to develop under the supervision of a palliative care specialist, that failure rate falls to 2 per cent. That is the data—not 6 per cent but 2 per cent—and even in those cases it could be lower. Some people want to go home to die in their last days or they want to pursue some treatment for religious or other reasons. So we should be clear that we are talking about a very small cohort of people for which the palliative care system is not effective. This is independent research conducted by a university in New South Wales.

I would also briefly draw the Committee's attention to some analysis that I undertook in terms of my modelling. I did this modelling in Victoria when I estimated, using international experience, that by 2030 you would have 1,000 deaths a year in Victoria—just using the standard international incidence of these voluntary assisted dying schemes overseas and applying them to the Victorian growth rate. That was published in *The Australian*, of course, as many of you would know. Using the similar analysis in New South Wales, that figure, between 2023 and 2030, will grow to 1,240 cases per year. That is the estimate based upon international experience. That compares to a death rate for motor vehicles in 2019 of 340 people. So this scheme is estimated to have a greater incidence of death—three times the incidence of death—of motor vehicle road fatalities in this State, so we are looking at something of some significance.

That also has to be said in the context of what has happened in Canada. As many of you would know, the Canadian scheme has simply exploded. In its first 12 months it grew by 34 per cent. Now it has come to a situation where you have 8,000 assisted suicides every year in Canada. That is a death rate of 2.5 per cent of all deaths in Canada, whereas these schemes are meant to only operate at 0.4 per cent of all deaths in any jurisdiction. So the data from Canada is genuinely scary. It is simply about the instance of the schemes. I will just draw this to the Committee's attention as social policy research and further suggest that that is an issue that should give members concern in relation to the bill.

I will make a final comment if I may. A position that we have taken as an organisation for some time, based upon the evidence of the oral medication in Oregon, is that there is a high degree of failure rate with the oral medication. It is distinct from the lethal injection. Failure rates are about 12 to 15 per cent. The test of effectiveness is that you die within 60 minutes—fall asleep within 60 minutes. Now, the evidence is that that does not occur in 12 to 15 per cent of cases, and there are horrific cases of people regurgitating the medicine and so forth. So I would draw to the Committee's attention the data that is evident from Oregon there and indicate that one option before all legislators in all jurisdictions is to consider whether this drug should not be reviewed by the Therapeutic Goods Administration like any other drug—like any Panadol pill that we have in the country—just to ensure it works as it is effected. One could speak longer, but I open myself to questions from the Committee members as appropriate when the others have made contributions.

The CHAIR: Thank you, Dr Long. I now invite Mr Brohier to make an opening statement. I believe you are on mute, Mr Brohier.

Mr BROHIER: Thank you, Chair. This bill poses four questions for this Committee and this House. Do you want more or less deaths in New South Wales in any given period? If you support this bill, you are voting for more deaths. The second question is this: Are you willing for the prescription and administration of poison to an 18-year-old who has an indefinite and unknown period of time in which to live, in which time a cure may be found for their condition? The one good section in this bill, in my submission, is section 7. It is a good section because it is honest. It says:

> (1) The Health Secretary may, in writing, approve a Schedule 4 poison or Schedule 8 poison for use …
>
> (2) A poison approved … is a voluntary assisted dying substance.

That is the definitional cover. The issue is if you support this bill, you are supporting the giving of poison to a living human being to kill them. The third question: Are you willing to allow assisted suicide on the basis of the suffering of a person when you do not know that death will relieve the suffering? The unspoken premise of this bill is death is better than a life of suffering. But if you look at it from the great traditions of faith from a Hindu or Buddhist view, you are in fact assigning that person to a new life in a new reincarnation. From an Islamic view, you are assigning that person to the hands of Allah for heaven or hell. From a Christian point of view, you are assigning that person either to heaven, if they have trusted the Lord Jesus Christ, or to hell.

It is only if you look at it from a purely material point of view that when we die we are nothing but dead fish on the beach that you can say death is better than suffering. Even then, you do not know that because you do not know whether nothing is better than something. The last question is this: Are you willing to vote for the death of a person when you know that everything that can be done to make a better life than a life of intense suffering—that is, the life of less suffering and more pleasure—cannot be provided to everyone in New South Wales because you know that there is not adequate provision of palliative care? You have heard plenty of evidence of that today. In the other place, in *Hansard* of 25 November 2021, page 81, there is some good evidence [audio malfunction].

The CHAIR: Mr Brohier, we have actually lost your audio. You may have muted yourself.

Mr BROHIER: Sorry?

The Hon. SCOTT FARLOW: You are back.

Mr BROHIER: I am back on?

The CHAIR: Yes, you are.

Mr BROHIER: Yes. There was a reference by the Hon. Trevor Khan to *Hunter and New England Area Health Service v A*, a 2009 decision of the New South Wales Supreme Court. It was suggested that it was the case of a schizophrenic; it was not. It was the case of a Jehovah's Witness who presented with renal failure. I make these points about that case. At paragraph 5, it is clear that the case was a decision from comparing the autonomy of a person with the duty of a State to uphold life. Therefore, it is not relevant to this discussion when you are considering the State wanting to authorise the taking of life.

At paragraphs 31 to 34, there was a discussion about when the doctrine of necessity kicks in. It was made clear that an advance care directive can be challenged if there is valid reason to suspect that it was not properly entered into—paragraph 34. At paragraph 35, the court said you cannot answer that question in the abstract. You have to look carefully at each situation and unpack the circumstances. Therefore, the proposition advanced by the Hon. Trevor Khan is, in my submission, not fairly put. Lastly, the case was not [disorder] because in *Mercy Hospitals Victoria Ltd v D1 & Anor* [2018] VSC 519, that was the case of another Jehovah's Witness where a 17-year-old had declined treatment as she was pregnant, and if she did not get treatment she would die. The court said:

> … I am not convinced that overriding her expressed choice would so rob her of her essential self as to outweigh the loss she would suffer through losing her life or sustaining a catastrophic injury.

Thank you. They are my submissions.

The CHAIR: Thank you very much for that, Mr Brohier. I will invite Mr Millard now to make a short opening statement.

Mr ALEXANDER MILLARD: Thank you, Chair. On behalf of the Human Rights Law Alliance [HRLA], I would like to thank the Committee for the opportunity to participate in this inquiry into the voluntary assisted dying bill. HRLA is Australia's only religious freedom law firm, specialising in the area of freedom of thought, speech and conscience. We regularly have carriage of matters in all States and Territories, and a significant part of HRLA's work includes advising religious bodies and organisations that deliver services in accordance with their strong faith commitments. HRLA opposes the voluntary assisted dying bill. The bill is unethical, harmful to individuals and trespasses on the conscience rights of religious individuals and organisations. It should be rejected in its entirety.

There are just two brief main points that HRLA would like to make this afternoon. The first is that the bill fails to provide adequate protections for the conscience rights of medical practitioners and others, which could result in them having to participate in the VAD process. The internationally recognised right to freedom of conscience and freedom of religion is set out in article 18 of the International Covenant on Civil and Political Rights. This is a strong non-derogable right according to the interpreted Siracusa principles and has not been adequately protected by the bill. If I could turn your attention to clause 9 of the bill, this clause provides limited protection to allow a registered health practitioner to refuse to:

> (a) participate in the request and assessment process,
>
> (b) prescribe, supply or administer a voluntary assisted dying substance,
>
> (c) be present at the time of the administration of a voluntary assisted dying substance.

However, this clause in the bill does not allow a health practitioner to fully remove themselves from any participation whatsoever in the intentional killing of another human being. The bill does not give a registered health practitioner a right to refuse to provide information to a person about voluntary assisted dying, but the amendments to clause 21 (5) remove the requirement for a conscientious objective to provide information approved by the health secretary in the second print. But a positive affirmation of the ability to not provide information should also be included. Also, the bill does not give a medical practitioner the ability to refuse to participate in an administration decision and to refuse to prepare or dispose of a voluntary assisted dying substance. The bill should allow a medical practitioner to fully remove themselves from the VAD process, and the lack of clarity in this regard needs to be corrected.

The second point that we would like to make is in regard to religious community service providers. An important aspect of the article 18 right to freedom of religious belief and activity is the freedom of religious communities to act in accordance with their convictions. The bill fails to allow faith-based community organisations, like aged-care providers, to completely remove themselves from participating in the VAD process. Facilities are still required to provide access to persons involved in the VAD process. They also require residents to be transferred for VAD purposes. A faith-based organisation should not be compelled to participate in the VAD process in these ways. The bill, in this manner, does not respect the strong conscience rights of individuals in faith communities and should be rejected. At the very least, it should be amended to allow medical practitioners and other service providers to completely remove themselves from any and every aspect of the VAD process. Thank you.

The CHAIR: Thank you very much for that. Dr Pike, can I invite you to make an opening statement, please?

Dr PIKE: Thank you, Chair. I would like to thank the Committee for the opportunity to present a few thoughts. The comments I wish to make are relatively broad and go to the question of vulnerable individuals particularly, but also the broader development of a culture surrounding death and dying. This bill permits State endorsement of the deliberate, premeditated and intentional termination of a human life at a time in human history, and in a country such as ours, where there is probably the least risk of dying in unbearable pain. Such an irreversible act demands an extremely high standard of safety and security, for surely no-one would wish there to be a mistake that results in the termination of the life of one of their fellow human beings. Even a small risk that this might happen in State-endorsed death is unacceptable.

One of the key reasons I am personally opposed to capital punishment is that the small risk that exists that someone's life might be terminated when that person does not meet the criteria for death is a great concern; in other words, that the person is innocent. I expect this might be a common position. Similarly, a mistake under the regime that this bill envisions that results in a person's life being terminated would be a tragedy, but that is indeed what has happened and continues to happen in those places that have accepted State-endorsed, intentional termination of life. Termination of life without explicit request, as many will be aware, is common in the Netherlands and Belgium and falls outside the criteria of voluntary and chosen death. Such deaths might be seen as mistakes within the system or casualties of it.

While this bill does not allow for deaths like these, the kinds of mistakes that will likely occur fall within the territory of pressure and expectation to choose death. This bill makes an attempt to ensure there is no coercion, pressure or undue influence. However, these can be subtle and internalised. Anyone who has dealt with vulnerable patients and the complexities of their relationships knows how pressures can be applied in ways that can subtly and not so subtly direct them into something they do not really want to do but feel that they ought to do. Research consistently reveals an internalised sense of burden as a reason for euthanasia and assisted suicide; it is easy to make someone feel like a burden.

Research also shows that the other primary reasons for choosing death are loss of ability to engage in meaningful activities and loss of dignity, but again, surely these are the types of things that others can help with. Meaning can be found and discovered even amongst great difficulty. Dignity can be enhanced in many ways. Patients can be assured of their worth and dignified by their value, but offering the option of death is to truncate these possibilities. The assumption of free and unfettered autonomy in the context of the offer of death is not realistic. The bioethicist Emmanuel Hirsch put it this way:

> A patient may truly want to die, but this desire is not the fruit of his freedom alone, it may be – and most often is – the translation of the attitude of those around him, if not of society as a whole, which no longer believes in the value of his life and signals this to him in all sorts of ways. Here we have a supreme paradox: someone is cast out of the land of the living and then thinks that he, personally, wants to die.

From what we know already about the disturbing incidents of elder abuse within families, most of the persuasive pressure to choose death would likely come from that direction, and it can be very hard to identify without considerable expertise and investigation over time. But pressure could easily come from elsewhere, too. If my reading of the bill is correct, it would permit a carer, as a provider of professional care services—perhaps someone who helps with cleaning or dressing—to initiate a discussion about euthanasia or assisted suicide as long as he or she, at the same time, says there are palliative care options available and that the person should discuss them with their doctor.

These options only have to be mentioned. It does not take much imagination to see how such discussion could prove very persuasive. The bill places medical practitioners as the primary gatekeepers to identify coercion, pressure and undue influence, and only if the practitioner thinks there might be pressure are they required to seek assistance. But it is not hard to see how mistakes might be made and someone might slip through the net—a mistake, an irreversible one, just one or a few, but still mistakes: people made to feel they really ought to go, so as to stop burdening others, and made to feel they are consuming resources that might be better spent, lives made to feel they have no remaining value, and so death becomes a benefit.

We often speak of cultures within organisations that determine how they operate so that one may be better than another, or how cultures surrounding home disability services might be delivered, or how the banking sector operates, or how health care is delivered. The culture surrounding death and dying and how it is framed and shaped will be changed by endorsing assisted suicide and euthanasia. We must look to those who have tried this experiment to see what happens. When we do, we see a culture that devalues some lives and where, rather than ensuring each death is a result of self-determination, there are many that are not: cases that might be seen either as mistakes—irreversible ones—or, more worryingly, before long, justifiable within the culture that develops.

In conclusion, my concerns about this bill are related not just to where the culture of death and dying will go and develop over time, even though I am convinced that cultural shift would be for the worse, but also to the immediate implications for vulnerable people who, by being handed the option to choose death, in fact do so for a complex of reasons that for many will involve pressure and undue influence. If I can finish on a personal note, my father currently fits the criteria for this bill. He is surrounded by people who love and value him, but I have imagined what it might be like him if he were not. What if he were surrounded instead by people who saw him as a burden, or by a society with a culture in which he felt he had no dignity left? What would it be like for him? Would he feel drawn to euthanasia or assisted suicide? In the end, I do not want a society in which the frail and sick elderly feel undervalued or devalued—one in which they might choose death because no one wants them. If we want an inclusive society, we can do much, much better than that.

The CHAIR: Thank you, Dr Pike. Dr Long and those witnesses on Webex, if you read your opening statements, would you mind sending them through or providing a copy? It assists Hansard with the transcribing of the opening statements. I will now open to questions. Mr Shoebridge?

Mr DAVID SHOEBRIDGE: My initial question is to Dr Long. Doctor, you talk about an inevitable rise to—how many deaths were you predicting in a decade under this legislation in New South Wales?

Dr LONG: In a year, Mr Shoebridge, 1,240, based on international evidence.

Mr DAVID SHOEBRIDGE: Perhaps some of the best international evidence comes from Oregon, which has had legislation for some 22 years and has a population that is just over half of New South Wales. Do you know how many deaths have occurred after 22 years of the legislation in Oregon?

Dr LONG: In the model which I produce Oregon data is included, as is data from Washington state, Belgian, the Netherlands and other jurisdictions.

The Hon. TREVOR KHAN: Well, that's a bit of a problem.

Dr LONG: When you look at all the jurisdictions, Mr Shoebridge—

Mr DAVID SHOEBRIDGE: Do you know how many deaths in Oregon in 22 years?

Dr LONG: I will take that question on notice, but it is in the data. It is probably in my computer.

The Hon. TAYLOR MARTIN: I suspect Mr Shoebridge has it in front of him.

Mr DAVID SHOEBRIDGE: I am happy to assist. The most recent year that we have full reporting for, which is 2019, says it is a total of 188—not 1,200, not 1,000, not 500, not 600. Twenty-two years after the legislation was put in place, 188—a population over half the size of New South Wales. That surely is far better data than your predictions.

Dr LONG: Well, Mr Shoebridge, I would simply seek to refute that by saying that the Oregon data is built into that model, and I am very happy to provide to you all the foundations of the model.

Mr DAVID SHOEBRIDGE: By all means.

Dr LONG: Obviously the graph is in here and it has a bunch of spreadsheets underpinning it, and that data includes the Oregon model. But even if we take the Oregon model as being one of the least expansive ones, I have drawn your attention to the Canadian model, which unquestionably has led to a death rate of 2.5 per cent of assisted suicides of all deaths. I think that Canadian data is actually not in this analysis. So the analysis in that sense is conservative.

The Hon. ANTHONY D'ADAM: I would like to ask Dr Long a question. On page 2 of your submission you say:

> What has happened overseas is that schemes that were originally designed to be narrow in scope expand rapidly to become a form of opting out for people who find life too hard.

Dr LONG: Yes.

The Hon. ANTHONY D'ADAM: In Canada, for example, is the criterion for accessing voluntary assisted dying people who find life too hard? Is that the criterion?

Dr LONG: The criteria, of course, now seem to be interpreted that you do not even need to have a terminal illness, as the Premier outlined.

The Hon. ANTHONY D'ADAM: My question is about whether they find life too hard.

Dr LONG: Sir, the argument is this. It is hard to read your name in the distance there. I apologise.

The Hon. ANTHONY D'ADAM: D'Adam.

Dr LONG: In particular, in the Netherlands and in Belgium the culture appears to be—this is not just—

The Hon. ANTHONY D'ADAM: Not the culture. I want to know whether the criteria for access to the scheme is akin to what you have suggested.

Dr LONG: Yes. The criteria are interpreted, shall we say, by the doctors who administer the scheme, particularly in northern European countries, Belgium and the Netherlands, to be an available option for people who no longer want to see out their last days. There is not a culture of palliative care in the way that we have in this place. It becomes an option, I respectfully submit, for people for whom life gets too tough. Rather than facing the prospect of death with all the fear, they have this option provided to them by the State. The rapid incidence of these schemes overseas indicates that that is becoming a cause of concern, particularly as the eligibility criteria for the schemes, as you are aware, have increasingly expanded over the years.

The Hon. TREVOR KHAN: In some jurisdictions.

Dr LONG: Yes. In many jurisdictions. That is right, Mr Khan. Not in all. But it is—

Mr DAVID SHOEBRIDGE: Not in Oregon.

The CHAIR: Can we not interrupt? The witness is providing—we will allow him to finish his answer. Then we can ask further questions.

Dr LONG: Certainly, in Canada the evidence is that, even by interpretation of the scheme, the incidence is incredibly increasing—34 per cent in its first year, Mr Khan.

The Hon. TREVOR KHAN: Sorry. Dr Long, the problem with constantly referring, I have heard it referred to today, to Canada is the complication in Canada is—Mr Shoebridge would know this better than me—they had a bill of rights. The legislation, as I understand, that originally was in place was challenged under various provisions in the bill of rights. The consequence of that was that the State was then given a period of time to revise their legislation to bring it in, consistent with the decision of the Supreme Court. That is as best as I remember. This was not a like with like in terms of New South Wales or, indeed, Oregon. This was a legislative scheme that was interrupted because of the impact of a Supreme Court decision that in itself was based on their bill of rights. That is quite different from the New South Wales context.

Mr DAVID SHOEBRIDGE: It was not a political decision created from a Parliament. It came through the constitutional oversight of the Supreme Court. Quite different.

Dr LONG: However, I would simply say to Mr Khan and to Mr Shoebridge that the Canadian evidence, even though the scheme is of a different—

The Hon. TREVOR KHAN: Sorry. We are not always on a unity ticket, I just might say.

Dr LONG: The Canadian scheme, which—

Mr DAVID SHOEBRIDGE: No. In fact, I object.

The CHAIR: Order! Hansard will struggle with this. We have got 10 minutes to go.

Dr LONG: Very quickly. I accept that the Canadian scheme is of a different structure to the bill that is proposed here and the eligibility criteria are different and are wider in the Canadian scheme. But it is salutary evidence, I believe. The incidence of the scheme, in such a short period of time, growing to 8,000 deaths a year and 2.5 per cent of all deaths in Canada is a very alarming statistic and not one which is contested.

The Hon. TREVOR KHAN: Right. But the problem that you have got in this is you are bringing in data from Europe, the northern European countries, which is a different style of scheme than what, essentially, the New South Wales, Victorian, Queensland, Western Australian schemes are, which is essentially based, with some permutations, on the Oregon model. Those are quite different from the Netherlands' and Belgium's schemes, are they not?

Dr LONG: It is certainly the case that the Oregon model is the basic model and has been less amended, perhaps, over the years than the other schemes. But—

Mr DAVID SHOEBRIDGE: It is the best comparator, Dr Long.

Dr LONG: While I accept that the Oregon model is the basis of the scheme, I would still say with respect that it is impossible to ignore the international evidence in relation to the desire, particularly for people with mental illness, to access the scheme. You received evidence, or the lower House received evidence, from David Kissane, a professor. He presented evidence, which was not challenged, I believe, before parliamentarians at a special hearing in relation to the incidence of mental health in Belgium. In our submission, we have the data about the large increase in access to mental health, particularly in Belgium and the Netherlands.

The CHAIR: Dr Long, I am just going to raise the point. There was no inquiry, I believe, in the lower House. So I am not sure where that evidence—

Dr LONG: It was just a special briefing offered to politicians by Mr Kissane. There is a record of it, I understand.

The Hon. TREVOR KHAN: Sure. But you would understand that there are various people who come along and give briefings to politicians of all persuasions. I must admit I have received some in my time where I have sat there and ground my teeth. I did not really see it as an appropriate course of action to throw bricks at the presenter. That is not always my approach, I might add.

Dr LONG: Sure. Fair enough. But—

The Hon. SCOTT FARLOW: Trevor has got a kiln up in the office.

Mr DAVID SHOEBRIDGE: There are those who provide briefings critical of Kissane, like very real critiques of Kissane's position.

Dr LONG: Sure. I think his data, which is very recent data, was quite disturbing.

Mr DAVID SHOEBRIDGE: Is highly criticised.

The Hon. GREG DONNELLY: You did not raise that this morning, when you had a chance, David. Professor Kissane was with us this morning.

Mr DAVID SHOEBRIDGE: For 1.2 minutes.

The CHAIR: Let us not see this degrade again. Let us just keep it very civil. Does anybody else have any questions?

The Hon. TREVOR KHAN: I think this has been very amiable, actually. It has done a lot better than previous ones.

The CHAIR: Surprisingly, yes. If there are no further questions, I am going to draw the hearing for today to a close. I want to thank the witnesses who made themselves available. Any questions that have been taken on notice, the secretariat will liaise with you in order to provide an opportunity to table. I thank those people that are viewing. We will return again on Monday morning, for the third hearing. Thank you.

Dr LONG: Thank you.

(The witnesses withdrew.)

The Committee adjourned at 17:07.