LEGISLATIVE COUNCIL

STANDING COMMITTEE ON LAW AND JUSTICE

Voluntary Assisted Dying Bill 2021

Report 79

February 2022

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Standing Committee on Law and Justice

Voluntary Assisted Dying Bill 2021

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Voluntary Assisted Dying Bill 2021

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Terms of reference

That:

(a) the provisions of the Voluntary Assisted Dying Bill 2021 be referred to the Standing Committee on Law and Justice for inquiry and report,

(b) the bill be referred to the committee upon receipt of the message on the Bill from the Legislative Assembly, and

(c) the committee report by the first sitting day in 2022.[1]

The terms of reference for the inquiry were referred to the committee by the Legislative Council on 19 October 2021.[2]

1 The original reporting date was the first sitting day in 2022 (*Minutes*, NSW Legislative Council, 19 October 2021, pp 2510-2511). The first sitting day in 2022 was later resolved as 22 February 2022 (*Minutes*, NSW Legislative Council, 16 November 2021, p 2713).

2 *Minutes*, NSW Legislative Council, 19 October 2021, pp 2510-2511.

Committee details

Committee members

The Hon Wes Fang MLC	The Nationals	*Chair*
The Hon Greg Donnelly MLC	Australian Labor Party	*Deputy Chair*
The Hon Lou Amato*	Liberal Party	
The Hon Anthony D'Adam MLC	Australian Labor Party	
Ms Cate Faehrmann MLC**	The Greens	
The Hon Scott Farlow MLC	Liberal Party	
The Hon Taylor Martin MLC	Liberal Party	
The Hon Rod Roberts MLC	Pauline Hanson's One Nation Party	

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* The Hon Lou Amato MLC replaced the Hon Trevor Khan MLC as a substantive member of the committee from 25 January 2022. The Hon Trevor Khan MLC was a substantive member of the committee to 6 January 2022.

** Ms Cate Faehrmann MLC substituted for Mr David Shoebridge MLC from 21 October 2021 for the duration of the inquiry.

Chair's foreword

The Voluntary Assisted Dying Bill 2021 is a private member's bill that was referred to the Standing Committee on Law and Justice for inquiry and report on 19 October 2021. The bill was debated in the Legislative Assembly in November 2021, and was passed, with amendments, by the Legislative Assembly on 26 November 2021.

The bill seeks to do the following:

- enable eligible persons with a terminal illness to access voluntary assisted dying;
- establish a procedure for, and regulate, access to, voluntary assisted dying; and
- establish the Voluntary Assisted Dying Board and provide for the appointment of members and functions of the Board.

This inquiry generated significant public interest and engagement, with the committee receiving around 39,000 responses to an online questionnaire, in addition to 3,070 submissions and three supplementary submissions, of which 107 were published. The committee also held three days of public hearings, hearing from over 75 witnesses.

It is clear that this is an issue with strong and passionate opinions, which are felt deeply by both sides of the debate. Further, it is also clear there is no consensus amongst stakeholders as to the merits of the bill. Indeed, there was no consensus amongst the committee members themselves.

In these circumstances, it is important to acknowledge the purpose of this inquiry has been to allow stakeholders to place their views on the record, so as to inform the House and assist with debate. The committee has in this report set out the background of the bill and more importantly, outlined the key arguments, both in support of, as well as in opposition to the bill.

The committee elected not to take a position on the bill, rather we elected to present the relevant evidence and testimony tendered during the inquiry, so the Legislative Council may consider it in any debate of the bill. As such, the committee simply recommended, the Legislative Council proceed with consideration of the bill.

On behalf of the committee, I would like to thank all participants for their respectful and considered contributions to this important inquiry. I also extend my gratitude to my fellow committee members for their commitment and dedication to this inquiry. Finally, I must acknowledge and commend the committee secretariat for their deft and diligent work on this most difficult of topics, which was made all the more difficult during a pandemic.

The Hon Wes Fang MLC
Committee Chair

Recommendations

Recommendation 1 **47**
That the Legislative Council proceed to consider the Voluntary Assisted Dying Bill 2021.

Conduct of inquiry

The terms of reference for the inquiry were referred to the committee by the Legislative Council on Tuesday 19 October 2021.

The committee received 3,070 submissions and three supplementary submissions, of which 107 were published.

The committee received around 39,000 responses from individual participants to an online questionnaire.

The committee held three public hearings at Parliament House in Sydney on 8 December 2021, 10 December 2021 and 13 December 2021.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents and answers to questions on notice.

Chapter 1 Introduction and background to the bill

This chapter outlines the introduction and passage of the Voluntary Assisted Dying Bill 2021 through the Legislative Assembly and the objects of the bill more broadly. In addition, this chapter provides an overview of the provisions of the bill and a comparison with similar schemes operating in other jurisdictions.

Introduction and passage of the bill in the Legislative Assembly

1.1 The Voluntary Assisted Dying Bill 2021 was introduced in the Legislative Assembly on 14 October 2021 by Mr Alex Greenwich MP, Member for Sydney. The bill was introduced as a private member's bill.

1.2 Notably, the bill was co-sponsored by 28 members across both Houses of the Parliament: in the Legislative Assembly Ms Jenny Aitchison MP, Mr Tim Crakanthorp MP, Mrs Helen Dalton MP, Ms Trish Doyle MP, Mr Lee Evans MP, Mr Alex Greenwich MP, Ms Jodie Harrison MP, Ms Jo Haylen MP, Ms Sonia Hornery MP, Ms Jenny Leong MP, Mr David Mehan MP, Mr Jamie Parker MP, Mr Greg Piper MP, Ms Tamara Smith MP, Ms Leisel Tesch AM MP, Ms Kate Washington MP, the Hon Leslie Williams MP and Ms Felicity Wilson MP; in the Legislative Council, Ms Abigail Boyd MLC, the Hon Anthony D'Adam MLC, Ms Cate Faehrmann MLC, Mr Justin Field MLC, the Hon John Graham MLC, the Hon Emma Hurst MLC, the Hon Trevor Khan MLC, the Hon Mark Pearson MLC, the Hon Adam Searle MLC and Mr David Shoebridge MLC.

1.3 Following its introduction, the bill was debated on 12 November 2021, 19 November 2021 and 25 November 2021. The question that the bill be read a second time was agreed to on division, 53 votes to 36, on the evening of 25 November 2021. Following this, a number of amendments put forward by members of the Legislative Assembly were debated on 25 November 2021 and 26 November 2021.

1.4 On 26 November 2021, the Legislative Assembly agreed to the third reading of the bill, as amended, on division, 52 votes to 32.

1.5 On 19 October 2021, the bill was referred by the Legislative Council to the Standing Committee on Law and Justice for inquiry and report.

1.6 This bill is not the first attempt to introduce a voluntary assisted dying (VAD) scheme in New South Wales. Most recently, the Hon Trevor Khan MLC introduced the Voluntary Assisted Dying Bill 2017 to the Legislative Council on 21 September 2017. This bill was defeated by one vote in the Legislative Council on 16 November 2017.

Objects and principles of the Voluntary Assisted Dying Bill 2021

1.7 The explanatory note to the Voluntary Assisted Dying Bill 2021 states that the objects of the bill are to:

- enable eligible persons with a terminal illness to access voluntary assisted dying, and

- establish a procedure for, and regulate, access to, voluntary assisted dying, and
- establish the Voluntary Assisted Dying Board and provide for the appointment of members and functions of the Board.[3]

1.8 Division 2 of the bill sets out a number of principles which underpin the bill. Clause 4(1) of the bill states that a person exercising a power or performing a function under the bill must have regard to the following principles:

- every human life has equal value
- a person's autonomy, including autonomy in relation to end of life choices, should be respected
- a person has the right to be supported in making informed decisions about the person's medical treatment and should be given, in a way the person understands, information about medical treatment options, including comfort and palliative care and treatment
- 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
- a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained
- a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding the person's care, treatment and end of life should be encouraged and promoted
- a person should be supported in conversations with the person's health practitioners, family, carers and community about care and treatment preferences
- a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language
- a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region
- there is a need to protect persons who may be subject to pressure or duress
- all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

Operation of the proposed Voluntary Assisted Dying Bill 2021

1.9 This section sets out the key elements of the scheme proposed in the Voluntary Assisted Dying Bill 2021, including the relevant eligibility criteria, the process for accessing the scheme, and safeguards imposed by the bill.[4]

3 Explanatory note, Voluntary Assisted Dying Bill 2021, p 1.

4 This section is drawn from Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021.

Eligibility criteria

1.10 The eligibility criteria that must be met before a person can access VAD are set out at cl 16 of the Bill. Clause 16 states that a person must:

- be 18 years old or over
- be an Australian citizen, permanent resident, or a resident for at least three years, and must have been ordinarily resident in New South Wales for 12 months before making a request
- be diagnosed with at least one disease, illness or medical condition that is advanced, progressive and will cause death, most likely within six months (or 12 months in the case of a neurodegenerative disease, illness or condition), and that is causing suffering that cannot be relieved in a way considered by the person to be tolerable
- have decision-making capacity in relation to VAD
- be acting voluntarily and without pressure or duress
- the request must be enduring.

1.11 Clause 6 of the bill defines decision-making capacity for the purposes of being eligible in relation to VAD. It provides that a patient has decision-making capacity if they have the capacity to:

(a) understand information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient

(b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision

(c) understand the matters involved in a voluntary assisted dying decision

(d) understand the effect of a voluntary assisted dying decision

(e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision

(f) communicate a voluntary assisted dying decision in some way.

1.12 Further, cl 6(2) states that a patient is:

- presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision, and
- presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity.

1.13 Additionally, Part 6 of the bill provides that the Supreme Court may review certain administrative decisions. This includes a decision that a person does not have decision-making capacity, is not acting voluntarily, or is acting because of pressure or duress.

Process for accessing VAD

1.14 Part 3 of the bill sets out the process for accessing VAD under the proposed scheme. The steps include:

- first request
- first assessment
- consulting assessment
- a written declaration by the patient
- final request
- final review.

First request

1.15 Division 2 of the bill sets out the requirements of the first request, noting that the request must be:

- clear and unambiguous
- made during a medical consultation
- made in person, or, if that is not practicable, in a way that is consistent with the relevant requirements of s 176(1)(a), which provides for the circumstances where communication between a patient and practitioner can occur using audiovisual communication.

1.16 Additionally cll 3 and 4 provide that a person may make the request verbally or in another way, for example, by use of gestures. A person may also make the request with the assistance of an interpreter.

1.17 Clause 10 of the bill sets out that a health care worker is not to initiate a discussion about voluntary assisted dying with a patient. However, the bill provides an exception for medical practitioners to initiate a VAD discussion if they provide information about treatment options and outcomes at the same time. Further, the bill provides an additional exception for health care workers if they simultaneously inform the person that palliative care and treatment options are available and should be discussed with a medical practitioner.

1.18 Following the first request, a medical practitioner must decide whether to accept or refuse the request. Under cl 21, the only reasons a medical practitioner may decide to refuse the first request are that:

- the practitioner has a conscientious objection to VAD, or is otherwise unwilling to perform the duties of a coordinating practitioner
- the practitioner is unable to perform the duties of a coordinating practitioner because of unavailability or another reason, or
- the practitioner is not eligible to act as a coordinating practitioner at the time the first request is made.

1.19 After the first request, a medical practitioner must record information regarding the request, the practitioner's decision to accept or refuse the request, and, if applicable, reasons for the refusal and if the practitioner has given the patient information required following a refusal of this kind.

1.20 Additionally, cl 23 requires the medical practitioner to complete a relevant approval form i.e. the first request form, and give a copy of this form to the Voluntary Assisted Dying Board within five days of their decision to accept or refuse the request.

1.21 Following this process, if the medical practitioner accepts the first request, the practitioner becomes the coordinating practitioner for the patient.

Assessments by medical practitioners

1.22 Following the first request being accepted, a person's eligibility is assessed by two medical practitioners:

- the coordinating practitioner for the first assessment
- the consulting practitioner following that first assessment, in what is referred to as the 'consulting assessment'.

1.23 The bill also sets out certain circumstances where a medical practitioner is unable to make a decision, and must refer the person to someone with the appropriate skills and training to make a decision, such as a psychiatrist. A practitioner must make a referral of this kind if they are unable to determine the following in their assessment:

- whether the disease, illness or medical condition meets the requirements
- whether the person has decision-making capacity
- whether the person is acting voluntarily and not under pressure or duress.

1.24 Further, the bill requires that medical practitioners meet certain eligibility requirements before they may act as a coordinating or consulting practitioner. Clause 18 of the bill requires that they must:

- hold specialist registration, or
- hold general registration and has practiced the medical profession for at least 10 years as the holder of general registration, and
- have completed the approved training as required under the scheme.

Written declaration

1.25 Division 5 of the bill sets out the process for a patient assessed as eligible for VAD making a written declaration. A patient may make this declaration if they have been assessed as eligible by the patient's coordinating practitioner, and the patient's consulting practitioner.

1.26 Further, the written declaration must be in the approved form, and given to the patient's coordinating practitioner. The declaration must state that the patient:

- makes the declaration voluntarily, and does not make the declaration because of pressure or duress
- understands its nature and effect.

1.27 The declaration must be signed by the patient in the presence of two witnesses. However, the bill also provides for a circumstance where a person may sign the written declaration on behalf of the patient if the patient is unable to sign the declaration, and the patient directs the person to sign the declaration. The bill sets out specific requirements for when this may occur at cl 43(4).

1.28 Following the written declaration, the coordinating practitioner is required to record the date when the declaration was made, and the date the declaration was received by the practitioner in the patient's medical record. Further, cl 47 requires that within five business days after receiving the declaration, the coordinating practitioner must give a copy to the VAD Board.

Final request and final review

1.29 Division 6 of the bill sets out the requirements relating to the final request and final review as part of the VAD process.

1.30 Clause 49 sets out that a patient generally cannot make a final request for VAD until at least five days after the first request was made. However, there are some exceptions to this requirement, including if the patient is likely to die or lose decision-making capacity before the end of the designated period.

1.31 Within five business days of receiving a final request made by a patient, the patient's coordinating practitioner must complete the final request form, and provide a copy of this form to the VAD Board.

1.32 Additionally, cl 52 requires that on receiving a final request made by a patient, the coordinating practitioner must:

- review all consulting assessment report forms in relation to the patient
- review the patient's written declaration
- complete the final review form in relation to the patient.

1.33 The bill provides for a patient to decide between self-administration, and practitioner administration. However, cl 60(6) requires that a witness must be present in the case of practitioner administration.

1.34 Following the final review, and the patient's decision regarding administration, the coordinating practitioner is required (as per cl 70) to request an authorisation to prescribe a substance from the VAD Board. The provisions concerning the prescribing, supplying and disposing of a VAD substance are set out in Part 4, Division 5 of the bill.

1.35 A more detailed summary of the proposed process for NSW is available at Appendix 1.

Safeguards

1.36 The bill includes a number of safeguards which are characteristic of other VAD schemes operating in Australia. These safeguards include:

- Clause 10 provides that health care workers are prohibited from initiating a discussion about or suggesting VAD, unless:
  - they are a medical practitioner and provide information about treatment options and outcomes to the person at the same time
  - they inform the person that palliative care and treatment options are available and should be discussed with the person's medical practitioner.
- As discussed above, cl 15 requires that multiple steps be taken to access VAD, which spans a minimum of five days. A person can only access VAD if:
  - the person has made a first request
  - the person has been assessed as eligible by both the coordinating and consulting practitioners
  - the person has made a written declaration
  - the person has made a final request
  - the person's coordinating practitioner has made the requisite certification in a final review form
  - the person has made a decision regarding how VAD will be administered
  - the person has appointed a contact person if the person has made a self-administration decision
  - a VAD substance authority has been issued by the Board.
- As part of the eligibility criteria set out in cl 16, it is required that a person accessing VAD must have decision-making capacity, and be acting voluntarily and not from pressure or duress.
- Clause 28 requires that a person who has been assessed as meeting the eligibility criteria for VAD must be provided with information regarding the following:
  - their diagnosis and prognosis
  - palliative care and treatment options
  - the risks associated with taking a VAD substance.
- Clauses 20 and 54 provide that a person may change their mind about VAD at any time during the process.
- Clause 18 requires medical practitioners participating in the scheme to have completed approved training, and met other criteria regarding their experience and qualifications.
- Clause 11 sets out that contravention of the requirements in the bill may constitute unsatisfactory professional conduct or professional misconduct.
- Part 7 sets out various offences including:
  - the unauthorised administration of a prescribed substance (maximum penalty of life imprisonment)
  - inducing another person to request or access VAD (maximum penalty of 7 years imprisonment)

  - inducing self-administration of a prescribed substance (maximum penalty of life imprisonment).

- Part 9 of the bill establishes a protection from liability for persons assisting another person in good faith to access VAD.
- Finally, Part 10 establishes the Voluntary Assisted Dying Board, which has a function of monitoring the operation of the Act, were it to be legislated.

Provisions for conscientious objection regarding VAD services

1.37 The bill provides for the conscientious objections of health practitioners to VAD. It also contains provisions to ensure that health care establishments and residential facilities are able to choose not to provide VAD services.

1.38 Clause 9 of the bill sets out that health practitioners with a conscientious objection to VAD have the right to refuse to:

- participate in the request and assessment process
- prescribe, supply or administer a VAD substance
- be present at the time of the administration of the VAD substance.

1.39 The bill states in cl 21 that if a first request is made to a medical practitioner with a conscientious objection, they must immediately inform the patient of their refusal and provide them with information specified by the Health Secretary for this purpose.

1.40 Additionally, medical practitioners may also refuse to participate if they are unwilling or unable to perform the duties of a coordinating or consulting practitioner.

1.41 With regard to health care establishments and residential facilities, cl 89 sets out that they may decide not to provide services relating to VAD at the establishment or facility. They may refuse to:

- participate in the request and assessment process
- participate in an administration decision
- prescribe, supply, store or administer a VAD substance
- be present at the time of the administration of the VAD substance.

1.42 However, cll 90 and 99 provide that the relevant establishment or facility must not hinder access to information about VAD. Additionally, residential facilities have some responsibilities, set out in Part 5, Division 2, requiring them to permit access to the facilities by others for VAD purposes.

Amendments agreed to in the Legislative Assembly

1.43 During consideration in detail of the bill, 46 amendments were agreed to by the Legislative Assembly.[5] In summary, the amendments:

- insert into the principles of the bill that 'high-quality care and treatment, including palliative care and treatment', along with 'voluntary assisted dying', be available for people in rural and regional communities[6]
- remove the power to regulate disciplinary matters for disability care workers, given they come under the jurisdiction of the Commonwealth's National Disability Insurance Scheme[7]
- provide that people with dementia are not eligible for VAD merely because they have that condition, and that people who permanently lose the capacity for decision-making for VAD at any time throughout the request and assessment process would cease to be eligible[8]
- provide for guidelines that the Health Secretary is required to establish, as well as the process to certify compliance with those guidelines. The guidelines:
  - prescribe the process that the coordinating and consulting practitioners must follow when referring patients, including a requirement for the coordinating and consulting practitioners, following their assessments, to confirm in their report to the VAD Board that they followed those guidelines
  - prescribe the functions and conduct of contact persons and include a requirement for the contact person to certify on the contact person appointment form that they agree to comply[9]
- remove the requirement that a conscientiously objecting practitioner must produce or provide a pamphlet or other information about VAD to the person seeking access[10]
- exclude registered nurses from becoming administering practitioners, exclude overseas-trained specialists with provisional or limited registration from acting as a coordinating or consulting practitioner, and add two medical practitioners to the VAD Board[11]
- include provisions relating to elder abuse and abuse of vulnerable people, such as the requirement that coordinating and consulting practitioners inform patients that applying pressure or duress to request VAD is unlawful and asking patients directly whether they have experienced pressure or duress from someone who is a beneficiary of their will[12]

5 NSW Parliament, *Legislative Assembly amendments agreed to*, Voluntary Assisted Dying Bill 2021.

6 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 81 (Joe McGirr).

7 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 105 (Alex Greenwich); *Hansard*, NSW Legislative Assembly, 25 November 2021, p 106 (Gareth Ward).

8 *Hansard*, NSW Legislative Assembly, 25 November 2021, pp 106-107 (Mark Coure).

9 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 107 (Mark Coure).

10 *Hansard*, NSW Legislative Assembly, 25 November 2021, pp 107-108 (Marjorie O'Neill).

11 *Hansard*, NSW Legislative Assembly, 25 November 2021, pp 107-108 (Marjorie O'Neill).

12 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 106 (Alex Greenwich); *Hansard*, NSW Legislative Assembly, 25 November 2021, p 107 (Rob Stokes).

- provide that, for a patient making a final request before the end of the designated period, it must be in the 'reasonable' opinion of the patient's coordinating practitioner that the patient is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of the designated period[13]
- remove the following more serious offences from the bill, and instead include them in the *Crimes Act 1900* and *Criminal Procedure Act 1986:*
  - unauthorised administration of a prescribed substance
  - inducing another person to request or access VAD
  - inducing self-administration of a prescribed substance
  - advertising Schedule 4 or 8 poison as a VAD substance[14]
- clarify that electronic signatures cannot be used for a written declaration by a patient unless the person cannot otherwise sign and usually does not, and that interpreters can charge for their services[15]
- require the Health Secretary to provide training, information and resources to coordinating and consulting practitioners on palliative care to ensure that they are able to comply with their obligations[16]

Voluntary Assisted Dying in other jurisdictions

1.44 This section outlines the operation of voluntary assisted dying schemes in other Australian jurisdictions, with specific comparison to the scheme proposed for New South Wales in the bill.

1.45 All states in Australia, other than New South Wales, have legislated voluntary assisted dying. Victoria was the first state to pass such legislation in 2017, with similar legislation subsequently passing in Western Australia in 2019. South Australia, Tasmania and Queensland all passed VAD legislation in 2021.[17]

1.46 While Victoria was the first state to legislate VAD, the Northern Territory was the first jurisdiction in the world to legalise VAD following passage of the *Rights of the Terminally Ill Act 1995*. However, the Act was subsequently overturned by the Australian Government. The *Euthanasia Laws Act 1997* (Cth) specifies that territory parliaments do not have the power to make laws permitting 'the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life'.[18]

13 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 105 (Alex Greenwich).

14 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 106 (Gareth Ward).

15 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 108 (Leslie Williams).

16 *Hansard*, NSW Legislative Assembly, 25 November 2021, p 108 (Leslie Williams).

17 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

18 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

1.47 To date, VAD schemes have commenced operation in Victoria and Western Australia. These schemes commenced on 19 June 2019 and 1 July 2021 respectively. All other states are still in the process of completing an implementation period of approximately 18 months.[19]

Comparison of VAD schemes in other states

1.48 The VAD schemes operating in other states require assessment by at least two medical practitioners who have completed special training, and allow for self-administration or practitioner administration. However, the schemes in Queensland and Western Australia preference self-administration, with practitioner administration only being available if self-administration is inappropriate in the circumstances.[20]

1.49 All legislated schemes in other states include various safeguards. However, one of the key differences between the states is whether health practitioners may initiate a conversation about VAD. In some states, health practitioners are prohibited from doing this.[21]

1.50 The New South Wales bill is similar to the Queensland and Western Australian legislation in that they allow for an exception for medical practitioners to initiate a VAD discussion if they provide information about treatment options and outcomes at the same time. However, the NSW VAD Bill provides an additional exception for health care workers if they simultaneously inform the person that palliative care and treatment options are available and should be discussed with a medical practitioner.[22]

1.51 It was noted by the proponent of the bill that this additional exception was included following consultation with the Australian Paramedics Association, given the frequency with which paramedics come into contact with people in significant distress because of their terminal illness.[23]

1.52 Another key difference in the model proposed in the NSW bill is that it requires a five day period between the person's first and final request for VAD. All other states, with the exception of Tasmania, require a nine day period.[24]

19 Australian Centre for Health Law Research, Queensland University of Technology, End of Life Law in Australia – Voluntary assisted dying and euthanasia.

20 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

21 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

22 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

23 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

24 Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 7.

Operation of the proposed scheme in the Bill as compared to other jurisdictions

1.53 The table found at Appendix 2 compares VAD laws in each of the Australian states. The information has been sourced from the Australian Centre for Health Law Research (Queensland University of Technology) analysis of relevant state legislation, and was compiled into this format by the NSW Parliamentary Library.

Chapter 2 Key issues

Arguments in support of the Voluntary Assisted Dying Bill 2021

2.1 This section outlines the arguments made by stakeholders who support the bill. This includes support for the specific VAD scheme which the bill establishes, as well as support for the introduction of VAD more broadly. Arguments in support of the bill include evidence of schemes operating effectively in other jurisdictions, and the need to ensure personal dignity and avoid suffering for people with a terminal illness.

General support for the VAD scheme proposed in the bill

2.2 Supporters of the bill told the committee that the scheme proposed in the bill is effective, balanced and proportionate. They also argued that the safeguards in the bill are sufficient to avoid elder abuse, or any other type of coercion.

2.3 Dying with Dignity NSW described the bill as 'conservative', and stated that it appropriately balances the rights of patients and health care workers. It also said that the bill:

- contains 'robust safeguards', which do not create unnecessary barriers for people accessing VAD[25]
- is a result of a long drafting and consultation process
- draws on laws passed in other Australian states, in addition to inquiries and reviews that have occurred in other jurisdictions.[26]

2.4 Along similar lines, Professor Lindy Willmott from the Australian Centre for Health Law Research stated that the bill was 'sensible and measured', and contained enough protections for vulnerable groups to ensure it would operate safely. Professor Willmott also stressed to the committee that the bill does not require further safeguards, and that propositions to this effect would merely make the scheme more difficult to access.[27]

2.5 In sum, the committee heard that the bill effectively serves the two main purposes of legislation introducing a VAD scheme, being the facilitation of access to VAD for eligible people, and establishing appropriate safeguards so ineligible people cannot access the scheme.[28]

2.6 Support for the scheme proposed in the bill was echoed by other peak bodies, including those who advocate on behalf of older people. The Council on the Ageing NSW, Seniors Rights Service and Older Women's Network all argued that the bill contained appropriate constraints, including the detailed process required to access VAD. They stated that the bill builds on work

25 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 2.

26 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 2.

27 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 8 December 2021 p 27.

28 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 8 December 2021 p 32.

done in other jurisdictions, and adequately protects vulnerable people from 'coercion and malpractice'.[29]

2.7 Relevant professional bodies, including the NSW Nurses and Midwives' Association and the Australian Paramedics Association (NSW), similarly expressed their support for the bill.[30] In evidence, Ms Shaye Candish, Assistant General Secretary, NSW Nurses and Midwives' Association stated that the bill 'offers a clear process for access to voluntary assisted dying in appropriate circumstances whilst also maintaining the rights of those who conscientiously object to participation'.[31]

2.8 In relation to the scheme's eligibility requirements, the committee heard that these were appropriate and sufficiently clear. In particular, stakeholders reiterated their support for the provisions relating to a person's capacity, and noted that the capacity requirements as they relate to VAD are similar to those generally used for other health care and legal decisions.[32]

2.9 Additionally, supporters of the bill told the committee that the requirement of 'intolerable suffering' was appropriate for the purposes of the scheme. Stakeholders warned against defining suffering any further, noting this may have the result of denying access to those who should be eligible, and would create other unnecessary difficulties.[33]

2.10 Professor Ben White, also from the Australian Centre for Health Law Research, summarised this position and told the committee that the combination of the relevant eligibility criteria, including that the illness is advanced, progressive, and on the balance of probabilities will cause death within 6 months, or 12 months for a neurodegenerative disease, means that there is no uncertainty when assessing eligibility for the VAD scheme.[34]

Voluntary Assisted Dying schemes in other jurisdictions

2.11 Supporters of the bill referred to the operation of VAD schemes in other jurisdictions in arguing for the introduction of VAD in NSW. They pointed to the safe operation of schemes similar to that being proposed by the bill, in addition to the overall positive impact of a VAD scheme.

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29 Evidence, Meagan Lawson, Chief Executive Officer, Council on the Ageing NSW, 13 December 2021, p 58; Evidence, Shannon Wright, Chief Executive Officer, Seniors Right Service, 13 December 2021, p 59; Evidence, Ms Beverly Baker, Chair, Older Women's Network NSW, 13 December 2021, p 58.

30 Submission 43, NSW Nurses and Midwives' Association, p 6; Submission 35, Australian Paramedics Association (NSW), p 1.

31 Evidence, Ms Shaye Candish, Assistant General Secretary, NSW Nurses and Midwives' Association, 8 December 2021, p 17.

32 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 8; Evidence, Mr Steve Offner, Communications Director, Go Gentle Australia, 8 December 2021, p 10.

33 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, pp 31-32; Evidence Professor Ben White, Australian Centre for Health Law Research, 13 December 2021, pp 31-32.

34 Evidence, Professor Ben White, Australian Centre for Health Law Research, 13 December 2021, p 30.

The Victorian VAD scheme and comparisons with the proposed NSW bill

2.12 The committee heard about the similarities of the scheme proposed in the bill to the VAD scheme that has been operating in Victoria since 2017. Supporters of the bill referred to the general success of the Victorian scheme as evidence in favour of implementing the NSW bill, and highlighted several changes and improvements in the NSW bill that have been developed based on the Victorian experience.

2.13 The committee was told that the Victorian scheme has been operating safely, and that the Victorian VAD Board had, to date, found no evidence of coercion amongst people accessing the scheme.[35]

2.14 This was reiterated by Associate Professor Charlie Corke, Acting Chair of the VAD Board in Victoria, who said that:

> The board is of the opinion that the Victorian Act is working, with overwhelming positive feedback from patients and families who have used the service. Our experience is documented in our reports of operation. The priority of the board is to ensure compliance with legislation. A detailed review of each and every case has identified no instance of clinical noncompliance and very few cases of administrative noncompliance.[36]

2.15 When discussing criticism of the Victorian scheme, stakeholders noted that the primary issues that have emerged have related to difficulty of access, with some aspects of the scheme being described as 'cumbersome'.[37]

2.16 In their submission, Professor Lindy Willmott and Professor Ben White outlined some of the issues that had been reported by doctors working within the Victorian scheme. They noted a number of delays, including with the oversight from the VAD Review Board, the permit approval process, and accessing relevant medications. They said that these delays ultimately created significant access challenges for patients, and noted that some patients had died during the process of seeking access to the scheme.[38]

2.17 Further, Professors Willmott and White told the committee that some of these access issues are a result of unnecessary amendments to the Victorian bill during its passage through the Parliament. They strongly cautioned against this occurring in New South Wales, and noted that additional and unnecessary safeguards make an 'already rigorous and very difficult process unworkable'.[39]

2.18 This was reiterated by Associate Professor Corke, who explained that these additional safeguards in the Victorian scheme have had the 'contradictory' effect of making it difficult for

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35 Evidence, Meagan Lawson, Chief Executive Officer, Council on the Ageing NSW, 13 December 2021, p 59.

36 Evidence, A/Professor Charlie Corke, Acting Chair, Voluntary Assisted Dying Review Board, Victoria, Senior Intensive Care Specialist, University Hospital Geelong, 13 December 2021, p 69.

37 Submission 97, Professor Lindy Willmott and Professor Ben White, pp 4-6.

38 Submission 97, Professor Lindy Willmott and Professor Ben White, p 8.

39 Evidence, Professor Ben White, Australian Centre for Health Law Research, 13 December 2021, p 28; Submission 97, Professor Lindy Willmott and Professor Ben White, pp 5-6.

patients to access the scheme, without appearing to improve the safety of the scheme more generally.[40]

2.19 In speaking to the differences between the proposed NSW scheme and the Victorian scheme, Professor Willmott stated that:

> The Victorian legislation has been in operation for two years, and there are important lessons to be learned from their experience ... The Victorian legislative model can be improved, and the New South Wales bill, as passed by the Legislative Assembly, has done just that.[41]

2.20 A specific issue identified in the Victorian scheme was the prohibition on registered health professionals initiating a conversation in relation to VAD. Doctors working within the scheme noted this as a particular concern, and argued that this prohibition can disadvantage people who have low health literacy, or culturally and linguistically diverse people.[42]

2.21 In contrast, the NSW bill provides an exception to such a prohibition, whereby health practitioners can initiate a conversation about VAD if it is discussed in the context of palliative care, and other treatment options.

2.22 The committee also heard that the NSW bill was an improvement on the Victorian scheme in relation to the eligibility of doctors who can act as a coordinating or consulting practitioner. The Victorian legislation requires a doctor to be a specialist in order to be a coordinating or consulting practitioner for the purposes of VAD. However, the NSW bill provides that a doctor is eligible if they are a specialist, or, have had generalist registration for 10 years.[43]

2.23 When discussing why this is a useful change, Professor Willmott explained that the requirements in Victoria create another access barrier, and in effect, mean experienced palliative care physicians, geriatricians and GPs are not able to be consulting or coordinating practitioners.[44]

Operation of VAD schemes internationally

2.24 Supporters of the bill stressed to the committee the importance of evidence-based law making with regard to the introduction of VAD in NSW. Specifically, stakeholders urged the committee to consider the breadth of evidence regarding the operation of VAD schemes internationally.[45]

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40 Evidence, A/Professor Charlie Corke, Acting Chair, Voluntary Assisted Dying Review Board, Victoria, Senior Intensive Care Specialist, University Hospital Geelong, 13 December 2021, p 70.

41 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, p 27.

42 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, p 33.

43 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, p 33.

44 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, p 33.

45 Submission 97, Professor Lindy Willmott and Professor Ben White, p 5.

2.25 The committee heard that VAD schemes have been operating in other countries for many years in a way that is safe and consistent with the intention of the relevant legislation.[46]

2.26 Stakeholders made specific reference to the limited changes to eligibility criteria in schemes operating internationally. This was in response to the argument put by opponents of the bill that one risk of such a scheme is that the eligibility criteria will inevitably be expanded in a dangerous way.

2.27 On this issue, Professor Willmott told the committee that there is no international evidence of this risk, and that there has only been very limited modification to the original eligibility criteria in some jurisdictions. Further, she referred to models in the United States, which are similar to the models in Australian jurisdictions, and stated that there have been no changes to the eligibility criteria in those contexts.[47]

2.28 Similarly, Professor White questioned the argument put by opponents of the bill that jurisdictions such as Belgium, the Netherlands and Canada have seen their VAD schemes significantly expanded, and eligibility criteria drastically widened, since the original introduction of those schemes. Professor White told the committee that there are important distinctions between the overseas schemes being referenced, and the model proposed in the NSW bill.[48]

2.29 The committee also heard about the international experience regarding the occurrence of coercion and abuse within VAD schemes. Stakeholders argued that that generally, there has been no evidence of this occurring. Dr Robert Marr pointed to the scheme that has been operating in Oregon for over 20 years, and the scheme in the Netherlands, and noted that the relevant oversight bodies have consistently found no evidence of systemic coercion.[49]

2.30 In addition to evidence about the safety of international schemes, the committee also heard about the benefits of these VAD schemes. In its submission, Dying with Dignity NSW referred to a study commissioned by Palliative Care Australia in 2018 which found that the implementation of VAD schemes in other jurisdictions has resulted in an increased policy focus on end-of-life care more generally, as well as a stronger focus on patient choice and autonomy.[50]

Frequency of access to VAD in other jurisdictions

2.31 Supporters of the bill outlined data relating to how frequently people utilise VAD in jurisdictions where a scheme has been legalised. Further, they noted that people who access such schemes do not always end up utilising VAD. They argued that this demonstrates that terminally ill patients experience the benefits of a VAD scheme merely by having the option of access, and are able to have a sense of personal choice and autonomy in regards to end-of-life care, even without ultimately using VAD.

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46 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, p 31; Evidence, Professor Ben White, Australian Centre for Health Law Research, 13 December 2021, p 31.

47 Evidence, Professor Lindy Willmott, Australian Centre for Health Law Research, 13 December 2021, p 31.

48 Evidence, Professor Ben White, Australian Centre for Health Law Research, 13 December 2021, p 31.

49 Evidence, Dr Robert Marr OAM, Vice President, Doctors Reform Society, 8 December 2021, p 47.

50 Submission 31, Dying with Dignity NSW, pp 11-12.

2.32 When discussing how many people access VAD, the committee heard evidence relating to the Victorian context. It was noted that in the first two years of the scheme operating, less than half of 1 per cent of all deaths in the state were through VAD. This amounted to approximately 330 deaths.[51]

2.33 The committee heard that this was consistent with the experience in other international jurisdictions, with only very small numbers of people accessing these schemes. It was noted that in Oregon, where VAD has been legal for over 20 years, less than 1 per cent of deaths are attributed to VAD. Stakeholders explained that even in jurisdictions with less conservative VAD schemes, numbers remained very low, for example, in the Netherlands, where approximately 5 per cent of deaths are attributed to VAD.[52]

2.34 Further, the committee heard evidence that approximately 30 to 40 per cent of patients who access VAD and are approved via the scheme ultimately do not take the medication that is prescribed. Stakeholders said that this was the experience internationally, as well as what was emerging from the evidence in Victoria and Western Australia.[53]

2.35 When explaining why this occurred, the committee heard that it operated as an 'insurance policy', and that having VAD as an option gives terminally ill patients a 'great reassurance'.[54] This position was summarised to the committee by Ms Janet Cohen, an advocate from Go Gentle Australia who is living with a terminal illness and who told the committee she has been approved to access an assisted death in Switzerland. Ms Cohen reiterated that being able to access VAD effectively operates as an insurance policy, and stated that:

> As with most people with a terminal illness, I am expecting that I will be in active palliative care by the time I need to make that decision. Yes, I may not need to access that option, but it is very reassuring to know that the exit door is open. It is a choice. It gives me greater choice.[55]

Avoiding unnecessary suffering and maintaining personal dignity

2.36 This section outlines the key arguments relating to the need to introduce VAD as a means of ensuring choice and dignity for people with a terminal illness. It also outlines the argument that VAD is a way of avoiding unnecessary suffering for individuals with a terminal illness, and their loved ones.

Providing an alternative to pain and suffering during the end of life

2.37 The committee heard evidence about the immense suffering and pain experienced by some people with a terminal illness before they die. Some stakeholders gave first-hand accounts of the experience of their loved ones, and made the argument that being forced to suffer in

51 Evidence, Mr Steve Offner, Communications Director, Go Gentle Australia, 8 December 2021, p 7.

52 Evidence, Dr Robert Marr OAM, Vice President, Doctors Reform Society, 8 December 2021, pp 45-46.

53 Evidence, Dr Robert Marr OAM, Vice President, Doctors Reform Society, 8 December 2021, pp 45-46.

54 Evidence, Dr Robert Marr OAM, Vice President, Doctors Reform Society, 8 December 2021, p 46.

55 Evidence, Ms Janet Cohen, Advocate, Go Gentle Australia, 8 December 2021, p 7.

extremely painful ways is cruel and unnecessary. They stated that introducing VAD is an effective way of addressing that issue, as it provides an alternative option for end-of-life care for those experiencing unbearable suffering as a result of a terminal illness.

2.38 Supporters of the bill spoke about 'bad deaths', and explained that 'even the best palliative care cannot always relieve the suffering of some dying people'.[56]

2.39 This was reiterated by representatives of the NSW Nurses and Midwives' Association, who explained that under the bill, VAD will only be accessed in the circumstances were all other available medical options have reached their limits. It was explained that there are instances where modern medicine cannot provide relief, and accessing VAD gives those individuals control over the circumstances of their death.[57]

2.40 This argument was summarised by Dr Robert Marr OAM, Vice President, Doctors Reform Society, who explained the circumstances in which VAD would be accessed:

> We are really talking about when people have terminal illnesses that are definitely going to kill them and we pretty much know how it is going to kill them in not a pleasant way. We are empowering these terminally ill people to choose for themselves how much suffering they want to endure. We will offer them the best palliative care. We can pretty much ease most pain—not all pain, I know; we cannot ease all suffering.[58]

2.41 In this context, the committee heard from a number of supporters of the bill who explained the severe physical, emotional, spiritual and existential pain they had seen their loved ones endure in the last stages of their life. Ms Shayne Higson recounted the experience of her mother, Jan, who died from brain cancer in 2012. Ms Higson said:

> When mum died in late 2012 there was no law to provide her with a more compassionate end-of-life option, so she was forced to endure the terrible end stages of that dreadful disease and we, her loved ones, were forced to watch on, powerless and traumatised.[59]

2.42 Ms Higson outlined the high-quality care her mother had received, but went on to say that:

> Despite all that support, mum did not die peacefully and the last 15 days of her life were cruel and harrowing. Just two weeks before her death, mum started to ask for some form of medication that would knock her out, but nothing the doctors prescribed eased her suffering or distress. Each day it just got worse and mum could not take it anymore; she kept asking, "Why are they doing this to me? Why are they torturing me?"[60]

2.43 The committee heard from Ms Abbey Egan, who told the story of her partner, Jayde, who died from cervical cancer in 2018. Ms Egan reiterated that although Jayde had access to good palliative care, there was no pain relief available that could adequately alleviate her suffering. When describing this experience, Ms Egan said that:

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56 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 2.

57 Evidence, Ms Shaye Candish, Assistant General Secretary, NSW Nurses and Midwives' Association, 8 December 2021, p 18.

58 Evidence, Dr Robert Marr OAM, Vice President, Doctors Reform Society, 8 December 2021, p 48.

59 Evidence, Ms Shayne Higson, Vice President, Dying with Dignity NSW, 8 December 2021, p 4.

60 Evidence, Ms Shayne Higson, Vice President, Dying with Dignity NSW, 8 December 2021, p 4.

> Jayde's last week on this earth was nothing short of hell, not only for Jayde but also for her family and my family, who were there to watch her leave. She was so dosed up on pain medication that she was hallucinating and thrashing around on the bed. She did not know where she was or who we were or what was happening for her, which was immensely distressing, not only for her but for us.[61]

2.44 She went on to describe in detail some of the physical suffering Jayde experienced:

> The tumour in her abdomen was so large that it was impacting her ability to use the toilet … 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.[62]

2.45 Ms Cathy Barry recounted the experience of her brother, Tom, whom she described as having experienced a 'truly appalling death'. Ms Barry recounted the extreme suffering Tom endured in the weeks before his death from facial cancer, and the difficulty of being unable to assist him. She said nothing could alleviate Tom's suffering, and on at least two occasions, he formally asked his family members to assist him to die.[63]

2.46 These stakeholders explained that they were sharing these stories with the committee in order to demonstrate the extreme pain experienced by some people at the end of their life, and argued that in these instances, access to VAD would have avoided what they described as an 'inhumane' experience for their loved ones.[64]

Access to choice and maintaining personal autonomy

2.47 Many supporters of the bill argued that VAD gives terminally ill people a sense of autonomy, choice and dignity during their illness and ultimately, during their death.

2.48 Stakeholders told the committee that the notion of choice is central to VAD, and emphasised that the scheme is voluntary. They stressed that introducing VAD would assist people who currently do not have a choice in their death, and provides a 'compassionate alternative' to the suffering outlined above.[65]

2.49 When describing the significance of having a choice, Dr David Leaf, NSW Convenor and National Co-Convenor, Doctors for Assisted Dying, told the committee that:

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61 Evidence, Ms Abbey Egan, Private individual, 8 December 2021, p 53.

62 Evidence, Ms Abbey Egan, Private individual, 8 December 2021, p 54.

63 Evidence, Ms Cathy Barry, Private individual, 8 December 2021, pp 52-54.

64 Evidence, Ms Cathy Barry, Private individual, 8 December 2021, p 53.

65 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 3; Evidence, Mr Steve Offner, Communications Director, Go Gentle Australia, 8 December 2021, p 8.

> Some patients want this as the least worst option. It allows them to take control and to be assured that their death will come in a timely and peaceful manner when they can withstand no longer … I support their autonomy.[66]

2.50 Loss of personal autonomy and dignity was referred to several times as a key reason why terminally ill people in other jurisdictions had elected to access VAD. It was explained that international evidence has consistently recorded that existential crisis and a loss of autonomy were the top reasons for access to VAD, ranking higher than physical pain. It was put to the committee that suffering of this kind associated with being terminally ill cannot be abetted by pain relief, or palliative care.[67]

2.51 The significance of maintaining personal autonomy and dignity was also expressed to the committee by Ms Cohen, who described being able to access VAD as 'deeply reassuring', and having put her 'back in the driver's seat', at a time when life 'feels increasingly out of control'.[68]

2.52 This was reiterated by other individuals who told the committee about their experiences caring for loved ones who were dying from a terminal illness. Ms Emma Schofield outlined the experience of her late husband, Amal:

> I think back to that time and I imagine what it would have meant to us if I could have just told him, "If all that is too much, if it gets too frightening or you just can't breathe properly, it is your choice whether you have to cope with that or not."[69]

2.53 Mr Paul Gabrielides recounted the experience of his wife Anne, who died in 2018, and spoke about how important having a choice in death would have been to Anne:

> People have asked me for the last four years, "If given the choice and if the laws were in place"—which they were not—"would Anne have opted to use it?" You have heard doctors say, "One in three actually use it," or, "Less than half actually use it." If that had been available, would she have made the decision to end her life, and, if she had, at what point? Right? I tell them this, "The premise of your question is wrong; it is incorrect. You should not be asking whether Anne would have or wouldn't have, what you should be asking is how comfortable and happy would she have lived over those past 12 months knowing that she had an option to do what she wanted to do"."[70]

2.54 Stakeholders also told the committee that providing access to VAD does not equate to a lack of support for palliative care. Rather, they argued that it critically important for patients to have access to a number of options, including high-quality palliative care, and to be empowered to make decisions for themselves in the context of end-of-life care.[71]

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66 Evidence, Dr David Leaf, NSW Convenor and National Co-Convenor, Doctors for Assisted Dying, 8 December 2021, p 39.

67 Evidence, Dr David Leaf, NSW Convenor and National Co-Convenor, Doctors for Assisted Dying, 8 December 2021, p 43.

68 Evidence, Ms Janet Cohen, Advocate, Go Gentle Australia, 8 December 2021, p 6.

69 Evidence, Ms Emma Schofield, Private individual, 8 December 2021, p 58.

70 Evidence, Mr Paul Gabrielides, Private individual, 8 December 2021, p 51.

71 Evidence, Ms Shaye Candish, Assistant General Secretary, NSW Nurses and Midwives' Association, 8 December 2021, p 18.

2.55 Stakeholders explained that evidence from Victoria and international jurisdictions where VAD is available shows that the majority of people who use VAD are also in palliative care. However, they stressed that simply expanding palliative care services does not provide to the same degree of choice and decision-making as introducing VAD as an option does.[72]

VAD as an alternative to suicide for terminally ill people

2.56 Supporters of the bill argued that the introduction of VAD will also have a positive impact on the loved ones of people who die from a terminal illness, as they will not have to see a loved one suffer unnecessarily. Stakeholders also noted the prevalence of suicide amongst terminally ill patients, and the long-term negative impacts deaths of this kind can have for those left behind.

2.57 Dying with Dignity NSW explained that data released early in 2020 showed that in 2019, over 20 per cent of suicides amongst people aged over 40 in the state were by people with a terminal or debilitating medical condition, or who had experience of a significant decline in physical health.[73]

2.58 The committee heard that families of loved ones who died through VAD, as opposed to dying by suicide, generally were able to grieve the death in a more healthy and positive way. It was noted that this was particularly the case amongst children and young people. Dr Leaf told the committee that:

> You can imagine coming home to find your father or loved one dead in some grisly way compared to having the opportunity to set a date, you know it is coming, the person dies peacefully, there is some music, you get to hold their hand, you get to have a cry and say goodbye. What do you think will be the difference for that community?[74]

2.59 This was reiterated by Dr Gavin Pattullo, whose wife, Vanessa, died by suicide after suffering from leukaemia. Dr Pattullo explained that not only would VAD have given Vanessa the ability to say goodbye and be with her family when she died, but it would have meant he could have accessed professional support without fear of being somehow implicated in her death.[75]

2.60 Stakeholders told the committee about the wide-reaching impacts of suicide of terminally ill people, noting the distress that is experienced by family, loved ones and first-responders who may discover the individual who has died. These suicides were described as 'lonely and often horrific', with supporters of the bill saying this category of suicide could largely be avoided if the bill is passed.[76]

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72 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 2; Evidence, Ms Shaye Candish, Assistant General Secretary, NSW Nurses and Midwives' Association, 8 December 2021, p 18.

73 Evidence, Ms Shayne Higson, Vice President, Dying with Dignity NSW, 8 December 2021, p 5.

74 Evidence, Dr David Leaf, NSW Convenor and National Co-Convenor, Doctors for Assisted Dying, 8 December 2021, p 45.

75 Evidence, Dr Gavin Pattullo, Senior Staff Specialist Anesthetist and Pain Medicine Physician, Royal North Shore Hospital, Senior Clinical Lecturer, University of Sydney, 8 December 2021, pp 45 and 39.

76 Evidence, Ms Shayne Higson, Vice President, Dying with Dignity NSW, 8 December 2021, p 5.

2.61 The committee also heard that having access to VAD can actually have the impact of terminally ill people choosing to prolong their life. Stakeholders said that this may be because they know they will not have to suffer a 'horrible death', and know they are able to end their suffering at a time of their choosing.[77]

2.62 In this regard, Mrs Rebecca Daniel told the story of her husband, Lawrie, who had multiple sclerosis, and took his own life in 2016. Mrs Daniel explained that this occurred far earlier than would have happened if Lawrie had access to VAD, as he 'was losing the use of his hands and he felt he needed to take action quickly before paralysis took control'.[78]

General community support for Voluntary Assisted Dying

2.63 Stakeholders who support the bill consistently pointed to there being broad community support for the introduction of a VAD scheme in NSW.

2.64 Dying with Dignity NSW told the committee that independent surveys have consistently shown 'overwhelming' public support for VAD laws. They said that support has ranged from 75 to 85 percent across all locations, demographics and political ideology.[79]

2.65 Similarly, Christians Supporting Choice for Voluntary Assisted Dying told the committee that a 2012 Newspoll found that VAD was supported in similar numbers amongst people who identified as religious.[80]

2.66 The committee heard that there is also support for VAD amongst relevant trade unions who are involved in the delivery of health care services. Both the NSW Nurses and Midwives' Association and the Australian Paramedics Association (NSW) indicated that 85 per cent and 82 per cent of their members, respectively, indicated support for the introduction of VAD legislation.[81]

2.67 Further, in its submission, Go Gentle stated that other groups who are the 'most directly affected by this issue' support VAD, including the state branches of the Council on the Ageing, Cancer Voices, the Older Women's Network and the Council for Civil Liberties.[82]

2.68 The Council on the Ageing spoke to community support for VAD in their submission to the inquiry, noting that in a survey conducted in 2021, support for VAD amongst people over 50 in New South Wales was approximately 72 percent.[83]

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77 Evidence, Dr Robert Marr OAM, Vice President, Doctors Reform Society, 8 December 2021, p 46.

78 Evidence, Mrs Rebecca Daniel, Private individual, 8 December 2021, p 56.

79 Evidence, Ms Penny Hackett, President, Dying with Dignity NSW, 8 December 2021, p 2.

80 Submission 1, Christians Supporting Choice for Voluntary Assisted Dying, p 4.

81 Submission 43, NSW Nurses and Midwives' Association, p 6; Submission 35, Australian Paramedics Association (NSW), p 1.

82 Submission 49, Go Gentle Australia, p 6.

83 Submission 16, Council on the Ageing (COTA) NSW, p 3.

Arguments against the Voluntary Assisted Dying Bill 2021

2.69 This section outlines the arguments made by stakeholders who oppose the bill. This includes opposition to the specific scheme which the bill establishes, as well as opposition to euthanasia and assistance to suicide more broadly. Arguments made against the bill include that it would introduce a fundamental change to the criminal law and to the way society values every human life; that it would undermine efforts to prevent suicide; there is potential for abuse and coercion that poses an unacceptable risk to vulnerable people, including the elderly, those with mental illness and people with disability; that it would have an adverse impact on First Nations people; concerns amongst the medical profession and the risk of medical errors; lack of access to palliative care; euthanasia and assistance to suicide requested for feeling a burden and for loneliness; no poison can be guaranteed to cause a rapid, peaceful and humane death; concerns about the likely increase in the number of deaths under the bill; conscientious objection, both individual and institutional, and residential aged care and health care facilities; general religious opposition to VAD; and the risk of eligibility criteria being expanded.

Terminology – 'Voluntary Assisted Dying' or 'Euthanasia' and 'Assistance to suicide'

2.70 The Dictionary in Schedule 1 of the bill provides that '**voluntary assisted dying** means the administration of a **voluntary assisted dying substance** … .'

2.71 Clause 7 of the bill defines a '**voluntary assisted dying substance**' to be 'a Schedule 4 poison or Schedule 8 poison' approved by the Health Secretary 'for use under this Act for the purpose of causing a patient's death.'

2.72 Opponents of the bill pointed out that:

> … this makes it clear that 'voluntary assisted dying' does not refer to any processes that simply make the dying process more comfortable but solely to acts directed at the administration of a poison in a sufficient dose to cause death. Section 57 of the Bill specifies that the lethal poison may either be **self-administered** – that is the person may be prescribed a lethal poison by a practitioner to be ingested by that person in order to cause the person's death – or **practitioner administered** – that is the lethal poison may be injected by a medical practitioner, nurse practitioner or registered nurse in order to cause the person's death.[84]

2.73 Opponents of the bill submitted that the term 'voluntary assisted dying' and other terms used in the bill were 'euphemistic terms used to make harsh realities seem more palatable' and argued that practitioner administration of a poison for the purpose of causing a patient's death should be called 'euthanasia' and the prescription and supply of a poison to be self-administered for the purpose of causing a patient's death should be called 'assistance to suicide'.[85]

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84 Submission 20, Australian Care Alliance, p 5.

85 Submission 20, Australian Care Alliance, p 5. See also Submission 13, Professor Margaret A. Somerville, pp 15-16; Submission 41, The Anscombe Bioethics Centre, p 10; Submission 95, Plunkett Centre for Ethics, p 3; Submission 63, Associate Professor Peter Kurti, pp 19-25; Answers to supplementary questions, Dr John Fleming, p 4; Answers to supplementary questions, Professor David Kissane, pp 1-3; Answers to supplementary questions, Professor Bernadette Tobin AO, pp 2-3; Answers to supplementary questions, Professor Margaret A. Somerville AM, pp 1-2; Answers to supplementary questions, Associate Professor Megan Best, p 1; Answers to supplementary questions,

Fundamental change to law, medicine and society

2.74 Stakeholders argued that the bill would fundamentally change the criminal law in NSW by effectively creating a new category of 'justifiable homicide',[86] creating broad exceptions to the criminal law prohibitions of murder, as well as of aiding, abetting, inciting or counselling another person to commit suicide. The Australian Care Alliance argued that as the bill would bring about 'profound changes' to the criminal law it should be subject to the most careful scrutiny, and that the proper tests for its safety ought to be:

> … the same ones that are usually applied to any proposal to reintroduce capital punishment: Can we craft a law that will ensure there will not be even one wrongful death? Can we ensure that any deaths under this law are humane - that is both rapid and peaceful?[87]

2.75 The committee also heard that introducing VAD may send a dangerous message to people who are sick, in that they may feel compelled to access the scheme because they felt like a burden to their loved ones. Opponents of the bill argued that there is a risk that terminally ill people may see others accessing the scheme, and fear they too are becoming a burden to their family, and therefore make a choice to access the scheme that is not truly voluntary.[88]

2.76 This perspective was summarised by Dr Gregory Pike, Director of the Adelaide Centre for Bioethics and Culture, who hypothesised the thought process of sick or vulnerable people who may feel obligated to access VAD:

> But it is not hard to see how mistakes might be made and someone might slip through the net … 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.[89]

2.77 Stakeholders suggested that the existence of such a scheme, and the option of being able to access it, represents a subtle influence or pressure which could suggest to people that it is an option they should take. It was stated that research in jurisdictions where VAD has been legalised has shown that an 'internalised sense of burden' has been referred to as a reason for accessing the scheme. Opponents of the bill argued that this reflects a fundamental failure of public policy, and a disruption to the general social principle of ensuring vulnerable people are cared for.[90]

2.78 Opponents of the bill also said that VAD represents a dangerous departure from the general social principle of counselling people against ending their life. They argued that the importance

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Dr Eugene Moylan, pp 1-2; Answers to supplementary questions, Dr Rachel Hughes and Mark Green, pp 1-3; Answers to supplementary questions, Julia Abrahams, pp 2-3.

86 Submission 86, Mr Paul Santamaria QC, p 3.

87 Submission 20, Australian Care Alliance, p 8.

88 Evidence, Dr Frank Brennan AM, Palliative Care Physician, St George and Calvary Hospitals Sydney, Senior Lecturer, University of NSW, 10 December 20201, p 29.

89 Evidence, Dr Gregory Pike, Director, Adelaide Centre for Bioethics and Culture, 10 December 2021, p 67.

90 Evidence, Dr Gregory Pike, Director, Adelaide Centre for Bioethics and Culture, 10 December 2021, p 67.

of this principle is evident in the provision of suicide prevention efforts, and that VAD would undermine the message that each individual life is valued and worthy. Stakeholders said that the more ethical approach would be to continue to commit to providing support to the sick and vulnerable.[91]

2.79 Stakeholders told the committee that VAD reflects a move away from the principle that life is valuable and should not be prematurely ended. They argued it would 'threaten great harm to our culture and the fabric of our civil society', because it undermines the fundamental respect and value of each individual human life.[92]

2.80 This position was summarised by Professor Margaret Somerville, Professor of Bioethics at the University of Notre Dame Australia, who explained the possible broader social outcomes and risks of introducing VAD:

> 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?[93]

2.81 This point was reiterated by Dr John Fleming, Retired Academic and Former President of Campion College Australia, who said that:

> Making legal exceptions to the law against killing fellow innocent citizens compromises the capacity of the State to protect the lives of all its citizens impartially….The issue at stake is the inalienability of the right to life and the duty of the State to protect impartially the rights of all its citizens, and especially the weak and the vulnerable.[94]

Suicide prevention

2.82 Supporters of the bill claim that it would prevent the suicide of people with a terminal illness.

2.83 However, opponents of the bill gave evidence that similar claims made in relation to Victoria's Voluntary Assisted Dying Bill 2017 – that it would prevent up to 50 suicides each year – have been proved incorrect and that the suicide rate in Victoria has not decreased.

2.84 The Australian Care Alliance cited data on suicide from the Coroners Court of Victoria showing that there were more suicides in Victoria in 2020 than in 2017 concluding that 'there is no evidence that the anticipated decrease of 50 deaths by (non-authorised) suicide each year has

91 Evidence, Bishop Michael Stead, Anglican Church Diocese of Sydney, 13 December 2021, p 76; Evidence, Rev. Dr. John McClean, Convenor, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in the State of NSW, 10 December 2021, p 15.

92 Evidence, Adjunct Associate Professor Peter Kurti, Director, Culture, Prosperity & Civil Society Program, Centre for Independent Studies and Adjunct Professor of Law, University of Notre Dame Australia, 10 December 2021, p 57; Submission 65, Dr Frank Brennan AM, pp 4-5.

93 Evidence, Professor Margaret A. Somerville AM, Professor of Bioethics, Affiliate at the Institute for Ethics and Society, University of Notre Dame Australia, 10 December 2021, p 3.

94 Evidence, Dr John Fleming, Retired Academic and Former President of Campion College Australia, 13 December 2021, p 44.

been achieved'. It pointed out that if the 144 cases in 2020 of self-administration of a lethal poison prescribed and supplied for use by a person to end their life under a permit issued by the Victorian Secretary of the Department of Health and Human Services were correctly counted as suicides then there was an increase of 21.2 per cent in suicides in 2020 compared to 2017. If the 31 deaths by practitioner administration in Victoria in 2020 are also taken into account, then the increase was 25.8 per cent.[95]

2.85 The Anscombe Centre submitted that 'There is good evidence that legalising assisted suicide will increase rates of self-initiated death and will not help prevention of (non-assisted) suicide'.[96] This evidence includes a detailed study by David Albert Jones and David Paton, 'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?'[97]

2.86 Opponents of the bill argued that if the NSW Government facilitated suicides under this bill it would undermine commitments under the National Mental Health and Suicide Prevention Plan to aim for zero suicides within health care settings; reduce the availability, accessibility and attractiveness of the means to suicide; and establish public information campaigns to support the understanding that suicides are preventable. They also argued that the bill would create a two-system model where some people were excluded from all suicide prevention efforts and their suicides were presented as wise choice and actively facilitated by the NSW Government, sending 'the message that some people would be better off dead and that suicide can be a peaceful, beautiful thing and a wise choice'.[98]

Potential for abuse and coercion within VAD

2.87 Opponents of the bill argued that the risk of abuse occurring within the scheme proposed in the bill is too high, and consequently, the legislation should not be passed. They argued that there is a high likelihood of elder abuse and coercion occurring in VAD schemes generally, as these risks are inherent to the operation of the schemes. Further, it was argued that in addition to these broad risks, the specific scheme proposed in the bill does not contain sufficient safeguards.

Risks of coercion of elderly and vulnerable people

2.88 The committee heard that VAD poses a significant risk to vulnerable people, in that they can be coerced or manipulated into accessing the scheme. Stakeholders explained that this kind of coercion could occur within the context of existing elder abuse, and would have permanent consequences.

2.89 Stakeholders referred to the Royal Commission into Aged Care Quality and Safety, and noted the existence of significant issues relating to elder abuse. They argued that this context makes

95 Submission 20, Australian Care Alliance, p 47

96 Submission 41, Anscombe Bioethics Centre, p 1.

97 Submission 41, Anscombe Bioethics Centre, pp 9-10.

98 Submission 20, Australian Care Alliance, pp 45-46. See also Submission 75, St Vincent's Heath Australia, p 7; Submission 48, Australian Christian Lobby, pp 29-30; Answers to supplementary questions, Mr Gregory Bondar, pp 4-5.

the VAD proposal significantly more dangerous, as it could lead to these issues being exacerbated.[99]

2.90 In its submission, Catholic Health Care noted that the Royal Commission found that almost 40 per cent of people living in residential aged care have experienced some form of abuse or neglect. They argued that the introduction of VAD will only worsen this already significant problem.[100]

2.91 In addition to the Royal Commission into Aged Care Quality and Safety, the committee heard that a number of other inquiries undertaken both in New South Wales and at a Commonwealth level have examined and identified significant issues relating to elder abuse. They are as follows:

- New South Wales Legislative Council, General Purpose Standing Committee No. 2, *Elder abuse in New South Wales,* Report 44, June 2016
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability First Progress Report (20 December 2019), Third Progress Report (10 February 2021), Fourth Progress Report (30 August 2021) and Fifth Progress Report (8 February 2022)
- New South Wales Legislative Council, Select Committee on the Provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, June 2021
- Australian Institute of Family Studies, *National Elder Abuse Prevalence Study: Final Report*, December 2021.[101]

2.92 The committee heard about the seriousness of elder abuse, with stakeholders outlining what they had observed in the sector:

> 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.[102]

2.93 Some stakeholders told the committee that VAD also poses a significant risk to people living with mental health issues. They argued that the scheme proposed in the bill does not adequately screen people who may be suffering from a mental illness such as depression which may affect their decision-making capacity, and therefore, could result in people wrongfully accessing VAD.[103]

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99 Evidence, Mr Mark Green, National Director Mission, Little Company of Mary Health Care (Calvary) Ltd, 10 December 2021, p 51.

100 Submission 77, Catholic Health Australia, p 7.

101 Submission 67, The Hon Greg Donnelly MLC, p 2; Submission 67A, The Hon Greg Donnelly MLC, p 1.

102 Evidence, Ms Julia Abrahams, Chief Legal Counsel, Catholic Heathcare and Member, Catholic Health Australia, 10 December 2021, p 54.

103 Evidence, Professor David Kissane, Professor and Chair of Palliative Medicine Research, The University of Notre Dame Australia, and The Cunningham Centre for Palliative Care Research, St Vincent's Sydney, 10 December 2021, p 35; Answers to supplementary questions, Professor David Kissane, pp 3-4; Answers to supplementary questions, Professor Margaret A. Somerville AM, p 3;

2.94 Expanding on this point, the Australian Care Alliance told the committee about circumstances in Oregon where people had accessed VAD on the basis of their depression and subsequent suicidal ideation, rather than because of the impacts of their terminal illness. They argued that the depression should have been identified and treated in the first instance, rather than allowing that person access to VAD.[104] The Alliance also cautioned that:

> There is no model from any jurisdiction that has legalised assisted suicide and/or euthanasia for adequately ensuring that no person who is assisted to commit suicide or killed directly by euthanasia is suffering from treatable clinical depression or other forms of mental illness that may affect the capacity to form a competent, settled, determination to die by assisted suicide or euthanasia.[105]

2.95 The Australian Care Alliance also argued that people living with a disability are particularly vulnerable, and could be subject to wrongful death by VAD. On this point they cited the late Stella Young who wrote that 'social attitudes towards disabled people come from a medical profession that takes a deficit view of disability. This is my major concern with legalising assisted death; that it will give doctors more control over our lives. As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I've experienced some of the very worst disability prejudice and discrimination'. Further, they told the committee that some of the reasons given by people who access VAD, such as changes to their quality of life, or being unable to engage in activities they once did, are experienced by people with a disability. They said that this sends a dangerous message to people with a disability, and makes them particularly vulnerable to being coerced or encouraged to access VAD when they otherwise would not wish to.[106]

Difficulty in determining coercion

2.96 Numerous stakeholders stressed to the committee the inherent difficulty of assessing if a decision to access VAD is being made in a genuinely voluntary way, or if a person is being coerced. HammondCare told the committee that experts in the area had identified the difficulty of this assessment as one of the most significant concerns about the scheme, stating: 'no number of indicia will ever be able to provide health professionals with concrete certainty that an individual is requesting VAD voluntarily'.[107]

2.97 Stakeholders therefore argued that VAD 'places vulnerable people at greater risk of having their lives ended without their consent', specifically in the context of being coerced into accessing a scheme of this kind.[108]

Answers to supplementary questions, Associate Professor Megan Best, pp 2-3; Answers to supplementary questions, Professor Bernadette Tobin AO, p 3; Answers to supplementary questions, Dr Rachel Hughes and Mark Green, pp 5-7; Answers to supplementary questions, Greg Smith SC, p 1.

104 Submission 20, Australian Care Alliance, pp 31-33.

105 Submission 20, Australian Care Alliance, p 32.

106 Submission 20, Australian Care Alliance, pp 33-35.

107 Submission 105, HammondCare, p 9.

108 Submission 105, HammondCare, p 5.

2.98 The committee also heard that coercion of this kind can occur in subtle ways, and thus, be difficult to detect.[109]

2.99 In particular, opponents of the bill explained that the influence or pressure to access VAD may be so subtle that it does not fulfil the definition of coercion as set out in the bill, but nevertheless means the decision to access the scheme is not truly voluntary. Dr Frank Brennan AM, Palliative Care Physician, St George and Calvary Hospital, described coercion as occurring along a spectrum, and said that:

> At one end there is no pressure or influence; at the other extreme is coercion and undue influence. Between those two ends, some degree of influence or pressure may occur that is not picked up within the statutory definition. These influences may be overt or covert.[110]

2.100 Dr Brennan gave a number of examples of what he described as covert, or subtle influence, which included: the person feeling that their family thinks they are living too long, frustration amongst family members, seeing others choose VAD, and the normalisation of VAD in society.[111]

2.101 The committee also heard evidence about the practical difficulties of assessing if a person is being coerced into accessing VAD. Stakeholders explained that the doctors assessing a person's eligibility may be generally ill-equipped to make these decisions, due to a lack of specific training in this area, and potentially, minimal previous interaction with the patient.[112]

2.102 Further, opponents of the bill argued that a doctor would have to observe an instance of coercion or duress during the process of seeking to access VAD for them to determine that a person was being coerced. They stated that this would be 'inherently unlikely' to occur, given that the relevant family members who may have been involved in the coercion could be present when the eligibility assessment is occurring.[113]

Insufficient safeguards contained within the bill

2.103 Stakeholders told the committee that in addition to the general risks VAD poses, the bill before Parliament contains insufficient safeguards, and thus poses an even greater risk to the community. They identified a lack of safeguards in relation to the assessment of capacity and coercion, in addition to issues relating to the proposed assessment process and eligibility criteria.[114]

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109 Submission 77, Catholic Health Australia, p 7; Evidence, Professor Roderick MacLeod MNZM, HammondCare Associate and Honorary Professor, University of Auckland, 10 December 2021, p 37; Evidence, Dr John Obeid, Consultant Physician and Geriatrician, 10 December 2021, p 30.

110 Submission 65, Dr Frank Brennan AM, p 5.

111 Submission 65, Dr Frank Brennan AM, p 5.

112 Submission 86, Mr Paul Santamaria QC, p 16; Submission 24, The Hon Greg Smith SC, p 15.

113 Submission 86, Mr Paul Santamaria QC, p 16.

114 Submission 44, Health Professionals Say No, p 9; Submission 95, Plunkett Centre for Ethics, p 4; Submission 75, St Vincent's Health Australia, pp 5-6; Submission 78, Associate Professor Megan Best, p 2.

2.104 In relation to the assessment of capacity and the difficulty of determining whether a person is being coerced, opponents of the bill argued that the bill does not provide sufficient safeguards to ensure that this assessment can be done in the best and most effective way.[115]

2.105 In particular, some stakeholders argued that the requirements in the bill regarding specialisation for medical practitioners involved in the VAD assessment process are inadequate.[116]

2.106 Clinical Professor Richard Chye, Director, Sacred Heart Supportive & Palliative Care, St Vincent's Health Network Sydney, told the committee that despite his many years of experience as a palliative care specialist, he would not be well placed to assess if a person was being coerced to access VAD as a means to pay off debts, for example. He argued that it is unrealistic to expect a VAD assessor to be able to make these kinds of determinations without the requisite time spent with the patient, or specialist experience.[117]

2.107 It was put to the committee that there should be a requirement that a mental health specialist, such as a psychologist or a psychiatrist, be involved in the eligibility assessment for access to VAD. Stakeholders argued that this is necessary to ensure that capacity and coercion can be effectively established by a practitioner with expertise in the field.[118]

2.108 Stakeholders argued that the bill is also deficient in that it assumes capacity in a person seeking to access VAD, unless proven otherwise. Opponents of the bill said that the doctor assessing eligibility may have limited experience in assessing capacity, specifically in relation to vulnerable people, and there should be a positive requirement to establish capacity.[119]

2.109 Opponents pointed out that 'under the bill there is no check of decision-making capacity when self-administration occurs, which may be months after the lethal poison was prescribed. If the person was tricked or bullied into ingesting it, who would know?'[120]

2.110 On a related note, the committee heard from some stakeholders that the medical practitioners involved in determining eligibility for VAD should either be specialists in the field of the person's illness, or in palliative care more generally. They argued that without this requirement, there is no guarantee that a person is receiving accurate information, and is fully aware of all treatment options available to them.[121]

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115 Evidence, Dr John Obeid, Consultant Physician and Geriatrician, 10 December 2021, p 30; Evidence, The Hon Greg Smith, 10 December 2021, p 21; Evidence, Mr Paul Santamaria QC, 10 December 2021, p 25.

116 Evidence, Clinical Professor Richard Chye, Director, Sacred Heart Supportive & Palliative Care, St Vincent's Health Network Sydney, 10 December 2021, p 53; Evidence, Dr John Daffy, Treasurer, Australian Care Alliance, 10 December 2021, p 58.

117 Evidence, Clinical Professor Richard Chye, Director, Sacred Heart Supportive & Palliative Care, St Vincent's Health Network Sydney, 10 December 2021, p 53.

118 Evidence, Associate Professor Andrew Cole, Chief Medical Officer, HammondCare, 10 December 2021, p 50; Evidence, Dr John Obeid, Consultant Physician and Geriatrician, 10 December 2021, p 30.

119 Evidence, Dr John Obeid, Consultant Physician and Geriatrician, 10 December 2021, p 30.

120 Submission 20, Australian Care Alliance, p 3.

121 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 27; Evidence, Mr Michael McAuley, President, St Thomas More Society, 10 December 2021, p 32; Evidence, Dr Sarah

2.111 Dr Sarah Wenham, a specialist palliative care physician practicing in the Far West Local Health District, explained this to the committee:

> … 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.[122]

2.112 A further concern identified was around the provision in the bill allowing medical practitioners to initiate discussions about VAD in certain circumstances.[123]

2.113 Finally, the committee heard that in addition to the safeguards in the bill being inadequate, they are also fundamentally unworkable, and therefore, ineffective. Mr Paul Santamaria QC, Barrister, Owen Dixon Chambers, said that:

> Moreover, all the statutory "protections" that are incorporated into the Bill type are not worth a pinch of salt unless there are realistic opportunities for unlawful conduct of family members, aged-care operators or, heaven forbid, unethical medical practitioners to be detected – and prosecuted. Nothing in this Bill ought encourage diligent parliamentarians to believe that prosecution for unlawful conduct which has caused the death of vulnerable persons is other than the stuff of dreams.[124]

Impact of VAD on First Nations people

2.114 Some stakeholders argued that there had not been adequate consultation with First Nations people regarding the introduction of VAD in New South Wales, and told the committee that there are significant concerns regarding how VAD will impact Aboriginal people.

2.115 The Australian Care Alliance referred to comments made by Senator Pat Dodson, who when referring to VAD, said that given First Nations people are over-represented at all stages of the health system, it would be irresponsible to 'vote in favour of another avenue to death'. Further, they noted his comment that VAD would leave First Nations people even more vulnerable, and that efforts should be taken to prolong life.[125]

Wenham, Specialist Palliative Care Physician, Far West Local Health District, 10 December 2021, p 44; Answers to supplementary questions, Professor David Kissane, pp 7-8; Answers to supplementary questions, Greg Smith SC, p 2; Answers to supplementary questions, Associate Professor Megan Best, pp 5-6

122 Evidence, Dr Sarah Wenham, Specialist Palliative Care Physician, Far West Local Health District, 10 December 2021, p 44.

123 Submission 34, St Thomas More Society, pp 28-29; Answers to supplementary questions, Professor David Kissane, pp 6-7; Answers to supplementary questions, Greg Smith SC, p 2; Answers to supplementary questions, Associate Professor Megan Best, pp 4-5

124 Submission 86, Mr Paul Santamaria QC, p 16.

125 Submission 20, Australian Care Alliance, p 26; Submission 40, Right to Life NSW, p 10-12; Answers to supplementary questions, Mr Gregory Bondar, pp 2-3.

2.116 Additionally, The Australian and New Zealand Society of Palliative Medicine told the committee that they had concerns about the impacts of VAD on First Nations people due to the lack of access to quality palliative care, and end of life care, in some Indigenous communities. They also identified 'cultural concerns' regarding the 'translation and dissemination of VAD' amongst First Nations people.[126]

Concerns amongst the medical profession and the risk of medical errors

2.117 Opponents of the bill told the committee about objections to VAD from within the medical community. Stakeholders outlined concerns about the conscientious objections provisions in the bill, in addition to the general philosophical objection to VAD held by some medical practitioners. The committee also heard about the unreliability of diagnosis and prognostication, and how this could impact the operation of the scheme. Opponents noted that even supporters of the bill, such as Mr Andrew Denton (founder and director of Go Gentle Australia), have admitted that 'There is no guarantee ever that doctors are going to be 100% right'.[127]

2.118 The committee heard that there were medical practitioners who have a fundamental opposition to VAD on the basis it is contradictory to the guiding principle of 'first do no harm'. A number of medical practitioners told the committee that as doctors, they are dedicated to preserving life, and this scheme would be a radical departure from the purpose of practicing medicine.[128]

2.119 The Australian Care Alliance said that:

> [M]edicine, since the time of Hippocrates has included a commitment by a physician to "benefit my patients according to my greatest ability and judgement, and [to] do no harm or injustice to them". This commitment to benefit the patient is fully consistent with the Hippocratic tradition not to "administer a poison to anybody when asked to do so, nor [to] suggest such a course".[129]

2.120 The Australian Care Alliance also stated that this millennia-old approach to the duty of the physician was affirmed by the World Medical Assembly at its 70th General Assembly in October 2019. The ACA cited the WMA as stating that:

> The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.
>
> For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with

126 Submission 70, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), pp 2-4.

127 Submission 20, Australian Care Alliance, p 8.

128 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 27; Evidence, Adjunct Associate Professor Peter Kurti, Director, Culture, Prosperity & Civil Society Program, Centre for Independent Studies and Adjunct Professor of Law, University of Notre Dame Australia, 10 December 2021, p 57.

129 Answers to supplementary questions, Australian Care Alliance, pp 2-3.

> decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.
>
> No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.
>
> Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient.[130]

2.121 In accordance with this position, the Australian Medical Association in its Position Statement Euthanasia and Physician Assisted Suicide affirms:

> 3.1 The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.[131]

2.122 The Australian Care Alliance stated that agreeing to provide or administer a lethal poison to a person is not and never can be 'patient-centred care', and is in every case an abandonment of the patient by affirming that the patient would be better off dead and that no further patient-centred care will be offered. The ACA also said that authentic patient-centred care stands in solidarity with the patient until the end of life, including offering holistic palliative care when further treatment is no longer indicated or has been refused by the patient'.[132]

2.123 It was argued that rather than pursuing VAD, it is more aligned with the principles of good medicine to focus on improving palliative care, and relieving suffering in patients. Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, told the committee: 'We need to maintain the role of medical practitioners as healers, not as agents of voluntary assisted dying'.[133]

2.124 Further, some stakeholders argued that VAD is fundamentally not a 'legitimate medical act', given it requires a doctor to be involved in the purposeful killing of a patient. These stakeholders argued that VAD should not be considered within the framework of medicine or healthcare.[134]

2.125 The Australian and New Zealand Society for Geriatric Medicine – NSW Division submitted that:

> … frail older people may be put in a position of considering VAD because they feel that they are 'a burden' on others (such as family members, carers and the health care system). Such feelings are often due to underlying depression, lack of availability of

130 World Medical Association, *WMA Declaration on Euthanasia and Physician-Assisted Suicide*, 23 November 2021, https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide

131 Australian Medical Association, *Position Statement: Euthanasia and Physician Assisted Suicide,* 24 November 2016, https://www.ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016.

132 Answer to supplementary questions, Australian Care Alliance, pp 2-3

133 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 28.

134 Evidence, Associate Professor Megan Best, Associate Professor of Bioethics, Institute for Ethics and Society, The University of Notre Dame Australia, 10 December 2021, p 45.

> community services or family dynamics. It is possible that someone may consider an older frail older person eligible on the grounds that they have a limited life expectancy.[135]

2.126 The committee also heard that given the fundamental issues that some medical practitioners have with VAD, the provisions for conscientious objection in the bill do not go far enough. Some stakeholders described these provisions as 'limited', and said that staff who conscientiously object to VAD would nevertheless inevitably be 'complicit in actions against their professional ethics and usual standards of knowledge'. It was argued that this would lead to conflict and tensions within workplaces, in addition to the personal ethical and philosophical challenges imposed on the relevant individuals.[136]

2.127 Opponents of the bill said that the limitations of these provisions will be particularly evident in residential aged-care facilities. Stakeholders explained that while staff in aged-care facilities will not be required to participate in VAD, the bill requires that people must not be restricted from accessing VAD in the facility, on the basis of this being their home. The committee heard that this effectively overrides the conscientious objection of the facility, and that it will, in practice, be impossible for the property, staff and resources of the facility to not be involved in VAD.[137]

2.128 Finally, the committee heard evidence from medical professionals regarding the difficulty of accurate diagnosis and prognostication for the purposes of VAD. Stakeholders explained that it is not uncommon for mistakes to be made during diagnosis, and the subsequent prognosis of how long someone has to live.

2.129 The committee heard that as a consequence of such errors, a person could access VAD essentially 'under a false premise'.[138] As Dr Moylan put it: '… incorrect prognostication will ultimately mean that people will be assisted to die that may have lived significantly longer than might have been anticipated.'[139]

2.130 In this context, it was explained that prognostication is very difficult, and produces a forecast of a likely outcome, rather than a certain outcome. Professor Roderick MacLeod, HammondCare Associate and Honorary Professor, University of Auckland, said that studies have shown prognosis can be, and often is, wrong.[140]

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135 Submission 57, Australian and New Zealand Society for Geriatric Medicine – NSW Division, p 1.

136 Evidence, Clinical Associate Professor Maria Cigolini, Clinical Associate Professor and Lecturer, University of Sydney in Medicine, and Administrator, Health Professionals Say No, 10 December 2021, p 41.

137 Evidence, Mr Alexander Millard, Solicitor, Human Rights Law Alliance, 10 December 2021, p 55.

138 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 27.

139 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 27.

140 Evidence, Professor Roderick MacLeod MNZM, HammondCare Associate and Honorary Professor, University of Auckland, 10 December 2021, p 37.

2.131 Further, Dr Moylan explained that in the context of life expectancy for cancer patients, it is very difficult to provide a life expectancy within a six-month time frame. He said that while it is possible to predict when someone is in the last three to six weeks of their life, it is 'patently incorrect' to say that death can often be accurately predicted within the next six months.[141]

2.132 The committee heard a number of examples of people with terminal illnesses being given a prognosis that ultimately was not accurate. Opponents of the bill said that this demonstrated a fundamental risk of VAD, in that people will be able to access the scheme based on an inaccurate prognosis, when they would have otherwise been able to continue to live their life.[142]

2.133 The Australian Care Alliance said that it is 'certain' wrongful deaths will occur, due in part to wrong diagnosis and prognosis. They said that this cannot be avoided in any VAD scheme, but is of particular concern in this bill as a specialist medical practitioner is not required to be involved in the process.[143]

2.134 Further, the Australian Care Alliance referenced international evidence regarding this issue, including a German study which found that, on autopsy, approximately 10 per cent of all clinically diagnosed cancer cases were found to not have cancer. Further, the submission referenced a number of examples of individuals taking legal action on the basis that they were incorrectly diagnosed with a terminal illness, noting that if VAD had been legal in those jurisdictions, such a diagnosis could have resulted in wrongful deaths.[144]

Lack of access to palliative care

2.135 The committee heard from a number of opponents of the bill and peak bodies representing palliative care services about the inadequate access to high-quality palliative care in New South Wales, particularly for those living in rural, regional and remote communities. Further, opponents of the bill argued that for VAD to be a genuine and informed choice, equitable access to palliative care must exist and be a priority, before legalising VAD.

2.136 Stakeholders stressed to the committee that currently, there is 'no consistent access to palliative care' due to insufficient funding of resources and services, both in home and hospital settings, as well as for the education and support of health care professionals, carers and families in understanding what palliative care is.[145]

2.137 Similarly, stakeholders told the committee that there is a lack of access and delivery of high-quality specialist palliative care in New South Wales. For example, Dr Wenham stated that only

141 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 27.

142 Evidence, Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital, 10 December 2021, p 27.

143 Evidence, Dr John Daffy, Treasurer, Australian Care Alliance, 10 December 2021, p 58.

144 Submission 20, Australian Care Alliance, pp 12-13.

145 Evidence, Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc., 10 December 2021, p. 27; Evidence, Ms Linda Hansen, Chief Executive Officer, Palliative Care NSW, 10 December 2021, pp 32-33.

50 per cent of people living in New South Wales that would benefit from palliative care are able to access it, and only half of those people are accessing specialist support.[146]

2.138 Further, many stakeholders asserted that the lack of access to palliative care services, particularly specialist care services, is only intensified in regional and rural communities. Dr Wenham expanded on the challenges that lead to highly variable access to palliative care in these areas, telling the committee:

> We don't have a specialist hospice or dedicated palliative care beds staff by specialist nurses in any of our Far West LHD facilities. Therefore, if a person doesn't want to or is unable to be cared for at home, the only option is dying in the local hospital, which may be hundreds of kilometres away from their home and community.[147]

2.139 Reflecting on data collated by the PM Glynn Institute, and on evidence presented to the hearing of the inquiry by Portfolio Committee No. 2 into Health outcomes and access to health and hospital Services in rural, regional and remote New South Wales held on 19 March 2021, Dr Michael Casey submitted that:

> The workforce shortage in palliative care, particularly in outer regional and remote areas of New South Wales, raises serious questions about equity in the provision of palliative care and access to it. This is a significant problem in its own right. It also raises serious questions about legalising euthanasia and assisted suicide in a situation where access to palliative care for those at the end of life or suffering from a life-limiting illness is neither universal nor equitable … if there is no effective access to palliative care for some people, whether they are in the regions or in the cities, it is difficult to see how ensuring that assisted dying is available to all offers suffering people a genuine choice, or genuinely respects their autonomy. If the choice is between assisted dying on the one hand, and the absence of effective pain and symptom control and accompaniment by family and carers on the other, it is a false choice and one which it is unjust to offer.[148]

2.140 Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc. gave evidence that:

> … access to specialist palliative care is extremely important. Whilst we have grown and developed palliative care in this State … we certainly do not have equitable access. So people, when we talk about informed choice, need to have access to make that informed choice. It is great in the theoretical model but in the real world we are still … nowhere near funding what we do need.[149]

2.141 Many opponents of the bill argued that without access to high-quality palliative care, especially within regional and rural communities, people with a life-limiting diagnosis might be more likely to choose VAD in the absence of any other real options. In particular, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, noted that it was 'difficult to countenance how a person

146 Evidence, Dr Sarah Wenham, Specialist Palliative Care Physician, Far West Local Health District, 10 December 2021, p 44.

147 Submission 66, Dr Sarah Wenham, p. 4.

148 Submission 83, Dr Michael Casey, pp 1-2.

149 Evidence, Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc., 13 December 2021, p 27.

could be really given a choice' when access to the services they need to make an informed choice are 'not funded at a level that is accurate'.[150]

2.142 The committee also heard from health care professionals providing palliative care, who argued that improving and ensuring access to quality palliative care must be the priority before introducing VAD. For example, Dr Frank Brennan AM, Palliative Care Physician at St George and Calvary Hospitals Sydney, urged the committee to return to the VAD debate when there is universal access to palliative care, stating that there is 'not enough of us and not enough settings'.[151]

2.143 Additionally, a number of palliative care physicians argued that VAD is fundamentally at odds with the practice of good palliative care, and the efforts of doctors working within this speciality. These physicians commented that 'palliative care promotes quality of life; VAD gives up on life',[152] and argued that introducing VAD runs the risk of weakening palliative care, essentially rendering it futile.[153]

2.144 The committee noted the comments made in the New South Wales Auditor-General's Report: Performance Audit, Planning and evaluating palliative care services in NSW:

> NSW Health's approach to planning and evaluating palliative care is not effectively coordinated. There is no overall policy framework for palliative and end-of-life care, nor is there comprehensive monitoring and reporting on services and outcomes.
>
> NSW Health has a limited understanding of the quantity and quality of palliative care services across the state, which reduces its ability to plan for future demand and the workforce needed to deliver it. At the district level, planning is sometimes ad hoc and accountability for performance is unclear.
>
> The capacity of LHDs to use accurate and complete data to plan and deliver services is hindered by multiple disjointed information systems and manual data collections. Further, a data collection on patient outcomes, for benchmarking and quality improvement, is not used universally. This limits the ability of districts to plan, benchmark and improve services based on outcomes data.

150 Evidence, Dr Brendan Long, Chief Executive Office, Right to Life NSW, 10 December 2021, p 64; Answers to supplementary questions, Professor Margaret A. Somerville AM, p 4; Answers to supplementary questions, Professor Bernadette Tobin AO, pp 1-2; Answers to supplementary questions, Associate Professor Megan Best, pp 3-4; Answers to supplementary questions, Professor David Kissane, pp 5-6; Answers to supplementary questions, Dr Eugene Moylan, pp 2-3.

151 Evidence, Dr Frank Brennan AM, Palliative Care Physician, St George and Calvary Hospitals Sydney, and Senior Lecturer, University of NSW, 10 December 2021, p 28.

152 Evidence, Professor David Kissane, Professor and Chair of Palliative Medicine Research, The University of Notre Dame Australia, and The Cunningham Centre for Palliative Care Research, St Vincent's Sydney, 10 December 2021, p 35.

153 Evidence, Adjunct Clinical Professor Leeroy William, Immediate Past President, The Australian and New Zealand Society of Palliative Medicine, 10 December 2021, p 35; Evidence, Professor David Kissane, Professor and Chair of Palliative Medicine Research, The University of Notre Dame Australia, and The Cunningham Centre for Palliative Care Research, St Vincent's Sydney, 10 December 2021, p 35; Evidence, Professor Roderick MacLeod MNZM, HammondCare Associate and Honorary Professor, University of Auckland, 10 December 2021, p 36.

> NSW Health's engagement with stakeholders is not systematic. The lack of an overall stakeholder engagement strategy puts at risk the sustainability and value of stakeholder input in planning and limits transparency.[154]

Euthanasia and assistance to suicide requested for feeling a burden and for loneliness

2.145 Opponents of the bill cited data from other jurisdictions that have legalised euthanasia and assistance to suicide demonstrating that it was not primarily requested due to concerns about pain or other physical symptoms but rather for concerns such as a decreasing ability to participate in activities that made life enjoyable, loss of autonomy and loss of dignity. According to the Australian Care Alliance, in Oregon, the majority of those requesting a prescription of a lethal substance to end their life made the request because they felt that they were a 'physical or emotional burden on family, friends, or caregivers'.[155]

2.146 The Australian Care Alliance cited a recent report[156] on elder abuse in Australia as demonstrating a 'a correlation between all abuse subtypes and low social support (including social isolation and loneliness)' and drew attention to a similar correlation between isolation and loneliness and requests for euthanasia as indicated in the Sixth annual report for Quebec which stated that nearly one in four (24%) people requested to have their lives ended by euthanasia because they were experiencing 'isolation or loneliness'.[157]

No poison can be guaranteed to cause a rapid, peaceful and humane death

2.147 Opponents of the bill gave evidence on the various poisons used to cause death in other jurisdictions that have legalised euthanasia and assistance to suicide or in jurisdictions which use poisons for capital punishment.[158] The Australian Care Alliance argued that this evidence shows that so far there is no evidence of a poison that will result in a rapid, peaceful and human death on every occasion it is used. As reported in a key article in *Anaesthesia*, cited by the ACA:

> Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose (≤9%), a relatively high incidence of vomiting (≤10%), prolongation of death (by as much as seven days in ≤4%), and failure to induce coma, where patients re-awoke and even sat up (≤1.3%). This raises a concern that some deaths may be inhumane.[159]

2.148 The ACA said that official reports from the Netherlands comment on several cases of the muscle relaxant being administered when the person was not in a full coma and therefore potentially causing pain. According to the ACA, complications involved in euthanasia (practitioner administration under the bill) included spasm or myoclonus (muscular twitching),

154 New South Wales Auditor-General's Report: Performance Audit, Planning and evaluating palliative care services in NSW: NSW Health, August 2017, p 2.

155 Submission 20, Australian Care Alliance, p 34.

156 Qu, L. et al. *National Elder Abuse Prevalence Study: Final Report*, Dec 2021, https://apo.org.au/sites/default/files/resource-files/2021-12/apo-nid315734.pdf.

157 Answers to supplementary questions, Australian Care Alliance, pp 5-7.

158 Submission 20, Australian Care Alliance, pp 51-56.

159 Submission 20, Australian Care Alliance, pp 51-52

cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heartbeat), excessive production of mucus, hiccups, perspiration, and extreme gasping.[160]

2.149 The ACA also stated that in Oregon in 2018 one in nine (11.11 per cent) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose or had other complications; that the interval from ingestion of lethal drugs to unconsciousness has been as long as four hours (in 2017); that the time from ingestion to death has been as long as 104 hours (4 days and 8 hours); and that one person in 2018 took 14 hours to die.[161]

2.150 Dr Brendan Long, Chief Executive Officer, Right to Life NSW told the committee that the poison used in Victoria for self-administration is 15 g of sodium pentobarbital.[162] The Australian Care Alliance said that this poison is also used for capital punishment, and referred the committee to the following:

- Anaesthetist David Waisel who has stated that '… during judicial lethal injections … there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering'.
- Autopsies conducted by anaesthetist Joel Zivot and others on inmates executed by sodium pentobarbital, found that they had drowned in lung secretions (pulmonary oedema) in 84 per cent of cases.
- In her 2015 dissent in *Glossip v Gros*, US Supreme Court Justice Sonya Sotomayor, characterised death by lethal injection as 'the chemical equivalent of being burned at the stake'.[163]

2.151 The Australian Care Alliance concluded:

> The Bill cannot guarantee that those assisted to commit suicide or euthanised by a medical practitioner, nurse practitioner or registered nurse once authorised by an appointed State official under this Bill will not die a 'cruel and inhumane' death. No scheme for assisted suicide and euthanasia so far enacted or proposed can guarantee a humane, rapid and peaceful death.[164]

Concerns about the likely increase in the number of deaths under the bill

2.152 Dr Brendan Long gave evidence that based on the initial experience in Victoria and Western Australia, and taking into account data from jurisdictions in North America and Europe showing an annual average growth rate of 17 per cent in deaths by legalised euthanasia and assistance to suicide, there could be as many as 1,400 deaths in New South Wales in 2030 if the bill were to become law.[165]

160 Submission 20, Australian Care Alliance, p 52.

161 Submission 20, Australian Care Alliance, pp 52-53.

162 Answers to questions on notice, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, p 5

163 Submission 20, Australian Care Alliance, pp 54-56.

164 Submission 20, Australian Care Alliance, p 56.

165 Answers to questions on notice, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, pp 3-4

2.153 The Australian Care Alliance publication, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia*, cited in its submission, documents the increase in numbers of deaths by euthanasia and assistance to suicide in each jurisdiction where these have been legalised.[166] For example:

- In Oregon, '… deaths from ingesting lethal substances prescribed under Oregon's *Death With Dignity Act* reached 245 in 2020 (up 28.3% from 2019) continuing a steady rise at an average growth of 15% per annum, since 1998, the first year of the Act's operation when 16 people died under its provisions. These deaths in 2020 accounted for 0.61% of all deaths in Oregon that year (up 19.53% from 2019)'.[167]
- in the Netherlands, '… reported deaths from euthanasia rose nearly fourfold (382%) from 1815 in 2003, the first year under the new law, to 6938 deaths reported in 2020 … 4.12% of all deaths. … In 2019, one in sixteen (6.2%) deaths in the Netherlands of persons aged between 60 and 80 years of age resulted from reported acts of euthanasia or assisted suicide'.[168]
- in Canada: 'The number of cases each year doubled in 3 years from 2,838 in 2017, the first full year of legalisation, to 5,660 in 2020 with annual increases of 57.8% (2017 to 2018); 26.4% (2018 to 2019) and 34.2% (2019 to 2020). … In 2020 euthanasia and assisted suicide accounted for 2.45% of all deaths in Canada, with provincial rate highest in British Columbia (3.84%) … The rate for Quebec reached 3.62% of all deaths for the period 1 July 2020 to 31 March 2021'.[169]
- In Victoria: 'As of 30 June 2021, 331 people had their lives intentionally ended under the Act – 49 by euthanasia and 264 by assistance to suicide. In the twelve-month period, July 2020-June 2021, 201 people died under the Act – an increase of 55% from the 130 who died in the first year of its operation. Deaths by euthanasia and assistance to suicide in the six months January to June 2021 represent over 0.5% of all deaths in Victoria for that period. It took Oregon 21 years to reach that rate!'[170]
- In Western Australia, there were 50 deaths under that state's *Voluntary Assisted Dying Act 2019* between 1 July 2021 and 31 October 2021 – representing 1.07 per cent of all deaths in WA in those four months. This is more than double the rate in Victoria after two years of operation and 75 per cent higher than Oregon's rate after 23 years of legalisation but similar to Canada's rate in 2017 - its first full year of legalisation. Further, in the first seven months of legalisation, 68 per cent of deaths under WA's Act resulted from practitioner administration of a lethal poison (euthanasia) and only 32 per cent from self-administration (suicide). This rate of euthanasia compared to assisted suicide is 4.6 times that in Victoria in the first two years of legalisation. International evidence suggests that

166 Submission 20, Australian Care Alliance, p 2, quoting Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments.

167 Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, p 8.

168 Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, pp 29-30.

169 Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, pp 62-63.

170 Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, p 83.

> where euthanasia – practitioner administration – is readily available then the overall rate of deaths by this method is much higher than in those jurisdictions, such as Oregon, which only permit self-administration of the lethal poison (suicide).[171]

2.154 Opponents of the bill suggested that 'given that the NSW scheme more closely reflects the Western Australian model than the Victorian model', New South Wales could see the ' … sort of massive expansion in assisted suicide case numbers we have seen under the Canadian assisted suicide and lethal injection (euthanasia) scheme'.[172]

Conscientious objection, both individual and institutional, and residential aged care and health care facilities

2.155 Opponents of the bill pointed out that Part 5 of the bill would force a residential aged care facility or health care facility that has a policy of complete non-participation in the processes established under the bill leading up to and including the administration or self-administration of a lethal poison to cause a person's death to nonetheless participate in facilitating some of those processes.

2.156 In the case of a residential aged care facility, this may include forcing the facility to permit a medical or nurse practitioner on to the premises to administer the lethal poison and cause the death of a resident.

2.157 In responding to supplementary questions Archbishop Anthony Fisher OP, Archbishop of Sydney on behalf of the Catholic Bishops of New South Wales and the Bishops of the Australian-Middle East Christian Apostolic Churches explained:

> Attempts in the Voluntary Assisted Dying Bill 2021 (Bill) to protect individual conscience rights while offering little or no protection for those individuals to associate in institutions that are operated in accordance with a particular ethos wrongly presume that individual conscience rights can be adequately respected without also preserving the rights of an institution to maintain ethical policies that align with the consciences of the individuals involved.
>
> Part 5 of the Bill is not only an egregious attack on the religious freedom of religious care facilities, particularly residential aged care facilities, it will result in the undermining of the culture of care in these facilities that have served the people of New South Wales so well. This is especially the case for Part 5, Division 2 of the Bill, which requires a religious aged care facility to allow every aspect of the euthanasia and assisted suicide process, including the administration of lethal drugs, to occur on its site.
>
> […]
>
> Faith-based residential aged care facilities should not be required to allow any aspect of euthanasia or assisted suicide on their premises because to do so would require faith-based institutions and those who own, operate and reside in them to act against their core beliefs.

171 Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, p 95.

172 Answers to questions on notice, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, pp 2-4.

> Many residents choose Catholic aged care facilities because of their Catholic ethos, particularly the fundamental belief that human life should be protected at all stages. Many families choose Catholic aged care facilities for the same reason. Their choices at the end of life must also be respected. Catholic aged care facilities must be able to continue to offer residents and potential residents the guarantee that euthanasia and assisted suicide will never be facilitated or performed on site.[173]

General religious opposition to VAD

2.158 The committee heard evidence from stakeholders who outlined the general religious objections to voluntary assisted dying, first and foremost being that VAD is fundamentally at odds with their central religious beliefs. Opponents of the bill explained that these religious beliefs also underpin some of the arguments regarding the need to care for sick and vulnerable people in ways other than VAD, and the negative impact of VAD on the broader social fabric.

2.159 A number of religious leaders and organisations put on record their opposition to the bill, and to VAD more generally. This included the Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Christian Apostolic Churches, the Grand Mufti of Australia, the Rabbinical Council of NSW, the Baptist Association of NSW and ACT, the Presbyterian Church of Australia in the State of NSW and the Anglican Church Diocese of Sydney.[174]

2.160 These stakeholders outlined the fundamental religious view held across different religions and faith traditions that life should not be ended by a person, as death is determined by God's will.[175]

2.161 Rabbi Nochum Schapiro, President, Rabbinical Council of NSW said in his evidence:

> 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. … So, in summary, we are each created in the divine image. We each

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173 Answers to supplementary questions, Archbishop Anthony Fisher OP, pp 2, 6-7. See also Answers to supplementary questions, Ms Julia Abrahams, pp 3-4; Submission 76, Human Rights Law Alliance, p 4; Submission 54, Little Company of Mary Health Care (Calvary), p 7; Submission 77, Catholic Health Australia, pp 8-9; Submission 70, The Australian and New Zealand Society of Palliative Medicine, pp 5-6.

174 Submission 38, Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Christian Apostolic Churches, p 3; Evidence, Dr Ibrahim Abu Mohamed, His Eminence the Grand Mufti of Australia, 10 December 2021, p 9; Evidence, Rabbi Nochum Schapiro, President, Rabbinical Council of NSW, 10 December 2021, p 16; Submission 15, Baptist Association of NSW and ACT, p 1; Submission 53, The Presbyterian Church of Australia in the State of NSW; p 3, Submission 42, The Anglican Church Diocese of Sydney, p 2.

175 Evidence, Dr Ibrahim Abu Mohamed, His Eminence the Grand Mufti of Australia, 10 December 2021, p 9; Evidence, Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches, 10 December 2021, p 13; Evidence, Rabbi Nochum Schapiro, President, Rabbinical Council of NSW, 10 December 2021, p 10.

> have a mission to bring goodness and godliness into the world and that mission continues until we take our last breath. Thank you.[176]

2.162 As His Eminence the Grand Mufti of Australia put it in evidence to the committee:

> 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.[177]

2.163 Stakeholders also explained to the committee that caring for the sick and the vulnerable is a critical part of the belief systems of the major religions, as well as of the overall social fabric.[178]

2.164 The committee heard that caring for the sick and dying is core to the mission of religious believers. Stakeholders referred to the long history of churches providing health care, aged care and palliative care. Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches told the committee that:

> 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 invaluable 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.[179]

2.165 Stakeholders explained the importance of religious aged-care and residential facilities, and expressed concern about the fact that while facilities are able to opt-out of providing VAD under the NSW bill, a resident must be allowed to access VAD within the facility. They argued that this fundamentally imposes on the rights of the people working and living in these facilities, and could create a situation where bystanders either feel exposed to VAD, or unintentionally involved in the process.[180]

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176 Evidence, Rabbi Nochum Schapiro, President, Rabbinical Council of NSW, 10 December 2021, p 16.

177 Evidence, Dr Ibrahim Abu Mohamed, His Eminence the Grand Mufti of Australia, 10 December 2021, p 9.

178 Evidence, Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches, 10 December 2021, p 8.

179 Evidence, Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches, 10 December 2021, p 8.

180 Submission 77, Catholic Health Australia, p 9.

2.166 Opponents of the bill argued that the introduction of VAD will have a negative social impact, both in terms of how the community views and treats sick and vulnerable people, and how sick and vulnerable people perceive their worth. It was put to the committee that while religious beliefs underpin these views to some extent, they are relevant to the broader community, and can be characterised as more general philosophical beliefs.[181]

2.167 As referred to above, religious leaders told the committee that their objection to VAD was not exclusively based in the belief that ending life early is interfering with God's will. Rather, they told the committee that it reflects a fundamental shift and disruption to the social fabric, which impacts religious and non-religious people alike. Opponents of the bill argued that VAD ultimately represents a failure to care for the sick and the vulnerable.[182]

2.168 Opponents of the bill explained that the introduction of a VAD scheme would send a message to vulnerable people that their lives are not as valuable or worthy as the lives of younger and healthier people, and that you need to have a certain degree of bodily autonomy and dignity to live a worthy and valuable life.[183]

2.169 This position was summarised by Archbishop Fisher, who told the committee:

> 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.[184]

Risk of eligibility criteria being expanded

2.170 Some stakeholders argued that while the scheme proposed in the bill may be relatively narrow in terms of who is eligible to access VAD, there is a risk that this criteria will be expanded over time. They argued that this would allow a greater number of people to access VAD, and would mean that scheme in practice would not be aligned with the intention of the legislation, or the evidence used to support its passage.

2.171 In this context, the committee heard evidence relating to the operation of VAD schemes in international jurisdictions where the eligibility criteria has changed since those schemes were originally introduced, and that people who were not originally intended to be able to access VAD, can now access it.

2.172 For example, Professor Margaret Somerville AM, Professor of Bioethics, Affiliate at the Institute for Ethics and Society, University of Notre Dame Australia, told the committee about

181 Evidence, Mr Paul Santamaria QC, Barrister, Owen Dixon Chambers, 10 December 2021, p 23.

182 Evidence, Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches, 10 December 2021, p 8.

183 Evidence, Bishop Michael Stead, Anglican Church Diocese of Sydney, 13 December 2021, p 78.

184 Evidence, Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches, 10 December 2021, p 8.

the operation of medical assistance in dying (MAID) in Canada. She said that in less than four years, the scheme operating in Canada has seen a dramatic shift away from the original strict eligibility criteria, to requests for 'euthanasia on demand' being approved. Further, Professor Somerville said that death is no longer required to be reasonably foreseeable in order for someone to access the scheme, and that it is possible that people experiencing only mental illness, and not physical illness, will be able to access the scheme in early 2023.[185]

2.173 Further, Professor Somerville said that at the end of 2020, approximately 21,589 people had died through the MAID scheme, which accounted for approximately 2.35 per cent of deaths in Canada. Additionally, she stated that the number of deaths increased by 34.2 per cent between 2019 and 2020.[186]

2.174 In addition to the example of legislation being widened in Canada, the committee also heard about the operation of VAD in Oregon. The committee heard that the laws in Oregon had been 'relaxed', both in terms of who is eligible and how the scheme operates. Professor John Keown, Anscombe Bioethics Centre, highlighted the possibility of this risk occurring in any jurisdiction where VAD is legal, and said that : '…the logical extension of laws like those in Oregon, involving the removal of its current 'obstacles' to wider access, is only a matter of time'.[187]

2.175 The committee was also provided with evidence about the VAD scheme in Belgium, which stakeholders argued was operating in a manner inconsistent with its original intentions, in that people are now able to access the scheme who should not be eligible. Professor David A. Jones, Director, Anscombe Bioethics Centre, told the committee that terminal sedation is being used in Belgium as a form of 'euthanasia lite'. Professor Jones said that this is being done with and without the consent of the patient, and is being used for people who do not otherwise require this sedation for symptom control.[188]

2.176 Professor Jones told the committee that the circumstance in Belgium is not a result of amendments to the legislation, but rather, changes to the culture of medicine. He argued that as doctors have already 'crossed that line' by participating in VAD, it has fundamentally altered the practice of medicine in a negative and dangerous way.[189]

2.177 The argument regarding the inevitable expansion of eligibility criteria was summarised by Professor Jones, who said that:

> 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.[190]

185 Evidence, Professor Margaret A. Somerville AM, Professor of Bioethics, Affiliate at the Institute for Ethics and Society, University of Notre Dame Australia, 10 December 2021, p 2.

186 Evidence, Professor Margaret A. Somerville AM, Professor of Bioethics, Affiliate at the Institute for Ethics and Society, University of Notre Dame Australia, 10 December 2021, pp 2-3.

187 Submission 80, Professor John Keown DCL, p 8.

188 Evidence, Professor David A. Jones, Director, Anscombe Bioethics Centre, 10 December 2021, p 4.

189 Evidence, Professor David A. Jones, Director, Anscombe Bioethics Centre, 10 December 2021, p 4.

190 Evidence, Professor David A. Jones, Director, Anscombe Bioethics Centre, 10 December 2021, p 5.

Proposed amendments to the Voluntary Assisted Dying Bill 2021

2.178 Over the course of the inquiry the committee heard, through a number of submissions, oral evidence, answers to questions on notice and answers to supplementary questions, many proposals regarding possible amendments to the Voluntary Assisted Dying Bill 2021. All these details are accessible on the inquiry's webpage.

Committee comment

2.179 The committee has attempted in this report to set out the background and key provisions of the Voluntary Assisted Dying Bill 2021, and importantly, to outline the key arguments in support of the bill, and in opposition to the bill.

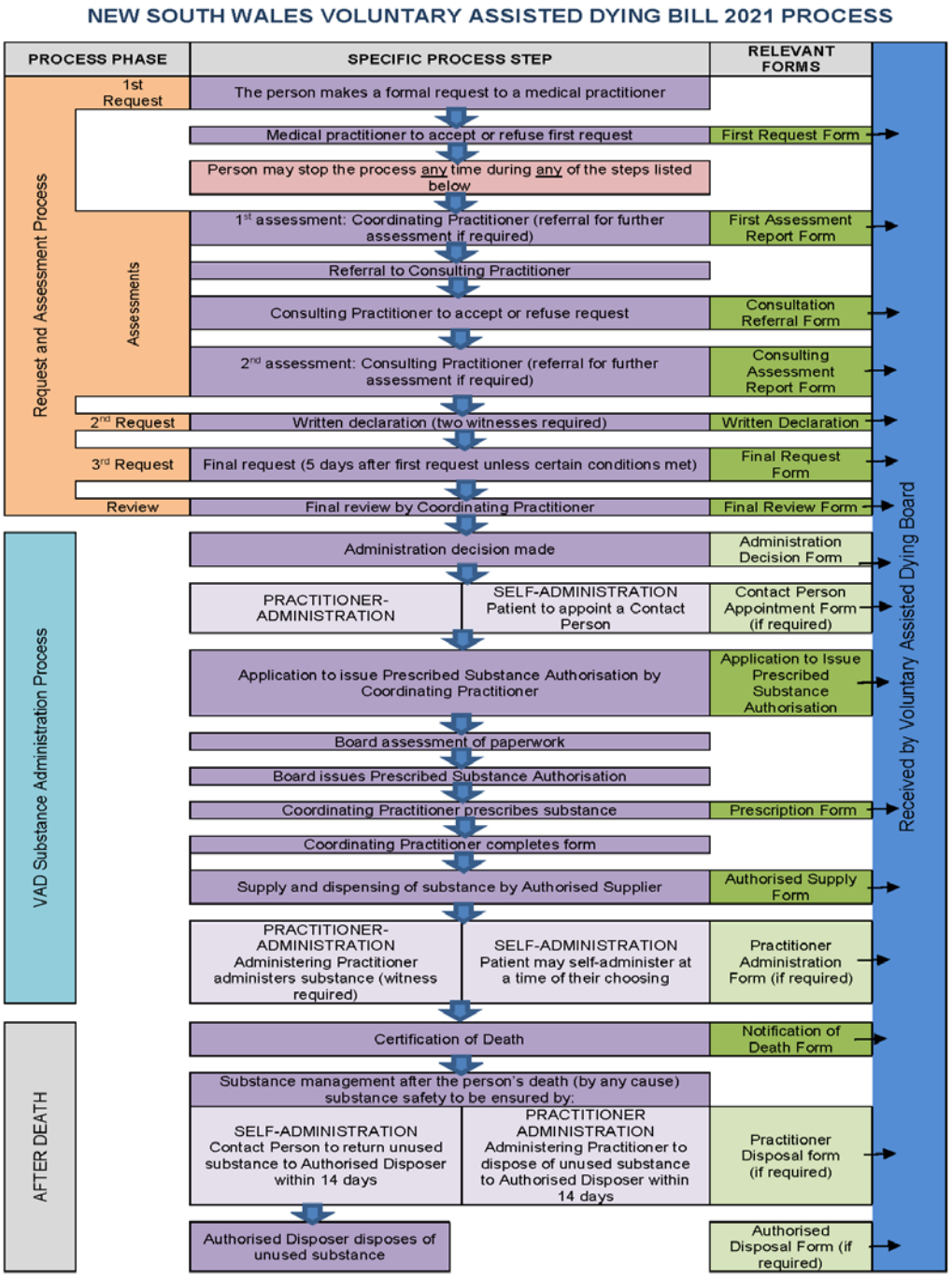
2.180 The issue at stake is one that is deeply felt on both sides of the debate. Perhaps unsurprisingly, there is no consensus amongst stakeholders to the inquiry as to the merits of the Voluntary Assisted Dying Bill 2021. Indeed, nor is there consensus on the committee.

2.181 In these circumstances, the purpose of this inquiry has been to allow stakeholders – including advocacy groups, legal experts, religious groups, the medical profession and members of the community – to place their views on the record, in order to inform debate on the bill in the House. Accordingly, the committee refers the bill back to the House for further consideration.

Recommendation 1

That the Legislative Council proceed to consider the Voluntary Assisted Dying Bill 2021.

Appendix 1 Flow chart of proposed VAD process



Talina Drabsch, NSW Parliamentary Research Service, Issues Backgrounder – Voluntary Assisted Dying Bill 2021 (NSW): a comparison with legislation in other States, No 2/October 2021, p 5, available here.

Appendix 2 Comparison of VAD laws in Australian states

	QLD	SA	TAS	VIC	SA
Legislation	Voluntary Assisted Dying Act 2021	Voluntary Assisted Dying Act 2021	End-of-Life Choices (Voluntary Assisted Dying) Act 2021	Voluntary Assisted Dying Act 2017	Voluntary Assisted Dying Act 2019
Commences	1 January 2023	On a date to be proclaimed, likely to be late 2022/early 2023	On a date to be proclaimed or on 23 October 2022.	19 June 2019	1 July 2021
Definition	VAD is the administration of a voluntary assisted dying substance and includes steps reasonably related to that administration	VAD is the administration of a voluntary assisted dying substance and includes steps reasonably related to such administration.	VAD is the administration to a person, or the self-administration by a person, of a VAD substance.	VAD is the administration of a voluntary assisted dying substance and includes steps reasonably related to such administration	VAD is the administration of a voluntary assisted dying substance, and includes steps reasonably related to such administration
Eligibility criteria	aged 18 or over;	aged 18 or over;	aged 18 or over;	aged 18 or over;	aged 18 or over;
	has a disease, illness, or medical condition that is: advanced, progressive, and will cause death, most likely within 12 months;	has a disease, illness, or medical condition that is: incurable, advanced, progressive, and will cause death within 6 months (or 12 months in the case of a neurodegenerative-e disease, illness or condition);	is suffering intolerably in relation to a disease, illness, injury, or medical condition that: is advanced, incurable and irreversible; is expected to cause their death within 6 months (or 12 months in the case of a person with a neurodegenerative-e disease, illness or condition).	is diagnosed with a disease, illness or medical condition that is: incurable; advanced, progressive and will cause death within six months (or 12 months in the case of a person with a neurodegenerative disease, illness or condition);	is diagnosed with at least one disease, illness or medical condition that: is advanced, progressive and will cause death, probably within 6 months (or 12 months, in the case of a neurodegenerative disease, illness or condition);
	is suffering intolerably because of the disease, illness, or medical condition;	is suffering intolerably because of the disease, illness, or medical condition; and is acting freely and without coercion.	See above.	it is causing suffering to the person that cannot be relieved in a manner that the person finds tolerable.	it is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;
	Is acting voluntarily and without coercion;	See above.	Is acting voluntarily;	Not specified.	is acting voluntarily and without coercion; and has an enduring request for VAD.
Eligibility criteria (contd.)	is an Australian citizen, permanent	is an Australian citizen or permanent resident of Australia, and	is an Australian citizen, permanent resident of Australia, or has	is an Australian citizen or permanent resident, ordinarily	is an Australian citizen or permanent resident, and at

	resident of Australia, or has been ordinarily resident in Australia for at least 3 years prior to making the first request (or granted an exemption); and is ordinarily resident in Queensland for 12 months prior to the first request (or granted an exemption);	ordinarily resident in South Australia for 12 months before making a first request;	been resident in Australia for at least 3 continuous years prior to making a first request, and has been ordinarily resident in Tasmania for 12 months prior to the first request;	resident in Victoria, and, at the time of making a first request for VAD, has been resident in Victoria for at least 12 months;	the time of making a first request for VAD ordinarily resident in Western Australia for at least 12 months;
	has decision making capacity in relation to VAD	has decision making capacity in relation to VAD;	has decision-making capacity;	has decision-making capacity;	has decision-making capacity for VAD;
	A person will be presumed to have capacity to make a VAD decision unless it can be shown otherwise.	A person is presumed to have capacity to make a VAD decision unless it can be shown otherwise.	A person will be presumed to have capacity to make a VAD decision unless it can be shown otherwise.	A person is presumed to have capacity to make a VAD decision unless it can be shown otherwise.	A person will be presumed to have capacity to make a VAD decision unless it can be shown otherwise.
	A person who is suffering from a disability or mental illness alone will not be eligible for VAD, but must meet all the eligibility criteria	A person suffering from a disability or mental illness alone will not be eligible for VAD, but must meet all the eligibility criteria.	A person who is suffering from a disability or mental illness alone will not be eligible for VAD but must meet all the eligibility criteria.	Disability or mental illness alone do not satisfy the eligibility requirements for accessing VAD, but must meet all the eligibility criteria.	Disability or mental illness alone will not satisfy the eligibility requirements for accessing VAD, but must meet all the eligibility criteria.
	A person may apply to the Queensland Civil and Administrative Tribunal for review of certain decision.	A person may apply to the South Australian Civil and Administrative Tribunal for review of certain decisions.	Some decisions may be reviewed by the Voluntary Assisted Dying Commission.	Some decisions may be reviewed by the Victorian Civil and Administrative Tribunal.	Some decisions may be reviewed by the State Administrative Tribunal.
Process involved	Two medical practitioners assess whether a person is	Two medical practitioners assess whether a person is eligible for VAD.	Two medical practitioners assess whether a person is eligible for VAD.	A person's eligibility to access VAD must be independently	A person's eligibility to access VAD must be independently

	eligible for VAD. Both must have completed mandatory training and meet other eligibility requirements.	Both must have completed mandatory training and meet other eligibility requirements.	Both must have completed mandatory training and meet other eligibility requirements.	assessed by at least two medical practitioners who have completed mandatory training, and meet other eligibility requirements.	assessed by at least two medical practitioners who have completed mandatory training and meet other eligibility requirements.
	Timeframes apply to each of the steps in the process.	Timeframes apply to each of the steps in the process.	There are timeframes that apply to each of the steps in the process	There are timeframes that apply to each of the steps in the process.	There are timeframes that apply to each of the steps in the process.
	A person can access VAD once the request and assessment process is completed, and the coordinating practitioner completes a final review form.	N/A	A person will be able to access VAD once: the request and assessment process is completed; an administering health practitioner has been appointed; a VAD substance authorisation has been obtained from the Commission; and the VAD substance has been prescribed.	N/A	A person can access VAD once the request and assessment process is complete, the coordinating practitioner has completed a final review form.
Process involved (contd.)	There are two types of administration: self-administration and practitioner administration. A person can only choose practitioner administration if self-administration is inappropriate.	There are two types of administration: self-administration, and practitioner administration. After a permit has been issued, the person may self-administer the VAD substance, at a time or place or their choosing.	There are two types of administration: private-self administration, and administration that is not private self-administration.	There are two types of administration: self-administration, and practitioner administration.	There are two types of administration: self-administration and practitioner administration.
	The administering practitioner may be either the coordinating practitioner, or another medical practitioner, nurse	An application may be made for a practitioner administration permit if a person is physically incapable of self-administering or digesting the medication.	For a person to be supplied a VAD substance, the administering health practitioner must check again that the person has decision-making capacity and is acting voluntarily. This must occur	N/A	A person can only elect practitioner administration if the coordinating practitioner advises that self-administration would be inappropriate due to the person's ability to self-

Process involved (contd.)	practitioner, or registered nurse to whom the role has been transferred. They must satisfy eligibility requirements and have completed the mandatory training.		within 48 hours of the person giving final permission. The person can then give final permission for VAD in an approved form, which includes information about how the substance will be administered.		administer; the person's concerns about self-administering; or the method for administering the medication that is suitable to the person.
	The VAD substance can be self-administered by the person at a time and place of their choosing. Other people (e.g. family and friends) may be present if the person wishes, but cannot assist. The person may change their mind at any time.	Other people may be present if the person wishes, but cannot assist.	The person may self-administer the VAD substance at a time and place of their choosing. Other people may be present.	In most cases, the VAD medication will be self-administered by the person at a time and place of their choosing. Other people may be present if the person wishes but cannot assist.	The VAD medication is able to be self-administered by the person at a time and place of their choosing. Other people may be present but cannot assist. A health practitioner or a witness is not be required to be present for self-administration.
	There is no requirement for a health practitioner or witness to be present for self-administration.	There is no requirement for a medical or other health practitioner, or a witness, to be present for self-administration.	If private self-administration is not appropriate due to the person's ability to self-administer, their concerns about doing this, or the method of administration, an administering health practitioner administration certificate can be issued.	If the person is physically incapable of self-administering or digesting the medication the coordinating medical practitioner may apply for a practitioner administration permit authorising them to administer the medication to the person. It must take place in the presence of a witness. Anyone the person chooses may also be present during practitioner administration.	N/A

	An eligible witness must be present when the VAD substance is administered by a practitioner.	A witness must be present when the VAD substance is administered by a practitioner.	N/A	Practitioner administration is required to take place in the presence of a witness.	Practitioner administration is required to take place in the presence of a witness.
Safeguards	Health care workers prohibited from initiating a VAD discussion, other than medical practitioners and nurse practitioners (if certain information is provided at the same time).	Registered health practitioners are prohibited from initiating a discussion about VAD.	There are limits on when medical practitioners and other registered health practitioners can initiate a discussion about VAD.	Health practitioners are prohibited from initiating a discussion about VAD.	Health care workers are prohibited from initiating a discussion about or suggesting VAD, unless they are a medical practitioner or nurse practitioner and provide information about treatment options and outcomes to the person at the same time.
	A family member or carer cannot request VAD on somebody's behalf.	A family member or carer cannot request VAD on somebody's behalf.	A family member or carer will not be able to request VAD on a person's behalf.	A family member or carer cannot request VAD on somebody's behalf.	A family member or carer cannot request VAD on somebody's behalf.
	The person will need to make at least three separate requests for VAD.	The person will need to make at least three separate requests for VAD.	The person must make at least three separate requests for VAD. The person also needs to give final permission before a VAD substance can be administered.	A person must make at least three separate requests for VAD.	The person must make at least three separate requests for VAD.
	The person's decision to access VAD must be made voluntarily and without coercion	The person's decision to access VAD must be made voluntarily, freely and without coercion.	The person's decision to access VAD must be voluntary and made without coercion.	N/A	The person's decision to access VAD must be voluntary and made without coercion (confirmed at each stage).
Safeguards (contd.)	There is a waiting period of 9 days from the first request before a person can make a final request.	N/A	N/A	N/A	N/A

Safeguards (contd.)	The person must be provided with information about their diagnosis and prognosis, available treatment and palliative care options.	The person must be provided with information about their diagnosis and prognosis, available treatment and palliative care options.	The person requesting VAD must be provided with information about their diagnosis and prognosis, available treatment and palliative care options.	The person must be provided with information about their diagnosis and prognosis, available treatment and palliative care options, and risks associated with taking the lethal medication (i.e. death).	The person requesting VAD must be given information about their diagnosis and prognosis, available treatment and palliative care options, and risks associated with taking the VAD medication (i.e. death).
	The person is able to change their mind about VAD at any time.	The person is able to change their mind about VAD at any time.	The person is able to change their mind about VAD at any time	The person must also be advised that they may decide at any time not to continue the VAD process.	The person can change their mind about VAD at any time.
	Medical practitioners, nurse practitioners, and registered nurses participating in providing VAD must undergo mandatory approved training and meet certain eligibility criteria.	Medical practitioners participating in providing VAD must undergo mandatory approved training and meet certain eligibility criteria.	Medical practitioners, nurse practitioners and registered nurses participating in VAD must complete mandatory training and meet certain eligibility criteria.	To provide VAD medical practitioners must have the necessary expertise and experience as set out in the legislation, and successfully complete the accredited training, and mandatory reporting requirements for health practitioners and employers where they believe another practitioner's conduct breaches the Act.	Health practitioners must receive training about identifying and assessing risk factors for abuse or coercion.
	N/A	A permit must be issued by the Chief Executive before any person is able to access VAD.	A VAD substance authorisation must be issued by the Commission before any person is able to access VAD.	VAD medication cannot be administered without a permit authorising self-administration or practitioner administration.	N/A
	Offences (punishable by fines or imprisonment of up to 7 years) for anyone who induces a person to access VAD.	Offences (punishable by fines or imprisonment of up to 5 years) for anyone who induces a person to access VAD.	Offences (punishable by fines or imprisonment of up to 5 years) for anyone who induces a person to access VAD.	Offences (punishable by up to 5 years imprisonment) for anyone who induces another person to request VAD or take the VAD medication.	Offences (punishable by up to 7 years imprisonment) for anyone who induces another person to request or access VAD.

	N/A	N/A	N/A	Regulations govern the prescription, dispensing and disposal of VAD medications.	Regulations govern the prescription, dispensing and disposal of VAD medications.
	Protections from liability for persons assisting another person, in good faith, to access VAD.	Protections from liability for persons assisting another person, in good faith, to access VAD.	Protections from liability for persons assisting a person, in good faith, to access VAD.	N/A	Protection from criminal liability for persons who, in good faith, assist a person to access VAD, or are present when VAD medication is administered, and protection from criminal and civil liability for health practitioners acting within the Act.
	The VAD Review Board will monitor, report, research, and review eligible decisions.	The VAD Review Board will be responsible for monitoring, reporting, research, and reviews of eligible decisions.	The Voluntary Assisted Dying Commission will be responsible for monitoring, reporting, research, reviews of eligible decisions, and issuing the VAD substance authorisation.	The Voluntary Assisted Dying Review Board is responsible for monitoring, reporting, compliance, safety and research functions.	The Voluntary Assisted Dying Review Board is responsible for monitoring, reporting, and research.
Compulsory participation?	Registered health practitioners with a conscientious objection to VAD will have the right not to participate in VAD. They can refuse to: provide information about VAD; participate in the request and assessment process; participate in an administration decision; supply, prescribe or administer a	Health practitioners with a conscientious objection to VAD will have the right not to participate in VAD. They can choose not to: provide information about VAD; participate in the request and assessment process; supply, prescribe or administer a VAD substance; be present at the time of administering a VAD substance; and dispense a prescription for a VAD substance.	Health practitioners with a conscientious objection to VAD will have the right not to participate in VAD. However, if a person makes a first request to access VAD, the medical practitioner must provide the person with the contact details of the VAD Commission, even if they have a conscientious objection.	Health practitioners with a conscientious objection to VAD have the right to choose not to participate in VAD. They are under no obligation to: provide information about VAD to a person; or participate in any part of the VAD process, including assessing the eligibility of a person; or supplying, prescribing, administering, or being present prior to, during or following	Health practitioners with a conscientious objection to VAD have the right to choose not to participate in VAD. There is no obligation to: participate in the request and assessment process, prescribe, supply or administer VAD medication, or be present at the time VAD medication is administered.

Compulsory participation? (contd.)	VAD substance; or be present at the time of administering a VAD substance.			administration of a VAD medication.	
	If a person makes a first request for VAD to a medical practitioner with a conscientious objection, the practitioner must immediately inform the person that they refuse the request.	N/A	If a medical practitioner refuses a person's first request, they must, as soon as is reasonably practicable (and within 7 days) advise the person that they refuse the first request; note the person's request (and the refusal to accept it) on the person's medical records; and notify the VAD Commission that they have refused the request.	N/A	If a person makes a first request for VAD to a medical practitioner with a conscientious objection, the practitioner must immediately inform the person that they refuse the request.
	All medical practitioners have to provide certain information to a person who makes a first request for VAD, including the details of a VAD Care Navigator Service.	N/A	N/A	N/A	All medical practitioners (even if they object to VAD, or are not eligible to provide VAD) have to provide approved information to a person who makes a first request for VAD
	Facilities providing health services, residential aged care services or personal care services have the right to refuse to participate in VAD, but will still have some obligations	Residential facilities must allow all residents to access information about VAD and make requests for VAD. Further, generally, health services (e.g. private hospitals and private institutions) who refuse to participate in VAD must ensure that patients are advised of the service's refusal to permit	N/A	N/A	N/A

		VAD; have arrangements in place to transfer the person to other facilities so they can access VAD; and take reasonable steps to facilitate such a transfer.			
	Speech pathologists who have a conscientious objection also have specific obligations, including not to impede the person's access to speech pathology services in relation to VAD	N/A	N/A	N/A	N/A
Can a health practitioner initiate discussion of VAD?	Medical practitioners and nurse practitioners may initiate a discussion with a person about VAD if, at the same time, they inform the person about the treatment options and palliative care options available, and the likely outcomes of treatment.	It is unlawful for a registered health practitioner to initiate a discussion about VAD with a person, or suggest VAD to them. However, they may provide information about VAD if a person requests it.	A medical practitioner may initiate a conversation about VAD if, at the same time, the medical practitioner also informs the person about the treatment and palliative care options available and the likely outcomes.	A registered health practitioner is prohibited from initiating a discussion about VAD or suggesting VAD to a person, but can provide information about VAD at a person's request.	A medical practitioner or nurse practitioner is able to initiate a discussion or suggest VAD to a person so long as they also inform the person, at the same time, about available treatment and palliative care options, and their likely outcomes.
Can a health practitioner initiate discussion of VAD? (contd.)	Health care workers are prohibited from initiating a discussion or suggesting VAD, but can provide information about VAD on a person's request.	N/A	Other registered health practitioners can initiate conversations about VAD if they inform the person during the conversation that a medical practitioner would be the most appropriate person with whom to discuss VAD and	N/A	Health care workers are prohibited from initiating a discussion or suggesting VAD but can provide information about VAD on a person's request.

			the person's care and treatment options.		
	N/A	N/A	If a person requests information about VAD, nothing prevents another person from providing information about the VAD process	N/A	N/A

Appendix 3 Submissions

No.	Author
1	Christians Supporting Choice for Voluntary Assisted Dying
1a	Christians Supporting Choice for Voluntary Assisted Dying
2	Mrs Donna Adolfson
3	Mr Arian Levanael
4	Ms Maryanne Platt
5	Doctors for Voluntary Assisted Dying Choice NSW
6	Mr Nicholas Cowdery AO QC
7	St. Michael's Catholic Church
8	Holy Innocents Parish
9	Dynamic Stride Podiatry
10	Dr Gavin Pattullo
11	Dr Eugene Moylan
12	Mr Julian Gardner AM
13	Professor Margaret A. Somerville AM
14	Voluntary Assisted Dying South Australia (VADSA)
15	Baptist Association of NSW and ACT
16	Council on the Ageing (COTA) NSW
17	Mr Greg Cornwell AM
18	Rationalist Society of Australia
19	Women's Forum Australia
20	Australian Care Alliance
21	Adelaide Centre for Bioethics and Culture
22	Cathy Barry, Angela White and Tony Barry
23	NSW Council for Civil Liberties
24	The Hon. Greg Smith SC
25	Palliative Care New South Wales
26	Dying With Dignity Victoria Inc
27	DIGNITAS - To live with dignity - To die with dignity
28	ACON
29	Avant Mutual
30	Catholic Women's League Australia – New South Wales Inc
31	Dying with Dignity NSW

No.	Author
32	Live and Die Well
33	FamilyVoice Australia (NSW)
34	St Thomas More Society
35	Australian Paramedics Association (NSW)
36	Doctors for Assisted Dying Choice
37	The Clem Jones Group
38	Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Christian Apostolic Churches
39	The National Civic Council, The Australian Family Association (NSW), and Anna Krohn
40	Right to Life NSW
41	The Anscombe Bioethics Centre
42	Anglican Church Diocese of Sydney
43	New South Wales Nurses and Midwives' Association
44	Health Professionals Say No
45	Cherish Life
46	Dying with Dignity WA
47	Positive Life NSW
48	Australian Christian Lobby
49	Go Gentle Australia
50	HOPE: Preventing Euthanasia and Assisted Suicide Ltd
51	National Secular Lobby
52	Sydney Institute of Palliative Medicine
53	The Presbyterian Church of Australia in the State of NSW
54	Little Company of Mary Health Care (Calvary)
55	Anglicare Sydney and Anglicare Northern Inland
56	Humanists Australia
57	Australian and New Zealand Society for Geriatric Medicine - NSW Division
58	Church of the Flying Spaghetti Monster Australia
59	VALE (Voluntary Assisted Life Ending) Group
60	Cancer Voices NSW
61	Secular Association of NSW
62	Dr Xavier Symons
63	Associate Professor Peter Kurti
64	Professor George L. Mendz
65	Dr Frank Brennan AM

No.	Author
66	Dr Sarah Wenham
67	The Hon. Greg Donnelly MLC
67a	The Hon. Greg Donnelly MLC
67b	The Hon. Greg Donnelly MLC
68	Dr Abdulrazak Mohamad
69	MIGA
70	The Australian and New Zealand Society of Palliative Medicine (ANZSPM)
71	Palliative Care Nurses Australia Inc
72	Department of Health Victoria
73	Dementia Australia
74	Australian Medical Association (NSW) Ltd
75	St Vincent's Health Australia
76	Human Rights Law Alliance
77	Catholic Health Australia
78	Associate Professor Megan Best
79	The Greek Orthodox Archdiocese of Australia
80	Professor John Keown DCL
81	Clinical Professor Richard Chye
82	Ms Penny Hackett
83	Dr Michael Casey
84	Mr Ashley Dewell et al.
85	The Hon. Mike Gaffney MLC
86	Mr Paul Santamaria QC
87	Professor David Kissane
88	Name suppressed
89	Mrs Janet Edwards
90	Mrs Lynette McManus
91	Dr John Obeid
92	Dr Stephen Parnis
93	The Law Society of New South Wales
94	Dr John Fleming
95	Plunkett Centre for Ethics
96	Public Health Association of Australia (PHAA)
97	Professor Lindy Willmott and Professor Ben White
98	Dying with Dignity Queensland

No.	Author
99	Physical Disability Council of NSW
100	Dr Andrew McGee
101	New South Wales Bar Association
102	The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
103	Miss Anna Walsh
104	Ms Shayne Higson
105	HammondCare
106	Ms Janet Cohen
107	Australian Lawyers Alliance

Appendix 4 Witnesses at hearings

Date	Name	Position and Organisation
Wednesday 8 December 2021 **Macquarie Room** **Parliament House, Sydney**	Ms Penny Hackett	President, Dying with Dignity NSW
	Ms Shayne Higson	Vice President, Dying with Dignity NSW
	Mr Steve Offner	Communications Director, Go Gentle Australia
	Ms Janet Cohen	Advocate, Go Gentle Australia
	Mr Ian Wood	Christians Supporting Choice for Voluntary Assisted Dying
	Ms Shaye Candish	Assistant General Secretary, NSW Nurses and Midwives' Association
	Ms Laura Toose	Legal Officer NSW Nurses and Midwives' Association
	Ms Aprelle Fleming RN	Member, NSW Nurses and Midwives' Association
	Mr Simeon Beckett	Barrister, NSW Bar Association
	Mr Trent Glover	Barrister, NSW Bar Association
	Mr Nicholas Cowdery AO QC	Immediate Past President, NSW Council for Civil Liberties
	Professor Ben White	Australian Centre for Health Law Research
	Professor Lindy Willmott	Australian Centre for Health Law Research
	Dr David Leaf	NSW Convenor and National Co-Convenor, Doctors for Assisted Dying Choice
	Dr Robert Marr OAM	Vice President, Doctors Reform Society
	Dr Gavin Pattullo	Senior Staff Specialist Anaesthetist and Pain Medicine Physician, Royal North Shore Hospital, Senior Clinical Lecturer, University of Sydney

Date	Name	Position and Organisation
	Ms Abbey Egan	Private individual
	Ms Cathy Barry	Private individual
	Mr Paul Gabrielides	Private individual
	Ms Jan Edwards	Private individual
	Ms Emma Schofield	Private individual
	Ms Rebecca Daniel	Private individual
Friday 10 December 2021 Macquarie Room Parliament House, Sydney	Professor Margaret A. Somerville AM	Professor of Bioethics, Affiliate of the Institute for Ethics and Society, University of Notre Dame Australia
	Professor David A. Jones	Director, Anscombe Bioethics Centre
	Archbishop Anthony Fisher OP	Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian-Middle East Christian Apostolic Churches
	Dr Ibrahim Abu Mohamed	His Eminence the Grand Mufti Of Australia
	Dr Abdulrazak Mohamad	Senior Consultant Physician, Medical and Scientific Advisor to His Eminence the Grand Mufti of Australia
	Rabbi Nochum Schapiro	President, Rabbinical Council of NSW
	Mr Andrew Sloane	Senior Lecturer in Old Testament and Christian Thought, Director of Research at Morling College, Baptist Association of NSW and ACT
	Rev. Dr. John McClean	Convenor, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in the State of NSW
	Dr Joanna Barlow	Member, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in the State of NSW

Date	Name	Position and Organisation
	Mr Paul Santamaria QC	Barrister, Owen Dixon Chambers
	The Hon. Greg Smith SC	Former NSW Attorney-General and Minister for Justice
	Mr Michel McAuley	President, St Thomas More Society
	Dr Frank Brennan AM	Palliative Care Physician, St George and Calvary Hospitals Sydney, Senior Lecturer, University of NSW
	Dr John Obeid	Consultant Physician and Geriatrician
	Dr Eugene Moylan	Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital
	Adjunct Clinical Professor Leeroy William	Immediate Past President, The Australian and New Zealand Society of Palliative Medicine
	Professor David Kissane	Professor and Chair of Palliative Medicine Research, University of Notre Dame Australia, and The Cunningham Centre for Palliative Care Research, St Vincent's Sydney
	Professor Roderick MacLeod MNZM	HammondCare Associate and Honorary Professor, University of Auckland
	Clinical Associate Professor Maria Cigolini	Clinical Associate Professor and Lecturer, University of Sydney in Medicine, Administrator, Health Professionals Say No
	Associate Professor Megan Best	Associate Professor of Bioethics, Institute for Ethics and Society, The University of Notre Dame Australia
	Dr Sarah Wenham	Specialist Palliative Care Physician, Far West Local Health District
	Ms Julia Abrahams	Chief Legal Counsel, Catholic Healthcare, Member, Catholic Health Australia

Date	Name	Position and Organisation
	Clinical Professor Richard Chye	Director, Sacred Heart Supportive & Palliative Care, St Vincent's Health Network, Sydney
	Mr Mark Green	National Director Mission, Little Company of Mary Health Care (Calvary) Ltd
	Dr Rachel Hughes	Director of Palliative Care, Calvary Mater Newcastle, Little Company of Mary Health Care (Calvary) Ltd
	Dr Andrew Montague	General Manager, Health and Palliative Care, HammondCare
	Associate Professor Andrew Cole	Chief Medical Officer, HammondCare
	Mr Grant Millard	Chief Executive Officer, Anglicare Sydney and Anglicare Northern Inland
	The Hon. Christine Campbell	Chair, Australian Care Alliance
	Dr John Daffy	Treasurer, Australian Care Alliance
	Dr Bernadette Tobin AO	Director, Plunkett Centre for Ethics
	Adjunct Associate Professor Peter Kurti	Director, Culture, Prosperity & Civil Society Program, Centre for Independent Studies and Adjunct Associate Professor of Law, University of Notre Dame Australia
	Dr Brendan Long	Chief Executive Officer, Right to Life NSW
	Mr Christopher Brohier	Director, Australian Christian Lobby
	Mr Alexander Millard	Solicitor, Human Rights Law Alliance
	Dr Gregory Pike	Director, Adelaide Centre for Bioethics and Culture
Monday 13 December 2021 **Jubilee Room** **Parliament House, Sydney**	Dr Danielle McMullen	President, Australian Medical Association NSW
	Dr Nigel Lyons	Deputy Secretary, Health System Strategy and Planning, NSW Health

Date	Name	Position and Organisation
	Ms Leanne O'Shannessy	Executive Director, Legal and Regulatory Services, General Counsel, NSW Health
	Associate Professor Charlotte Hespe	NSW & ACT Faculty Chair, Royal Australian College of General Practitioners
	Professor Carmelle Peisah	Conjoint Professor, University of New South Wales, Clinical Professor, University of Sydney, Founder and President, Capacity Australia, and Member, The Royal Australian and New Zealand College of Psychiatrists
	Ms Linda Hansen	Chief Executive Officer, Palliative Care NSW
	Ms Therese Smeal	President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc.
	Dr Michael Casey	Director, PM Glynn Institute, Australian Catholic University
	Dr Cris Abbu	Policy and Projects Manager, PM Glynn Institute, Australian Catholic University
	Dr John Fleming	Retired Academic, Former President of Campion College Australia
	Ms Branka van der Linden	Director, HOPE: Preventing Euthanasia and Assisted Suicide Ltd
	Mr Gregory Bondar	NSW & ACT State Director, Family Voice Australia (NSW)
	Ms Meagan Lawson	CEO, Council on the Ageing NSW
	Ms Karen Appleby	Manager, Policy and Campaigns, Council on the Ageing NSW
	Ms Beverly Baker	Chair, Older Women's Network (OWN)
	Ms Shannon Wright	Chief Executive Officer, Seniors Rights Service

Date	Name	Position and Organisation
	Dr Cameron McLaren	Private individual
	Dr Greg Mewett	Palliative Care Physician, Grampians Regional Palliative Care Team, Ballarat Health Services
	Associate Professor Charlie Corke	Acting Chair, Voluntary Assisted Dying Review Board, Victoria, Senior Intensive Care Specialist, University Hospital Geelong
	Bishop Michael Stead	Anglican Church Diocese of Sydney

Appendix 5 Minutes

Minutes no. 39
Thursday 21 October 2021
Standing Committee on Law and Justice
Members' Lounge, Parliament House, Sydney at 2.02 pm

1. Members present
Mr Fang, *Chair*
Mr Donnelly, *Deputy Chair*
Mr D'Adam
Ms Faehrmann (substituting for Mr Shoebridge for the duration of the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021) (from 2.15 pm)
Mr Farlow
Mr Khan
Mr Martin
Mr Roberts
Mr Shoebridge (until 2.15 pm)

2. Previous minutes
Resolved, on the motion of Mr Martin: That draft minutes nos. 36, 37 and 38 be confirmed.

3. Correspondence
The committee noted the following items of correspondence:

Received:

- 30 August 2021 – Letter from Mr Michael McHugh SC, President, NSW Bar Association, to Chair, seeking clarification in relation to a recommendation from the 2020 Review of the Compulsory Third Party insurance scheme report.
- 21 October 2021 – Email from Mr Shoebridge to the secretariat advising that Ms Faehrmann will be substituting for him for the duration of the inquiry into provisions of the Voluntary Assisted Dying Bill 2021.

Sent:

- 7 September 2021 – Letter from Chair to Mr Michael McHugh SC, President, NSW Bar Association, responding to the request for clarification of a recommendation from the 2020 Review of the Compulsory Third Party insurance scheme report.

4. 2020 Review of the Workers Compensation scheme

4.1 Follow up hearing in December
Resolved, on the motion of Mr Shoebridge: That a follow-up hearing of 3 hours' duration be held on 15 December 2021, with 1 hour and 45 minutes set aside for icare and 1 hour for SIRA.

5. Inquiry into the provisions of the Voluntary Assisted Dying Bill 2021

5.1 Terms of reference
The committee noted the following terms of reference referred by the House on 19 October 2021:

That:

(a) the provisions of the Voluntary Assisted Dying Bill 2021 be referred to the Standing Committee on Law and Justice for inquiry and report,

(b) the bill be referred to the committee upon receipt of the message on the bill from the Legislative Assembly,

(c) the committee report by the first sitting day in 2022, and

(d) on the report being tabled, a motion may be moved immediately for the first reading and printing of the bill.

5.2 Proposed timeline

Resolved, on the motion of Mr Farlow: That the committee adopt the following timeline for the administration of the inquiry:

- Closing date for submissions and online questionnaire: 22 November 2021
- Hearings: Wednesday 8 December, Friday 10 December and Monday 13 December, with a half day reserve date on Wednesday 15 December 2021. Further, that the hearings be arranged so that there is one day to hear from supporters of the bill, one day to hear from opponents of the bill, and one day to hear from government representatives.
- Report deliberative – TBC once the 2022 sitting calendar is finalised
- Report tabling – TBC once the 2022 sitting calendar is finalised.

Resolved, on the motion of Mr Khan: That when inviting government agencies to make a submission, inviting government witnesses to hearings and in the Chair's opening statement, it be made clear that government representatives are expected not to take a position on the bill, but only to provide factual information on matters such as current legal and medical arrangements for those in care approaching end of life and how the provisions of the legislation might work should the legislation pass the Parliament.

5.3 Stakeholder and witness list

Resolved, on the motion of Mr D'Adam*:* That the following stakeholders be invited to make a submission:

- NSW Health
- NSW Police
- NSW Department of Communities and Justice
- Dying with Dignity
- NSW Council for Civil Liberties
- Human Rights Law Centre
- St James Ethics Centre
- Palliative Care NSW
- Aged and Community Services Australia
- Australian Medical Association (NSW Branch)
- Law Society of New South Wales
- NSW Bar Association
- Australian Paramedics Association (NSW)
- Police Association of NSW
- Health Services Union NSW/ACT/Queensland
- NSW Nurses and Midwives' Association
- Australian Christian Lobby
- Catholic Bishops of NSW
- Catholic Healthcare Australia
- Anglican Church Diocese of Sydney
- Uniting Church Synod of NSW & ACT
- Greek Orthodox Church of Australia
- Rabbinical Council of NSW

Resolved, on the motion of Mr D'Adam: That members have until close of business Tuesday 26 October 2021 to nominate additional stakeholders to make submissions and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

5.4 Online questionnaire

Resolved, on the motion of Mr Donnelly: That the committee conduct an online questionnaire to capture individuals' views with the following questions and preamble:

> On 19 October 2021, the NSW Legislative Council's Standing Committee on Law and Justice commenced an inquiry into provisions of the Voluntary Assisted Dying Bill 2021.
>
> The objects of this Bill, as set out in the explanatory note, are to:
>
> '(a) enable eligible persons with a terminal illness to access voluntary assisted dying, and
> (b) establish a procedure for, and regulate access to, voluntary assisted dying, and
> (c) establish the Voluntary Assisted Dying Board and provide for the appointment of members and functions of the Board.'
>
> Further information about the inquiry, including the terms of reference, can be found on the committee's website.
>
> As part of the inquiry, the committee is seeking public comment on the bill through the following questions. Responses are due by 22 November 2021.
>
> Responses may be used in the committee's report. Names and contact details of respondents will not be published. The questionnaire will take approximately 5 minutes to complete.

1. Please enter your contact details.

   Name:
   Email address:
   Postcode:

2. Are you a resident of NSW? Select one of these options:
   a. Yes
   b. No

3. Position on the bill:
   The objects of the Voluntary Assisted Dying Bill 2021, as set out in the explanatory note, are to:
   '(a) enable eligible persons with a terminal illness to access voluntary assisted dying, and
   (b) establish a procedure for, and regulate access to, voluntary assisted dying, and
   (c) establish the Voluntary Assisted Dying Board and provide for the appointment of members and functions of the Board.'

   Based on your own understanding and the description above, what is your position on the Voluntary Assisted Dying Bill 2021? Select one of these options:
   a. Support
   b. Partially support
   c. Support with amendments
   d. Oppose

4. *Based on the response selected at question 3, the respondent will be directed to a customised question asking them to explain their position on the bill*:
   a. Please explain why you support the bill (max 300 words)
   b. Please explain why you partially support the bill (max 300 words)
   c. What amendments would you like incorporated? (max 300 words)
   d. Please explain why you oppose the bill (max 300 words)

5. Do you have any other comments? (max 300 words)

Resolved, on the motion of Mr D'Adam: That the committee not accept pro formas.

Mr D'Adam moved: That the secretariat publish real-time data from the online questionnaire.

Question put and negatived.

5.5 Questionnaire report
The committee deferred consideration of the preparation of a summary report of responses to the online questionnaire to a later meeting.

5.6 Advertising
All inquiries are advertised via Twitter, Facebook, stakeholder emails and a media release distributed to all media outlets in New South Wales.

Facebook posts may be boosted or advertised. The focus of advertising will be to encourage participation in the online questionnaire rather than submissions. Therefore, apart from an email to nominated stakeholders, the submission process will not be publicly advertised.

6. Adjournment
The committee adjourned at 2.58 pm, *sine die*.

Stephen Frappell / Sharon Ohnesorge
Committee Clerks

Minutes no. 40
Thursday 25 November 2021 2021
Standing Committee on Law and Justice
Members' Lounge, Parliament House, Sydney at 2.01 pm

1. Members present
Mr Fang, *Chair*
Mr Donnelly, *Deputy Chair*
Mr D'Adam
Ms Faehrmann
Mr Farlow
Mr Khan
Mr Martin
Mr Roberts

2. Previous minutes
Resolved, on the motion of Mr Martin: That draft minutes no. 39 be confirmed.

3. Correspondence
The committee noted the following items of correspondence:

Received:

- 26 October 2021 – Email from Mr Ian Wood, National Co-Ordinator, Co-founder and Spokesperson, Christians Supporting Choice for Voluntary Assisted Dying, requesting that members of Christians Supporting Choice for Voluntary Assisted Dying be able to make written submissions, and seeking more information on the submission process
- 27 October 2021 – Letter from the Hon John Watkins AM, Board Chair, Catholic Health Australia to the Chair, requesting that members of Catholic Health Australia be able to make a submission and to

give evidence at a public hearing for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021

- 28 October 2021 – Email from Ms Julia Thoener, Policy and Advocacy Advisor, The Royal Australian and New Zealand College of Psychiatrists, seeking to make a submission to the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 10 November 2021 – Email from Mr Gerard Hayes, Secretary, NSW, ACT, QLD, Health Services Union, declining to make a submission to the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 22 November 2021 – Letter from Professor Euan M Wallace AM, Secretary, Victorian Department of Health to Chair, providing a submission to the inquiry into provisions of the Voluntary Assisted Dying Bill 2021.

Sent:

- 26 October 2021 – Email from the secretariat to from Mr Ian Wood, National Co-Ordinator, Co-founder and Spokesperson, Christians Supporting Choice for Voluntary Assisted Dying, in response to questions regarding the submission making process for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 28 October 2021 – Email from the secretariat to the Hon John Watkins AM, Board Chair, Catholic Health Australia in response to questions regarding the submission making process for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 28 October 2021 – Email from the secretariat to Ms Julia Thoener, Policy and Advocacy Advisor, The Royal Australian and New Zealand College of Psychiatrists, in response to questions regarding the submission making process for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021.

4. Inquiry into provisions of the Voluntary Assisted Dying Bill 2021

4.1 Chair's draft hearing schedules

The committee discussed the Chair's draft hearing schedules.

Resolved, on the motion of Mr Khan: That the committee invite the witnesses identified in the Chair's draft hearing schedule to appear at the hearing on 8 December 2021, with the addition of private individuals to be nominated by Mr Khan via email.

Resolved, on the motion of Mr Donnelly: That the committee invite the witnesses identified in the Chair's draft hearing schedule to appear at the hearing 10 December 2021, subject to any amendments or additions of organisations and individuals as identified by Mr Donnelly.

Resolved, on the motion of Mr Farlow:

- That the committee invite the witnesses identified in the Chair's draft hearing schedule to appear at the hearing on 13 December 2021
- That the afternoon sessions be reserved for any additional witnesses to be nominated by the committee, or for any invited witnesses who are unable to appear at the time they have been allocated on 8 and 10 December 2021.

4.2 Provision of any amendments to the Voluntary Assisted Dying Bill 2021 to witnesses

Resolved, on the motion of Mr Donnelly: That if the Voluntary Assisted Dying Bill 2021 is amended in the Legislative Assembly, the following documents be provided to witnesses prior to their appearance at a public hearing:

- the second print of the Voluntary Assisted Dying Bill 2021
- the Hansard extract of the consideration in detail stage of the debate
- the sheet of amendments agreed to by the Legislative Assembly.

5. Inquiry into the Road Transport Amendment (Medicinal Cannabis-Exemptions from Offences) Bill 2021

5.1 Terms of reference

The committee noted the following terms of reference referred by the House on 23 November 2021:

That:

(a) the Road Transport Amendment (Medicinal Cannabis-Exemptions from Offences) Bill 2021 be referred to the Standing Committee on Law and Justice for inquiry and report,

(b) the committee report by 23 June 2022.

5.2 Proposed timeline

Resolved, on the motion of Ms Faehrmann: That the committee:

- not commence the inquiry until after the tabling of the report into provisions of the Voluntary Assisted Dying Bill 2021
- authorise the secretariat to note this on the inquiry webpage.

6. Adjournment

The committee adjourned at 2.26 pm, *sine die*.

Madeleine Dowd
Committee Clerk

Minutes no. 41
Wednesday 8 December 2021
Standing Committee on Law and Justice
Macquarie Room, Parliament House, Sydney at 9.03 am

1. Members present

Mr Fang, *Chair*
Mr Donnelly, *Deputy Chair*
Mr D'Adam
Ms Faehrmann (from 11.03 am)
Mr Farlow
Mr Khan
Mr Martin
Mr Roberts
Mr Shoebridge (substituting for Ms Faehrmann) until 10.23 am

2. Previous minutes

Resolved, on the motion of Mr Khan: That draft minutes no. 40 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received:

- 2 December 2021 - Email from Ms Donna Austin, Research Officer, Health Services Union NSW/ACT/Qld, to the secretariat, declining the committee's invitation to appear at a public hearing into the Voluntary Assisted Dying Bill inquiry.

4. Inquiry into provisions of the Voluntary Assisted Dying Bill 2021

4.1 Public Submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 1-65, 67-87, 89-99, 101-103.

4.2 Name supressed submissions

The committee noted that the following submission was partially published by the committee clerk under the authorisation of the resolution appointing the committee: submission no. 88.

4.3 Partially confidential submissions

Resolved, on the motion of Mr Farlow: That the committee authorise the publication of submission nos. 66 and 100 with the exception of identifying or sensitive information which is to remain confidential, as per the recommendation of the secretariat.

4.4 Questionnaire report

Resolved, on the motion of Mr Shoebridge: That the secretariat prepare a summary report of responses to the online questionnaire for publication on the website and use in the report, and that:

- only responses from NSW participants will be analysed in the report
- the committee authorises the secretariat to publish the questionnaire report on the inquiry website unless any member raises an objection to publication via email
- individual responses be kept confidential on tabling.

4.5 Live streaming and recording of hearing

Resolved, on the motion of Mr Khan: That the committee authorise publication of the video recordings for all hearings of the inquiry into the Voluntary Assisted Dying Bill 2021 on the Parliament's YouTube channel.

4.6 Answers to questions taken on notice

Resolved, on the motion of Mr Farlow: That the committee request answers to questions on notice be returned by Friday 28 January 2022 for all witnesses appearing on 8 December, 10 December and 13 December 2021.

4.7 Declaration of co-sponsorship of the Voluntary Assisted Dying Bill 2021

The committee noted the declarations of Mr D'Adam, Mr Khan and Mr Shoebridge that they are co-sponsors of the Voluntary Assisted Dying Bill 2021.

4.8 Public hearing

Witnesses and the public were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Penny Hackett, President, Dying with Dignity NSW
- Ms Shayne Higson, Vice President, Dying with Dignity NSW
- Mr Steve Offner, Communications Director, Go Gentle Australia
- Ms Janet Cohen, Advocate, Go Gentle Australia
- Mr Ian Wood, Christians Supporting Choice for Voluntary Assisted Dying

Ms Hackett tendered the following document:

- State of Suffering, New South Wales, Testimonies of the damage done in absence of a Voluntary Assisted Dying Law, Dying with Dignity NSW and Go Gentle Australia

Mr Offner tendered the following documents:

- The Damage Done, Go Gentle Australia
- Voluntary Assisted Dying: A Guide to the Debate in NSW, October 2021, Go Gentle Australia

Mr Wood tendered the following documents:

- VAD and scheduling of drugs and poisons
- VAD and 'suicide contagion'

- Copy of Reverend Michael Dowling's address to South Australian VAD Forum on behalf of Christians Supporting Choice for Voluntary Assisted Dying, 16 March 2021
- Our Right to Die – Lessons for Britain from the European experience, Mr Chris Davies MEP

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Shaye Candish, Assistant General Secretary, NSW Nurses and Midwives' Association
- Ms Laura Toose, Legal Officer NSW Nurses and Midwives' Association
- Ms Aprelle Fleming RN, Member, NSW Nurses and Midwives' Association

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Simeon Beckett, Barrister, NSW Bar Association
- Mr Trent Glover, Barrister, NSW Bar Association
- Mr Nicholas Cowdery AO QC, Immediate Past President, NSW Council for Civil Liberties
- Professor Ben White, Australian Centre for Health Law Research
- Professor Lindy Willmott, Australian Centre for Health Law Research

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Dr David Leaf, NSW Convenor and National Co-Convenor, Doctors for Assisted Dying Choice
- Dr Robert Marr OAM, Vice President, Doctors Reform Society
- Dr Gavin Pattullo, Senior Staff Specialist Anaesthetist and Pain Medicine Physician, Royal North Shore Hospital, Senior Clinical Lecturer, University of Sydney

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Abbey Egan, Private individual
- Ms Cathy Barry, Private individual
- Mr Paul Gabrielides, Private individual

Ms Barry tendered the following document:
- Four images of Ms Barry's brother, Mr Tom Barry

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Jan Edwards, Private individual
- Ms Emma Schofield, Private individual
- Ms Rebecca Daniel, Private individual

Ms Daniel tendered the following document:
- A collection of documents prepared by Ms Daniel's husband, Mr Lawrie Daniel

The evidence concluded and the witnesses withdrew.

The hearing concluded at 4.24 pm.

4.9 Election of Deputy Chair – 10 December 2021

The Chair called for nominations for Acting Chair for the duration of his absence during the public hearing on Friday 10 December 2021.

Mr Khan moved: That notwithstanding the resolution appointing the committee, Mr Roberts be elected Acting Chair for the duration of the Chair's absence during the public hearing on 10 December 2021.

There being no further nominations, the Chair declared Mr Roberts elected Acting Chair for the duration of his absence during the public hearing on 10 December 2021.

5. Adjournment

The committee adjourned at 4.28 pm until 8.30 am, Friday 10 December 2021, Macquarie Room, Parliament House (second public hearing, inquiry into the provisions of the Voluntary Assisted Dying Bill 2021).

Madeleine Dowd
Committee Clerk

Minutes no. 42
Friday 10 December 2021
Standing Committee on Law and Justice
Macquarie Room, Parliament House, Sydney at 8.31 am

1. Members present

Mr Fang, *Chair* (8.31 am – 9.25 am, and 12.23 pm – 5.11 pm)
Mr Donnelly, *Deputy Chair*
Mr D'Adam
Mr Farlow (8.31 am – 11.57 pm, and 2.09 pm – 5.11 pm)
Mr Khan
Mr Martin
Mr Roberts (Acting Chair from 9.25 am until 12.23 pm)
Mr Shoebridge (substituting for Ms Faehrmann) (8.31 am - 11.57 am, and 2.12 pm – 5.11 pm.

2. Correspondence

The committee noted the following items of correspondence:

Received:

- 6 December 2021 - Email from Mr Angus Skinner, Research Manager, Police Association of NSW to the secretariat, declining the committee's invitation to appear at a public hearing for the Voluntary Assisted Dying Bill inquiry
- 7 December 2021 – Email from Mr Mark Johnstone, Director, Policy & Practice, Law Society of NSW, advising that Ms Juliana Warner, President, is unable to appear at a public hearing for the Voluntary Assisted Dying Bill inquiry
- 7 December 2021 – Email from Ms Cate Faehrmann MLC advising that Mr David Shoebridge MLC will be substituting for the morning of the hearing of 8 December 2021 and the full day of 10 December 2021 for the Voluntary Assisted Dying Bill inquiry
- 8 December 2021 – Email from Ms Amanda Beezley, Executive Assistant, Older Persons Advocacy Network, advising that Mr Craig Gear, CEO, is unable to attend a public hearing for the Voluntary Assisted Dying Bill inquiry, and advising that Ms Shannon Wright, Seniors Rights Service, will attend in his place.

3. Inquiry into provisions of the Voluntary Assisted Dying Bill 2021

3.1 Public Submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 104 -106.

3.2 Public hearing

Witnesses and the public were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Professor Margaret A. Somerville AM, Professor of Bioethics, Affiliate of the Institute for Ethics and Society, University of Notre Dame Australia
- Professor David A. Jones, Director, Anscombe Bioethics Centre

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian-Middle East Christian Apostolic Churches
- Dr Ibrahim Abu Mohamed, His Eminence the Grand Mufti Of Australia
- Dr Abdulrazak Mohamad, Senior Consultant Physician, Medical and Scientific Advisor to His Eminence the Grand Mufti of Australia

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Rabbi Nochum Schapiro, President, Rabbinical Council of NSW
- Mr Andrew Sloane, Senior Lecturer in Old Testament and Christian Thought, Director of Research at Morling College, Baptist Association of NSW and ACT
- Rev. Dr. John McClean, Convenor, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in the State of NSW
- Dr Joanna Barlow, Member, Gospel, Society and Culture Committee, The Presbyterian Church of Australia in the State of NSW

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Paul Santamaria QC, Barrister, Owen Dixon Chambers
- The Hon Greg Smith SC, Former NSW Attorney-General and Minister for Justice

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Michel McAuley, President, St Thomas More Society
- Dr Frank Brennan AM, Palliative Care Physician, St George and Calvary Hospitals Sydney, Senior Lecturer, University of NSW
- Dr John Obeid, Consultant Physician and Geriatrician
- Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital

Mr McAuley tendered the following document:

- Addendum to submission - Critical Issues Relating to Voluntary Assisted Dying Bill 2021, authored by Mr Michael McAuley

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Adjunct Clinical Professor Leeroy William, Immediate Past President, The Australian and New Zealand Society of Palliative Medicine
- Professor David Kissane, Professor and Chair of Palliative Medicine Research, University of Notre Dame Australia, and The Cunningham Centre for Palliative Care Research, St Vincent's Sydney
- Professor Roderick MacLeod MNZM, HammondCare Associate and Honorary Professor, University of Auckland

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Clinical Associate Professor Maria Cigolini, Clinical Associate Professor and Lecturer, University of Sydney in Medicine, Administrator, Health Professionals Say No
- Associate Professor Megan Best, Associate Professor of Bioethics, Institute for Ethics and Society, The University of Notre Dame Australia
- Dr Sarah Wenham, Specialist Palliative Care Physician, Far West Local Health District

Clinical Associate Professor Cigolini tendered the following document:

- Opening statement, Clinical Associate Professor Cigolini, 10 December 2021

Mr Donnelly took a point of order regarding the relevance of a question asked by Mr Shoebridge.

The Chair did not uphold the point of order and ruled the question in order.

Witnesses, media and the public withdrew.

Mr Donnelly stated his grounds for dissent from the ruling of the Chair.

The Committee deliberated

Witnesses, the public and the media were re-admitted.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Julia Abrahams, Chief Legal Counsel, Catholic Healthcare, Member, Catholic Health Australia
- Clinical Professor Richard Chye, Director, Sacred Heart Supportive & Palliative Care, St Vincent's Health Network, Sydney
- Mr Mark Green, National Director Mission, Little Company of Mary Health Care (Calvary) Ltd
- Dr Rachel Hughes, Director of Palliative Care, Calvary Mater Newcastle, Little Company of Mary Health Care (Calvary) Ltd
- Dr Andrew Montague, General Manager, Health and Palliative Care, HammondCare
- Associate Professor Andrew Cole, Chief Medical Officer, HammondCare
- Mr Grant Millard, Chief Executive Officer, Anglicare Sydney and Anglicare Northern Inland

Ms Abrahams tendered the following document:

- Opening statement, Ms Julia Abrahams, 10 December 2021

Mr Mark Green tendered the following document:

- Opening statement, Mr Mark Green, 10 December 2021

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- The Hon. Christine Campbell, Chair, Australian Care Alliance
- Dr John Daffy, Treasurer, Australian Care Alliance
- Dr Bernadette Tobin AO, Director, Plunkett Centre for Ethics
- Adjunct Associate Professor Peter Kurti, Director, Culture, Prosperity & Civil Society Program, Centre for Independent Studies and Adjunct Associate Professor of Law, University of Notre Dame Australia

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Brendan Long, Chief Executive Officer, Right to Life NSW
- Mr Christopher Brohier, Director, Australian Christian Lobby
- Mr Alexander Millard, Solicitor, Human Rights Law Alliance
- Dr Gregory Pike, Director, Adelaide Centre for Bioethics and Culture

The evidence concluded and the witnesses withdrew.

The hearing concluded at 5.08 pm.

3.3 Tendered documents

Resolved, on the motion of Mr D'Adam: That the secretariat contact Ms Cathy Barry to ascertain whether she objected to the documents tendered during the hearing on 8 December 2021 being published.

3.4 Invite to Bishop Michael Stead, Anglican Church Diocese of Sydney

Resolved, on the motion of Mr Farlow: That the secretariat contact Bishop Michael Stead, Anglican Church Diocese of Sydney, to advise that the committee may not use the full scheduled 45 minutes for his evidence on Monday 13 December 2021.

4. Adjournment

The committee adjourned at 5.11 pm, until 8.15 am, Monday 13 December 2021, Jubilee Room, Parliament House (third public hearing, inquiry into the provisions of the Voluntary Assisted Dying Bill 2021).

Madeleine Dowd
Committee Clerk

Minutes no. 43
Monday 13 December 2021
Standing Committee on Law and Justice
Jubilee Room, Parliament House, Sydney at 8.17 am

1. Members present

Mr Fang, *Chair*
Mr Donnelly, *Deputy Chair*
Mr D'Adam
Mr Farlow (8.17 am – 12.30 pm, 2.30 pm – 5.22 pm)
Mr Khan
Mr Martin
Mr Roberts

2. Apologies

Ms Faehrmann

3. Inquiry into provisions of the Voluntary Assisted Dying Bill 2021

3.1 Public hearing

Witnesses and the public were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Dr Danielle McMullen, President, Australian Medical Association NSW

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning, NSW Health
- Ms Leanne O'Shannessy, Executive Director, Legal and Regulatory Services, General Counsel, NSW Health

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Associate Professor Charlotte Hespe, NSW & ACT Faculty Chair, Royal Australian College of General Practitioners
- Professor Carmelle Peisah, Conjoint Professor, University of New South Wales, Clinical Professor, University of Sydney, Founder and President, Capacity Australia, and Member, The Royal Australian and New Zealand College of Psychiatrists
- Ms Linda Hansen, Chief Executive Officer, Palliative Care NSW
- Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc.

Professor Peisah tendered the following documents:

- The Royal Australian and New Zealand College of Psychiatrists, Position statement on Voluntary Assisted Dying 2021, September 2020
- 'The Nexus Between Elder Abuse, Suicide, and Assisted Dying: The Importance of Relational Autonomy and Undue Influence', Anne P F Ward, Carmelle Peisah, Brian Draper, Henry Brodaty
- 'Biggest Decision of Them All – Death and Assisted Dying: Capacity Assessments and Undue Influence Screening', Carmelle Peisah, Linda Sheahan and Ben P. White
- 'The Human Rights of Older People with Mental Health Conditions and Psychosocial Disability to a Good Death and Dying Well', Carmelle Peisah, Elizabeth L. Sampson, Kiram Rabheru, Anne Wand, Mari Lapid

The following witnesses were sworn and examined:

- Dr Michael Casey, Director, PM Glynn Institute, Australian Catholic University
- Dr Cris Abbu, Policy and Projects Manager, PM Glynn Institute, Australian Catholic University
- Dr John Fleming, Retired Academic, Former President of Campion College Australia
- Ms Branka van der Linden, Director, HOPE: Preventing Euthanasia and Assisted Suicide Ltd
- Mr Gregory Bondar, NSW & ACT State Director, Family Voice Australia (NSW)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Meagan Lawson, CEO, Council on the Ageing NSW
- Ms Karen Appleby, Manager, Policy and Campaigns, Council on the Ageing NSW
- Ms Beverly Baker, Chair, Older Women's Network (OWN)
- Ms Shannon Wright, Chief Executive Officer, Seniors Rights Service

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Cameron McLaren, Private individual
- Dr Greg Mewett, Palliative Care Physician, Grampians Regional Palliative Care Team, Ballarat Health Services
- Associate Professor Charlie Corke, Acting Chair, Voluntary Assisted Dying Review Board, Victoria, Senior Intensive Care Specialist, University Hospital Geelong

Dr McLaren tendered the following documents:

- PowerPoint Presentation, Voluntary Assisted Dying: Date from Victoria, Internationally, and the Victorian Community of Practice Case Series, Dr Cameron McLaren
- PowerPoint Presentation, Voluntary Assisted Dying in Victoria: A case series of patient characteristics 2019-2021, Dr Cameron McLaren
- PowerPoint Presentation, Voluntary Assisted Dying in Victoria: Comparing reasons for applying with Canada and Oregon, Dr Cameron McLaren

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Bishop Michael Stead, Anglican Church Diocese of Sydney

The evidence concluded and the witnesses withdrew.

The hearing concluded at 5.15 pm.

3.2 Tendered documents

Resolved, on the motion of Mr Khan: That the committee accept and publish the following documents tendered during the public hearings on 8 December 2021, 10 December 2021 and 13 December 2021:

- State of Suffering, New South Wales, Testimonies of the damage done in absence of a Voluntary Assisted Dying Law, Dying with Dignity NSW and Go Gentle Australia, tendered by Ms Penny Hackett
- The Damage Done, Go Gentle Australia, tendered by Mr Steve Offner
- Voluntary Assisted Dying: A Guide to the Debate in NSW, October 2021, Go Gentle Australia, tendered by Mr Steve Offner
- VAD and scheduling of drugs and poisons, tendered by Mr Ian Wood
- VAD and 'suicide contagion', tendered by Mr Ian Wood
- Copy of Reverend Michael Dowling's address to South Australian VAD Forum on behalf of Christians Supporting Choice for Voluntary Assisted Dying, 16 March 2021, tendered by Mr Ian Wood
- Our Right to Die – Lessons for Britain from the European experience, Mr Chris Davies MEP, tendered by Mr Ian Wood
- Addendum to submission - Critical Issues Relating to Voluntary Assisted Dying Bill 2021, tendered by Mr Michael McAuley
- Opening statement, 10 December 2021, tendered by Clinical Associate Professor Maria Cigolini
- Opening statement, 10 December 2021, tendered by Ms Julia Abrahams
- Opening statement, 10 December 2021, tendered by Mr Mark Green
- The Royal Australian and New Zealand College of Psychiatrists, Position statement on Voluntary Assisted Dying 2021, September 2020, tendered by Professor Carmelle Peisah
- 'The Nexus Between Elder Abuse, Suicide, and Assisted Dying: The Importance of Relational Autonomy and Undue Influence', Anne P F Ward, Carmelle Peisah, Brian Draper, Henry Brodaty, tendered by Professor Carmelle Peisah
- 'Biggest Decision of Them All – Death and Assisted Dying: Capacity Assessments and Undue Influence Screening', Carmelle Peisah, Linda Sheahan and Ben P. White, tendered by Professor Carmelle Peisah
- 'The Human Rights of Older People with Mental Health Conditions and Psychosocial Disability to a Good Death and Dying Well', Carmelle Peisah, Elizabeth L. Sampson, Kiram Rabheru, Anne Wand, Mari Lapid, tendered by Professor Carmelle Peisah
- PowerPoint Presentation, Voluntary Assisted Dying: Data from Victoria, Internationally, and the Victorian Community of Practice Case Series, tendered by Dr Cameron McLaren
- PowerPoint Presentation, Voluntary Assisted Dying in Victoria: A case series of patient characteristics 2019-2021, tendered by Dr Cameron McLaren
- PowerPoint presentation, Voluntary Assisted Dying in Victoria: A retrospective case series assessing the application process, tendered by Dr Cameron McLaren
- PowerPoint Presentation, Voluntary Assisted Dying in Victoria: Comparing reasons for applying with Canada and Oregon, tendered by Dr Cameron McLaren.

4. Adjournment

The committee adjourned at 5.22 pm, *sine die.*

Madeleine Dowd
Committee Clerk

Draft minutes no. 45
Tuesday 15 February 2022
Standing Committee on Law and Justice
Room 814/815, Parliament House, Sydney, 1.02 pm

1. Members present
Mr Fang, *Chair*
Mr Donnelly, *Deputy Chair*
Mr Amato
Mr D'Adam
Ms Faehrmann
Mr Farlow
Mr Martin
Mr Roberts

2. Change of membership
The committee noted that Mr Amato replaced Mr Khan as a substantive member of the committee from 25 January 2022.

3. Draft minutes
Resolved, on the motion of Mr Martin: That draft minutes no. 41, 42 and 43 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received:

- 3 December 2021 – Email from Dr Stephen Parnis, Emergency Physician, St Vincent's Hospital, declining an invitation to appear at a public hearing for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 6 December 2021 – Email from Mr Angus Skinner, Research Manager, Police Association NSW, declining an invitation to the PANSW to appear at a public hearing for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 9 December 2021 – Email from Ms Anna Walsh, Lecturer, School of Law, The University of Notre Dame Australia to the secretariat declining an invitation appear at a public hearing for the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 20 December 2021 – Email from Mr Geoff Brindle providing additional information regarding the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 21 December 2021 – Email from Mr Kenneth Chambaere to the committee, contesting evidence presented to the committee during the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 21 January 2022 – Letter from Ms Maree McCabe AM, Dementia Australia to the Chair regarding the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 4 February 2022 – Email from Professor John Keown DCL, Kennedy Institute of Ethics, Georgetown University to the secretariat, providing additional information regarding the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021
- 15 February 2022 – Additional documents provided by Professor Lindy Willmott and Professor Ben White, Australian Centre for Health Law Research, regarding the inquiry into the provisions of the Voluntary Assisted Dying Bill 2021.

Sent:

- 10 January 2022 – Email from the secretariat to submission makers noting receipt of their submission, and advising that due to the number of submissions made to the inquiry, not all submissions were able to be published.

5. 2020 Review of the Workers Compensation scheme

5.1 Answers to questions on notice

Resolved, on the motion of Mr Donnelly: That Tab A, an attachment to icare's answers to questions on notice, received on 7 February 2022, be kept confidential.

6. Inquiry into provisions of the Voluntary Assisted Dying Bill 2021

6.1 Unprocessed submissions

Resolved, on the motion of Mr Donnelly: That as previously agreed via email, unprocessed submissions by private individuals, which were distributed confidentially to members on 21 December 2021, not be processed by the secretariat and be kept confidential.

6.2 Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to questions on notice from Associate Professor Megan Best, Associate Professor of Bioethics, Institute for Ethics and Society, The University of Notre Dame Australia – received 27 January 2022
- answers to questions on notice from Dr Andrew Montague, General Manager, Health and Palliative Care, HammondCare – received 31 January 2022
- answers to questions on notice from Dr Brendan Long, Chief Executive Officer, Right to Life NSW – received 31 January 2022
- answers to questions on notice from Ms Karen Appleby, Manager, Policy and Campaigns, Council on the Ageing NSW – received 22 December 2021
- answers to questions on notice from Professor Margaret A. Somerville AM, Professor of Bioethics, Affiliate of the Institute for Ethics and Society, University of Notre Dame Australia – received 13 December 2021
- answers to questions on notice from Mr Mark Green, National Director Mission, Little Company of Mary Health Care (Calvary) Ltd – received 31 January 2022
- answers to questions on notice from Ms Branka van der Linden, Director, HOPE: Preventing Euthanasia and Assisted Suicide Ltd – received 28 January 2022
- answers to questions on notice from NSW Health – received 28 January 2022
- answers to questions on notice from Professor Carmelle Peisah, Conjoint Professor, University of New South Wales, Clinical Professor, University of Sydney, Founder and President, Capacity Australia and Member, Royal Australian and New Zealand College of Psychiatrists – received 28 January 2022
- answers to questions on notice from Professor David A. Jones, Director, Anscombe Bioethics Centre – received 29 January 2022
- answers to questions on notice and supplementary questions from Australian Care Alliance – received 19 January 2022
- answers to supplementary questions from Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian-Middle East Christian Apostolic Churches – received 28 January 2022
- answers to supplementary questions from Associate Professor Andrew Cole, Chief Medical Officer, HammondCare – received 27 January 2022
- answers to supplementary questions from Associate Professor Megan Best, Associate Professor of Bioethics, Institute for Ethics and Society, The University of Notre Dame Australia – received 24 January 2022
- answers to supplementary questions from Professor David Kissane, Professor and Chair of Palliative Medicine Research, University of Notre Dame Australia, and The Cunningham Centre for Palliative Care Research, St Vincent's Sydney – received 12 January 2022
- answers to supplementary questions from Dr Bernadette Tobin AO, Director, Plunkett Centre for Ethics – received 28 January 2022

- answers to supplementary questions from Dr Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre, Senior Staff Specialist, Medical Oncology, Liverpool Hospital – received 29 January 2022
- answers to supplementary questions from Rev. Dr. John Fleming, Retired academic, Former President of Campion College Australia – received 7 January 2022
- answers to supplementary questions from Professor Margaret A. Somerville AM, Professor of Bioethics, Affiliate of the Institute for Ethics and Society, University of Notre Dame Australia – received 29 December 2021
- answers to supplementary questions from Mr Grant Millard, Chief Executive Officer, Anglicare Sydney and Anglicare Northern Inland – received 28 January 2022
- answers to supplementary questions from Mr Gregory Bondar, NSW & ACT State Director, Family Voice Australia – receive 28 January 2022
- answers to supplementary questions from Mr Mark Green and Dr Rachel Hughes, Little Company of Mary Health Care (Calvary) Ltd – received 31 January 2022
- answers to supplementary questions from Ms Julia Abrahams, Chief Legal Counsel, Catholic Healthcare and Member of Catholic Health Australia – received 28 January 2022
- answers to supplementary questions from Ms Linda Hansen, Chief Executive Officer, Palliative Care NSW – received 2 February 2022
- answers to supplementary questions from Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc. – received 27 January 2022
- answers to supplementary questions from NSW Health – received 28 January 2022
- answers to supplementary questions from Professor David A. Jones, Director, Anscombe Bioethics Centre – received 29 January 2022
- answers to supplementary questions from The Hon Greg Smith SC, Former NSW Attorney-General and Minister for Justice – received 27 January 2022
- additional information – Associate Professor Charlotte Hespe, NSW & ACT Faculty Chair, Royal Australian College of General Practitioners – received 21 December 2022
- additional information – Ms Emma Schofield, Private individual – received 9 December 2021
- additional information – Ms Emma Schofield, Private individual – received 10 December 2021
- additional information – Ms Janet Cohen, Advocate, Go Gentle Australia – received 31 December 2021.

Resolved, on the motion of Mr Donnelly: That the following answers to questions on notice and supplementary questions be published on the inquiry webpage:

- answers to supplementary questions from the New South Wales Bar Association – received 3 February 2022
- answers to questions on notice from Dr Michael Casey and Dr Cris Abbu – received 7 February 2022
- answers to questions on notice from Dr Brendan Long – received 6 February 2022
- answers to supplementary questions from Dr Michael Casey and Dr Cris Abbu – received 7 February 2022
- answers to supplementary questions from Professor Leeroy William – received 15 February 2022
- answers to questions on notice from Professor Leeroy William – received 15 February 2022.

6.3 Online questionnaire

The committee noted that as agreed by email, the online questionnaire report was published on the inquiry webpage.

6.4 Consideration of Chair's draft report

The Chair submitted his draft report entitled *Provisions of the Voluntary Assisted Dying Bill 2021*, which, having been previously circulated, was taken as being read.

Mr Donnelly moved: That paragraph 2.69 be omitted: 'This section outlines the arguments made by stakeholders who oppose the bill. This includes opposition to the specific VAD scheme which the bill

establishes, as well as opposition to VAD more broadly. Arguments made against the bill include general religious opposition to the bill, in addition to broader negative social implications of the bill. Stakeholders opposing the bill also argued that the bill contains insufficient safeguards, and therefore involves an inherent risk to vulnerable people', and the following new paragraph be inserted instead:

'This section outlines the arguments made by stakeholders who oppose the bill. This includes opposition to the specific scheme which the bill establishes, as well as opposition to euthanasia and assistance to suicide more broadly. Arguments made against the bill include that it would introduce a fundamental change to the criminal law and to the way society values every human life; that it would undermine efforts to prevent suicide; there is potential for abuse and coercion that poses an unacceptable risk to vulnerable people, including the elderly, those with mental illness and people with disability; that it would have an adverse impact on First Nations people; concerns amongst the medical profession and the risk of medical errors; lack of access to palliative care; euthanasia and assistance to suicide requested for feeling a burden and for loneliness; no poison can be guaranteed to cause a rapid, peaceful and humane death; concerns about the likely increase in the number of deaths under the bill; conscientious objection, both individual and institutional, and residential aged care and health care facilities; general religious opposition to VAD; and the risk of eligibility criteria being expanded.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new heading and paragraphs be inserted after paragraph 2.69:

'Terminology – 'Voluntary Assisted Dying' or 'Euthanasia' and 'Assistance to suicide'

The Dictionary in Schedule 1 of the bill provides that '**voluntary assisted dying** means the administration of a **voluntary assisted dying substance** … .'

Clause 7 of the bill defines a '**voluntary assisted dying substance**' to be 'a Schedule 4 poison or Schedule 8 poison' approved by the Health Secretary 'for use under this Act for the purpose of causing a patient's death.'

Opponents of the bill pointed out that: 'this makes it clear that 'voluntary assisted dying' does not refer to any processes that simply make the dying process more comfortable but solely to acts directed at the administration of a poison in a sufficient dose to cause death. Section 57 of the Bill specifies that the lethal poison may either be **self-administered** – that is the person may be prescribed a lethal poison by a practitioner to be ingested by that person in order to cause the person's death – or **practitioner administered** – that is the lethal poison may be injected by a medical practitioner, nurse practitioner or registered nurse in order to cause the person's death.' [FOOTNOTE: Submission 20, Australian Care Alliance, p 5.]

Opponents of the bill submitted that the term 'voluntary assisted dying' and other terms used in the bill were 'euphemistic terms used to make harsh realities seem more palatable' and argued that practitioner administration of a poison for the purpose of causing a patient's death should be called 'euthanasia' and the prescription and supply of a poison to be self-administered for the purpose of causing a patient's death should be called 'assistance to suicide'.' [FOOTNOTE: Submission 20, Australian Care Alliance, p 5. See also Submission 13, Professor Margaret A. Somerville, pp 15-16; Submission 41, The Anscombe Bioethics Centre, p 10; Submission 95, Plunkett Centre for Ethics, p 3; Submission 63, Associate Professor Peter Kurti, pp 19-25; Answers to supplementary questions, Dr John Fleming, p 4; Answers to supplementary questions, Professor David Kissane, pp 1-3; Answers to supplementary questions, Professor Bernadette Tobin AO, pp 2-3; Answers to supplementary questions, Professor Margaret A. Somerville AM, pp 1-2; Answers to supplementary questions, Associate Professor Megan Best, p 1; Answers to supplementary

questions, Dr Eugene Moylan, pp 1-2; Answers to supplementary questions, Dr Rachel Hughes and Mark Green, pp 1-3; Answers to supplementary questions, Julia Abrahams, pp 2-3.]

Ms Faehrmann moved: That the motion of Mr Donnelly be amended by omitting the last paragraph.

Amendment of Ms Faehrmann put.

The committee divided.

Ayes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Noes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Amendment of Ms Faehrmann resolved in the negative.

Original question of Mr Donnelly put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new paragraph be inserted after paragraph 2.72:

'Rabbi Nochum Schapiro, President, Rabbinical Council of NSW said in his evidence: '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. … 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'.' [FOOTNOTE: Evidence, Rabbi Nochum Schapiro, President, Rabbinical Council of NSW, 10 December 2021, p 16.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.73 be omitted: 'As His Eminence the Grand Mufti of Australia put it in evidence to the committee: '… 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", and the following new paragraph be inserted instead:

'As His Eminence the Grand Mufti of Australia put it in evidence to the committee: '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."

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.75 be amended by omitting: 'given the long involvement of religions in the delivery of health care and end-of-life care, it is necessary to consider the religious perspective on this issue. He explained that a failure to do this reflects an anti-religious bias, in addition to excluding a key stakeholder group involved in caring for terminally ill patients' after 'told the committee that', and inserting instead:

'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 invaluable 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.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following heading after paragraph 2.76 be omitted: **'Broader social implications of VAD**'.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following paragraphs 2.70-2.80, as amended, be omitted and inserted after paragraph 2.145:

'General religious opposition to VAD

The committee heard evidence from stakeholders who outlined the general religious objections to voluntary assisted dying, first and foremost being that VAD is fundamentally at odds with their central religious beliefs. Opponents of the bill explained that these religious beliefs also underpin some of the arguments regarding the need to care for sick and vulnerable people in ways other than VAD, and the negative impact of VAD on the broader social fabric.

A number of religious leaders and organisations put on record their opposition to the bill, and to VAD more generally. This included the Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Christian Apostolic Churches, the Grand Mufti of Australia, the Rabbinical Council of NSW, the Baptist Association of NSW and ACT, the Presbyterian Church of Australia in the State of NSW and the Anglican Church Diocese of Sydney.

These stakeholders outlined the fundamental religious view held across different religions and faith traditions that life should not be ended by a person, as death is determined by God's will.

As His Eminence the Grand Mufti of Australia put it in evidence to the committee: '… 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'.

Stakeholders also explained to the committee that caring for the sick and the vulnerable is a critical part of the belief systems of the major religions, as well as of the overall social fabric.

The committee heard that caring for the sick and dying is core to the mission of religious believers. Stakeholders referred to the long history of churches providing health care, aged care and palliative care. Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian and Middle East Christian Apostolic Churches told the committee that given the long involvement of religions in the delivery of health care and end-of-life care, it is necessary to consider the religious perspective on this issue. He explained that a failure to do this reflects an anti-religious bias, in addition to excluding a key stakeholder group involved in caring for terminally ill patients.

Stakeholders explained the importance of religious aged-care and residential facilities, and expressed concern about the fact that while facilities are able to opt-out of providing VAD under the NSW bill, a resident must be allowed to access VAD within the facility. They argued that this fundamentally imposes on the rights of the people working and living in these facilities, and could create a situation where bystanders either feel exposed to VAD, or unintentionally involved in the process.

Broader social implications of VAD

Opponents of the bill argued that the introduction of VAD will have a negative social impact, both in terms of how the community views and treats sick and vulnerable people, and how sick and vulnerable people perceive their worth. It was put to the committee that while religious beliefs underpin these views to some extent, they are relevant to the broader community, and can be characterised as more general philosophical beliefs.

As referred to above, religious leaders told the committee that their objection to VAD was not exclusively based in the belief that ending life early is interfering with God's will. Rather, they told the committee that it reflects a fundamental shift and disruption to the social fabric, which impacts religious and non-religious people alike. Opponents of the bill argued that VAD ultimately represents a failure to care for the sick and the vulnerable.

Opponents of the bill explained that the introduction of a VAD scheme would send a message to vulnerable people that their lives are not as valuable or worthy as the lives of younger and healthier people, and that you need to have a certain degree of bodily autonomy and dignity to live a worthy and valuable life.

This position was summarised by Archbishop Fisher, who told the committee:

> 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.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That the committee adjourn from 1.35 pm until 2.00 pm.

The committee resumed at 2.04 pm.

Mr Donnelly moved: That the following new paragraph and heading be inserted after paragraph 2.80:

'Fundamental change to law, medicine and society

Stakeholders argued that the bill would fundamentally change the criminal law in NSW by effectively creating a new category of 'justifiable homicide' [FOOTNOTE: Submission 86, Mr Paul Santamaria QC, p 3.], creating broad exceptions to the criminal law prohibitions of murder, as well as of aiding, abetting, inciting or counselling another person to commit suicide. The Australian Care Alliance argued that as the bill would bring about 'profound changes' to the criminal law it should be subject to the most careful scrutiny, and that the proper tests for its safety ought to be 'the same ones that are usually applied to any proposal to reintroduce capital punishment: Can we craft a law that will ensure there will not be even one wrongful death? Can we ensure that any deaths under this law are humane - that is both rapid and peaceful?" [FOOTNOTE: Submission 20, Australian Care Alliance, p 8.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.85: 'Submission 65, Dr Frank Brennan AM, pp 4-5.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.88 be omitted:

'Finally, the committee heard that introducing VAD would bring about 'profound changes' to the function of the criminal law, in addition to the general social fabric. Stakeholders argued that VAD is 'justified homicide', and effectively provides an exception in the criminal law to murder, as well as aiding, abetting, inciting or counselling another person to commit suicide. The Australian Care Alliance cautioned strongly against this change, and told the committee that this aspect of the bill should be carefully considered.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved that: That the following new heading and paragraphs be inserted after paragraph 2.87:

'Suicide prevention

Supporters of the bill claim that it would prevent the suicide of people with a terminal illness.

However, opponents of the bill gave evidence that similar claims made in relation to Victoria's Voluntary Assisted Dying Bill 2017 – that it would prevent up to 50 suicides each year – have been proved incorrect and that the suicide rate in Victoria has not decreased.

The Australian Care Alliance cited data on suicide from the Coroners Court of Victoria showing that there were more suicides in Victoria in 2020 than in 2017 concluding that 'there is no evidence that the anticipated decrease of 50 deaths by (non-authorised) suicide each year has been achieved'. It pointed out that if the 144 cases in 2020 of self-administration of a lethal poison prescribed and supplied for use by a person to end their life under a permit issued by the Victorian Secretary of the Department of Health and

Human Services were correctly counted as suicides then there was an increase of 21.2% in suicides in 2020 compared to 2017. If the 31 deaths by practitioner administration in Victoria in 2020 are also taken into account, then the increase was 25.8%. [FOOTNOTE: Submission 20, Australian Care Alliance, p 47.]

The Anscombe Centre submitted that 'There is good evidence that legalising assisted suicide will increase rates of self-initiated death and will not help prevention of (non-assisted) suicide.' [FOOTNOTE: Submission 41, Anscombe Bioethics Centre, p 1.] This evidence includes a detailed study by David Albert Jones and David Paton, 'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?' [FOOTNOTE: Submission 41, Anscombe Bioethics Centre, pp 9-10.]

Opponents of the bill argued that if the NSW Government facilitated suicides under this bill it would undermine commitments under the National Mental Health and Suicide Prevention Plan to aim for zero suicides within health care settings; reduce the availability, accessibility and attractiveness of the means to suicide; and establish public information campaigns to support the understanding that suicides are preventable. The bill would create a two-system model where some people were excluded from all suicide prevention efforts and their suicides were presented as wise choice and actively facilitated by the NSW Government, sending 'the message that some people would be better off dead and that suicide can be a peaceful, beautiful thing and a wise choice." [FOOTNOTE: Submission 20, Australian Care Alliance, pp 45-46. See also Submission 75, St Vincent's Heath Australia, p 7; Submission 48, Australian Christian Lobby, pp 29-30; Answers to supplementary questions, Mr Gregory Bondar, pp 4-5.]

Ms Faehrmann moved: That the motion of Mr Donnelly be amended by inserting 'They also argued that' before 'The bill would create'.

Amendment of Ms Faehrmann put and passed.

Original question of Mr Donnelly, as amended, put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Mr Donnelly moved: That paragraph 2.93 be amended by inserting 'First Progress Report (20 December 2019), Third Progress Report (10 February 2021), Fourth Progress Report (30 August 2021) and Fifth Progress Report (8 February 2022).' after 'Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability'.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.95: 'Answers to supplementary questions, Professor David Kissane, pp 3-4; Answers to supplementary questions, Professor Margaret A. Somerville AM, p 3; Answers to supplementary questions, Associate Professor Megan Best, pp 2-3; Answers to supplementary questions, Professor Bernadette Tobin AO, p 3; Answers to supplementary questions, Dr Rachel Hughes and Mark Green, pp 5-7; Answers to supplementary questions, Greg Smith SC, p 1.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.97 be amended by:

a) omitting 'They argued that 'social prejudice and ignorance … is widespread amongst physicians', and that this could lead to incorrect diagnosis and a 'pessimistic prognosis'.', and inserting instead:

'On this point they cited the late Stella Young who wrote that 'social attitudes towards disabled people come from a medical profession that takes a deficit view of disability. This is my major concern with legalising assisted death; that it will give doctors more control over our lives. As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I've experienced some of the very worst disability prejudice and discrimination'.'

b) omitting in the footnote 'pp 33-34' and inserting instead 'pp 33-35'.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.105: 'Submission 44, Health Professionals Say No, p 9; Submission 95, Plunkett Centre for Ethics, p 4; Submission 75, St Vincent's Health Australia, pp 5-6; Submission 78, Associate Professor Megan Best, p 2.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new paragraph be inserted after paragraph 2.110:

'Opponents pointed out that 'under the bill there is no check of decision-making capacity when self-administration occurs, which may be months after the lethal poison was prescribed. If the person was tricked or bullied into ingesting it, who would know?" [FOOTNOTE: Submission 20, Australian Care Alliance, p 3.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.111: 'Answers to supplementary questions, Professor David Kissane, pp 7-8; Answers to supplementary questions, Greg Smith SC, p 2; Answers to supplementary questions, Associate Professor Megan Best, pp 5-6.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.113: 'Answers to supplementary questions, Professor David Kissane, pp 6-7; Answers to supplementary questions, Greg Smith SC, p 2; Answers to supplementary questions, Associate Professor Megan Best, pp 4-5.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following paragraphs 2.115-2.122, as amended, be omitted and inserted after paragraph 2.145:

'Risk of eligibility criteria being expanded

Some stakeholders argued that while the scheme proposed in the bill may be relatively narrow in terms of who is eligible to access VAD, there is a risk that this criteria will be expanded over time. They argued that this would allow a greater number of people to access VAD, and would mean that scheme in practice would not be aligned with the intention of the legislation, or the evidence used to support its passage.

In this context, the committee heard evidence relating to the operation of VAD schemes in international jurisdictions where the eligibility criteria has changed since those schemes were originally introduced, and that people who were not originally intended to be able to access VAD, can now access it.

For example, Professor Margaret Somerville AM, Professor of Bioethics, Affiliate at the Institute for Ethics and Society, University of Notre Dame Australia, told the committee about the operation of medical assistance in dying (MAID) in Canada. She said that in less than four years, the scheme operating in Canada has seen a dramatic shift away from the original strict eligibility criteria, to requests for 'euthanasia on demand' being approved. Further, Professor Somerville said that death is no longer required to be reasonably foreseeable in order for someone to access the scheme, and that it is possible that people experiencing only mental illness, and not physical illness, will be able to access the scheme in early 2023.

Further, Professor Somerville said that at the end of 2020, approximately 21,589 people had died through the MAID scheme, which accounted for approximately 2.35 per cent of deaths in Canada. Additionally, she stated that the number of deaths increased by 34.2 per cent between 2019 and 2020.

In addition to the example of legislation being widened in Canada, the committee also heard about the operation of VAD in Oregon. The committee heard that the laws in Oregon had been 'relaxed', both in terms of who is eligible and how the scheme operates. Professor John Keown, Anscombe Bioethics Centre, highlighted the possibility of this risk occurring in any jurisdiction where VAD is legal, and said that : '…the logical extension of laws like those in Oregon, involving the removal of its current 'obstacles' to wider access, is only a matter of time'.

The committee was also provided with evidence about the VAD scheme in Belgium, which stakeholders argued was operating in a manner inconsistent with its original intentions, in that people are now able to access the scheme who should not be eligible. Professor David A. Jones, Director, Anscombe Bioethics Centre, told the committee that terminal sedation is being used in Belgium as a form of 'euthanasia lite'. Professor Jones said that this is being done with and without the consent of the patient, and is being used for people who do not otherwise require this sedation for symptom control.

Professor Jones told the committee that the circumstance in Belgium is not a result of amendments to the legislation, but rather, changes to the culture of medicine. He argued that as doctors have already 'crossed that line' by participating in VAD, it has fundamentally altered the practice of medicine in a negative and dangerous way.

The argument regarding the inevitable expansion of eligibility criteria was summarised by Professor Jones, who said that:

> 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.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Resolved, on the motion of Mr Donnelly: That the heading above paragraph 2.123 be amended by omitting 'Impact of VAD on Aboriginal people' and inserting instead 'Impact of VAD on First Nations people'.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.124: 'Submission 40, Right to Life NSW, p 10-12; Answers to supplementary questions, Mr Gregory Bondar, pp 2-3.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the heading above paragraph 2.126 be amended by inserting 'and the risk of medical errors' after 'Concerns amongst the medical profession'.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.126 be amended by inserting at the end: 'Opponents noted that even supporters of the bill, such as Mr Andrew Denton (founder and director of Go Gentle Australia), have admitted that 'There is no guarantee ever that doctors are going to be 100% right'. [FOOTNOTE: Submission 20, Australian Care Alliance, p 8.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.127 be amended by omitting 'The committee heard that some medical practitioners have a fundamental opposition to VAD' and inserting instead 'The committee heard that there were medical practitioners who have a fundamental opposition to VAD'.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new paragraphs be inserted after paragraph 2.127:

'The Australian Care Alliance said that '[M]edicine, since the time of Hippocrates has included a commitment by a physician to "benefit my patients according to my greatest ability and judgement, and [to] do no harm or injustice to them". This commitment to benefit the patient is fully consistent with the Hippocratic tradition not to "administer a poison to anybody when asked to do so, nor [to] suggest such a course".' [FOOTNOTE: Answers to supplementary questions, Australian Care Alliance, pp 2-3.]

The Australian Care Alliance also stated that this millennia-old approach to the duty of the physician was affirmed by the World Medical Assembly at its 70th General Assembly in October 2019. The ACA cited the WMA as stating that:

> The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.
>
> For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.
>
> No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.
>
> Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient." [FOOTNOTE: World Medical Association, *WMA Declaration on Euthanasia and Physician-Assisted Suicide*, 23 November 2021, https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide.]

In accordance with this position, the Australian Medical Association in its Position Statement Euthanasia and Physician Assisted Suicide affirms:

> 3.1 The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient. [FOOTNOTE: Australian Medical Association, *Position Statement: Euthanasia and Physician Assisted Suicide,* 24 November 2016, https://www.ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016.]

The Australian Care Alliance stated that agreeing to provide or administer a lethal poison to a person is not and never can be 'patient-centred care', and is in every case an abandonment of the patient by affirming that the patient would be better off dead and that no further patient-centred care will be offered. The ACA also said that authentic patient-centred care stands in solidarity with the patient until the end of life, including offering holistic palliative care when further treatment is no longer indicated or has been refused by the patient.' [FOOTNOTE: Answer to supplementary questions, Australian Care Alliance, pp 2-3.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new paragraph be inserted after paragraph 2.129:

'The Australian and New Zealand Society for Geriatric Medicine – NSW Division submitted that:

> … frail older people may be put in a position of considering VAD because they feel that they are 'a burden' on others (such as family members, carers and the health care system). Such feelings are often due to underlying depression, lack of availability of community services or family dynamics. It is possible that someone may consider an older frail older person eligible on the grounds that they have a limited life expectancy.' [FOOTNOTE: Submission 57, Australian and New Zealand Society for Geriatric Medicine – NSW Division, p 1.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Resolved, on the motion of Mr Donnelly: That paragraph 2.139 be amended by omitting 'rural and regional communities' and inserting instead 'rural, regional and remote communities'.

Mr Donnelly moved: That the following new paragraphs be inserted after paragraph 2.142:

'Reflecting on data collated by the PM Glynn Institute, and on evidence presented to the hearing of the inquiry by Portfolio Committee No. 2 into Health outcomes and access to health and hospital Services in rural, regional and remote New South Wales held on 19 March 2021, Dr Michael Casey submitted that:

> The workforce shortage in palliative care, particularly in outer regional and remote areas of New South Wales, raises serious questions about equity in the provision of palliative care and access to it. This is a significant problem in its own right. It also raises serious questions about legalising euthanasia and assisted suicide in a situation where access to palliative care for those at the end of life or suffering from a life-limiting illness is neither universal nor equitable … if there is no effective access to palliative care for some people, whether they are in the regions or in the cities, it is difficult to see how ensuring that assisted dying is available to all offers suffering people a genuine choice, or genuinely respects their autonomy. If the choice is between assisted dying on the one hand, and the absence of effective pain and symptom control and accompaniment by family and carers on the other, it is a false choice and one which it is unjust to offer. [FOOTNOTE: Submission 83, Dr Michael Casey, pp 1-2.]

Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc. gave evidence that:

> … access to specialist palliative care is extremely important. Whilst we have grown and developed palliative care in this State … we certainly do not have equitable access. So people, when we talk about informed choice, need to have access to make that informed choice. It is great in the theoretical model but in the real world we are still … nowhere near funding what we do need.' [FOOTNOTE: Evidence, Ms Therese Smeal, President, Palliative Care NSW, and Senior Palliative Care Clinical Nurse Consultant and Member, Palliative Care Nurses Australia Inc., 13 December 2021, p 27.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following be inserted into the footnote at the end of paragraph 2.143: 'Answers to supplementary questions, Professor Margaret A. Somerville AM, p 4; Answers to supplementary questions, Professor Bernadette Tobin AO, pp 1-2; Answers to supplementary questions, Associate Professor Megan Best, pp 3-4; Answers to supplementary questions, Professor David Kissane, pp 5-6; Answers to supplementary questions, Dr Eugene Moylan, pp 2-3.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new paragraphs be inserted after paragraph 2.145:

'The committee noted the comments made in the New South Wales Auditor-General's Report: Performance Audit, Planning and evaluating palliative care services in NSW:

> NSW Health's approach to planning and evaluating palliative care is not effectively coordinated. There is no overall policy framework for palliative and end-of-life care, nor is there comprehensive monitoring and reporting on services and outcomes.
>
> NSW Health has a limited understanding of the quantity and quality of palliative care services across the state, which reduces its ability to plan for future demand and the workforce needed to deliver it. At the district level, planning is sometimes ad hoc and accountability for performance is unclear.
>
> The capacity of LHDs to use accurate and complete data to plan and deliver services is hindered by multiple disjointed information systems and manual data collections. Further, a data collection on patient outcomes, for benchmarking and quality improvement, is not used universally. This limits the ability of districts to plan, benchmark and improve services based on outcomes data.
>
> NSW Health's engagement with stakeholders is not systematic. The lack of an overall stakeholder engagement strategy puts at risk the sustainability and value of stakeholder input in planning and limits transparency.' [FOOTNOTE: New South Wales Auditor-General's Report: Performance Audit, Planning and evaluating palliative care services in NSW: NSW Health, August 2017, p 2.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr D'Adam, Mr Donnelly, Ms Faehrmann, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That the following new headings and paragraphs be inserted after new paragraph 2.146:

'Euthanasia and assistance to suicide requested for feeling a burden and for loneliness

Opponents of the bill cited data from other jurisdictions that have legalised euthanasia and assistance to suicide demonstrating that it was not primarily requested due to concerns about pain or other physical symptoms but rather for concerns such as a decreasing ability to participate in activities that made life enjoyable, loss of autonomy and loss of dignity. According to the Australian Care Alliance, in Oregon, the majority of those requesting a prescription of a lethal substance to end their life made the request because they felt that they were a "physical or emotional burden on family, friends, or caregivers". [FOOTNOTE: Submission 20, Australian Care Alliance, p 34.]

The Australian Care Alliance cited a recent report [FOOTNOTE: Qu, L. et al. *National Elder Abuse Prevalence Study: Final Report*, Dec 2021, https://apo.org.au/sites/default/files/resource-files/2021-12/apo-nid315734.pdf.] on elder abuse in Australia as demonstrating a 'a correlation between all abuse subtypes and low social support (including social isolation and loneliness)' and drew attention to a similar correlation between isolation and loneliness and requests for euthanasia as indicated in the Sixth annual report for Quebec which stated that nearly one in four (24%) people requested to have their lives ended by euthanasia because they were experiencing 'isolation or loneliness'. [FOOTNOTE: Answers to supplementary questions, Australian Care Alliance, pp 5-7.]

No poison can be guaranteed to cause a rapid, peaceful and humane death

Opponents of the bill gave evidence on the various poisons used to cause death in other jurisdictions that have legalised euthanasia and assistance to suicide or in jurisdictions which use poisons for capital punishment. [FOOTNOTE: Submission 20, Australian Care Alliance, pp 51-56.] The Australian Care Alliance argued that this evidence shows that so far there is no evidence of a poison that will result in a rapid, peaceful and human death on every occasion it is used. As reported in a key article in *Anaesthesia*, cited by the ACA:

> Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose (≤9%), a relatively high incidence of vomiting (≤10%), prolongation of death (by as much as seven days in ≤4%), and failure to induce coma, where patients re-awoke and even sat up (≤1.3%). This raises a concern that some deaths may be inhumane. [FOOTNOTE: Submission 20, Australian Care Alliance, pp 51-52.]

The ACA said that official reports from the Netherlands comment on several cases of the muscle relaxant being administered when the person was not in a full coma and therefore potentially causing pain. According to the ACA, complications involved in euthanasia (practitioner administration under the bill) included spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heartbeat), excessive production of mucus, hiccups, perspiration, and extreme gasping. [FOOTNOTE: Submission 20, Australian Care Alliance, p 52.]

The ACA also stated that in Oregon in 2018 one in nine (11.11 per cent) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose or had other complications; that the interval from ingestion of lethal drugs to unconsciousness has been as long as four hours (in 2017); that the time from ingestion to death has been as long as 104 hours (4 days and 8 hours); and that one person in 2018 took 14 hours to die. [FOOTNOTE: Submission 20, Australian Care Alliance, pp 52-53.]

Dr Brendan Long, Chief Executive Officer, Right to Life NSW told the committee that the poison used in Victoria for self-administration is 15 g of sodium pentobarbital. [FOOTNOTE: Answers to questions on notice, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, p 5.] The Australian Care Alliance said that this poison is also used for capital punishment, and referred the committee to the following:

- Anaesthetist David Waisel who has stated that '… during judicial lethal injections … there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering'.

- Autopsies conducted by anaesthetist Joel Zivot and others on inmates executed by sodium pentobarbital, found that they had drowned in lung secretions (pulmonary oedema) in 84% of cases.
- In her 2015 dissent in *Glossip v Gros*, US Supreme Court Justice Sonya Sotomayor, characterised death by lethal injection as 'the chemical equivalent of being burned at the stake'. [FOOTNOTE: Submission 20, Australian Care Alliance, pp 54-56.]

The Australian Care Alliance concluded:

> The Bill cannot guarantee that those assisted to commit suicide or euthanised by a medical practitioner, nurse practitioner or registered nurse once authorised by an appointed State official under this Bill will not die a 'cruel and inhumane' death. No scheme for assisted suicide and euthanasia so far enacted or proposed can guarantee a humane, rapid and peaceful death. [FOOTNOTE: Submission 20, Australian Care Alliance, p 56.]

Concerns about the likely increase in the number of deaths under the bill

Dr Brendan Long gave evidence that based on the initial experience in Victoria and Western Australia, and taking into account data from jurisdictions in North America and Europe showing an annual average growth rate of 17 per cent in deaths by legalised euthanasia and assistance to suicide, there could be as many as 1,400 deaths in New South Wales in 2030 if the bill were to become law. [FOOTNOTE: Answers to questions on notice, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, pp 3-4.]

The Australian Care Alliance publication, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia*, cited in its submission, documents the increase in numbers of deaths by euthanasia and assistance to suicide in each jurisdiction where these have been legalised. [FOOTNOTE: Submission 20, Australian Care Alliance, p 2, quoting Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments.] For example:

- In Oregon, '…deaths from ingesting lethal substances prescribed under Oregon's *Death With Dignity Act* reached 245 in 2020 (up 28.3% from 2019) continuing a steady rise at an average growth of 15% per annum, since 1998, the first year of the Act's operation when 16 people died under its provisions. These deaths in 2020 accounted for 0.61% of all deaths in Oregon that year (up 19.53% from 2019).'[FOOTNOTE: Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, p 8.]
- in the Netherlands, '… reported deaths from euthanasia rose nearly fourfold (382%) from 1815 in 2003, the first year under the new law, to 6938 deaths reported in 2020 … 4.12% of all deaths. … In 2019, one in sixteen (6.2%) deaths in the Netherlands of persons aged between 60 and 80 years of age resulted from reported acts of euthanasia or assisted suicide.' [FOOTNOTE: Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, pp 29-30.]
- in Canada: 'The number of cases each year doubled in 3 years from 2,838 in 2017, the first full year of legalisation, to 5,660 in 2020 with annual increases of 57.8% (2017 to 2018); 26.4% (2018 to 2019) and 34.2% (2019 to 2020). … In 2020 euthanasia and assisted suicide accounted for 2.45% of all deaths in Canada, with provincial rate highest in British Columbia (3.84%) … The rate for Quebec reached 3.62% of all deaths for the period 1 July 2020 to 31 March 2021.' [FOOTNOTE: Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, pp 62-63.]
- In Victoria: 'As of 30 June 2021, 331 people had their lives intentionally ended under the Act – 49 by euthanasia and 264 by assistance to suicide. In the twelve-month period, July 2020-June 2021, 201 people died under the Act – an increase of 55% from the 130 who died in the first year of its operation. Deaths by euthanasia and assistance to suicide in the six months January to

> June 2021 represent over 0.5% of all deaths in Victoria for that period. It took Oregon 21 years to reach that rate!' [FOOTNOTE: Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, p 83.]

- In Western Australia, there were 50 deaths under that state's *Voluntary Assisted Dying Act 2019* between 1 July 2021 and 31 October 2021 – representing 1.07% of all deaths in WA in those four months. This is more than double the rate in Victoria after two years of operation and 75% higher than Oregon's rate after 23 years of legalisation but similar to Canada's rate in 2017 - its first full year of legalisation. Further, in the first seven months of legalisation, 68% of deaths under WA's Act resulted from practitioner administration of a lethal poison (euthanasia) and only 32% from self-administration (suicide). This rate of euthanasia compared to assisted suicide is 4.6 times that in Victoria in the first two years of legalisation. International evidence suggests that where euthanasia – practitioner administration – is readily available then the overall rate of deaths by this method is much higher than in those jurisdictions, such as Oregon, which only permit self-administration of the lethal poison (suicide). [FOOTNOTE: Mr Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia,* 21 December 2021, https://www.australiancarealliance.org.au/flawed_experiments, p 95.]

Opponents of the bill suggested that 'given that the NSW scheme more closely reflects the Western Australian model than the Victorian model', New South Wales could see the ' … sort of massive expansion in assisted suicide case numbers we have seen under the Canadian assisted suicide and lethal injection (euthanasia) scheme'. [FOOTNOTE: Answers to questions on notice, Dr Brendan Long, Chief Executive Officer, Right to Life NSW, pp 2-4.]

Conscientious objection, both individual and institutional, and residential aged care and health care facilities

Opponents of the bill pointed out that Part 5 of the bill would force a residential aged care facility or health care facility that has a policy of complete non-participation in the processes established under the bill leading up to and including the administration or self-administration of a lethal poison to cause a person's death to nonetheless participate in facilitating some of those processes.

In the case of a residential aged care facility, this may include forcing the facility to permit a medical or nurse practitioner on to the premises to administer the lethal poison and cause the death of a resident.

In responding to supplementary questions Archbishop Anthony Fisher OP, Archbishop of Sydney on behalf of the Catholic Bishops of New South Wales and the Bishops of the Australian-Middle East Christian Apostolic Churches explained:

> Attempts in the Voluntary Assisted Dying Bill 2021 (Bill) to protect individual conscience rights while offering little or no protection for those individuals to associate in institutions that are operated in accordance with a particular ethos wrongly presume that individual conscience rights can be adequately respected without also preserving the rights of an institution to maintain ethical policies that align with the consciences of the individuals involved.
>
> Part 5 of the Bill is not only an egregious attack on the religious freedom of religious care facilities, particularly residential aged care facilities, it will result in the undermining of the culture of care in these facilities that have served the people of New South Wales so well. This is especially the case for Part 5, Division 2 of the Bill, which requires a religious aged care facility to allow every aspect of the euthanasia and assisted suicide process, including the administration of lethal drugs, to occur on its site.
>
> […]
>
> Faith-based residential aged care facilities should not be required to allow any aspect of euthanasia or assisted suicide on their premises because to do so would require faith-based institutions and those who own, operate and reside in them to act against their core beliefs.

> Many residents choose Catholic aged care facilities because of their Catholic ethos, particularly the fundamental belief that human life should be protected at all stages. Many families choose Catholic aged care facilities for the same reason. Their choices at the end of life must also be respected. Catholic aged care facilities must be able to continue to offer residents and potential residents the guarantee that euthanasia and assisted suicide will never be facilitated or performed on site.' [FOOTNOTE: Answers to supplementary questions, Archbishop Anthony Fisher OP, pp 2, 6-7. Also see Answers to supplementary questions, Ms Julia Abrahams, pp 3-4; Submission 76, Human Rights Law Alliance, p 4; Submission 54, Little Company of Mary Health Care (Calvary), p 7; Submission 77, Catholic Health Australia, pp 8-9; Submission 70, The Australian and New Zealand Society of Palliative Medicine, pp 5-6.]

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.146 be omitted: 'This section outlines a number of issues and potential amendments that were proposed to the Voluntary Assisted Dying Bill 2021 by key stakeholders. This includes the Australian Medical Association (NSW), the Royal Australian and New Zealand College of Psychiatrists, and the NSW Bar Association. These bodies generally had a neutral stance on the bill, but raised a number of considerations and amendments which in their view, stand to improve the bill.', and the following new paragraph be inserted instead:

> 'Over the course of the inquiry the committee heard, through a number of submissions, oral evidence, answers to questions on notice and answers to supplementary questions, many proposals regarding possible amendments to the Voluntary Assisted Dying Bill 2021. All these details are accessible on the inquiry's webpage.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraphs 2.147-2.152, including any headings, be omitted:

> **'Amendments proposed by the Australian Medical Association (NSW)**
>
> The Australian Medical Association (AMA) NSW is an independent association representing the medical profession in NSW. In its submission, the AMA stated that the issue of access to VAD is one for society and for government. However, the AMA noted that its role is to ensure that the views of the medical profession are represented, and to ensure the scheme is as appropriate and effective as it can be.
>
> The AMA NSW identified a number of aspects of the bill as 'requiring close consideration', including:
>
> - requirements of medical practitioners who conscientiously object to participating in VAD, and what information must be passed on to patients
> - the requirement that a final request not be made until five days after the first request was made, with the AMA stating that they preferred the approach taken in Victoria and in Western Australia, where generally, there is a requirement of a nine day period between the first and final request

- the requirements relating to the assessment of decision-making capacity, with the AMA recommending further consultation with the Royal Australian and New Zealand College of Psychiatrists regarding the appropriateness of capacity assessments, and the referral of patients to psychiatrists
- the circumstances in which a practitioner may administer a voluntary assisted dying substance
- restrictions regarding who can initiate a discussion regarding VAD.

Amendments proposed by the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the peak body representing psychiatrists in Australia and New Zealand. In its submission, it was noted that many members of RANZP are experts in matters relating to capacity, consent, human rights and quality care at the end of life, thus making their perspective on VAD relevant.

RANZCP identified a number of key considerations regarding VAD generally, and the bill before Parliament. These included:

- the important role of psychiatrists when considering VAD, specifically in the context of determining decision-making capacity
- the need for capacity assessment and undue influence screening for all patients applying for access to VAD, and for this kind of assessment to only be undertaken by medical practitioners with specialty training in the area
- the need to be conscious of the impact of VAD on older people, and ageism more generally
- careful scrutiny of the implications of VAD for people with a disability, specifically in the context of residential facilities.

Amendments proposed by the New South Wales Bar Association

In their submission to the inquiry, the Bar Association remarked that they would not 'consider the merits of the bill', but rather, would 'consider the bill from the perspective of the various, and sometimes conflicting, obligations under international human rights law'.

Some of the key considerations identified by the Bar Association were as follows:

- impacts of the bill on a number of human rights, including: the right to life; the prohibition on cruel, inhuman or degrading treatment; rights to freedom of thought, conscience and religion; rights to privacy and family life; and the rights of persons with disabilities
- possible ambiguity regarding the term 'advanced, progressive and will cause death', as it relates to eligibility for access to VAD
- possible ambiguity regarding the term 'suffering', in the context of eligibility for access to VAD
- the presumption of capacity, and what steps should be taken to determine if a person has decision-making capacity in the context of access to VAD
- reinforcing who is not eligible to access VAD in the draft bill
- recommendation that ineligibility for VAD should be reviewable by the Supreme Court
- offences established by the bill.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin, Mr Roberts.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang.

Question resolved in the affirmative.

Mr Donnelly moved: That paragraph 2.155 be omitted: 'In these circumstances, the purpose of this inquiry has been to allow stakeholders – including advocacy groups, legal experts, religious groups, the medical profession and members of the community – to place their views on the record, in order to inform debate on the bill in the House. Accordingly, the committee refers the bill back to the House for further consideration.', and the following new paragraph be inserted instead:

'In light of the evidence presented to the inquiry, the committee concludes that the bill is not and cannot be made safe for the citizens of New South Wales, especially the most vulnerable. The bill is not fit for the purpose it is intended for, therefore it should not proceed any further in the Legislative Council.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang, Mr Roberts.

There being an equality of votes, question resolved in the negative of the casting vote of the Chair.

Mr Donnelly moved: That Recommendation 1 be omitted: 'That the Legislative Council proceed to consider the Voluntary Assisted Dying Bill 2021', and the following new recommendation be inserted instead:

'**Recommendation 1**

In light of the evidence presented to the inquiry, the committee concludes that the bill is not and cannot be made safe for the citizens of New South Wales, especially the most vulnerable. The bill is not fit for the purpose it is intended for, therefore it should not proceed any further in the Legislative Council.'

The committee divided.

Ayes: Mr Amato, Mr Donnelly, Mr Farlow, Mr Martin.

Noes: Mr D'Adam, Ms Faehrmann, Mr Fang, Mr Roberts.

There being an equality of votes, question resolved in the negative of the casting vote of the Chair.

Resolved, on the motion of Mr Roberts: That:

- The draft report as amended be the report of the committee and that the committee present the report to the House;
- The transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, responses to an online questionnaire and summary report of the online questionnaire, and correspondence relating to the inquiry be tabled in the House with the report;
- Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- Dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
- The report will be tabled in the House on 22 February 2022;
- The Chair to advise the secretariat and members if they intend to hold a press conference, and if so, the date and time.

8. Adjournment

The committee adjourned at 3.20 pm, *sine die*.

Madeleine Dowd
Committee Clerk

Appendix 6 Dissenting statements

Hon Lou Amato MLC, Liberal Party

The bill would fail to ensure that only those meeting the eligibility criteria could access a prescription of a lethal substance to be used to cause the person's death.

Under its provisions some people who either do not have a terminal illness, or who would live significantly longer than the 6 months (or in some circumstances 12 months) set by the bill, would have their lives prematurely and unnecessarily ended.

This is inevitable, given that, as even Andrew Denton, founder of Go Gentle Australia, has conceded, "*There is no guarantee ever that doctors are going to be 100% right.*"[191]

Evidence before the inquiry demonstrated a substantial risk of medical errors in both diagnosis and prognosis, including cases of people being legally assisted to suicide and later found by autopsy not to have had a terminal illness (Pietro D'Amico, Switzerland 2013), or of people offered assisted suicide on the basis of having less than 6 months to live but still alive over two decades later (Jeanette Hall, offered assisted suicide in Oregon 2000, still alive today!).[192]

The provisions of the bill cannot guarantee that before a person is administered or self-administers a lethal poison to cause the person's death, that the person actually has a terminal illness with less than six months (or less than 12 months for some conditions) to live.

By using the term "*balance of probabilities*" – which is not a medical term - the bill encourages guessing and guarantees that some – perhaps 50% or more – of those assessed as eligible would have lived longer than the 6 or 12 month estimate.

Evidence before the inquiry showed that an accurate prognosis is very difficult to make.

The failure of the bill to include any requirement for a specialist to be involved in confirming the diagnosis of a terminal illness or the prognosis for the person recklessly compounds this risk.

Finding 1: The provisions of the bill fail to limit access to those who are actually eligible. If it were to become law the bill will inevitably result in unnecessary and wrongful premature deaths.

Nor do the provisions of the bill guarantee that before accessing a lethal poison to end their lives, people are given access to all effective medical treatment and care, including palliative care. Some people will die who could have been effectively treated. Others will die unnecessarily whose concerns about pain control or other matters could have been relieved with the right care.

The bill does not require the involvement of either a specialist in the alleged terminal illness or in palliative medicine. It relies on two medical practitioners without the requisite qualifications or experience to inform the person of all available treatment and care options and the likely outcomes. This guarantees

191 Andrew Denton on *The Project*, 19 June 2019, https://youtu.be/VvsN47Uqbt0

192 Submission 20, Australian Care Alliance, p. 11-17

that some people will have their lives prematurely and wrongfully ended by administration of a lethal poison.

Evidence before the inquiry demonstrated that where similar laws are in place this is occurring. For example, a Canadian study found that people with possibly treatable lung cancer were being offered and given euthanasia without even having a biopsy to confirm whether an apparent lung cancer was treatable or not.[193]

Palliative medicine is specifically aimed at relieving not just physical symptoms but also many existential concerns at the end of life. To facilitate suicide or euthanasia of people without first ensuring access to a palliative care assessment by a qualified and experienced practitioner is poor medicine and bad law.

Finding 2: If passed, the bill will lead to deaths of people who could have been treated or whose suffering could have been satisfactorily relieved without ending their lives.

Women's Forum Australia presented the inquiry with 10 reasons why women were disproportionately at risk from the bill. These reasons included:

- Women live longer than men and more of them experience elder abuse (15.8% of non-indigenous women experienced elder abuse compared to 13.5% of men[194]);
- Women are more likely to survive a spouse or partner and experience social isolation and loneliness – risk factors for both elder abuse and requests for euthanasia or assistance to suicide;
- Women have less financial resources when elderly – cost of health treatment is a risk factor for requesting euthanasia or assistance to suicide; and
- Women are more likely to feel a burden on others and request euthanasia or assistance to suicide for this reason.[195]

Data on suicide rates in European countries where euthanasia or assisted suicide has been legalised shows "it is women who have most been placed at risk of avoidable premature death from changes in rates of intentional self-initiated death and from changes in rates of non-assisted suicide".[196]

Finding 3: The bill is likely to have a disproportionate effect on women, placing women at greater risk of being coerced, or feeling obliged, to request a lethal poison to end their lives.

In addition to these findings, I concur with the findings set out in the dissenting statements from the Hon Scott Farlow MLC, the Hon Taylor Martin MLC and the Hon Greg Donnelly MLC. I join with each of them in this recommendation:

193 Submission 20, Australian Care Alliance, p. 19-20

194 Qu, L. et al. *National Elder Abuse Prevalence Study: Final Report,* Dec 2021, p. 60, https://aifs.gov.au/publications/national-elder-abuse-prevalence-study-final-report

195 Submission 19, Women's Forum Australia

196 Jones DA, "Euthanasia, Assisted Suicide, and Suicide Rates in Europe", *Journal of Ethics in Mental Health*, Open Volume 11 (2020-), 7 February 2022, https://jemh.ca/issues/open/JEMH-Open-Volume.html

RECOMMENDATION: In light of the evidence presented to the inquiry, the bill is not and cannot be made safe for the citizens of New South Wales, especially the most vulnerable. The bill is not fit for the purpose it is intended for; therefore it should not proceed any further in the Legislative Council.

Hon Scott Farlow MLC, Liberal Party

The bill fails to adequately protect vulnerable people from having their lives wrongfully ended.

The evidence before the inquiry highlighted the connection between elder abuse and the risk of wrongful deaths under the bill through coercion and undue influence. The alleged safeguards in the bill are "wallpaper thin"[197] and would not be effective in preventing these deaths.

The most recent report[198] on the incidence and nature of elder abuse in Australia confirms concerns that if this bill were to become law elderly people in NSW who were supplied with a lethal poison could be at risk from adult children and intimate partners perpetrating financial, physical and psychological abuse – including by seeking to hasten the death of the person for financial benefit; bullying or nagging the person to ingest the poison; or even physically forcing the person to ingest the poison.

Notably, the bill provides no protections whatsoever once the lethal poison is prescribed and supplied for "self-administration", including no requirement for an independent witness at the time of death by ingestion of the lethal poison to verify that it was self-administered voluntarily and no check as to whether decision-making capacity has deteriorated since the lethal substance was prescribed and supplied even though weeks, months or even years may have elapsed.

Evidence before the inquiry demonstrated that there was a real danger of failure to identify coercion; that the online training under the Victorian scheme was woefully inadequate and that the penalties for coercion under the Bill were unenforceable and therefore offered no protection.

Finding 1: Elderly and other vulnerable people are at risk of wrongful deaths under the bill due to coercion and undue influence. The alleged safeguards in the bill are not capable of preventing these abuses.

People lacking decision-making capacity, including those with undiagnosed mental illness, are also at risk of wrongful deaths as they are not capable of fully informed consent.

The processes set out in the bill for assessing decision-making capacity are deeply flawed.

Clause 6 (2) (b) of the bill would create a presumption that a person has decision-making capacity unless "*shown not to have the capacity*". This would enable an assessing medical practitioner to tick the box for decision-making capacity without carrying out any of the standard tests for assessing decision-making capacity.

Evidence before the inquiry demonstrated that this presumption of decision-making capacity in the case of people diagnosed with a terminal illness is not well-founded and is dangerous; that medical practitioners are frequently over-confident in their ability to assess decision-making capacity accurately; and that undiagnosed depression or other mental illness can adversely impact on decision-making capacity.

197 Submission 86: Mr Paul Santamaria QC, para 34

198 Qu, L. et al. *National Elder Abuse Prevalence Study: Final Report,* Dec 2021, p. 60, https://aifs.gov.au/publications/national-elder-abuse-prevalence-study-final-report

Finding 2: The provisions of the Bill are not capable of ensuring that only those with decision-making capacity access life-ending lethal poisons. This leaves those with impaired decision-making capacity, including some people with mental illness, at risk of wrongful death.

The bill seeks to impose euthanasia by administration of a lethal poison throughout New South Wales, including (Clause 97) in aged care residences operated under a shared religious or other ethos that fundamentally rejects the intentional ending of the lives of their residents as contrary to the duty of care and to the well-being of the whole community of the facility – residents, families and staff.

The notion that the intentional killing of one resident in such a facility will not have any adverse effect on other residents or the staff is disingenuous at best and a ruthless pretence at worst.

Similarly, the bill seeks to impose obligations on health care facilities operated under a shared religious or other ethos that fundamentally rejects the intentional ending of the lives of their patients to actively facilitate the transfer of patients for the purpose of undergoing each stage of the processes required under the bill, including for the administration of a poison in order to cause the patient's death.

Internationally recognised human rights include not just individuals' right to freedom of thought, conscience and religion but also the right "in community with others and in public or private, to manifest" that religion or belief in "observance, practice and teaching"[199]. In health and aged care settings, this means all who choose to work or receive care at institutions with a shared ethos that rejects euthanasia and assisted suicide have the right to have that shared ethos protected from violation by the State or third parties – such as medical practitioners facilitating or administering a lethal poison under this bill.

Finding 3: The Bill would violate the human rights of those who have chosen to associate - as operators, staff, residents or patients - in aged care residential and health care facilities with shared ethos of belief that rejects any intentional ending of the lives of residents or patients as incompatible with their human dignity and the duty of care due to them.

In addition to these findings, I concur with the findings set out in the dissenting statements from the Hon Lou Amato MLC, the Hon Taylor Martin MLC and the Hon Greg Donnelly MLC. I join with each of them in this recommendation:

RECOMMENDATION: In light of the evidence presented to the inquiry, the bill is not and cannot be made safe for the citizens of New South Wales, especially the most vulnerable. The bill is not fit for the purpose it is intended for; therefore it should not proceed any further in the Legislative Council.

199 International Covenant on Civil and Political Rights, Article 18

Hon Taylor Martin MLC, Liberal Party

The most striking impression from the evidence presented to the inquiry is of a serious disconnect between the small, limited category of people the proponents of the bill claim it is intended to benefit and the actual scope of the bill's provisions when examined in the light of the available data from other jurisdictions which have legalised euthanasia or assistance to suicide.

In his second reading speech, Mr Greenwich referred to "*people who are in the final stages of a terminal illness and who are experiencing cruel suffering that cannot be relieved by treatment or palliative care*" and who are faced only with *"a slow and agonising death"*.

With respect, Mr Greenwich is editorialising – the bill does not limit access to those "*in the final stages*" of a terminal illness; it does not require that the "*suffering*" be "*cruel*"; it does not require that the suffering "*cannot be relieved by treatment or palliative care*"; it does not limit access to those who face a "*slow and agonising death*".

A careful examination of the bill's provisions shows that there is a lack of definition of "*suffering*", which means that while proponents focus on those people with allegedly unrelievable physical suffering, the actual scope of the bill includes access to a life-ending lethal poison for people with psychological or existential suffering, including suffering that could be satisfactorily relieved with the right help.

Evidence from other jurisdictions which have legalised euthanasia or assistance to suicide demonstrates that only a minority of cases of assistance to suicide or euthanasia involve concerns about pain, noting that even in these cases the person may not actually be experiencing uncontrolled pain, (27.4% - Oregon 1998-2020), while many more cases involve people with concerns about being a burden on others (59.2% - Oregon 2019), an inability to participate in enjoyable activities (94.3% - Oregon 2020)[200], feelings of social isolation or loneliness (24% - Quebec 2020/21)[201] and financial matters (9% - Washington 2018).[202]

Finding 1: The Bill fails to adequately define "suffering" to limit it to intolerable, unrelievable physical pain. The Bill would, therefore, facilitate suicide or euthanasia by administration of a lethal poison of people experiencing existential concerns such as feeling a burden on others and loneliness.

Attempts by proponents to distinguish deaths under the Bill from other suicides or even to deny, as Clause 12 of the Bill attempts to do, that ingesting a lethal poison with the intention of causing one's own death is an act of suicide, are unpersuasive.

Indeed, evidence before the inquiry pointed to a real risk of increasing the overall rate of suicides in New South Wales if the Bill were to become law.

A key study found that legalising assisted suicide in some American States was associated with an increase in the overall rate of suicides of 6.5% and of the elderly (65 years and older) by 14.5%.[203]

200 https://www.australiancarealliance.org.au/oregon

201 https://www.australiancarealliance.org.au/canada

202 https://www.australiancarealliance.org.au/washington_state

203 Jones, David A and D. Paton. "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" *Southern Medical Journal* 108 (2015): 599–604

Claims by the Victorian Minister for Health and Human Services that the passage of the *Voluntary Assisted Dying Bill 2017* would prevent about 50 suicides each year have been demonstrated to be ill-founded with the official suicide count going from 694 in 2017 to 698 in 2020, with an additional 144 suicides by lethal poison that year being recorded as "Confirmed deaths - Medication [that is a lethal poison] was self-administered" – a 21% increase I overall suicides.[204]

This increase in suicides following legalising, normalising, justifying and indeed glamorising some suicides is hardly surprising given the well-established "Werther effect" of suicide contagion. It would be reckless to follow Victoria in this dangerous social experiment.

Believing that every suicide is a tragedy – not just for the person who takes their own life but for their family and friends and for society as a whole – we all need to reaffirm our joint commitment to work "towards zero suicides in NSW".[205]

Under the National Mental Health and Suicide Prevention Plan, NSW is committed to "aim for zero suicides within health care settings" and to "reduce the availability, accessibility and attractiveness of the means to suicide".[206] The bill would undermine these efforts by formally approving, promoting and facilitating the provision of a particular means of suicide – a Schedule 4 or Schedule 8 poison approved under the bill to be used for the purpose of causing a person's death.

Finding 2: The bill's attempt to deny that deaths caused by the self-administration of a lethal poison prescribed under its provisions is unpersuasive. If passed, the bill will not lead to a decrease in suicides in NSW and is likely to lead to an increase in suicides.

In addition to these findings, I concur with the findings set out in the dissenting statements from the Hon Scott Farlow MLC, the Hon Lou Amato MLC and the Hon Greg Donnelly MLC. I join with each of them in this recommendation:

RECOMMENDATION: In light of the evidence presented to the inquiry, the bill is not and cannot be made safe for the citizens of New South Wales, especially the most vulnerable. The bill is not fit for the purpose it is intended for; therefore it should not proceed any further in the Legislative Council.

204 Submission 20, Australian Care Alliance, p. 46-47

205 Strategic Framework for Suicide Prevention in NSW 2018–2023, p. 15, https://www.health.nsw.gov.au/mentalhealth/Pages/suicide-prevention-strategic-framework.aspx

206 COAG Health Council, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017, p. 23-24, http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

Hon Greg Donnelly MLC, Australian Labor Party

To provide full context and meaning to this short statement if not done so already, can I invite you to read within the report all the content commencing with the heading "Arguments against the Voluntary Assisted Dying Bill 2021" on page 24 through to paragraph 2.177 on page 46 inclusive. I also strongly encourage the reading of the submissions, oral evidence, answers to questions on notice, answers to supplementary questions and links, all referenced between the said pages. I also recommend the reading of the full day of oral evidence provided by opponents of the bill on Friday, 10th December 2021 and by Ms Therese Smeal, Ms Linda Hansen, Dr Michael Casey, Dr Cris Abbu, Dr John Fleming, Mr Gregory Bondar, Ms Branka van der Linden and Bishop Michael Stead on Monday, 13th December 2021.

First and foremost, it must be said as noted by Professor Margaret A. Somerville AM in her evidence to the inquiry, that people on both sides of the assisted suicide and euthanasia debate are well intentioned and believe that they are fighting for the greater good, it is just that they do not agree on what this is. Neither side wants to see people suffer and it is common ground that we have obligations to relieve suffering, especially healthcare professionals. Moreover, the debate we are having is not about if we will die, for that is a certainty, but how we will die and whether some ways of dying, namely assisted suicide and euthanasia, are unethical and dangerous, especially to vulnerable people and are destructive of important shared values between ourselves, on which we base our societies (Submission No 13, page 2).

The proponents of this bill are implacably committed to preventing it containing plain, clear language that states its unambiguous intention and resultant outcome. The obviously euphemistic terminology "Voluntary Assisted Dying" or "VAD" is carefully crafted and highly polished with a single purpose in mind; make what are the harsh realities of the bill palatable. So let us be in no doubt about what the bill provides for. If the bill was to pass the Parliament and enter onto the statute books, it would enable citizens to be given assistance to commit suicide and doctors, including nurse practitioners, to kill their patients, both provided for under a legislative framework established and fully funded by the state. This is what the bill provides for and no soothing narcotic, phraseology can or will change its intention and resultant outcome.

It has become almost cliché when attempting to comprehend and fully understand the societal effect of using euphemistic language, to cite and quote the great English author George Orwell and his classic book 1984. We of course live in a liberal democracy nevertheless, as the well known American community activist and political theorist Saul Alinsky famously said: "He who controls the language controls the masses." We of course would scoff, even feel insulted at the idea of being thought of as part of "the masses" or behaving sheep-like when it comes to adopting a position on VAD.

As part of pushing back against the "comfortable numbness" that has enveloped this debate, we all must be honest with ourselves. Legalising assisted suicide and euthanasia, despite what the proponents claim, is not as one submission author said: "… just an incremental evolution of the socio-cultural paradigm on which we base our society. It is a radical revolution overturning some of our most important and fundamental values that have guided us for millennia as a society."

To be sure, those representing the monotheistic religions (Christianity, Judaism and Islam) who gave evidence to the inquiry reflected on how their faith traditions could not and did not countenance assisted suicide and euthanasia. However, one does not have to believe in an omnipotent being who created and sustains the world and universe to harbour deep and serious concerns, indeed fundamental opposition to the practices of assisted suicide and euthanasia. Let us be honest with ourselves i.e. tell ourselves the truth before we tell ourselves the lie, is it really possible to have a good bit of assisted suicide and a good

bit of euthanasia? And if we are able to truly complete the mental gymnastics required to say "yes" to the question, how do you logically, intellectually, philosophically, politically or in any other way you want to cut it, draw the line and say this far, but no further. Looking at where these matters have progressed to and are going in The Netherlands, Belgium and Canada in particular, as outlined in a great deal of evidence to the committee, it is downright disingenuous and insulting for the proponents of the bill to claim that opponents are somehow beating up the issue of the risk of eligibility criteria being stretched and expanded over time.

In addition to what has been outlined above, those opposing the bill articulated a number of other serious implications of the proposed legislation. These matters are far from minor and are detailed on pages 24-46 inclusive of the report. All the matters raised are significant in their own right, the effect of which is to make the bill in any form unsupportable by this Parliament.

I conclude by confirming that I concur with the Findings set out in the Dissenting Statements to this report from the Hon. Lou Amato MLC, the Hon. Taylor Martin MLC and the Hon. Scott Farlow MLC. I join with each of them to unequivocally state that the recommendation from this report should be:

Recommendation 1

In light of the evidence presented to the inquiry, the committee concludes that the bill is not and cannot be made safe for the citizens of New South Wales, especially the most vulnerable. The bill is not fit for the purpose it is intended for, therefore it should not proceed any further in the Legislative Council.

Ms Cate Faehrmann MLC, The Greens

I write this dissenting statement reluctantly, however I believe it is necessary due to the way in which the Chair's draft report was substantially changed during the committee deliberative meeting held to agree on the final report, which was attended by all members. What was originally a considered and objective Chairs' draft report, which documented the evidence of both supporters and opponents of the bill equally and fairly, is now unbalanced and no longer represents the extent of the evidence heard from both sides of this debate. This is due to the insertion of a raft of lengthy amendments by Mr Greg Donnelly on behalf of opponents to Voluntary Assisted Dying. These amendments were not only unnecessary but now stand in the final report unable to be refuted by evidence, facts or witness testimony.

Refuting some of the amendments

A dissenting statement does not afford me the space to offer contrary and expert evidence against some of the new additions to the report by way of Donnelly's amendments. However, I wish to highlight correspondence received by the committee from Kenneth Chambaere, Professor Public Health, Sociology and End-of-Life Ethics from the Vrije Universiteit Brussel (VUB) & Ghent University, Belgium, in response to what he says is significant misrepresentation of his research by one of the witnesses who gave evidence at the Inquiry – the Anscombe Bioethics Centre. His correspondence reads:

> *"It has come to my attention that evidence from (a.o.) Belgium has been used in one of the submissions regarding Provisions of the 2021 VAD bill. It relates to the submission No. 41 - The Anscombe Bioethics Centre. In this submission the author recycles an argument that I have rebutted a few times before in Australian media. Please see following links for this rebuttal:*
>
> *https://www.gogentleaustralia.org.au/author_of_belgium_study_hits_back*
> *https://theconversation.com/separating-fact-from-fiction-about-euthanasia-in-belgium-58203*
>
> *As I feel the Anscombe submission significantly misrepresents the Belgian situation, and particularly our own research, I was inclined to send the Committee this reaction. It is abundantly clear from our peer-reviewed international publications that the Anscombe author's interpretation and twisting of our empirical findings is fundamentally flawed. In my opinion, this gives away their a priori partiality in the VAD debate, in that they cherry-pick and twist evidence to fit their moral stance.*
>
> *Always prepared to provide further clarifications when requested."*

The inclusion of Professor Chambaere's correspondence by way of this dissenting statement is important because several of Mr Donnelly's amendments had the effect of ensuring the inclusion of lengthy evidence from opponents regarding the supposed failings of the Belgium scheme. Under the heading 'Risk of eligibility criteria being expanded' Donnelly's amendment inserted the following evidence into the final report:

> The committee was also provided with evidence about the VAD scheme in Belgium, which stakeholders argued was operating in a manner inconsistent with its original intentions, in that people are now able to access the scheme who should not be eligible. Professor David A. Jones, Director, Anscombe Bioethics Centre, told the committee that terminal sedation is being used in Belgium as a form of 'euthanasia lite'. Professor Jones said that this is being

> done with and without the consent of the patient, and is being used for people who do not otherwise require this sedation for symptom control.
>
> Professor Jones told the committee that the circumstance in Belgium is not a result of amendments to the legislation, but rather, changes to the culture of medicine. He argued that as doctors have already 'crossed that line' by participating in VAD, it has fundamentally altered the practice of medicine in a negative and dangerous way.

In fact, assisted dying law experts who gave evidence to the committee including Ben White, Professor of End-of-Life Law and Regulation at Queensland University of Technology (QUT) and Linda Willmott, Professor, Faculty of Business & Law at QUT, told the committee that this 'slippery slope' and 'criteria widening' argument put forward by opponents has been resoundingly refuted by evidence from around the world where VAD schemes are in place, including in Belgium. Professor White told the committee:

> There is evidence tracking what has happened in Belgium and in the Netherlands over the last two decades. There was research before voluntary assisted dying was legalised in those jurisdictions and after, and those concerned about a slippery slope would point to, for example, unlawful ending of life happening more frequently due to voluntary assisted dying becoming lawful. In fact, the experience has been the opposite. The Belgian and Dutch teams have collected data on a category of death, which is LAWER, which is effectively ending life without explicit request; it is basically ending someone's life without them seeking voluntary assisted dying. That has actually declined over time and declined after the passing of the assisted dying legislation.[207]

And from the evidence of Professor Willmott:

> The other aspect of the slippery slope is that once you enact this legislation, then Parliament will widen the criteria—for example, the eligibility criteria—and, I guess, again, we urge you to look at the evidence. There has been some modification, very limited modification, in some places. For example, in the United States, which has a model very similar to the Australian model, the eligibility criteria have not changed. There is not evidence of that slippery slope that some people claim.[208]

The minutes that are contained in the appendices of this report attest to the number of amendments that were moved by Mr Donnelly and the way in which they changed the balance and tone of the final report.

[207] Hansard, Wednesday, 8 December 2021, p31.

[208] Ibid.