



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair), Ms Tara Cheyne MLA,
Mrs Elizabeth Kikkert MLA, Ms Caroline Le Couteur MLA.

Submission Cover Sheet

End of Life Choices in the ACT

Submission Number: 191

Date Authorised for Publication: 29/3/18



9th March 2018

Committee Secretary
Select Committee on End of Life Choices in the ACT
Legislative Assembly for the ACT
GPO Box 1020
CANBERRA ACT 2601

Dear Committee Secretary,

RE: Inquiry into End of Life Choices in the ACT

My name is Greg Donnelly and I am a member of the New South Wales Legislative Council. As the Committee may be aware, late last year the New South Wales Legislative Council debated a bill that provided for physician-assisted suicide and euthanasia. The bill was entitled the *Voluntary Assisted Dying Bill 2017*. The following link will take you to the webpage relating to the bill <https://www.parliament.nsw.gov.au/bills/Pages/bill-details.aspx?pk=3422>. The bill was debated, voted on and defeated.

As you would expect both MLCs and MLAs received a significant number of submissions and letters from organisations and constituents expressing serious concerns regarding the proposed legislation and calling on both Houses to unanimously oppose the bill. With respect to the submissions and letters, they dealt with both the broader concerns relating to physician-assisted suicide and euthanasia legislation as well as particular deficiencies and shortcomings regarding the bill that was before the Parliament.

In terms of this inquiry, what I thought may be useful to the Committee would be to provide it with a selection of documents outlining various concerns about the proposed legislation in New South Wales. Even though some of the comments related specifically to the particular bill being considered in this state before the Legislative Council, I believe the vast majority of reflections and considerations are directly relevant to the Australian Capital Territory inquiry. For ease of reference, I have placed the documents under particular subject headings. They are as follows:

Elder Abuse

1. General Purpose Standing Committee No. 2 *Elder Abuse in New South Wales* Report No. 44 dated 24th June 2016
<https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf>;
2. Australian Law Reform Commission *Elder Abuse – A National Legal Response* Final Report dated May 2017
https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_31_may_2017.pdf;
3. Newspaper articles:
 - a. “Financial Abuse of Parents Growing” by Sue Williams –Sun Herald dated 27th August 2017 <https://www.domain.com.au/news/financial-abuse-of-elderly-parents-on-the-rise-as-housing-becomes-more-unaffordable-20170827-gy33zq/>;
 - b. “Australian Dream Becomes Nightmare for the Elderly” by Graham Hill –The Sydney Morning Herald dated 30th August 2017 (attachment two); and
 - c. “Loved Ones Pose Biggest Threat to Old People’s Assets” by Caroline Overington – The Weekend Australian dated 9th-10th September 2017
<http://www.theaustralian.com.au/news/inquirer/loved-ones-pose-biggest-threat-to-old-peoples-assets/news-story/966cfe0e6dfdf43044b5049ffd3638a1>.

Suicide Prevention

1. NSW Parliamentary Research Service e-brief 03/2017 dated July 2017
<https://www.parliament.nsw.gov.au/researchpapers/Documents/Suicide%20prevention.pdf>.

New South Wales Auditor-General’s Report – Planning and Evaluating Palliative Care Services in NSW

1. The New South Wales Auditor-General released on 17th August 2017 an important report entitled *Planning and evaluating palliative care services in NSW*. The following link will take you to the report <http://www.audit.nsw.gov.au/publications/latest-reports/palliative-care>.

Submissions and Commentary on Proposed NSW Legislation

1. Submission by the Royal Australasian College of Physicians regarding the Draft *Voluntary Assisted Dying Bill 2017* dated July 2017 (N.B. the submission relates to the NSW draft bill) <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf>;
2. Submission by the St Vincent’s Health Australia regarding the Draft *Voluntary Assisted Dying Bill 2017* dated 14th July 2017 (N.B. the submission relates to the NSW draft bill)

http://www.healthprofessionalssayno.info/uploads/1/0/9/2/109258189/svha_nsw_voluntary_assisted_dying_bill_submission_final.pdf; and

3. Analysis of the *Voluntary Assisted Dying Bill 2017* by State Member for Ku-ring-gai, Alister Henskens SC MP (attachment three).

Media Articles

1. "So Much to Lose if we Allow Voluntary Assisted Dying" by John Watkins – The Sydney Morning Herald dated 14th August 2017 <http://www.smh.com.au/comment/so-much-to-lose-if-we-allow-voluntary-assisted-dying-20170814-gxvivj.html>.
2. "Why I'll Be Voting "No" to Assisted Dying Bill" by Walt Secord - The Sydney Morning Herald dated 2nd September 2017 <http://www.smh.com.au/comment/why-ill-be-voting-no-to-the-voluntary-assisted-dying-bill-2017-20170830-gy70p3.html>;
3. "Euthanasia: Definition Matters" by Paul Russell – The Spectator Australia dated 4th September 2017 <https://www.spectator.com.au/2017/09/euthanasia-words-matter/>;
4. "Legalising Assisted Dying Would be a Failure of Collective Human Memory and Imagination" by Margaret Somerville – The Guardian Australia dated 20th September 2017 <https://www.theguardian.com/commentisfree/2017/sep/20/legalising-assisted-dying-would-be-a-failure-of-collective-human-memory-and-imagination>;
5. "New York Courts Rule Against "Aid in Dying" and Warn of its Dangers" by Richard M. Doerflinger – The Public Discourse dated 29th September 2017 <http://www.thepublicdiscourse.com/2017/09/20144/>; and
6. "Paul Keating: Voluntary Euthanasia is a Threshold Moment for Australia, and One we Should Not Cross" by Paul Keating – The Sydney Morning Herald dated 19th October 2017 <http://www.smh.com.au/comment/paul-keating-voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html>.

Academic and Journal Articles

1. "Unaddressed Issues in The Australian Euthanasia Debate" by Margaret Somerville dated 13th March 2017 (attachment four); and
2. "Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper" by Lois Snyder Sulmasy, JD et. al. – published in the Annals of Internal Medicine dated 19th September 2017 <http://annals.org/aim/article/2654458/ethics-legalization-physician-assisted-suicide-american-college-physicians-position-paper>.

Helpful Websites

There are two particular websites that provide reputable information relating to physician-assisted suicide and euthanasia. The following links will take you to them:

1. **HOPE: Preventing Euthanasia & Assisted Suicide** - <http://www.no euthanasia.org.au/>;
and
2. **Euthanasia Prevention Coalition** - <https://www.epcc.ca/>.

Correspondence to NSW MLAs and MLCs

1. HammondCare dated 7th September 2017 (attachment five);
2. Dr Doug Bridge dated 11th September 2017 (attachment six);
3. Plunkett Centre for Ethics dated 12th September 2017 (attachment seven);
4. Associate Professor Ghauri Aggarwal dated 13th September 2017 (attachment eight);
5. Sydney Institute of Palliative Medicine dated 15th September 2017 (attachment nine);
6. Palliative Care New South Wales dated 15th September 2017 (attachment ten);
7. NSW Society of Palliative Medicine Inc. dated 18th September 2017 (attachment eleven);
8. Bishop Peter Comensoli, Catholic Diocese of Broken Bay dated 19th September 2017 (attachment twelve);
9. Archbishop Glenn Davies, Anglican Archbishop of Sydney dated 20th September 2017 (attachment thirteen);
10. Archbishop Anthony Fisher, Catholic Archbishop of Sydney dated 21st September 2017 (attachment fourteen);
11. The Australian & New Zealand Society of Palliative Medicine dated 21st September 2017 (attachment fifteen);
12. Catholic Health Australia dated 26th September 2017 (correspondence no. 1) (attachment sixteen);
13. Health Professionals Say No! undated but received 27th September 2017 (correspondence no. 1) (attachment seventeen);
14. Baptist Churches of NSW & ACT dated 3rd October 2017 (attachment eighteen);
15. L J Goody Bioethics Centre dated 3rd October 2017 (attachment nineteen);
16. Lives Worth Living dated 3rd October 2017 (attachment twenty);
17. AMA National President, Dr Michael Gannon dated 6th October 2017 (attachment twenty one);
18. Ms Anna Walsh dated 6th October 2017 (attachment twenty two);
19. Chair of Calvary, The Hon. John Watkins AM dated 9th October 2017 (attachment twenty three);
20. The Australian Family Association dated 9th October 2017 (attachment twenty four);
21. St Vincent's Health Australia dated 10th October 2017 (attachment twenty five);
22. Catholic Health Australia dated 11th October 2017 (correspondence no. 2) (attachment twenty six);
23. Palliative Care Nurses Australia dated 11th October 2017 (twenty seven);
24. Health Professionals Say No! undated but received 12th October 2017 (correspondence no. 2) (attachment twenty eight); and
25. Mr Xavier Symons undated but received 13th October 2017 (attachment twenty nine).

Other Material

1. Statement by Professor Theo Boer dated 16th July 2014 urging legislators to not support physician-assisted suicide and euthanasia legislation (attachment thirty);
2. "*Euthanasia and physician-assisted suicide: focus on the data*" by Ezekiel Emanuel – Medical Journal of Australia dated 1st May 2017 (attachment thirty one);

3. "Real care, love and compassion – the alternative to euthanasia" by Australian Catholic Bishops Conference <https://www.catholic.org.au/euthanasia-pamphlets/1647-real-care-love-and-compassion-the-alternative-to-euthanasia-dl/file>;
4. Report of the Health Committee to the New Zealand House of Representatives dated August 2017 https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24;
5. Research Note entitled "*The Gendered Risks of Euthanasia and Assisted Suicide*" and Fact Sheet by Women's Forum Australia dated October 2017 (attachment thirty two); and
6. Letter from the Institute for Ethics & Society, The University of Notre Dame, Australia dated 19th October 2017 (attachment thirty three).

If you would like me to answer any questions or provide oral evidence at a hearing that may be scheduled as part of the inquiry, do not hesitate to contact me on (02) [REDACTED] or by email on [REDACTED]

Yours sincerely,

[REDACTED]

Greg Donnelly MLC
Parliament of New South Wales

Elder financial abuse



Executive Summary August 2017



Australian dream becomes nightmare for the elderly

Sydney Morning Herald, Sydney, General News, Graham Hill

30 Aug 2017

Page 20 • 661 words • Photo No • Type News Item • Size 295.00 cm² • NSW • Australia • Print - Sydney Morning Herald & Sun Herald • ID 836002653



Soaring house prices are fuelling rising levels of elder abuse in Australia.

This wickedness can, however, be addressed if there is the political and public will to put a stronger legal safety net under vulnerable elderly people.

Growing numbers of older people are being pressured by adult children to guarantee enormous loans.

Legal aid commissions regularly deal with elderly parents who have gone guarantor without understanding they will be legally liable for the debt if the borrower defaults. This problem will only worsen unless we require lenders to ensure older Australians have independent legal and financial advice before these individuals offer their home to secure a loan or agree to be guarantor. As well, there should be a "cooling off" period within which guarantors can withdraw from the arrangement.

The pressure on older people can be immense. Adult children sometimes deny access to grandchildren if an elderly parent does not agree to be a guarantor or provide funds for a home deposit.

Legal Aid family law divisions regularly provide advice to grandparents about gaining access to grandchildren. All too often, we hear of conversations that go like this: "Mum, if we can't get funds to complete our deposit, and get a guarantor for our loan, we'll have to move interstate. The other option is that we move in with you. Your place is too big for you since dad died."

The boom in property prices has resulted in a spike in the numbers of adult children taking over an elderly parent's home and refusing to move out. Vulnerable parents are unable to free themselves of an abusive son or daughter who insists on living rent-free. This is often compounded by physical or emotional abuse. One woman in her 80s was repeatedly beaten by her 45-year-old son who rejected her pleas for him to move out. He had access to his frail mother's bank accounts, restricted her social activities and allowed her only a small amount of her pension.

At times, rising house prices result in an adult child persuading an elderly parent to sell up and buy a home with them. Problems arise when the relationship between parent and child breaks down and cohabitation can no longer continue.

Legal aid commissions have come across many cases where the older person thought they were jointly purchasing the new property but it turned out they were not registered on the title.

Legal assistance is vital to empower vulnerable older Australians and to reduce elder abuse.

However, court action isn't always the solution where families are involved. It can be costly, long and emotionally painful. There is another choice though; across Australia, legal aid commissions are quietly resolving thousands of high-conflict family law disputes involving separated couples who disagree about the living arrangements for children. Legal aid commissions run these family dispute resolution mediation services to enable separated couples to resolve their differences, with the assistance of a lawyer, outside a courtroom. These services have an 80 per cent success rate in settling disputes. Many people affected by civil law elder abuse disputes would benefit if legal aid commissions were funded to extend this service to them. It would



© 2017 Sientia. All rights reserved. This document is for the personal use of the individual user only. It is not to be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or by any information storage and retrieval system. For more information, contact us at www.sientia.com.au.

Sientia AIDP provides services to resolve family law disputes. The extent of our services is limited to the resolution of the legal issues contained in the attached document. We do not provide legal advice or representation in the courts.

enable civil disputes involving family members to be resolved outside court, through a process that can be much swifter and less painful than courtroom litigation.

Australians are living to unprecedented ages at a time when their adult children and adult grandchildren face unprecedented housing prices. I must stress that financial abuse is not the only form of abuse affecting older Australians. Mistreatment includes physical, psychological or sexual harm.

However, financial abuse is becoming more prevalent and this emerging issue requires a vigorous response from the community.

In recent times Australia has risen to the challenge of addressing the scourge of domestic violence.

The issue of elder abuse requires a commitment of similar proportions.

Dr Graham Hill is the chairman of National Legal Aid, the body representing legal aid commissions in all states and territories.

[Download print article](#)

Audience

93,403 CIRCULATION

Analysis of the Voluntary Assisted Dying Bill 2017
By Alister Henskens SC MP

EXECUTIVE SUMMARY OF THIS PAPER

- A. Everybody brings to this debate their own personal history including various family, life, humanistic, spiritual, religious and other perspectives. This paper is not intended to debate those issues or change minds on them. It is merely intended to consider legal issues arising out of the proposed Bill and to report a number of other matters relevant to the operation of the Bill which I have investigated.
- B. This paper contains:
1. This executive summary;
 2. Then the detailed paper which has:
 - a. An introduction – at page 12;
 - b. An explanation of the paper's methodology and the nature of the investigations undertaken – at page 13;
 - c. A summary of the provisions of the Bill which will explain how assisted dying would operate in practice – at page 16;
 - d. Observations on the nature of expert evidence including medical evidence in court proceedings – at page 24;
 - e. A detailed analysis and critique of the Bill – at page 27;
 - f. A discussion of some other relevant matters – at page 48;
- C. The paper's major findings are that:

This Bill creates Confusion not Clarity

1. This Bill is the first piece of legislation (to my knowledge) since the abolition of capital punishment which allows for a person to intentionally end the life of another person (or aid and abet that act) without any legal punishment or sanction.

2. There is a strong public interest that any legislation that results in the lawful ending of a person's life is clear to follow, well drafted, without legal ambiguity and protective of any vulnerable persons.
3. Unfortunately, this Bill is not well drafted, is confusing to follow, has critical definitions left out and has many other shortcomings.
4. For example, the most important person, other than the patient, under the Bill is the primary medical practitioner, who is in charge of making relevant inquiries and who ultimately assists the patient to die.
5. A primary medical practitioner is described in clause 9 as a "registered medical practitioner."
6. There is no definition in the Bill of what is a "registered medical practitioner."
7. A person will answer the description under the Bill if they are registered as a medical practitioner anywhere in the world and such a person could therefore legally assist people to die.
8. The Bill does not include any period of practice or experience to be a "registered medical practitioner."
9. There are other examples given in the paper of similar shortcomings.

Medical Opinions Are Required that Cannot be Given

10. For the purpose of my investigation, I consulted doctors (without knowing their attitude to euthanasia) with specialities granted a role under this Bill.
11. The Bill requires medical practitioners to give a number of medical opinions that they tell me that they are not medically qualified to make.
12. Central to a patient's right to physician-assisted suicide under the Bill is that a person must have a terminal illness with only 12 months to live.
13. The medical advice that I have received is that, in most if not all cases, it is impossible to accurately predict a terminal patient's likely date of death more than about 2 – 3 weeks from the patient's actual death.
14. The central plank of the Bill, that a person can be accurately assessed to have 12 months or similar to live, is a medical fallacy in almost all cases.
15. A former Senator of the Parliament of the Netherlands told me that the Dutch did not include a criterion of the period to the time of death under their euthanasia legislation because their medical advice was the same as mine -

that no long term accurate prediction beyond a few weeks from death can be made as to how long a person has to live.

16. At a higher professional leadership level than I consulted, the Federal AMA's considered opinion is against physician- assisted suicide, which is also the American College of Physicians' position.

Psychiatric Assessment is Inadequate

17. The exposure draft of the Bill required a psychiatrist or psychologist to give an opinion on whether the patient requesting to die was of sound mind and whether the decision making capacity of the patient had been adversely affected by his or her state of mind. These requirements have been taken out of the Bill that was the subject of the second reading speech and replaced with the requirement that the patient only has to have decision- making capacity.
18. A professor of psychiatry has advised me that, under the current Bill, a patient can have a psychiatric condition (e.g. depression) causing the patient to ask his doctor to die and which, if not present, might have had the consequence that the patient did not proceed – but the expert psychiatrist or psychologist is not required to test for or report on any psychiatric motivation to die.
19. This has a cumulative impact because, under Clause 18(1)(c) of the Bill, the illness giving rise to the right to assisted death can be terminal because the patient has unreasonably (perhaps due to a mental disease like depression) refused treatment that can cure the illness.
20. A person with a terminal illness is likely to experience 5 stages of grief by reason of being told that they have a terminal illness.
21. The patient's 5 stages of grief are likely to be of 6 – 9 months duration.
22. A decision to end a patient's life during the 5 stages of grief could be changed at the end of that period into a decision to continue to want to live when the grief has resolved.
23. For example, in another area of medical concern, many paraplegic and quadriplegics wish to end their life during these 5 phases of grief but go on to want to live and in fact have very satisfying lives.

24. The Bill also requires the psychiatrist or psychologist to report on whether the patient's decision to request physician-assisted suicide has been made freely, voluntarily and after due consideration. Again, my expert advice is that a psychiatrist would be no better than any other person (including a lawyer) in determining whether there has been family coercion or the like upon the patient making the decision to die.
25. But the assessment of the psychiatrist/psychologist, which they have no particular professional expertise to make, is the only measure in the Bill designed to detect possible duress or coercion upon the patient from family members or others.
26. This taken with other matters developed in the paper has caused me to arrive at the conclusion that there is not adequate protection under the Bill for vulnerable people who are subjected to actual duress or coercion.
27. Even if psychiatrists and psychologists were requested under the Bill (which they are not) to ascertain whether a person who wants to die is doing so as the actions of somebody of a sound mind, they would have only a limited basis for doing so – medical orthodoxy is that suicidal ideation is the consequence of a mental illness, not a rational choice without the presence of a mental illness.
28. Rather than reducing the number of cancer patients from suiciding, there is research cited by the American College of Physicians that jurisdictions with the availability of euthanasia have seen a 6% increase in total suicides.
29. Whilst we can only speculate on why this is the case, it is possible that people that are suicidal are more comfortable to take their own life because the state has sanctioned physician-assisted suicide.
30. We need to know more about why the suicide levels have increased with the availability of euthanasia.

Consent and Duress

31. The idea that somebody may want to encourage a relative to end their life when they do not really want to may seem fanciful to many people who have a loving family and a good relationship with their relatives.

32. My experience as a legal practitioner has shown me that, in some families, family members can be shamelessly and aggressively motivated by the prospect of an inheritance.
33. Furthermore, since becoming an MP, I have been reliably informed of the incidence of elder abuse in our community. Even in a relatively affluent electorate like Ku-ring-gai, I have been told (by people working in our community with seniors), that there are elderly people eating cat or dog food while living in multi-million dollar homes because of family control over their finances or an absence of family financial support.
34. It may be uncomfortable to confront but, taking into account credible accounts of elder abuse in our community, this Bill could motivate greedy relatives to put pressure on a family member patient to end their life earlier than the patient wants.
35. The obligation on a psychiatric or psychological assessment under this Bill to determine whether a “patient’s decision to request the assistance to die has been made freely, voluntarily and after due consideration”(i.e. free from duress by greedy relatives) is not capable of a scientific assessment by a psychiatrist or psychologist and so will therefore have a significant margin of error.
36. Further, under the Bill, the primary or secondary medical practitioners, treating doctors or nurses can be aware that a patient who has requested to die is being subjected to actual duress from a relative or other third party but those medical professionals have no obligation under the Bill to report those matters to anyone (including the psychiatrist or psychologist making an assessment under the Bill).
37. As a consequence, the patient can be legally assisted to die by the primary medical practitioner without there being a truly voluntary request by the patient.
38. Attention needs to be directed in this context as to what would provide certainty that all vulnerable patients are without any coercion by a family member or other close person.
39. What is clear is that the protections in the Bill with regard to the voluntary nature of the patient’s actions are wholly inadequate and almost non-existent.

40. If passed, there will be instances of death under this Bill where there has been a request to die by the patient under duress which will in law mean there has been a state-sanctioned murder.
41. As the main witness to this abuse has died, any action against the wrong doer/s is unlikely.

Court Review is an Illusive Protection

42. Included in the Bill is a right for family members to have a court review of the process prior to death.
43. But this is not a right in reality.
44. It is impossible to bring a court case to protect a relative, whom you know has been subjected to duress by another family member, if you do not know that they have requested to end their life under the Bill.
45. There is no obligation on a patient or anyone else to inform close family members that the patient/ relative has requested to die under this Bill.
46. Therefore, the first occasion that some people may find out that their spouse, parent, child, brother or sister has requested to die under the Bill may be after they have medically had their life ended.
47. Furthermore, the grounds for any legal challenge to a request for an assisted death are limited in scope and do not include grounds at common law such as duress, oppression, undue influence or unconscionable conduct.

Other Vulnerable Patients

48. The decision-making capacity definition means that patients with an intellectual disability may be able to have physician assisted suicide under the Bill.

Objectivity of the Medical Opinions under the Bill

49. None of the medical practitioners doing assessments under the Bill is required to be the patient's treating doctor. Each can be a pro-euthanasia, hired-gun doctor negating the intended independent medical practitioner protections in

the Bill. There is no necessity that in practice there will be balanced medical assessments under this proposed law.

50. Unlike adversarial court proceedings where an expert opinion can be tested by cross examination, a partisan expert opinion under this Bill can stand untested as an essential and important criterion upon which somebody may die.

51. Further, given the time involved and the magnitude of the issues involved that the medical assessments include, the voluntary participation of a patient's treating medical practitioners to perform the obligations imposed upon them under the Bill is questionable – but those treating doctors are probably the best able and most independent persons to determine the issues arising under the Bill.

Very Late In The Terminal Illness

52. The process under the Bill takes a minimum of 9 days from the first request to die until death.

53. I strongly doubt that many, if any, patients with a terminal illness will go through the process under the Bill, including 3 costly medical examinations and reports (unlikely to be covered by Medicare or private medical insurance), to reduce the end of their life from 14-21 days by about 5 to 12 days.

54. Concerns about this Bill need to be weighed against this meagre 5 to 12 day maximum benefit that will apply to most, if not all, patients where proper medical assessments of when they are likely to die are made.

No Pain Needed to be Able to Die

55. Clause 9(2)(e) of the Bill requires that the patient is experiencing severe pain or suffering or incapacity to an extent unacceptable to the patient. The test is wholly subjective without any objective medical verification. It also allows for deaths where there is not any severe pain but only a "physical incapacity" or an unspecified other "suffering" that is not the same as "severe pain". Presumably, that is psychological suffering.

56. Under Clause 18 (1)(c) of the Bill, even if medical treatment can provide proper relief from severe pain, suffering or physical incapacity, the fact that they can all be resolved does not prevent a doctor from still being able to assist the patient to die if there is no “cure” for the terminal illness through medical measures acceptable to the patient. This is of great concern, having regard to any concerns about a patient being encouraged by their family or friends to die.

57. The Bill is sufficiently broad in its terms that it effectively allows any terminally ill patient (who can secure two doctors to say they have less than 12 months to live and a psychiatrist to say the patient understands the medical advice they are being given) to end their life regardless of their actual level of pain because they only have to claim that their “suffering” is unacceptable to them.
Is this an Improvement on the Status Quo?

58. The Bill will probably create, in some cases of an unknown number, a new kind of psychological suffering for:

- a. some patients who are subjected to coercion to end their life early; and
- b. family members who may be asked to, and do reluctantly, give the patient relative their moral support, to end the patient's life.

59. All legislation can have unintended consequences. There is no empirical evidence that this Bill will not create more distress and problems than it is trying to solve.

60. Post-Traumatic Stress Disorder (**PTSD**) is a potential unintended consequence for those involved in the termination of life, including doctors and family members.

61. There seems to be a conflict of medical opinions on the benefits of palliative care. Some doctors say that all palliative care is effective and others that it is not in all cases. The professional advice I have received is that those who receive modern palliative care but do not respond to it are small in number.

Many Patients With No Benefit

62. Patients who are in chronic pain or who have a very low quality of life but do not have a terminal illness are not able to die under this proposed legislation.

These include :

(a) patients suffering from Alzheimer's and like diseases;

(b) those with painful rheumatoid arthritis;

(c) cardiac cripples; or

(d) those who do not have mental capacity at the time that a medical opinion can first be given as to the likely time to their death.

63. If this Bill is passed, it is reasonable to assume that persons advocating on behalf of these types of patients excluded under the Bill will then advocate for their right to physician-assisted suicide because this Bill has at its heart the notion that there is a justification for state-sanctioned suicide. This has in fact occurred in the Netherlands, where the number of patients using euthanasia has increased over time to now be 4.6% of all deaths in that country or more than 6000 people every year.

64. Given these international trends, there should be no assumption this legislation will necessarily be only limited in its use, thus emphasising the need for care to ensure the legislation is as good as it can be.

No Requirement for a Humane Manner of Death

65. The Bill provides that a doctor may prescribe, prepare or give only an authorised substance for a patient to die.

66. The authorised substance is to be specified by regulation.

67. There is no obligation under the Bill for the manner of death to be humane, painless and without distress.

68. A doctor may only administer the authorised substance if the patient is "physically incapable of self-administration." Otherwise, the patient has to take the life ending medication themselves and not necessarily under any medical supervision.

69. The Bill currently precludes the much more proficient method of euthanasia, which is that a doctor injects a drug to put the patient to sleep and then a

further drug is injected to end the patient's life. I understand that this is the process in the Netherlands.

Poor Penalty Provisions and Deterrent of Unconscionable Conduct

70. Clause 14 of the Bill, which is designed to deter interested persons from financially benefiting from their position of power under the Bill, contains no penalties for any transgressions or any requirement to repay any ill-gotten gains.

71. The intent of Clauses 15 and 16 is to deter improper conduct with regard to the assistance to die and have maximum penalties of only 4 years in gaol. This falls well short of the maximum of life imprisonment for conspiracy to murder to obtain a financial advantage or the maximum 10 years imprisonment for fraud.

Jurisdiction Shopping Cost Drain

72. A person living in another State of the Commonwealth can move after they have been diagnosed with a terminal illness and become ordinarily resident in NSW.

73. They are free to avail themselves of medical services in order to have the possibility of using the provisions of this Bill.

74. The Bill could operate as an incentive to put more demand upon NSW medical services.

Under 25s Not Covered

75. Eighteen years of age is the age of legal maturity but this Bill says that people of that age cannot make the decision to die.

76. Other protections could instead be put in place for those who are 18 – 25 years of age.

The Bill's Operation in Practice

77. The AMA does not support this Bill.

78. Doctors feel reluctant to become a person who facilitates death rather than saves lives.

79. There will have to be a significant cultural shift in the medical profession for the Bill to operate properly in practice, especially when the medical profession is being asked to perform a number of tasks which are not medical in nature.

THE PAPER IN DETAIL

Introduction

1. The Voluntary Assisted Dying Bill 2017 is co-sponsored by a cross party group consisting of Alex Greenwich MLA, Trevor Khan MLC, Lee Evans MLA, Mehreen Faruqi MLC and Lynda Voltz MLC. The Coalition and Labor parties have been granted a conscience vote on the Bill.

2. Everybody brings to this debate their own personal history including various family, life, humanistic, spiritual, religious and other perspectives. This paper is not intended to debate those issues or change minds on them. It is merely intended to consider legal issues arising out of the proposed Bill and to report a number of other matters relevant to the operation of the Bill which I have investigated. I have interviewed many different medical practitioners because we do not, to my knowledge, currently have any member of the medical profession elected to the NSW Parliament. This was essential because the proposed legislation has a central role for doctors and assumes that they are able to give certain opinions and will co-operate with the implementation of this proposed legislation.

3. This paper contains:
 - a. an explanation of the paper's methodology and the nature of the investigations undertaken;

 - b. a summary of the provisions of the Bill which will explain how assisted dying would operate in practice;

 - c. observations on the nature of expert evidence including medical evidence in court proceedings;

 - d. a detailed analysis and critique of the Bill; and

- e. a discussion of other relevant matters.

Methodology

4. Under our current laws, it is permissible for a patient to refuse medical treatment that has the effect of keeping the patient alive. For example, a patient who has a kidney condition requiring dialysis can refuse, lawfully, to have any dialysis treatment and that patient will certainly die within 14 days. The patient cannot be forced to take food intravenously or dialysis treatment that would keep the patient alive. Similarly, a patient dependent upon other machines to keep them alive can request that machinery be turned off and a medical practitioner can lawfully follow that instruction, knowing that the effect will be to end the life of the patient.
5. Under the current law, administering morphine to a patient to treat their pain, which may have the medical effect of shortening the patient's life, is a lawful step that can be taken by a doctor.¹ Refusal of treatment which has a by-product of shortening life, is sometimes called passive euthanasia and is legal. What cannot be performed now by a medical doctor is active euthanasia meaning, any steps to administer or supply a drug with the sole intention of causing or facilitating death. These may seem to involve very fine distinctions but the legal line is understood and applied day in and day out by the medical profession under our current laws.
6. The proposed legislation gives a central role to the medical profession. After the exposure draft was released and well before any publicity about the legislation, I embarked from mid-March 2017 upon a number of interviews (face-to-face where possible) with several members of the medical profession. These interviews were arranged in a deliberate fashion. Medical practitioners were sought out on the basis of their area of expertise and geographical

¹ It should be noted that during the seminars at Parliament House on 20 and 21 September 2017, it was contended by several palliative care physicians that pain relieve such as morphine does not shorten a patient's life.

convenience without knowing where they stood on the issue of euthanasia or assisted dying. As the proposed Bill had not yet achieved much, if any, publicity at the time that I conducted most of my interviews, it was not possible that the matters that I was informed of by the doctors were influenced by the more recent public discussion that has taken place. At a convenient time during an interview, I asked the doctor to give me their opinion on whether they supported euthanasia or assisted dying. As it turned out, a majority of the medical practitioners that I consulted did not support assisting patients to die. This would appear to reflect the current position of their professional body, the Australian Medical Association. The types of doctors consulted included (in order of consulting them):

- (a) a medical oncologist;
- (b) a clinical and laboratory haematologist;
- (c) a palliative care specialist;
- (d) a neurological specialist;
- (e) a practising psychiatrist;
- (f) a pain specialist;
- (g) a Professor of Psychiatry who participates in clinical practice and research into mood disorders;
- (h) a general practitioner with an elderly cohort of patients;
- (i) a joint palliative care and pain management physician specialising in the treatment of cancer patients; and
- (j) a retired palliative care specialist.

7. In order to inform myself as to the euthanasia legislation of the Netherlands and how it operates in practice, through the kind assistance of the Australian Ambassador to The Hague, I was able to be introduced to and to speak over the telephone with:

(a) Mr Jacob Kohnstamm, a lawyer and the National Co-ordinating Chairman of the Assessment Committee under the Dutch euthanasia legislation. Mr Kohnstamm was also a member of the Dutch Senate when their euthanasia legislation was passed;

(b) Dr Gerrit Kimsma, a Dutch general practitioner experienced in the practice of euthanasia, who is also a lecturer in medical ethics at the Radboud University, Nijmegen; and

(c) Mr Eric van Wijlick, who is the euthanasia contact at the Royal Netherlands Medical Association.

All of these gentlemen from the Netherlands are strong advocates for the euthanasia law and believe that it operates well in their country.

8. The Royal Netherlands Medical Association gave me a number of documents in English explaining the current Dutch system which I will refer to further below.

9. I also had a one-on-one meeting with two board members of the advocacy group Dying with Dignity, who shared with me various written material and with whom I discussed some of the issues raised by this paper.

10. I would like to thank the people that I have consulted for giving me their valuable time and answering my questions. I take full responsibility for any misunderstandings I have arising out of our conversations. The views in this paper are my own and not of these individuals.

11. Although I had a conflicting engagement, David Garnsey of my office, who is a very experienced and highly qualified lawyer, attended the presentation (arranged by the Dying with Dignity group at Parliament House) by Dr Leigh Dolin, the Past President of the Oregon Medical Association, on the manner in which assisted dying operates in the USA state of Oregon. David has provided me with a report of the presentation and a copy of his notes made during the presentation.
12. David Garnsey and I also attended the seminar at Parliament House on 21 September and David attended the seminar at Parliament House on 20 September 2017 on the topic of assisted dying.
13. I have also taken note of the material that has been sent to all MPs by various groups this year.

Summary of the Proposed Bill

14. The following summary is provided of the important provisions in the Bill for the purposes of explaining its proposed operation. Because the structure of the Bill is confusing, I have tried to explain the sequential operation of the process under the Bill as clearly as I can.
15. A patient may request a registered medical practitioner, who is not a close relative of the patient, for assistance to end the patient's life if five criteria are satisfied:²
 - (a) the patient is 25 years of age ;
 - (b) the patient is an Australian citizen or a permanent resident of Australia, and is ordinarily resident in NSW;

² Clause 9

- (c) the patient is suffering from an illness which, in the reasonable medical judgement of a medical practitioner, will result in the death of the patient within 12 months (defined as a “terminal illness” under clause 4 of the Bill);
- (d) the registered medical practitioner has informed the patient that the patient is suffering from a terminal illness (as defined) ; and
- (e) the patient is experiencing severe pain, suffering or physical incapacity to an extent unacceptable to the patient.

16. A patient may rescind a request for assistance to voluntarily end the patient's life at any time and in any manner.³

17. If the Clause 9 requirements are met and the patient has not rescinded his or her request for assistance to end their life, then the medical practitioner who is to assist the patient to end the patient's life (called the **primary medical practitioner**) must undertake a number of further steps under Part 4 (Clauses 17-23) of the Bill before the primary medical practitioner can assist in ending the life of the patient. These further steps include:

- (a) the primary medical practitioner must examine the patient;⁴
- (b) another registered medical practitioner eligible to conduct an examination (called the **secondary medical practitioner**) must independently also examine the patient;⁵
- (c) the second medical practitioner must be qualified in a relevant speciality to provide the diagnosis or treatment of the terminal illness in respect of which the patient is suffering;⁶ and

³ Clause 10

⁴ Clause 17(1)

⁵ Clause 17(1)

⁶ Clause 17(3)(a)

(d) there are provisions which attempt to keep a separation of association and therefore a degree of independence between the primary and secondary medical practitioners but these are limited to defined family, employment and commercial relationships.⁷

18. Before the patient can be assisted to die, the primary medical practitioner must form the opinion that:⁸

(a) the patient is suffering from an illness which will, in his or her reasonable medical judgement, result in the death of the patient within 12 months;

(b) the illness is causing the patient severe pain, suffering or incapacity to an extent unacceptable to the patient; and

(c) there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure.⁹

19. The secondary medical practitioner must prepare a written opinion agreeing with the three opinions of the primary medical practitioner in relation to the patient, set out in the previous paragraph of this paper.¹⁰

20. After the primary and secondary medical practitioners have independently examined the patient, the primary medical practitioner must inform the patient in writing of information relating to:

(a) the nature of the illness and its likely course;

⁷ Clause 17(2), 17 (3)(b) – (c) and clause 8

⁸ Clause 18(1)

⁹ In the exposure draft of the Bill there were two other conditions which have now been deleted from the Bill, namely that the medical practitioner also formed the view that:

(a) Any medical treatment reasonably available to the patient is confined to the relief of pain or suffering; and

(b) The patient has considered the possible implications of the patient's assisted death for the spouse or de facto partner or family of the patient.

¹⁰ Clause 18(2)

- (b) the medical treatment, including palliative care, counselling and psychiatric support and measures for keeping the patient alive, that might be available to the patient;
- (c) the consequences of the administration to the patient of an authorised substance, including the risk and possible adverse consequences of the administration not resulting in the death of the patient; and
- (d) the right of the patient to rescind a request for assistance.¹¹

21. The primary medical practitioner must also offer to refer the patient to a palliative care specialist – the patient is not required to accept the offer.¹²

22. The patient, after receiving that information and the offer of referral, must tell the primary medical practitioner if they still wish to have the doctor's assistance to terminate their life.¹³

23. The patient must next be examined and assessed by an independent qualified psychiatrist or an independent qualified psychologist¹⁴ who, after an examination of the patient, must provide a written report¹⁵ to the primary and secondary medical practitioners, by including the expression of an opinion as to whether¹⁶:

- (a) the patient has decision-making capacity in relation to the request for assistance; and
- (b) the patient's decision to request the assistance to die has been made freely, voluntarily and after due consideration.¹⁷

¹¹ Clause 19 (1)

¹² Clause 19(3)

¹³ Clause 19(4)

¹⁴ Clause 20 (1)

¹⁵ Clause 20(3)

¹⁶ Clause 20(4)

¹⁷ The exposure draft has been changed. It previously also required that:

(a) the patient be of sound mind; and

24. Decision-making capacity under the Bill is defined in relation to a request for assistance as a patient having the capacity to:¹⁸

- (a) understand the facts relevant to the patient's illness and condition; and
- (b) understand the medical treatment and other options available to the patient; and
- (c) assess the consequences of the patient's decision to request the assistance and understand the impact of those consequences on the patient, and
- (d) communicate the patient's decision (whether by speaking, sign language or any other means).

25. The primary medical practitioner must provide the secondary medical practitioner and the psychiatrist or psychologist, prior to their examinations, with any prior reports given to that primary medical practitioner which has rejected a request for assistance under the Bill.¹⁹

26. After all of these steps have been taken and not earlier than seven days²⁰ after making the initial request to the primary doctor for assistance, the patient must then sign a declaration of their consent to be assisted to die²¹ or, if the patient is physically unable to sign the request certificate, make an audio-visual record of:

- (a) the patient reading aloud the patient's declaration on the request certificate; or

(b) the patient's decision making capacity was not adversely affected by his or her state of mind.

¹⁸ Clause 7

¹⁹ Clause 21

²⁰ Clause 22(4)

²¹ In the form set out in Schedule 1 of the Bill under clause 22(1)

(b) any other person reading the declaration aloud with the apparent agreement of the patient, if the patient is unable to read the declaration aloud.²²

27. It is a requirement that the primary medical practitioner be present during the signing of the request certificate or the making of an audio-visual request and both the primary and secondary medical practitioners must sign the request certificate in the presence of the patient.²³ There is also a requirement that an interpreter (if any) signs the request certificate.²⁴

28. There is a cooling-off period in so far as the primary medical practitioner cannot provide assistance to a patient to end their life until 48 hours after the request certificate was completed²⁵.

29. If all these matters are complied with, then the primary medical practitioner may either:

(a) assist the patient to end the patient's life; or

(b) for any reason and at any time, refuse to provide that assistance.²⁶ It is clear that there is no obligation on any person to be a primary or secondary medical practitioner for the purposes of the Bill.²⁷

30. It is made clear that the primary medical practitioner should be guided by general medical standards and any regulations with regard to the substances given by the primary medical practitioner to end the patient's life.²⁸

31. There are various integrity provisions which prevent the primary or secondary medical practitioners, psychiatrists/psychologists, interpreters or close

²² Clause 22(3)

²³ Clause 22(5)-(7)

²⁴ Clause 22(8)

²⁵ Clause 12

²⁶ Clause 11 (1) and (2)

²⁷ Clause 11(3)

²⁸ Clauses 6 and 13

relatives of any of those people from obtaining any financial advantage from an assisted dying.²⁹

32. Close relatives of the patient may apply to the Supreme Court claiming that the request certificate is not an effective request certificate for the purposes of the Act.³⁰

33. There is no duty upon any health care facility operator, health care provider or other person to participate in any steps under the Act.³¹

34. The Bill provides protection from liability in that:

(a) persons acting in good faith by participating in the lawful provision of assistance under the Act, incur no civil or criminal liability;

(b) dealing in any way with an unused authorised substance³², is not deemed to be participating in the provision of assistance³³; and

(c) a lawful assisted death is not to be regarded as a suicide for the purposes of section 31C of the *Crimes Act 1900*.³⁴

35. Wills, contracts or other agreements of any person are void if they purport to impact on whether a person may make or rescind a request for assistance, or provide assistance, under the Act.³⁵ A request to die does not have any impact upon liabilities under other contracts.³⁶

36. A death with assistance under the Act must be reported to the Coroner and to the Voluntary Assisted Death Review Board and medical records retained.³⁷

²⁹ Clauses 14-16

³⁰ Clause 24. A close relative is defined in clause 3 as being a parent, guardian or child of the person or a brother, sister, half or step brothers or sisters, spouse or de facto partner of the patient.

³¹ Clause 28(1)

³² As defined in Clause 29(5)

³³ Other than by destroying or possessing it for that purpose under section 29(3)(f)

³⁴ Clause 29 (7)

³⁵ Clause 30 (1)

³⁶ Clause 30(2)

³⁷ Clauses 31-34

37. The Bill establishes a Voluntary Assisted Death Review Board and sets out its functions.³⁸ The Board will review each assisted death under the Act and will also monitor the scheme, refer any breaches to the relevant authorities, conduct research, make recommendations to improve the operation of the law and report to Parliament and to the public. The Board will consist of 7 members including:

- (a) A Chairperson appointed by the Minister;
- (b) The State Coroner or a nominee of the State Coroner;
- (c) a representative of the NSW Board of the Medical Board of Australia;
- (d) a representative of the NSW AMA or The Royal Australasian College of Physicians;
- (e) a representative of The Royal Australian and NZ College of Psychiatrists or Australian Clinical Psychology Association Ltd;
- (f) a representative of Palliative Care NSW Inc;
- (g) a person who, in the opinion of the Minister, has relevant expertise in law.

38. Breaches of clauses 15 or 16 are the only indictable offences created by the Bill.³⁹

39. A Ministerial review of the Act is to take place after 5 years with a report to Parliament by 6 years after its commencement.⁴⁰

40. As already noted, the above is an explanation of the legislation by attempting to put the sequence of each step involved in a request for assisted dying in a chronological order. The draft Bill does not do that and its current

³⁸ Part 8 and Schedule 2 of the Bill

³⁹ Clause 46

⁴⁰ Clause 47

organisation will be confusing as a consequence to those who have to operate under it if it is passed into law. The Parliamentary drafting could be greatly improved to promote accessibility to the provisions of the Bill and to ensure that there are not errors in process in practice.

Observations on the Nature of Expert Evidence

41. Court proceedings have traditionally had a healthy scepticism with regard to expert (sometimes called opinion) evidence. The reason is that expert evidence presents opinions as if they are a fact. The most dramatic illustration of the unreliability of this sort of evidence was in the Lindy Chamberlain prosecution.

42. In that case, a Scotland Yard “expert” scientist gave an opinion that there was foetal blood underneath the dashboard of the Chamberlain’s vehicle. In fact, the so called “foetal blood” was a rust suppressant. The evidence that foetal blood was present in the vehicle was critical to a jury finding Lindy Chamberlain to be guilty of the murder of her daughter. The inconsistency between the foetal blood opinion and the rust opinion escaped the full exhaustion of Court appeal rights to the High Court of Australia and was not exposed until a Royal Commission was held into the soundness of the conviction for murder. After the foetal blood opinion was declared to be wrong by the Royal Commission, Lindy Chamberlain was pardoned and freed from goal.

43. Wherever expert opinion is frequently used in the legal system, camps of experts seem to develop. There are experts who are renowned to be “pro plaintiff” or “pro prosecution” and experts who are renowned to be “pro defendant”. These camps tend to develop in areas where there are repetitive types of the same kind of litigation involving experts. This is probably because experts can make a living out of conducting the sorts of cases that they give evidence in by being retained regularly by one side or the other (the same could also be said of lawyers). The areas of litigation of this kind which immediately come to mind include planning experts, financial experts giving

opinions as to loss of future income, business valuation experts, economic experts in competition law cases, land valuation experts, psychiatric experts as to criminal insanity and medical experts in personal injury cases.

44. In personal injury litigation there are well-known medical practitioners who are considered to be “pro plaintiff” and medical practitioners who are believed to be “pro insurance company”. In the famous High Court of Australia decision on apprehended bias of *Vakouta v Kelly* (1989) 167 CLR 568, a judge at first instance referred to three insurance company doctors in the case as the “unholy trinity”. The judge was found to have created a reasonable apprehension that he had pre-judged the evidence of the doctors and should have disqualified himself.

45. Notwithstanding the Judge’s comments giving rise to a reasonable apprehension of bias, his comments reflected a widely held view within the legal profession at the time, which was that expert medical opinions in personal injury litigation were not independent and could be influenced by the self-interest of the party seeking it. Unlike adversarial court proceedings where an expert opinion is to be tested by cross examination, a partisan expert opinion under this Bill will stand untested as an essential and important criterion upon which somebody may die.

46. Generally speaking, medical opinions given by “treating doctors” tend to be more unguarded than evidence given by full-time professional forensic medical expert witnesses. That is because the treating doctor does not necessarily understand the full forensic consequence of expressing views in a certain way. These treating doctors also often see giving medical evidence as a burden upon their usual medical practice and are not necessarily giving evidence in such a way as to attract future opportunities to give expert evidence to a court.

47. However, by reason of the doctor/patient relationship, treating doctors, to my observation, can in some cases be unreliable for other reasons, including that they are consciously or sub-consciously influenced by their pre-existing

relationship and try to help their patient rather than be wholly objective. These are important matters in the context of the Bill because there is nothing within the provisions of the proposed legislation which require the primary medical practitioner to be either the patient's treating doctor or randomly selected. This is a major departure from the Dutch legislation where the request for euthanasia is made to the patient's treating doctor.

48. Furthermore, I was informed that a request for euthanasia under the Dutch system is the most unwelcome request that a medical practitioner can receive. That is because the medical practitioner is required to go through a number of stringent administrative steps to fulfil the request of the patient. Under Dutch law, the doctor ends up being referred to a criminal prosecutor if there are any failings in the process.

49. If the Bill does not specify that the primary medical practitioner must be the patient's treating doctor (unless the treating doctor has a conscientious objection) then I fear that an industry of specialist medical (and probably pro assisting dying) hired guns will emerge, similar to what has occurred in the area of personal injuries (and other expert-heavy types of) litigation. This will mean that the Bill, which assumes the occurrence of even-handed medical opinions, will probably not achieve its objective in practice.

50. When discussing several of the medical issues, a number of specialists commented that it would be undesirable to have "technical amateurs" deciding some of the medical issues that can arise under the Bill. A panel approved by the Health Minister, in consultation with the AMA, relevant College or other peak professional body, of doctors willing to perform the role of objective medical assessor and give a genuine even-handed objective opinion would be an improvement to the Bill, with members of the panel operating as at least one of the medical practitioners and probably as the psychiatrist/psychologist expert in all cases.

51. While discussing expert evidence, it is important to note that the legal definition of an expert under Section 79 of the *Evidence Act* is a person who is

able to express an opinion because they have specialised knowledge based on the person's training, study or experience. This is important to keep in mind because, when I later discuss other provisions of the legislation, it will become apparent that there is not a specialised knowledge, on my advice, based on training, study or experience for some of the medical opinions that are sought to be provided pursuant to the Bill.

Commentary on the Provisions of the Bill

Clause 9 of the Bill (see paragraph 15 above) – Eligibility and the Request to Die

52. As will have already been observed, the Bill gives a central role to the primary medical practitioner. The primary and secondary medical practitioners do not have to be the treating doctors of the patient. Further, no qualifications are set out for the primary medical practitioner under Clauses 3 and 9, other than the practitioner is not a close relative of the patient (as defined in Clause 9) and is a “registered medical practitioner.”

53. Who falls under the description of a registered medical practitioner under the Bill is not easy to determine. There is no actual definition of a “registered medical practitioner” in the Bill. A confusing reverse definition is possible in that the definition under clause 5(2) of a “designated health practitioner” includes a registered medical practitioner under the Health Practitioner Regulation National Law. However, even if this operates as a reverse definition of a “registered medical practitioner”, there is no definition in the Bill of what is meant by “the Health Practitioner Regulation National Law.”

54. A loose definition of this kind for the person with a central role under the Bill is highly unsatisfactory. It allows for the possibility of “registered medical practitioners” from foreign jurisdictions with dubious qualifications to be lawfully ending people's lives under this Bill. On the most probable available construction of the Bill, a registered medical practitioner, trained and registered in any jurisdiction (even if with much lower standards than NSW), could be lawfully ending lives in NSW if the legislation is passed.

55. Given the central role of “medical practitioners” under the Bill, it is highly damaging to the integrity of the Bill that such a basic concept does not have a proper definition. Furthermore, to properly perform the functions of a medical practitioner under the Bill, a doctor should, at the very least, have a current Australian medical provider number with a certain level of practical experience, such as practical experience of no less than a period of 7 years in duration.

56. The Bill uses the terminology that a person must be suffering from a terminal illness as a necessary criterion for the availability for assisted dying. Most would commonly understand that to be an illness which at some time may kill you. However, under Clause 3 (1) of the Bill, a terminal illness is defined as an illness which will, in a reasonable medical judgement result in the death of a patient within 12 months. This gives rise to several questions. Firstly, what is the standard of proof that a doctor needs to apply in forming this opinion? Is it just a 50.01% probability of death in 12 months, beyond reasonable doubt or what might be called a scientific certainty of death in 12 months? The Bill is silent on the criteria to be applied. This is important because when I asked doctors how often it is possible to predict when a terminally ill patient is 12 months from death, they said rarely, if ever.

57. The consistent advice that I have received is that predictions as to life expectancy do not conform to an opinion to the standard of a medical certainty and would not conform to the standard of evidence required for a court proceedings. One doctor described the time to death as only “a best guess.” For most terminal illnesses, it is not possible to predict the time of death more than about 2 or 3 weeks in advance of when a person actually dies. At this point the patient starts to exhibit certain changes, physically, emotionally and physiologically that start to point to an impending death. Also, for many terminal illnesses, there are different treatment options and it is usually only when these are exhausted that the patient is not actively treated and is put on a “best supportive care” plan, which is palliative only. Medical science has, by and large, not been directed towards the accurate prediction

of when people will die, which the Bill assumes can take place. Instead, medical science is fundamentally focussed upon keeping people alive for as long as possible.

58. The psychiatric advice that I have received is that most mental health is treatable and would not fall into the definition of a terminal illness. However, it may be an added protection for those with mental ill-health for them to be expressly excluded from the definition of a terminal illness under the Bill.

59. In the case of cancer, in respect of which about 80 percent of the deaths by euthanasia in the Netherlands take place, I am told that it is possible only to predict about 2 or 3 weeks in advance of death when a person is likely to die. That has a profound importance for this Bill. If a person is so advanced in their illness that they only have 2 or 3 weeks to live before they can avail themselves of assisted dying, are they likely to wish to go through the many bureaucratic steps in the Bill already described in order to shorten their life by only a small number of days? The minimum period of time between the first request of a doctor to assist the patient to die and actual death under the Bill is 9 days (putting together the 7 days under Clause 22 and the 2 days cooling off period under Clause 12 of the Bill).

60. I strongly doubt if many people will bother to go through the 9 day steps of the Bill with three costly medical examinations when it is unlikely to be available until their illness is so advanced that they only reduce their life by about 5 to 12 days. It is unlikely that most people will be able to or want to use this legislation in practice.

61. I was informed that, with motor neuron disease, the medium time from diagnosis to death is 18-24 months. This is, one half live longer and one half-lives shorter than that time. I was also informed that some recent research suggests that, depending upon how quickly the disease progresses between the initial early stages, it may be possible to statistically express an opinion at a point in time that a person has about 12 months to live under that terminal condition. However, it would seem that this is still not a medical certainty and

has the same problems of prediction already mentioned. With motor neuron disease, patients are fully conscious and feel distress. There may be other relatively rare diseases beyond the 14 -21 day accurate prediction of death but on the advice I have taken they appear to be few in number.

62. This practical problem with the Bill is largely a problem of medical science.

The haematologist told me that, 6 months from death, it is impossible to tell if a lymphoma patient will survive, as many do, or die. In Oregon, the 6 month (rather than 12 month) from death criterion before there can be an assisted death is unlikely to change the operation of the Bill in practice. The Dutch legislation has no time specified before death but that would be something that would change the nature of the proposed legislation entirely because people who are in pain or suffering, or with a physical disability but without a terminal illness would then also be able to die. This could include paraplegics still coming to terms with their dramatically altered life, people with painful chronic cardiac conditions or other medical conditions resulting in pain which are not terminal.

63. Another aspect of medical science which is problematic for the 12 months from death criterion is the dynamic nature of medical research. New cures and treatments for chronic or terminal conditions are discovered from time to time. Under the legislation, people may die in circumstances where, if their life was allowed to follow normal treatment, the terminal illness may have become treatable. HIV AIDS is a good example where a certain death sentence in the 1980s became changed at a point in time in the 1990s to a manageable non-fatal disease upon the discovery of new drugs.

64. Another criterion for assisted dying under Clause 9 of the Bill is that, because of the terminal illness, the patient is experiencing severe pain, suffering or incapacity to an extent unacceptable to the patient. It is not clear whether the suffering or physical incapacity has to be severe like the pain or merely that the terminally ill patient has the most minor physical incapacity from the illness. The suffering could be completely psychological grief treatable by the medical profession. I think most supporters of some form of euthanasia want

it for unbearable pain and not for it to be available because of what might be fear of the unknown or limited physical incapacity. With regard to the severe pain, or suffering or physical incapacity, it is wholly subjective. Whilst different people appear to have different tolerances for pain (and why one person's tolerance for pain is greater than another person's is not completely understood), making it a subjective test means that there is no requirement for a doctor to also objectively satisfy themselves that any severe pain complained of is probably actually occurring.

65. This effectively means that if it was possible to predict death 12 months in advance, and the patient was not actually suffering pain but merely informed a doctor that they were suffering pain or some other kind of "suffering" or physical incapacity which was intolerable to them, the patient would (if the other requirements existed) be entitled to assisted dying under the Bill. This is particularly relevant to the psychological trauma caused by a person finding out that they have been diagnosed with, say, cancer. I was told that there are 5 stages of grief which can take from 6 – 9 months. This has important consequences for the 12 month from death criterion. Somebody within one of the 5 stages of grief may want assisted dying at that time but when they finish going through all of the stages of grief, would not want to do so. The psychiatric advice was that it would be undesirable to assess someone as they may set in motion a process that they feel they cannot change.

66. I was told that it is believed medically that the same receptors to the brain which convey physical pain also convey psychological pain. It is therefore possible that the unacceptable pain being suffered by the patient is of a psychological rather than physical kind. The importance of that distinction is that psychological pain could be the consequence of grief having regard to a diagnosis of a terminal illness, which will probably occur as part of the ordinary grieving process. It is also a pain which may be capable of treatment. Therefore, the provision could be improved by the availability of assisted dying by a requirement that it is limited to instances of pain and the pain is physical in its origin and medically verifiable as a probability.

67. The final requirement under Clause 9 of the proposed Bill is that the patient must be at least 25 years of age, an Australian citizen, or a permanent resident of Australia and ordinarily resident in New South Wales. The requirement of ordinary residence in New South Wales is desirable because it will prevent jurisdiction hopping within Australia for terminally ill patients. However, the clause does not specify for how long a person must be ordinarily resident in NSW before coming under the Act.

68. At common law, someone is ordinarily resident in a jurisdiction merely because they have decided to permanently reside there. It is possible that, unless a person has been ordinarily resident in NSW for a qualifying period, upon a diagnosis for terminal illness, people from jurisdictions without any form of euthanasia may come to NSW. They could become a further burden on the hospital and medical system of NSW because they feel that at some time during the course of their illness they may wish to avail themselves of the assisted dying legislation. There should be some protective provisions within the legislation to stop jurisdiction hopping of this kind.

69. The 25 year old age limitation is interesting. Although it is no doubt to protect against people who are not sufficiently mature enough to make a wise decision, it is highly anomalous that somebody can vote from the age of 18, become a Member of the Federal or State Parliament (like Wyatt Roy did at the age of 20), from the age of 18 years die in a war defending this country or be a primary medical practitioner under the age of 25 that assists the patient to die but none of those persons can be a patient and make a decision as to whether they wish to avail themselves of the provisions of the proposed Bill until the age of 25 years. I would suggest that a preferable position would be to have some extra physiological testing between say the age of 18 and 25, like under the Dutch legislation (where the doctors are required to apply particular attention to the decisional competence when people who are between the age of 12-18 who want to die), or court or other scrutiny to ensure that the patient is properly exercising their decision.

70. As already identified, in the exposure draft of the Bill there were two other conditions to be satisfied before a patient could avail themselves of assisted dying, which have now been deleted from the Bill. In the exposure draft, the primary medical practitioner also had to form the view that:

- a. any medical treatment reasonably available to the patient was confined to the relief of pain or suffering; and
- b. the patient had considered the possible implications of the patient's assisted death for the spouse or de facto partner or family of the patient.

71. This means that, under the Bill, a person can legally be assisted to die, even if medical treatment could cure the illness. Under clause 18(1)(c) it is clear that, if a cure is unacceptable to the patient, no matter how reasonable, the patient can have access under the Bill to physician assisted suicide.

72. Furthermore, there is no requirement for the patient to consider the impact upon the patient's family members or discuss with close family members the assisted death. The absence of such a provision highlights my concerns about the adequacy of the right to seek court review of the request to die under Part 5 of the Bill when relatives may have no knowledge of the existence of the request.

73. It would seem to me that at least some people with intellectual disabilities may have "decision-making capacity" under clause 7 and be able to request to die under this Bill. This is not an issue that I have discussed expressly with the medical practitioners, but the ability of patients with intellectual disabilities, and the possibility of pressure to be placed upon them, to request to die is a significant concern. . There are particular issues with regard to the vulnerabilities of this group in our community that does not appear to have been taken into account under the Bill.

Clauses 5 and 6 of the Bill – How the Assistance to Die is Given

74. Under Clauses 5 and 6 of the Bill, the primary medical practitioner assists or provides assistance to end a patient's life if he or she prescribes, prepares or administers to the patient an "authorised substance" or gives an authorised substance to the patient for self-administration. Substances which are authorised will be prescribed by regulation. There is therefore no detail within the Bill as to the sorts of medical substances and manner of death that will occur under the legislation. This is important because the medical practitioners to whom I spoke were not (unsurprisingly) aware of the "best" way in which to kill a person.

75. It could be that, having regard to the analysis above, the manner of death may be as painful and as uncomfortable as the likely only few days of living left to most patients if they were to die under normal circumstances and receive palliative care. There needs to be a medical discussion of what ways a person can humanely and painlessly die and to ensure that the Bill has a broad obligation within it that death must be humane and painless as the method of dying specified by regulation. The Bill provides that a doctor may only administer the authorised substance if the patient is "physically incapable of self-administration." The Bill currently precludes the much more proficient method of euthanasia, which is that a doctor administers a drug to put the patient to sleep and then a further drug is given at that point to end the patient's life. I understand that this is the process in the Netherlands.

Clause 10 – Rescission of the Request to Die

76. A right to rescind a request can be made at any time and the rescission must be notified to the primary medical practitioner. However, there are no provisions dealing with the recovery of the script or any fatal medications supplied under the request. In Oregon, 35% of people who go through the assisted dying process do not go ahead and use the medication to die. That could mean that there are significant amounts of deadly medication in the community, raising safety concerns.

77. A closer medical supervision of the administration of the medication could be desirable.

Clauses 14 – 16, 29 and 46 of the Bill (see paragraphs 31, 34 and 38 above) –
Improper Advantages or Conduct

78. Clause 14 of the Bill specifies that the primary medical practitioner, secondary medical practitioner, independent qualified psychiatrist/psychologist, interpreter (if any) or close relative (if assisting the person to die) or associate of those persons must not obtain a financial advantage from assisting a person to die. This provision is designed to stop any of these people individually or collectively conspiring to benefit from a death governed by the Bill. However, there is no penalty specified in the Bill if they were to obtain a financial advantage from the assisted dying. Nor is there any provision which requires them to pay back to the estate of the deceased person (as a debt due) any financial advantage which they have obtained.

79. By contrast, under Clause 15 of the Bill, any person giving or promising any financial or other advantage or threatening to cause a disadvantage to any primary medical practitioner or other person for assisting or refusing to assist the death or primary medical practitioner accepting any financial advantage for assisting to end a patient's life is liable to a penalty which includes a maximum imprisonment for 4 years. The secondary medical practitioner, independent psychiatrist/psychologist or interpreter or close relative of those persons could receive a financial advantage under Clause 14 without any penalty whatsoever. Under Clause 16 of the Bill, a person can also receive a maximum penalty of 4 years imprisonment for procuring the signing or witnessing of a request certificate under the Act by deception or improper influence, which is an indictable offence under Clause 46. The anomaly with regard to Clause 14, where the obligations can be breached without any penalty, should be rectified.

80. The maximum 4 years imprisonment for these offences appears to be very light. Penalties for like offences such as conspiracy to murder somebody in order to obtain a financial advantage, currently range from a maximum of imprisonment for life down to lesser sentences if the offence is fraud (10 years imprisonment) or larceny (5 years imprisonment) under sections 19A, 117 and 192E of the Crimes Act 1900 (NSW).

81. Clause 29 of the Bill is so broadly drafted that it could be used in a defence to any offences under Clauses 14 – 16. Clause 25 (1) should be redrafted to be clear it is subject to Clauses 14 – 16 of the Bill.

Clause 17 of the Bill (see paragraph 17 above) – Examination of the Patient

82. Under Clause 17 (3), the qualifications of the secondary medical practitioner are set out. All that is required is that the secondary medical practitioner be registered under the Health Practitioner Regulation National Law in a speciality in the medical profession that is relevant to the diagnosis or treatment of the terminal illness in respect of which the patient is suffering and that the secondary medical practitioner is not closely related to the primary medical practitioner by reason of employment, family relationship or membership of the same medical practice. The Health Practitioner Regulation National Law is not defined in the Bill. Again, there is no requirement that the secondary medical practitioner has any period of registration in the relevant specialty or any particular skills with regard to the terminal illness in question.

83. The primary and secondary medical practitioners could nonetheless be very close friends or perhaps share a similar philosophy on assisted dying. This is different to the Dutch system where there is a panel of people (not specialists necessarily and they can be general practitioners) who are available to be the secondary medical adviser under its legislation and the primary medical practitioner does not choose the second medical practitioner. In the Netherlands, the secondary medical adviser is supplied from a panel operated by the Royal Dutch Medical Association and is usually a person not well

known to the primary medical practitioner. I think a random selection by a person other than the primary medical practitioner is highly desirable so that there is a true independent check and balance in the system and there is not a pool of like-minded medical practitioners giving the medical opinions.

84. Furthermore, it has been pointed out to me by a number of the medical practitioners that there are significant sub-specialties within each area of specialisation in the medical profession. It has been suggested that it would be more desirable than the mechanism under the proposed Bill to allow for a panel of well-regarded experts, who have practised for a long period within a speciality, to provide a secondary medical opinion. The relevant medical College may devise a mechanism to select the panel of secondary medical specialist opinion-givers with relevant expertise to the terminal illness of the patient. The panel specialist may also have to be prepared to travel from time to time into regional areas in order to examine patients under the proposed Bill.

Clause 18 of the Bill (see paragraph 18 above) – Opinion of Medical Practitioners

85. The primary medical practitioner must form an opinion under the Bill that the patient has less than 12 months to live due to the terminal illness (see comments above), the illness is causing severe pain, suffering or physical incapacity to an extent unacceptable to the patient (see comments above) and that there is no medical measure acceptable to the patient that can be reasonably undertaken in the hope of effecting a cure.

86. The idea that there is not a medical cure acceptable to the patient is a wholly subjective test. The use of “reasonably be undertaken” gives a misleading impression because there is no obligation on the patient to act reasonably. The way clause 18(1)(c) is drafted, a patient can unreasonably reject reasonable measures to cure the terminal illness.

87. Significantly, the absence of any medical measures of any assistance only needs to be with regard to the terminal illness i.e. the absence of a “cure” under clause 18(1)(c). Even if medical science can provide proper relief from severe pain, suffering or physical incapacity, the fact that they can be resolved does not prevent a patient from still being able to be assisted to die under the legislation. This is of great concern having regard to any concerns about a patient being encouraged by their family or friends to die.
88. It is not clear whether the obligation upon the primary medical practitioner to form an opinion as to the Clause 18 criteria must be provided in writing to the patient as part of the written report to the patient under clause 19(1) of the Bill.
89. The “second medical practitioner”, like the primary medical practitioner, must form an opinion as to the same matters. It is required that the second medical practitioner provide his or her opinion on these matters in writing. Again, the same concerns as to the matters raised with regard to the primary medical practitioner would apply equally to the secondary medical practitioner except that the secondary medical practitioner may have some greater medical knowledge of the terminal illness and its implications.

Clause 19 of the Bill (see paragraph 20 above) – Information by the Primary Medical Practitioner to the Patient

90. Under Clause 19 (1) of the Bill, the primary medical practitioner must, after examining the patient, provide information in writing to the patient informing the patient of the nature of the illness and its likely course and of matters relevant to the medical treatment, including palliative care, counselling and psychiatrist support and the measures for keeping the patient alive that might be available. It is probably appropriate for a general practitioner to play this role given that there may be a number of different areas of speciality that are necessary to have input into the provision of a report of this kind. As a matter of drafting, the Clause should require “all relevant” information of the kind specified to be provided to the patient. In addition to the matters set out in Clause 19 (1) (a) - (e), it is desirable that the primary medical practitioner also

puts in writing the doctor's opinions required to have been formed under Clause 18(1)(a)-(c).

Clause 20 of the Bill (see paragraph 23 above) – Examination by the Psychiatrist/
Psychologist

91. Under Clause 20 of the Bill, either a qualified psychiatrist or a qualified psychologist must provide an expert opinion on whether the patient has decision-making capacity and the patient's decision to request the assistance has been made freely and voluntarily and after due consideration.
92. It has been suggested to me that is not appropriate for a psychologist to provide such opinions because psychologists are not qualified medical doctors and therefore not able to understand the physical aspects of the terminal illness and its impact upon the mind of the patient.
93. When I put to a psychiatrist that psychiatry was largely focused on preventing people with mood disorders from killing themselves as a consequence of their mental illness rather than ascertaining whether a sound person could reasonably want to kill themselves, it was conceded that there was no training, study or experience (being the legal definition of expert knowledge) that psychiatrists hold as to whether a person was sufficiently sane to want to kill themselves.
94. The exposure draft of the Bill required a psychiatrist or psychologist to give an opinion on whether the patient requesting to die was of sound mind and whether the decision making capacity of the patient had been adversely affected by his or her state of mind. These requirements have been taken out of the Bill that was the subject of the second reading speech and replaced with the requirement that the patient only has to have decision-making capacity.
95. A professor of psychiatry has advised me that, under the current Bill, a patient can have a psychiatric condition (eg. depression) causing the patient to ask

his doctor to die and which, if not present, might have had the consequence that the patient did not proceed – but the expert psychiatrist or psychologist is not required to test for or report on any psychiatric motivation to die.

96. This has a cumulative impact because, under Clause 18(1)(c) of the Bill, the illness giving rise to the right to assisted death can be terminal because the patient has unreasonably (perhaps due to a mental disease like depression) refused treatment that can cure the illness.
97. Therefore, the psychiatrist or psychologist is being asked to express opinions on whether “the patient has decision –making capacity” to want to kill themselves when they have no relevant expertise to do that. They are not required to report on whether the patient is subject to grief and may arrive at a decision that they do not wish to die if they were given more time.
98. An aspect of the psychiatrist or psychologist’s opinion under Clause 20(4)(b) of the Bill is whether the patient’s decision to request assistance to die has been made “freely, voluntarily and after due consideration”. The area of possible coercion of a patient is an area which concerns me greatly.
99. A recent survey of 1,000 Australians undertaken by Slater and Gordon Lawyers reported in the Sydney Morning Herald on 20 August 2017 showed that 26% of people who are in Gen Y expect to be able to buy their first home because of an inheritance from their parents, with almost ¼ of those people coming from NSW.
100. It is readily apparent within some family dynamics, that jostling takes place between siblings or other close relatives (or even people who have endeared themselves to a wealthy person) with regard to who will inherit parts of the estate of a person who will soon be deceased. These issues can become magnified in circumstances of family break-down or remarriage. In the succession cases that I have been briefed in as a barrister in private practice, complex family dynamics were very apparent.

101. Under the Bill, it is only the psychiatrist or psychologist who is responsible for determining when the patient is acting voluntarily. Even if the primary or secondary medical practitioners were aware, or saw evidence, of actual coercion of the patient by third parties, they are not required to report it under Clause 18 of the Bill or inform the psychiatrist or psychologist, nor would it prevent any medical practitioner from lawfully assisting the patient to die. I put to a psychiatrist that a specialist psychiatrist could not really ascertain whether there was express or implied pressure being brought to bear by family relatives upon a patient's decision to end their life.

102. In answer it was conceded that there is no area of expertise unique to psychiatry to do so and that lawyers or social workers could determine the presence or absence of any duress just as well. It was also conceded that, in order to properly determine whether that kind of pressure did or did not exist in relation to a patient could require multiple consultations with the patient and also probably interviews with close family members or other relevant people. However, the Bill assumes that a psychiatrist/psychologist, probably in one examination with the patient, can determine the free-will of a patient. If the psychiatrist under the Bill conducts multiple consultations of multiple people, the minimum period from the request to die until the actual death referred to above (9 days) will become even longer and the cost to the patient higher. But there is no guarantee that any actual duress by the family members upon the patient to die will be uncovered by the psychiatrist even with multiple interviews.

103. When I have voiced this concern about patient coercion with the Dutch participants in their system, they point to the fact that, under the Dutch medical system, it is impossible for a patient to ever go to hospital unless they have registered with a general practitioner. Therefore, within the Dutch system there is embedded a structural long-term relationship between the patient and a general practitioner, or at least the same GP practice. In the Netherlands the general practitioner is the person who performs the euthanasia.

104. Therefore, in the Netherlands, the person who is giving an opinion or making an assessment about the free-will of the patient's request for euthanasia, it is argued, has probably observed the patient through the progress of the disease, has some familiarity with the family dynamics operating in respect of the patient and can make a decision as to whether there is a sudden desire to be assisted to die. None of the provisions of the proposed Bill suggest that any in depth assessment of the voluntary nature of the request for assisted dying will occur through a single consultation with a psychiatrist, who will probably have no prior history with the patient, nor can the psychiatrists even be given a family history by the referring primary medical practitioner because that practitioner does not necessarily have any history with the patient.

105. Under the Dutch legislation, if the treating general practitioner has a conscientious objection to euthanasia, they are obliged to assist and provide all clinical notes to the substitute doctor who will be assessing the patient who has requested euthanasia. As discussed in relation to Clause 28 of the Bill, inadequate facilitative provisions are made in the Bill with regard to the various laws applying to patient privacy and confidentiality and the fact that professional notes and other documents on the doctor's file are probably legally owned by the doctor and not the patient.

Clause 21 – Provision of Information to Examining Doctors

106. There is a limited attempt to stop a patient shopping around for medical opinions after they have been assessed as not satisfying the prerequisites of the Bill.⁴¹ It requires only that the primary medical practitioner provide to any secondary medical practitioner or the psychiatrist/psychologist copies of previous reports given by other practitioners to him or her. The protection can be easily avoided by the patient going to a new primary medical practitioner who will then be relieved from the obligation under clause 21. In order to properly protect patients, there should be a requirement that any rejection of a request for assisted dying be notified to a central body and there be an

⁴¹ Clause 21

obligation under the Bill on all primary medical practitioners to consult with them as to earlier requests to die by the patient.

Clause 22 (see paragraphs 26-27 above) – The Request Certificate

107. One of the ways under the Bill that a patient may give a request certificate for assisted dying, is to make an audio-visual request. Under Clause 22 (3)(b), if the patient is unable to read the declaration aloud, any other person reading it aloud can do so with the apparent agreement of the patient.

108. It is what constitutes an “apparent” agreement of the patient which should be of some concern. If a patient is unable to read a declaration aloud and is unable to sign a patient declaration, it is difficult to understand how the psychiatric assessment under Clause 20 has taken place. If this is intended to cover situations of blind people then there could be no reason to be concerned. However, it is not so limited and is sufficiently broadly drafted that the consent protections would seem to be rendered nugatory. The primary medical practitioner and his or her reliability is paramount because, under the Bill, the primary medical practitioner must be present when any “apparent agreement” of the patient is given.

Clause 23 - Interpreters

109. Courts of law generally only accept persons as translators if they have a certification under the National Accreditation Authority for Translators and Interpreters (NAATI). The Bill does not require people to have such certification in the language of the patient (if not English). It merely requires that “an interpreter holds a professional qualification for interpreters described by the regulations (if any)”. If the regulation does not specify any qualification there is no quality control and integrity under the Bill verifying that the consent or advice given is properly understood by the patient. The clause should be changed to require NAATI accreditation or other acceptable qualification prescribed by the regulations (if any).

Part 5 – Review of Request for Assistance (See paragraph 32 above)

110. Under Clauses 24-27 of the Bill, close relatives of the patient may apply to the Supreme Court seeking an order that a request certificate is not effective. The primary medical practitioner and the patient must be a party to any such application along with the applicant relative. The Supreme Court may, on its own initiative or on the application of a close relative, decide to join as a party to proceedings any person who, in the opinion of the Court, should be a party to the proceedings.

111. Clause 24 is very prescriptive as to the matters of non-compliance under the Act which may give rise to an order by the Supreme Court that the request certificate is not effective. Rather than confining the criteria for review of the request certificate to the matters set out in Clause 24 (2)(a)-(c), it would be preferable for the court to have a broad discretion to give relief whenever a request certificate relating to the patient is not an effective request certificate for reasons including, but not confined to, paragraphs (a)-(c) of Clause 24(2). That would enable the common law to operate with regard to matters such as duress, oppression, undue influence or unconscionable conduct, none of which are, but should all be, specified under Clause 24 (2) as grounds of Court relief. There may be other irregularities within the process prescribed by the Bill that are not set out in Clause 24 (2)(a)-(c) which may make it undesirable for the request certificate to be effective in all of the circumstances of a particular case.

112. There is also a fundamental problem with the nature of the right sought to be given by Clause 24 of the Bill. There is no requirement under the Bill to notify close relatives that a request to die has been made by the patient. Therefore, if the close relative does not know such a request has been made, they can hardly review the situation and make an application to a Court to suggest coercion, duress or any other irregularity in the process. In my view, there should be a requirement to notify close relatives in the Bill.

113. It is anomalous that, under the *Succession Act*, all sorts of close relatives need to be notified with regard to any challenge to a will and a proposed re-adjustment of property distribution under a deceased estate. The sort of eligible persons under Section 57 of the *Succession Act* with regard to a Family Provision Act action gives a guide to the sort of persons that could have an interest in the fact that a request certificate has been made under the Bill.

Clause 30 (see paragraph 35 above) – Effect on Wills and Contracts

114. The intent of Clause 30 is not entirely clear. Clause 30 (1) of the Bill effectively specifies that any attempts to contract out of the right to assisted dying or to penalise someone within a will for the fact that they have engaged in assisted dying are invalid. The provisions of Clause 30 (1) of the Bill are contrary to the freedom of other people to take an attitude of their liking to whether someone should engage in voluntary assisted dying or not. People should have the ability to express their opinion in a will or contract about assisted dying, just as the proponents of the Bill wish to express their opinion via the Bill on the subject. At the moment, this is a legislative barrier to freedom of choice if that choice is inconsistent with the right to die under the Bill. Clause 30(1) is unduly proscriptive by denying people who take a contrary view to the Bill to express that in the will they make or the contracts they wish to enter into. This intolerant position should be rejected and the sub clause deleted from the Bill.

115. Clause 30 (2) of the Bill appears to be directed towards assisted dying not being an exclusion or limitation under an insurance policy but it is broader than that and should be confined only to insurance policies. At the moment, Clause 30 (2) is drafted sufficiently broadly that it applies to all contracts of any kind and again is an attack on the freedom of contract generally.

Part 7 Records and Reporting of Death

116. Clause 31 of the Bill specifies the sorts of records that the primary medical practitioner must keep. An anomaly is that the written report required by Clause 19 (1) is not referred to in Clause 31. Also, Clause 31 is consistent with the concern expressed earlier that the matters under Clause 18(1) required to be put in writing by the secondary medical practitioner under Clause 18(2) are not required to be put in writing by the first medical practitioner and given to the patient.

117. Under Clause 32 of the Bill, any assisted death is a reportable death under the Coroners Act. That means that a Coroner could investigate the circumstances of the death if the Coroner chose to do so. Whilst this may be appropriate in obviously suspicious cases, the Coroner already has a busy caseload and it is unlikely the Coroner will investigate many cases.

Part 8 Review Board

118. The Voluntary Assisted Death Review Board (**Review Board**) was not part of the exposure draft of the Bill.

119. The Bill has one of the 7 members of the Review Board as the State Coroner or his/her nominee.⁴² As every assisted death is a reportable death to the Coroner under clause 32 of the Bill, there is the ability for there to be a conflict of interest if the State Coroner sits on the Review Board.

120. In the Dutch legislation, there are only three members of their Review Board, having expertise in law, medicine and ethics with one of them being the Chairperson. I would suggest that the Bill is amended so that, in place of Clause (2)(a) and (g), the Minister has the power to appoint a Chairperson

⁴² Clause 35(2)(b)

and up to two other appointees in order to ensure that there are at least two members of the Review Board with expertise in each of law and ethics.

121. Clause 39 of the Bill allows for the Review Board to require information and/or records relating to the assisted death. There appears to be no ability to orally examine witnesses and, as there is not express abrogation of the right to claim a privilege against self-incrimination, any review could be highly limited in its scope. How clause 39 interacts with the privilege against self-incrimination should be explained.

122. Rather than having such a large number of medical representatives on the Review Board, it would be preferable to have one representative from the AMA and an ad hoc specialist member in the area of terminal illness sit on the Review Board for each different kind of patient who has been assisted to die.. A mode of appointment of the ad hoc specialist would have to be devised but presumably that could be done in consultation with the relevant College.

Clause 46 – Nature of Proceedings for Offences

123. Clause 46 (2) provides that only Sections 15 or 16 of the Act should be dealt with on indictment. In the event that Clause 14 also becomes an offence provision, as I have suggested, it should be added to this clause.

Clause 47 – Review of Act

124. A review of the Act will not be undertaken until 5 years' time with a report within a year thereafter. Given that this is new legislation, involving the State sanctioned death of our citizens, that period would appear to be too long. An investigation being undertaken after 3 years of operation with a report within 6 months of that time is appropriate.

Other Relevant Matters

Position of Australian Medical Association and The Doctor Patient relationship

125. The Bill has, as its central players assisting a patient to die, the primary and secondary medical practitioners and the psychiatrist/psychologist. Other than the patient, each of the other players is eligible to be a member of the AMA. In correspondence exchanged between Mr Greg Donnelly MLC and Dr Michael Gannon, the AMA Federal President, that was copied to all MLAs and MLCs on 5 and 6 October 2017, the official AMA position was set out and it is not to support the Bill. Dr Gannon attached the AMA Position Statement and a copy of his speech on 23 August 2017 to the National Press Club.

126. Further, the American College of Physicians in its paper "Ethics and the Legalization (sic) of Physician Assisted Suicide"⁴³ also does not support euthanasia and raises a number of concerns. These include the impact upon the professional relationship of a doctor turning from the patient's unambiguous champion of life to a mixed role where the doctor both saves and assists to end life. As a barrister and solicitor, I experienced 27 years of being in a position of professional trust. In situations of emotional stress and confusion, clients place a great deal of trust in their professional advisers. But the professional relationship can begin where the client is sceptical of the professional advisor until true trust is earned.

127. In the times where big decisions have to be made based upon professional advice, the relationship of trust is critical and can be highly influential. In a legal adviser/ client relationship, there is never a leave pass to throw a case. Under our current medical system there is never a leave pass to do other than save lives unless, after informed consent, the patient or authorised family member states that treatment is not wanted. Doctors are often people who have strong opinions and a strong belief in the correctness of their decisions. There is a legitimate concern that some doctors could use their influence to advance opinions unrelated to their medical training under this Bill and in

⁴³ Annals of Internal Medicine 19 September 2017

certain circumstances try to influence people to end their lives, even if that is not really the patient's preferred choice.

128. The American College of Physicians also raises important social justice issues about euthanasia. They are concerned that people can be made to feel they are a burden and that the patient seeks euthanasia for that reason. This has some support in the Dutch experience. Dr Kimsma informed me that most of his euthanasia patients did so, not from pain or a terminal disease but because they felt that they had grown old and lost the dignity of their lives. This is consistent with the concerns of the American College.

129. The American College of Physicians Paper also notes that, in jurisdictions where there is physician-assisted suicide, rather than total suicides reducing, (contrary to the justification that this Bill will reduce terminal patients who currently kill themselves) the availability of euthanasia has seen a 6% increase in total suicides. This may also reflect that legislation of this kind could convey to some people that suicide is acceptable if the State sanctions it, which is contrary to a raft of government suicide prevention programs in recent years.

Concerns of Doctors

130. Many of these concerns are held by the local doctors that I consulted. On a number of occasions, I have had discussions with doctors about the changing nature of trust between patient and doctor that would result from a doctor being not just the maintainer of life but also under the Bill becoming an ender of life. The implications for trust between doctor and patient and the standing of the medical profession was also a matter of concern to some medical practitioners.

131. Many doctors expressed to me a concern about this law being a thin edge of the wedge. They are concerned that a right to die can become a duty to die. Furthermore, patients without a terminal illness who have chronic pain will ask for the right to die. The concern was that, whilst initially a law designed to hasten people's death who are already certain to die, the law could devolve

over time to apply to people without chronic pain or terminal illness, as in the Netherlands where people who are suffering simply wish to die are able to do so.

132. This concern about the legislation would appear to have some justification, having regard to what I was told of the operation in practice of the Dutch legislation. Doctor Kimsma advised me that many of his patients were not 2-3 weeks from death but had decided to use euthanasia because they felt that they had lost their dignity of life by reason of becoming incontinent, immobile or otherwise unhappy with the situation that they were in.

133. Great psychiatric skill, I was advised, is required to ascertain whether the request to die is being generated by a depressive mood or a grief reaction from being told that a person has a terminal illness. Not all psychiatrists are skilled in these diseases nor are all psychologists. Medical training will not assist with the detection of coercion or pressure upon patients to request to end their lives.

Adequacy of Palliative Care

134. There is necessarily a relationship between palliative care and the need for assisted dying. The large boost in palliative care funding in the last budget has expanded the availability of better pain management across the State. Family anecdotes as to poor pain management in the death of a loved one many years ago may no longer be relevant to the current environment.

135. In determining the need for this legislation, I tried to get a feel for the number of patients who, when palliative care was available, did not respond to treatment.

136. One of the physicians told me that he had between 2000-2500 cancer patients per year. Less than 1/1000 patients were unable to have adequate pain management. The patients whose pain management was not adequate, were patients with what he described as "existential pain." Due to cultural or

belief system issues, the patients appeared to want to feel pain. With the use of psychologists or social workers, these patients were able to receive better treatment. The physician also informed me that new and improved approaches to palliative care were allowing fewer drugs (and therefore fewer side effects) and a better quality of life for terminally ill patients.

137. In the course of investigating this paper, I have taken the opportunity at public meetings or Party meetings to ask people to share with me their views on euthanasia. My impression is many people, at a high level of abstract thought, support euthanasia. But that support is without necessarily having considered many of the issues raised in this paper. Indeed, many have said to me that they supported it before having reservations, after discussing some of my practical concerns, about how such a law would operate. Many support euthanasia because they would like to have it as an option should they be dying a painful death – they would like euthanasia as a fall back option.

138. The people who feel most strongly about euthanasia from my discussions are a small minority of people. This is supported by the 2016 Senate results in NSW where the Voluntary Euthanasia Party received less votes than the Australian Motoring Enthusiasts Party, the Jacquie Lambie Party, the Cyclists Party, Drug Law Reform and half of the votes of the Australian Sex Party or Animal Justice Party and about 1/10th the vote of the Christian Democratic Party or Pauline Hanson's One National Party. Usually those who feel strongly about euthanasia have explained they have formed their opinions as a result of having a close family relative or friends who have had an unpleasant death. When recounting their own personal experience, people have frequently become very emotional. A relatively high proportion of these people have communicated to me that the person who was dying requested that they kill the patient and it is clear that there is a feeling of guilt that they did not comply with that request or, even if not asked to kill the patient, they nevertheless are guilty that they were suffering. It is understandable that to have a request made of them to kill a patient would be highly traumatic.

139. One of the palliative care specialists whom I consulted and who has worked in the area for 22 years gave me an account of a patient who was a friend of the specialist and died in circumstances where the pain management was good and the patient's family and friends were around the patient when she died. The specialist met a mutual friend about a week afterwards who expressed sorrow at the terrible circumstances in which the friend passed away.

140. This story raised the question of whether the psychological grief experienced by surviving relatives and friends may not be unknowingly transferred onto the dying relative or friend.

141. However, under our current system, doctors report very few requests from patients to die. Their experience is that the overwhelming majority of people want to cling onto life rather than to die early.

Modified Scheme?

142. As already discussed, the legislation will allow a terminally ill patient to end their life in circumstances where they are not undergoing any pain. Better legislation could be drafted which is tailored to particular circumstances surrounding particular diseases e.g. for motor neurone disease or chronic cardiac pain and the like in certain circumstances a patient could request to die even if it is not known when they will die; cancer patients could have assisted dying when they cease treatment and go into "comfort only" assistance if they are in physical pain and the patient was not responding to palliative care. The Bill would appear to be trying to do too much in a general fashion and, without sufficient medical focus, making it then inadequate for everybody.

Coercion

143. It would seem to me generally that there is a tension between crafting protections against vulnerable patients being coerced (by third parties) into

believing that they should kill themselves under the Bill and the speed with which it may be reasonable for them to want to die if in pain. This may be a tension which may never properly be resolved. The doctors tell me that very few people now ask them to die prematurely. It could be that it is undesirable to help the small number of people who would wish to end their life prematurely because it would create a new class of disadvantaged persons, namely patients with terminal illnesses who are vulnerable to being coerced into killing themselves.

144. The law has various protections against coercion, when a person is forced to, for example, enter into a contract, however, when the circumstances of duress no longer exist, the person the subject of coercion can seek relief from the legal relationships created because of the coercion. If a patient is assisted to die by coercion, there is no capacity to “bring back” the dead patient. This is a great dilemma with regard to assisted dying or euthanasia.

Cost

145. At a practical level, it is also necessary to raise the question of cost under the Bill. The Bill assumes that there will be multiple medical consultations. Only wealthy patients will be able to afford the professional fees involved in retaining the medical specialists, even under the Bill in its current form. Furthermore, the State government will have to divert funds from existing medical services to set up the Review Board. Also, if physician-assisted suicide is allowed by this Bill, and it becomes 4.6% of all deaths as in the Netherlands, many doctors are going to be tied up in the performance of the requirements of the Bill and not treating patients who are ill. These costs are part of the societal cost benefit analysis which needs to be considered before changing the status quo.

146. Furthermore, one of the doctors raised with me the time and cost and exposure to criminal prosecution which would be incurred by doctors who participate as the primary medical practitioner in assisted dying under the Bill. The doctor expressed the view that many doctors would be reluctant to be involved.

UNADDRESSED ISSUES IN THE AUSTRALIAN EUTHANASIA DEBATE

Margaret Somerville

INTRODUCTION

I have researched and written on euthanasia and physician-assisted suicide for four decades while holding academic appointments in both the Faculty of Law and the Faculty of Medicine at McGill University in Montreal. In a series of decisions, which I believe future generations of Canadians will seriously regret, Canada has recently legalized these interventions. I have just left McGill and Montreal to take a position as Professor of Bioethics in the School of Medicine at The University of Notre Dame Australia in Sydney and find myself immediately involved in the same debate about legalizing euthanasia and doctor-assisted suicide as we had in Canada.

As part of my involvement in these activities, I have written seven short articles focused on different aspects of the debate. They are gathered together below.

The first warns that the impact of legalized euthanasia, especially its risks and harms to vulnerable people, cannot be properly judged in isolation from the total social milieu in which it would be practised and looks at its dangers in a “post-truth” society in which the abuse of elderly people is endemic.

The second examines the unsupportable claim of pro-euthanasia supporters that the evidence from jurisdictions which have legalized euthanasia and/or physician-assisted suicide shows that legalizing these interventions does not open up any “slippery slopes”.

The third reports on the strategy of pro-euthanasia activists seeking to eliminate opposition to the legalization of euthanasia by labelling opposition as just a religious stance and arguing that religion and values based on religion have no place in the public square.

The fourth explores the importance of stories in forming our shared values and the impact of “good death” stories and “bad death” ones on the stances we take in the euthanasia debate. It relates a case where providing euthanasia

was a “bad death” story, in contrast to the usual “good death” stories associated with its provision by pro-euthanasia advocates.

The fifth describes a recent experience I had as an invited panellist on a Q&A session on “Voluntary Assisted Dying”, held as part of Australian Medical Association Victoria Congress 2017. I experienced it as a serious suppression by pro-euthanasia advocates of my freedom of speech as a person who opposes the legalization of euthanasia. Legislators, in particular, need to be very aware of this danger in deciding for or against legalizing euthanasia.

The sixth looks at what we could learn of importance to the decision about legalizing euthanasia from the indigenous wisdom of looking back seven generations to consult human memory (history) and looking forward seven generations through imagination. If it is legalized and becomes the norm governing death, how will our great-great-grandchildren die? Will we have left to future generations a world in which no reasonable person would want to live?

And the seventh looks at the wider and deeper impacts of legalizing euthanasia beyond simply legalizing the intentional infliction of death and proposes that they include damage to important existential human experiences and our ability to find meaning in life.

Together these articles identify some of the unaddressed issues in the euthanasia debate. That they are unaddressed is not accidental. They are avoided by pro-euthanasia advocates because exploring them establishes the case against legalizing euthanasia.

The strongest case for legalizing euthanasia is made at the level of the individual, seriously suffering, terminally ill person, who is competent, gives informed consent and asks for euthanasia. The pro-euthanasia argument is that it is cruel to deny that request and kindness demands that it be honoured. The wider and deeper concerns and consequences that such honouring raises and results in, respectively, establish the case against legalizing euthanasia. I identify some of these concerns and consequences, which it is essential lawmakers take into account in deciding whether or not to legalize euthanasia.

Finally, just to be clear, as there is a great deal of confusion about the definition of euthanasia and doctor-assisted suicide, euthanasia is a doctor administering a substance to a person with the intention of killing the person, physician-assisted suicide is a doctor prescribing medication with the intention

that the person should use it to commit suicide. Justified withholding or withdrawal of life-support treatment or the provision of fully adequate necessary pain management, even if that could shorten life, are not euthanasia or assisted suicide.

i) *POST-TRUTH, EUTHANASIA AND ELDER ABUSE: CONNECTING THE STORIES IN THE NEWS*

Exploring the connections that can be made among three very recent stories in the news, which at first glance seem unrelated, can provide important insights and warnings. These stories are that “post-truth” is the Oxford English Dictionary’s word of the year. That the Victorian Government will introduce an “assisted dying” bill in the second half of 2017 which, if passed, would legalize physician-assisted suicide and, in exceptional cases, euthanasia. And that the Australian Law Reform Commission has just released a discussion paper which documents elder abuse in Australia and seeks ways to prevent it.

a) *“Post-truth”*

Here’s how Wikipedia describes “post-truth” in relation to politics: “Post-truth politics (also called post-factual politics) is a political culture in which debate is framed largely by appeals to emotion disconnected from the details of policy, and by the repeated assertion of talking points to which factual rebuttals are ignored. Post-truth differs from traditional contesting and falsifying of truth by rendering it [truth] of "secondary" importance.” Or, one could add, of little or no importance at all.

In contemporary societies we increasingly use the prefix “post”: post-industrial; post-modern; post-feminist; post-religious; and so on, and now post-truth. We know what we were, we know we are no longer that, but we don’t yet know what we now are or are becoming.

Words are the tools of both truth and lies, so words matter. Nowhere is this truer than in the euthanasia debate.

b) The euthanasia debate

Word changes can be subtle and nuanced. So, for instance, when, as has happened in promoting the legalization of euthanasia and physician-assisted suicide, more words are used to describe something that already had a name – euthanasia has become “physician assisted dying” and even the word death is dropped - we should know that we are being manipulated and something is being concealed. That something is the intentional infliction of death.

The strongest case for the legalization of euthanasia is made at the level of the suffering identified individual who wants to die when and how they choose. Pro-euthanasia activist Andrew Denton makes the case for legalizing euthanasia in this way in describing his father’s death. We feel compassion for his father and Mr. Denton, himself, for the suffering they both endured and our hearts rightly go out to them.

In a post-truth society feelings matter more than facts, the heart rules the head. So the facts about the larger impact of legalizing euthanasia – what it will mean for healthcare institutions, professions and professionals; how it will damage foundational societal values, such as respect for human life in general and the prohibition on intentionally killing another human being, except to save life; the impact in the future of normalizing euthanasia; and so on - are ignored or even denied.

Even hard factual evidence is rejected: In Canada the courts accepted the pro-euthanasia claim that in the Netherlands and Belgium, where euthanasia is legal, there was no “logical slippery slope” (the situations and persons eligible for euthanasia expand rapidly and very substantially once it is legalized) or “practical slippery slope” (euthanasia is carried out in breach of the law, especially on vulnerable people), when the evidence is clearly otherwise, as has been recognized by the Irish Supreme Court and most recently the Supreme Court of South Africa.

We can question whether the current “progressive values” stance of giving priority to respect for individual autonomy over upholding values, such as respect for life, needed to protect the common good, means that we have become a narcissistic society, one focussed just on individuals’ claims, and that the denial of facts which would cause us to reject those claims is a “narcissistic unawareness”.

I hasten to add here that I am not denying the importance of feelings - they are one of the central ways of “human knowing” - but facts are, at the least, equally important, not least because good facts are essential for good ethics and good ethics is essential for good law.

And so to the third story where facts are needed and serious concerns raised about the abuse of one group of vulnerable people, namely, the elderly.

c) Elder abuse

Here’s a 12th December 2016 ABC website headline: *“Elder abuse inquiry calls for power of attorney changes to stop children ripping parents off”*.

The post continues: “A national register of enduring powers of attorney should be established to prevent greedy children from using the document as a “licence to steal” from their elderly parents, the Australian Law Reform Commission (ALRC) says”, referring to an ALRC discussion paper which is part of its inquiry into elder abuse, which includes elderly persons being victims of financial fraud. The paper notes “the potential for pressure and coercion in setting up the instruments [the powers of attorney appointing children to act on their parent’s behalf]” and that “early inheritance syndrome” is on the rise.

“With Australians living longer than ever before, the ALRC inquiry heard many examples of children who were impatient to get their hands on their parents' money and tried to claim their inheritance before they were entitled to it.

This is often described as “early inheritance syndrome”.

“It's as if the current generation wants it now and somehow they justify that it's okay to take mum or dad's money right now,” said Aged and Disability Advocacy Australia CEO, Geoff Rowe.”

There are no concrete statistics on the prevalence of elder abuse in Australia, but a 2016 research report to the Australian Government Attorney-General’s Department states that

“at the international level, the WHO (2015) recently reported that estimated prevalence rates of elder abuse in high- or middle-income countries ranged from 2% to 14% ... and that the perpetrators are likely to be related to the victim... [and] one study suggests that neglect could be as high as 20% among women in the older age group (Australian Longitudinal Study on Women’s Health

[ALSWH], 2014). Older women are significantly more likely to be victims than older men, and most abuse is intergenerational (i.e., involving abuse of parents by adult children), with sons being perpetrators to a greater extent than daughters.”

d) Combined effect

So consider in a “post-truth” society the combined effect in relation to elderly persons of “pressure and coercion”, “early inheritance syndrome”, abusers’ self-justification of the abuse, 2% to 14% of elderly persons being victims of abuse, abusers being relatives, and women being more at risk than men, in the context of legalized euthanasia. At the very least, we should have second thoughts about whether legalization is a good idea.

ii) DENIAL OF “SCOPE CREEP” AND ABUSE IN EUTHANASIA: LOGICAL AND PRACTICAL SLIPPERY SLOPES

For a long time, it’s puzzled me how proponents of the legalization of euthanasia can confidently claim, as they do, that in the Netherlands and Belgium, the two jurisdictions with the longest experience of legalized euthanasia, there have been no slippery slopes, when the evidence is clearly otherwise.

a) Definitions

The “logical slippery slope” occurs when the legalization of euthanasia for a very limited group of people in very limited circumstances is expanded to include more people in more situations. This has been described as “scope creep”.

The “practical slippery slope” occurs when euthanasia is carried out in breach of the legal requirements as to either who may have access or the situations in which they must find themselves for euthanasia to be permissible.

b) Logical slippery slope

The logical slippery slope is inevitable once euthanasia is legalized and becomes common place, as we can see in what has happened in the Benelux

countries. It's been rapidly expanded to more and more people in more and more situations. This is entirely foreseeable and to be expected. As we become familiar with interventions which we once regarded as unethical, our moral intuitions and ethical "yuck" factor responses become blunted and we move from rejection to neutrality, often even to approval of the action involved.

Legalizing euthanasia means that the rule that we must not intentionally kill another human being – this line in the sand which we must not cross, this most ancient ethical and legal barrier – is breached, indeed annihilated, and beyond it there is no other obvious stopping line which we must not violate, perhaps not even that euthanasia is only acceptable with the consent of the person on whom death is inflicted. People with Alzheimer's disease and other dementias have been euthanized in the Netherlands and Belgium.

Anti-euthanasia adherents believe that the prohibition on intentional killing of another human being is a line we must not cross, not only, because intentional killing is inherently wrong, but also, because, as British moral philosopher Dame Mary Warnock has put it, "you cannot successfully block a slippery slope except by a fixed and invariable obstacle", in the case of euthanasia, the rule that we must not intentionally kill.

There could also be a further explanation for the denial of a logical slippery slope by pro-euthanasia advocates, such as Oxford University bioethicist Professor Julian Savulesco and Andrew Denton in his address to the National Press Club, screened on ABC TV and iView, which is less obvious at first glance. This is that no potential slippery slope exists.

The basis for the pro-euthanasia case is that we must have respect for an individual's autonomy – their right to self-determination - including with regard to a decision that they prefer death to continued life and want help in terminating their life. Once that rationale is accepted and applied in its fullest sense, it's difficult to justify restrictions on access to euthanasia. Consequently, the diminishment or repeal of existing restrictions is not recognized as a slippery slope, rather, it's seen simply as more fully implementing respect for individual autonomy and the right to self-determination - the rationale used to justify euthanasia in the first place.

Consequently, it should not be surprising that the Dutch are now considering a special form of access to intentionally inflicted death for those who believe they have a "completed life", which they do not want to call or

treat as euthanasia, although it involves the same type of death-inflicting intervention. The movement to legalize such an intervention started with a petition to the Dutch Parliament that those who were “over seventy and tired of life” should be able to have assistance in terminating their lives. The age requirement can be questioned as being inconsistent with the right to self-determination rationale for allowing the intentional infliction of death and it’s been reported that debate has begun in the Dutch media on eliminating it.

c) Practical slippery slope

Pro-euthanasia advocates’ denial of a practical slippery slope – administration of euthanasia other than in compliance with the law – despite clear evidence to the contrary, might also be able to be explained on a related basis. If one believes there should be more or less open access to euthanasia, then legal requirements are annoying impediments and their breach is a trivial matter and as the old saying goes “de minimis non curat lex” – the law does not concern itself with trifles.

Another element in this denial might be acceptance of the “non-deprivation justification” of euthanasia, which was considered approvingly by Canadian courts in ruling that an absolute prohibition of euthanasia was unconstitutional. The rationale of this argument is that a person’s quality of life can be so bad, that the bad in continuing to live outweighs any good experienced in doing so, such that nothing good is lost if one is euthanized – there is no deprivation of anything worthwhile or valuable - indeed death can be seen as a benefit.

A breach of the law which is seen as trivial and as conferring a benefit is unlikely to be characterized as an abuse by those supporting euthanasia and so, like the logical slippery slope, the practical slippery slope is defined out of existence.

iii) EVICTING RELIGIOUS VOICES FROM THE PUBLIC SQUARE IS ANTIDEMOCRATIC AND DISCRIMINATORY

a) “Label as religious and dismiss” strategy

The Australian reports “Denton tells church to get out of euthanasia debate” (August 11, 2016) and the ABC website that “Andrew Denton has

lashed out at a ‘subterranean Catholic force’ of politicians and businessmen who he claims continue to thwart attempts to allow legally assisted voluntary euthanasia in Australia.”

This is the “label as religious – in particular, Roman Catholic - and dismiss” strategy of pro-euthanasia advocates. It’s applied to both clergy and members of the public with religious beliefs. The strategy is founded on the argument that religious beliefs are unacceptable as an informing principle for values decisions other than purely personal ones, especially those decisions relevant to public and social policy, and, consequently, religious people’s voices should be excluded from the public square.

It’s a strategy used to avoid addressing the arguments or views of people with religious beliefs, whether or not their arguments and views are religiously based: They *and their arguments* are dismissed simply on the basis of having a religious affiliation. The assumption underlying this strategy and purportedly justifying it is that people who have religious beliefs are puppets of their Church - unthinking, uncritical automatons.

People like Mr. Denton, who use this strategy, overlook that everyone has a belief system. For example, secularism and atheism are belief systems, yet their adherents are not automatically dismissed for being such and should not be, because in a democratic society everyone has a right to a voice in the public square. To silence people because they are religious is anti-democratic and discrimination, just as silencing atheists and secularists would be.

If Mr. Denton has good arguments against his Catholic opponents’ positions he should present them and show why these Catholics’ arguments should not prevail, instead of trying to suppress them. Indeed, his efforts to do the latter raises the issue of whether he believes his arguments will fail if they are competently challenged.

b) Emotions and moral intuitions matter

The euthanasia debate involves ethical decision-making, therefore, not only reason, but also other human ways of knowing, such as “examined emotions” and intuition, especially moral intuition, play an important role. A wise axiom in applied ethics is that “we ignore our feelings at our ethical peril.” That is not to say we should act just on the basis of our emotional reactions, but that we must carefully examine these reactions and take them into account in ethical decision making.

We must react with compassion and care for people who are suffering from horrible illnesses, but our reaction should be to kill the pain and suffering, not the person with the pain and suffering.

Humans have an innate reluctance to killing another human being and rightly recoil from doing so. Indeed, in the past, soldiers have been psychologically deprogrammed in order to be able to kill an enemy soldier at close quarters. So might we need to be more concerned about the ethics of doctors willing to inflict death, than the ethics of those who refuse to do so for reasons of conscience or religious belief?

A case in point has arisen in Canada where euthanasia has recently become legal. Pro-euthanasia advocates are trying to force doctors with conscientious or religious objections to euthanasia to participate in it, which is clearly unethical and wrong. We should keep in mind that a doctor's good conscience is a patient's last protection.

c) Words matter

Our choice of language is important and influential with regard to emotional and intuitive responses. For instance, Mr. Denton's use of the word "subterranean" in describing "a Catholic force" brings to mind secret, dark, nefarious forces and conspiratorial activity.

Pro-euthanasia advocates such as Mr. Denton speak in the neutral terminology of "assisted death" (we all want medical assistance when we are dying). They assiduously avoid the language of doctors inflicting death on their patients or, even more graphically, being allowed to kill them, as these latter descriptions rightly raise many people's moral and ethical concerns about this practice.

Very recently, Mr. Denton announced the launch of a pro-euthanasia lobby group called "Go Gentle Australia". It sounds like a catchline in an advertisement for Kleenex or toilet paper.

d) Seeking meaning in suffering

Mr. Denton had a traumatic experience with his father's death and is seeking to have some good – his perception of what is good - come out of that. He wants to make sure that others will benefit from the suffering his father endured by trying to ensure that they do not experience the same suffering. In

short, he wants to give his father's suffering meaning. Seeking meaning, especially in suffering, is innate to being human.

However, euthanasia will seriously harm our capacity to find meaning in the face of death, not promote it. It converts the mystery of death to the problem of death and offers a quick-fix technological solution to the problem, a lethal injection.

In contrast, making available fully adequate access to high quality palliative care for every Australian who needs it will help people to find meaning in the last days of life until death occurs naturally.

I note here that seeking good for others out of a traumatic medical event, such as Mr. Denton and his father experienced, is a very common reaction of people who themselves or their child, spouse or parent have been the victim of medical malpractice. Failure to take all reasonable steps to relieve the pain and suffering, especially of terminally ill people, is medical malpractice and, as is recognized in the Declaration of Montreal 2010, a breach of fundamental human rights.

I also note that the case Mr. Denton describes in his submission to The New Zealand Parliamentary Health Select Committee of the dying woman, who was in excruciating pain but refused pain management until a certain pre-determined time represents a gross violation of ethical medical practice, unprofessional conduct, medical malpractice (actionable negligence) and possibly criminal negligence. (See the Declaration of Montreal on pain management, which has been affirmed by the World Health Organization and the World Medical Association, which represents 9 million doctors worldwide.) This patient needed competent palliative care, not a lethal injection.

e) Identifying wider and deeper issues

The strongest case for legalizing doctor-assisted suicide and euthanasia is the one Mr. Denton makes, that is, the relief of the suffering of individual competent adults who want and consent to this. But, in deciding as a society whether to legalize doctor-assisted suicide and euthanasia, we must look beyond what an individual might want and consider far wider issues.

Importantly, these include:

- the impact of euthanasia on fragile or vulnerable people – those who are old or live with disabilities, or even just perceive themselves as a burden on their families;
- the impact on suicide prevention of the normalization of suicide as an acceptable response to suffering; and
- what it means for society and our shared values to move from caring for those unable to care for themselves to killing them.

What would be the impact on important values, such as respect for human life, in general, in society? Respect for life must be upheld at both the individual and the general societal level.

If fully adequate palliative care is not available, what would it mean that we are saying “we will not care for you but we will kill you”? Religion used to carry the value of respect for life for society as a whole, but in a secular society, such as Australia, the institutions of law and medicine carry this value. How would their capacity to do this be affected by society changing the law to allow the infliction of death and permitting doctors to do that?

f) Outcome in practice of legalizing euthanasia

Finally, what would the practical reality be if euthanasia were legalized in Australia? Most advocates of euthanasia propose there’s no danger in legalizing it because it will be rarely used and only in extreme circumstances. Mr. Denton is reported as saying that “less than 4 percent of deaths in The Netherlands were as a result of assisted death”, seemingly, and quite astonishingly, as demonstrating that this is a rare outcome. But if the same rate applied in Australia as in The Netherlands, using the lower more accurate figure of 3.6 percent, there would be around 5000 euthanasia deaths each year. Are we prepared to allow that? Can we live with it?

iv) THE IMPORTANCE OF STORIES IN THE EUTHANASIA DEBATE

a) Making the pro- and anti-euthanasia cases

The pro-euthanasia case is compact and quick and easy to make: It focuses on a terminally ill, seriously suffering, competent adult who gives informed consent to euthanasia and bases its claims to prevail on the obligation to respect that person's right to autonomy, self-determination and dignity.

The case against euthanasia is more complex and time-consuming to establish. It requires placing euthanasia in a much wider context that takes into account, among many other considerations, what its impact would be, not only in the present, but also in the future, and what protection of both vulnerable people and society demands.

b) Clash of values

Euthanasia involves a clash of two important values: respect for individual autonomy and respect for life. Pro euthanasia advocates give priority to autonomy; anti-euthanasia proponents to respect for life.

Respect for life is not just a religious value as pro-euthanasia advocates argue. All societies in which reasonable people would want to live must uphold respect for life and at two levels: Respect for every individual human life and respect for life in society in general. Even if legalizing euthanasia were viewed as not contravening the former, it seriously harms the latter.

Both the pro- and anti- euthanasia sides in the euthanasia debate are trying to persuade the public to affirm their stance. So how are they presenting their cases to the public?

c) Shared "death stories"

We form and support or reject the shared values on which we found our society, in part, by creating stories that we tell each other and buy into, in order to create the glue that binds us together as a community.

The pro-euthanasia case relies on "bad natural death" stories - stories of the extreme suffering of some terminally ill people who die a natural death - and characterizes and promotes euthanasia as an essential-to-provide kindness and its prohibition as cruelty.

Anti-euthanasia advocates often counter these stories with "good natural death" ones of people dying naturally and peacefully, in the presence of those they love, feeling that they have had a completed life. ("Good death" stories do not assume that death can be good, but rather that the process of dying a natural death can be "good" or "bad" and that we can to a large extent

influence which of these it is by the physical, psychological and spiritual care that we provide to the dying person.)

But there are also some “bad euthanasia death” stories, which support arguments against legalizing euthanasia. One, by journalist Guilia Crouch, was posted on the Mailonline on 28th January 2017. (<http://www.dailymail.co.uk/news/article-4166098/Female-Dutch-doctor-drugged-patient-s-coffee.html>.) It gives an account of the following facts:

Last month, a Dutch Regional Euthanasia Review Committee reported on a case brought before it: The woman patient had dementia. A woman doctor put a sedative in her coffee as a prelude to euthanizing her. The doctor said she didn’t tell her of the sedative or her plans for euthanasia, “because she did not want to cause her [patient] extra distress”. In deciding to euthanize her patient, the doctor was relying on a phrase in the patient’s declaration in her will that she could consider euthanasia “when I myself find it the right time”.

While being injected with the lethal drug, the woman woke up. She struggled and the only way the doctor could continue with the injection was by asking the woman’s family to help to restrain her, while she continued with the injection. The woman’s case notes recorded that she had said several times during the previous days, “I don’t want to die”.

The review committee concluded that the doctor “had crossed the line” by secretly giving the sedative and not stopping the injection when the woman resisted and had too broadly interpreted the woman’s declaration, but that the doctor had acted in “good faith” and should not be punished.

However, the chair of the review committee wants the case brought to court to create a precedent to enable other doctors to lethally inject people with dementia, without fear of legal repercussions.

d) So what can we learn from this story?

Even if we believe that euthanasia is not inherently wrong, its risks and harms to vulnerable people – those with disabilities, the elderly and the fragile - outweigh any benefits.

I have written previously, about the Australian Law Reform Commission’s research on elder abuse - between 4 and 14 percent of old people are abused most often by a close relative. It’s hard to imagine a more extreme form of

abuse than helping a doctor to euthanize an elderly relative by restraining the “loved one” who doesn’t want to die.

The Commission was concerned in particular about “early inheritance syndrome”, where a person, usually a child of the old person, obtains a power of attorney and uses the financial assets of their parent for themselves.

Many people worry about the cost of residential care for their elderly relatives and heirs see “their” inheritance, to which they feel entitled, dissipating. Many old people say they would rather be dead than go into a nursing home. Imagine adding euthanasia to this situation – it would certainly be a lethal cocktail.

e) Moral hazards

Euthanasia is, what is called in ethics, a moral hazard – that is, it opens up possibilities of breaches of ethics, such as I’ve just described.

A response might be that the moral hazard risk of euthanasia can be avoided if only assisted suicide is legalized. But it too is a moral hazard. Research shows that high on the list of reasons people want to die is that they feel that they are a burden on loved ones and there is an ever present danger of coercion.

There is also a broader moral hazard from assisted suicide: the general suicide rate has increased in jurisdictions that have legalized assisted suicide. (<http://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide/>; <http://alexschadenberg.blogspot.ca/2016/03/rushing-toward-death-euthanasia-in.html>) This is not surprising: state sanctioned assisted suicide endorses suicide as an appropriate response to suffering and suicide is contagious. Suicide is also the leading cause of death in young adults. This is a serious and major public health concern, which legalizing assisted suicide would only magnify.

How could this Dutch doctor have done what she did? That same question has been pondered over and over again in relation to the Nazi doctors.

It’s a result of a process of incremental desensitization of the doctor to what is involved: namely, killing her patient.

This desensitization results from multiple factors: Placing the “white coat” of medicine on euthanasia carries with it messages of the ethical validity of

euthanasia and its kindness. The language used to describe euthanasia is massaged and euphemized. The doctor is blinded by a conviction that this is best for the patient and she's only doing good for her. The doctor has no conscious recognition that this is not medical treatment and that she is acting contrary to medicine's healing mandate and beyond the proper goals of medicine.

The doctor's equanimity may, however, be only on the surface. At a deeper level of the psyche, carrying out euthanasia may have harmful impact on healthcare professionals. Doctors in the Netherlands and Canada are opting out because they are suffering mental trauma, including PTSD, from providing it. Some Canadian doctors who placed their names on a list of doctors willing to provide euthanasia withdrew their names after undertaking their first case saying it was too traumatic for them and they never wanted to do it again. (http://alexschadenberg.blogspot.com.au/2017/02/canadian-doctors-are-struggling-with.html?utm_source=EPC+Contacts&utm_campaign=b51a17a348-EMAIL_CAMPAIGN_2017_02_15&utm_medium=email&utm_term=0_d113c154ac-b51a17a348-157716225)

This too is not surprising: Doctors are trained to heal and save life wherever possible, not to intentionally take life. And all mentally healthy human beings have a powerful instinct against killing another human being.

We must never ignore the heart wrenching pleas of both those who are suffering and those who love them and want the loved one's suffering ended. But we must kill the pain and suffering, not the person with the pain and suffering.

v) SHUTTING UP BY SHOUTING DOWN: THE SUPPRESSION OF ANTI-EUTHANASIA STORIES: RESPECTING BOTH SIDES FREEDOM OF SPEECH IN THE EUTHANASIA DEBATE

a) The context

Very recently, I was a participant in a Q&A panel on "Voluntary Assisted Dying" at the Australian Medical Association Victoria Congress 2017. I was

pleased to have been invited and hopeful that there would be a balanced discussion, but also somewhat concerned that might not be realized in practice, given the membership of the panel.

The panel participants included the well-known advocate of the legalization of doctor-assisted suicide Andrew Denton and the leader of the Greens, Senator Richard Di Natale, who also supports its legalization in certain circumstances.

Unfortunately, my concerns materialized.

b) The events

First, my participation in the discussion was limited in several ways. Shortly before the event, the chair telephoned to tell me that the question of whether or not legalizing doctor assisted suicide or euthanasia was a good or bad idea, ethical or unethical, was not open for discussion.

She explained that the only topic to be discussed was the conditions which should apply for access to assisted suicide and how it should be regulated. In short, the panel was based on an assumption that legalizing assisted suicide was inevitable in Victoria, even though legislation has not yet been tabled in the Victorian Parliament, let alone debated or enacted. This assumption is a pro-assisted suicide/euthanasia strategy as it leads people to believe there is no point in discussing views opposing legalization.

Legislative bodies only regulate conduct that they and the community consider to be ethical under certain conditions and they regulate to set out those conditions. We prohibit conduct we believe to be inherently unethical, as those who oppose euthanasia believe it to be. Consequently, discussing regulation affirms the ethical acceptability of assisted suicide and euthanasia.

On more than one occasion, I was told by the chair that I had been invited as a lawyer and not an ethicist, despite the fact that the latter has been my main professional role for forty years. Given this proviso, it was not unexpected that the questions addressed to me from the chair were purely legal ones; for instance, I was asked to define mental capacity and dignity. This gave me speaking time and an appearance of fair time allocation among panellists, without my necessarily being able to address the anti-assisted

suicide/euthanasia arguments I wanted to propose, but I took the opportunity to present briefly some of them.

A theme developed by the panellists who agreed with legalizing assisted suicide was that being absolute on the issue of its legalization is “not helpful” and that the voices in the public square debate should be those of reasonable people who were not absolutists. This, in fact, amounts to another pro-euthanasia strategy, because if one is not against the legalization of assisted suicide or euthanasia, one is necessarily for it in some form. While some people might be uncertain where they stand, and many people say they are, there is no entirely neutral position.

At the beginning of the event, the chair told the audience that they should text questions to her and that she would collate and present them; those who did not have an iPhone were told they should raise their hand and ask the question in person. She added that if the questioner spoke for too long or was presenting commentary or policy, rather than a question, the audience could shout “No, no, no!” and she would cut off the person.

It seems reasonable to assume this invitation was offered only in relation to an audience member asking a question. But when I prefaced an intervention by saying that I wanted to describe a case of euthanasia that showed its risks and harms, the chair interjected and said “No stories please”, and a substantial percentage of the audience immediately joined in to shut me down, shouting, “No, no, no, no stories”.

In forty years of giving speeches on average around twenty five to thirty times a year, I have never encountered such an incident. Moreover, bear in mind that I was an invited guest speaker sought out by the AMA to be a Q&A panellist at the congress and the audience were all, or almost all, medical doctors.

This behaviour does not fulfil the requirements of respectful discussion. Indeed, it is designed to stifle, rather than facilitate, debate on an important social and medical issue, and I felt intimidated.

A positive aspect of the panel was that Andrew Denton - one of the very few people present who was not a medical doctor - did behave respectfully with regard to my anti-euthanasia arguments and towards me. And a positive and important message, delivered by the gerontologist and psychiatrist on the panel, was that we shouldn't even be talking of legalizing euthanasia until we

have fully adequate palliative care available to all who need and want it, which is far from the case at present in Australia.

In summary, I experienced this panel as involving silencing and intimidation and a failure to respect freedom of speech.

c) Self-censorship

Many people with traditional or conservative values, especially young people, when they encounter such experiences respond by self-censoring. They tell me, privately, that they share some of the values I present, but would never say so publicly for fear of being ridiculed or shamed or, even, not being employed or promoted. The same is true of many conservative politicians who fear losing votes.

Indeed, I had initially decided not to publish this article for fear that I and the case against doctor-assisted suicide and euthanasia would be discredited by being characterized as extreme and summarily dismissed. But then I realized that I, too, was falling prey to self-censorship.

We should also always keep in mind in the euthanasia debate that whether we are pro- or anti- legalizing doctor-assisted suicide and euthanasia, we have a common goal of relieving suffering. Where we disagree is the limits on the means we may use to do this. As I've written elsewhere, I believe we should kill the pain and suffering, not the person with the pain and suffering.

d) The wider consequences

The vignette that I describe has wide moral and ethical implications in relation to the quality and character of public debate, which is essential to a healthy democracy and maintaining a society in which reasonable people would want to live.

Perhaps one of the most disturbing aspects of this event is that it was an Australian Medical Association Victoria congress and, as I've noted already, almost everyone present, whether as speakers or in the audience, was a medical doctor. In secular, democratic, pluralist, multi-cultural societies like Australia, medicine is a major values-creating and values-carrying institution for society as a whole, because it is one of the few institutions to which we all personally relate. That means it must be open to taking into account the full range of people's commitments and values systems.

We need to ask whether, in the organization and conduct of this doctor assisted suicide-euthanasia panel, the AMA Victoria lived up to its responsibilities in this regard.

vi) LESSONS FROM INDIGENOUS WISDOM IN THE EUTHANASIA DEBATE

a) Looking to the past and the future in deciding about legalizing euthanasia

Some time ago, I was a member of an ethics committee set up as part of the Nuclear Waste Management Organization established by the Canadian Government to advise it on how it should deal with the complex issue of the disposal of nuclear waste.

At the first meeting of the committee, the chairperson asked us each to introduce ourselves and to make some brief remarks relevant to the disposal issue.

George Erasmus, who was the national chief of the Assembly of First Nations from 1985 to 1991, was a committee member. When it came to his turn, after a long moment of silence, George said softly, “Well if it had been up to us, we would never have been in this position, because we would never have allowed the technology that results in nuclear waste. We would have looked back seven generations for lessons from our ancestors and looked forward seven generations to its risks and harms to future generations and decided against its use.”

George’s words came to mind as wise advice for those of us engaging in the legalization of euthanasia debate currently raging in Australia. They struck me as especially *a propos* in light of the fact that Aboriginal and Torres Strait Island and First Nations communities in Australia and Canada, respectively, are, in my anecdotal experience, uniformly and adamantly opposed to euthanasia. What might these indigenous communities be perceiving that pro-euthanasia advocates are not?

Looking back seven generations is to consult history or, as John Ralston Saul evocatively calls it, “human memory”.

Since the time of Hippocrates 2,400 years ago, medicine has a history of the absolute prohibition of physicians intentionally killing their patients. Why now do some people want to abandon this foundational value guiding the practice of medicine?

We have always been faced with death and suffering and have never seen euthanasia as ethically acceptable medical treatment or, indeed, as medical treatment. Why then, when there is so much more we can do to relieve suffering, might our society suddenly think it is a good idea to allow doctors to inflict death? The contributing factors are multiple and complex, but at base the cause is a sole focus on upholding the individual's absolute right to autonomy and "choice", to the exclusion of other balancing considerations that should be taken into account.

b) The need to protect individuals AND the common good

These other considerations include what approach is needed to protect the common good, that is, the well-being of the community as a whole, not just the wishes and claims of an individual person, important as these are. The cultures of indigenous peoples are more cognisant of this need to protect the community and attuned to it, which could be one reason they reject euthanasia.

Pro-euthanasia advocates adamantly reject that the history of the Nazi horrors has anything to teach us and scorn anyone who dares to suggest that, when judiciously examined, it might provide insights and warnings. It's true that we will not see a Holocaust resulting from the legalization of euthanasia, but some of the origins of the Holocaust - in German doctors' involvement in small, allegedly well-motivated and compassionate medical acts and the justifications used to validate these acts - carry serious warnings that deserve attention in the current debate.

In using their imaginations to look forward seven generations in order to be warned of future harms and risks to their descendants, indigenous communities are again seeking to protect not only individuals, but also the community. How a person dies, when death is caused by euthanasia, affects not only that person, but also unavoidably affects others and the community, and not just in the present but also in the future.

To summarize, the strongest case for legalizing euthanasia is based in radical individualism and "presentism". It focuses on a suffering, competent

adult individual who asks for and gives informed consent to euthanasia to the exclusion of the impact on the community of allowing euthanasia, and ignores what we could learn from considering it in the context of both the past and the future.

c) Questions we must address

So in deciding about legalizing euthanasia we should learn an important lesson from indigenous wisdom and ask ourselves questions which include: How do we *not want* our great-great-grandchildren to die? What must we *not do* now if we are to leave to future generations a society in which reasonable people would want to live? Would an Australian society in which euthanasia had become a norm be such a society?

In thinking about that last question, further realities can be brought to light. If, as Andrew Denton claims, Australia will have the same rate of deaths by euthanasia as the Netherlands and Belgium, around 4 percent of all deaths, that will result in around 6000 euthanasia deaths annually, which would make euthanasia the sixth leading cause of death in Australia. It would fall between respiratory diseases and diabetes on the Australian Bureau of Statistics “Causes of Death 2015” list, and there would be 25 percent more deaths by euthanasia than from diabetes, five times the number of deaths from road accidents (1200 per annum) and twice the number of deaths from suicide (3000 per annum). Could Australians accept that?

The population of the Victorian town of Lakes Entrance is just under 6000. Would they be comfortable with wiping out with euthanasia each year the same number of people who presently live in that town?

vii) THE FLIGHT FROM MYSTERY: CHOICE, CONTROL AND FINDING MEANING AT THE END OF LIFE: THE CHALLENGE OF EUTHANASIA

a) “Choice, change and control”

People who espouse “progressive values”, who include those advocating for the legalization of euthanasia, adopt a mantra of “choice, change and control”.

Choice maximizes respect for individual autonomy which is the preeminent value of “progressivists”. Choice also allows change to be implemented and “progressivists”, often naïvely, simply assume that change is always for the better. And power to change can give one a power to control or at least an illusion that one is in control.

Why only an illusion? There are some things that we cannot control, or indeed change, no matter how much we might like to be able to do so. Death is one of them.

It’s an innate human characteristic to search for meaning and we do that whether or not we are religious. The questions the vast majority of us ask, “Who am I?” “Why am I here?”, manifest and articulate our search for meaning. Many of us recognize that there is a mystery at the centre of our responses to those questions, which are asked most powerfully in seeking meaning in relation to death. Consequently, death involves a mystery which we must accommodate. We can do that in various ways.

Euthanasia seeks to take control over death. It does so, as I’ve noted previously, by converting the mystery of death to the problem of death and offering a technological solution to that problem, namely a lethal injection. In doing so, it destroys the mystery of death and, thereby, the possibility of finding meaning in the presence of death.

I want to make clear that I am not promoting religion here, although that is one way, and was until the post-modern era the most common way, to find meaning, in particular in death. Rather, I am proposing that all of us need to be able to find meaning, if we are not to become nihilists and lead a life of despair. Today, many people find meaning in life by devoting themselves to a worthy cause that benefits others, including future generations, but that doesn’t help them to find meaning in death.

What I am proposing is that one of the serious harms of legalizing euthanasia is the intangible one of serious damage to our capacity to find meaning in death, which might be a requirement for finding meaning in life, in general. This might be caused, at least in part, by euthanasia’s impact of trivializing death.

b) The importance of shared stories, intimacy and leaving a legacy

We hear many stories of “bad deaths” told in support of legalizing euthanasia. Our hearts rightly go out to the people involved and we recognize that their motives of relief of suffering are good. But if we do not want to set in motion a much wider range of harms that legalizing euthanasia unavoidably causes, I propose that we must kill the pain and suffering, not the person with the pain and suffering. This makes it imperative that fully adequate palliative care, including pain management, be readily available to all who need it.

We should also balance the stories of “bad deaths” with those of “good deaths” – or perhaps it’s better phrased as deaths from which otherwise unavailable “goods” flow, not only to the dying person, but also, to many others. These include conversations that would never have taken place, reconciliations with family and long lost friends, and joys such as holding a first grandchild. French psychoanalyst Marie de Hennezel, who has cared for many dying people including President Francois Mitterand, describes this time and its possibilities as “intimate death”.

When we are dying, the vast majority of us also want to be remembered, to leave a legacy of our presence on this planet, and as Canadian psychiatrist Dr. Harvey Max Chochinov and his co-researchers have shown, we can help people to do this through a structured psychotherapeutic intervention which they call “dignity therapy”. This is an alternative to seeing euthanasia as necessary to respect a dying person’s dignity, a frequent justification of legalizing euthanasia.

c) Managing terror of death

Social psychologists propose that not just individuals, but also societies have a psyche and that both can experience terror. When we have a strong free-floating fear of something, for example, death, we seek to take control of it to reduce our fear and anxiety. The social psychologists speak of responding with “terror management devices” or “terror reduction mechanisms”. I believe euthanasia can be seen as such a device or mechanism for managing the fear of death. We can’t avoid death, but euthanasia allows those who seek it to get death before it gets them.

As individuals and a society we hide death away by euphemising the word. It is almost “politically unacceptable” to use “death”, “died” or “dead” in

relation to a person's "passing". We hide from our fears, which hinders our own preparation for death. We could also see euthanasia as limiting the capacity of a dying person to help to prepare others for a "good death" by showing them what used to be called "ars moriendi" (*the art of dying*). We have lost "death literacy".

d) Need for a deeper and broader societal conversation

Our conversation about whether it's a good or bad idea to legalize euthanasia needs to be much broader and deeper than it is at present. It's not sufficient just to focus on an individual suffering person who wants death inflicted, much as we must have the most sincere compassion for them and ensure that everything possible, other than killing them, is done to relieve their suffering.

Euthanasia raises profound issues about how we find meaning in life; its impact on law and medicine, the two institutions in a secular society which carry the value of respect for life for society as a whole; and its impact on one of our foundational values as a society, namely, that we must never intentionally kill another human being, except to save human life. Such considerations and many more must be taken into account in our decision making about legalizing euthanasia, if we are to act wisely and ethically. At present, the debate is very superficial and narrow and reduces one of the most solemn moments of life to a mere contractual undertaking.

CONCLUSION

Legalizing euthanasia would be a seismic shift in Australia's foundational societal value of respect for human life. It is different-in-kind not just different-in-degree from medical interventions we currently regard as ethical and legal. It is not, as pro-euthanasia adherents argue, just another small step along a path we've already taken in respecting refusals of treatment even if that results in death and requiring fully adequate pain management to be offered to patients. Euthanasia rebrands killing as kindness, which is very dangerous.

In deciding whether to legalize euthanasia we should keep in mind the axiom that "nowhere are human rights more threatened than when we act purporting to do only good", as that sole focus on doing good blinds us to the unavoidable risks and harms also present.

Margaret Somerville

Professor of Bioethics

The University of Notre Dame Australia

School of Medicine (Sydney Campus)

13th March 2017



HammondCare

An independent Christian charity

7 September 2017

The Hon. Greg Donnelly MLC
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr Donnelly,

This letter is to request your immediate review, and encourage your ultimate rejection of, the proposed NSW Voluntary Assisted Dying Bill 2017. This Bill fails to address the underlying reasons that people request assisted suicide and euthanasia, and undermines the value that we as a community place on human life.

The impacts of the changes proposed within the Bill will extend well beyond the individuals requesting medical assistance to hasten death. Should it pass, there is a grave risk that older people and those living with disability or life limiting illness will feel worthless and burdensome or be exposed to unprecedented pressure from family or society at large to end their life.

Evidence from overseas suggests that certain groups – including older people and people with disabilities – are particularly vulnerable to legislative creep. For example, in the Netherlands, the people able to access euthanasia has expanded significantly since legislation permitting hastened death was first introduced. Last year, more than 400 people in that country died by euthanasia as a result of dementia, psychiatric reasons and “advanced age”. In October 2016, the Dutch government signalled an intention to draft a law to legalise assisted suicide for people who feel they have “completed life”, while in Belgium, people under the age of 18 may utilise assisted suicide laws.

More must be done to remedy the fact that too many people endure “bad deaths”, suffering pain and other symptoms, a lack of dignity and emotional turmoil. However the solution does not lie in hastening death. Instead, the focus must be on improving end of life care through high quality palliative care services. Palliative care provides holistic relief from pain and other distressing symptoms while also supporting the psychological, emotional, spiritual and existential needs that often lead to requests for assisted suicide or euthanasia. In fact, based on the experience of HammondCare’s palliative care specialists, no request for assisted suicide should truly be considered informed when the person making it has not engaged meaningfully with palliative care services.

HammondCare

Level 2, 447 Kent St, Sydney NSW 2000

P +61 2 8280 8444 • F +61 2 9267 3103 • www.hammond.com.au

HammondCare is an independent Christian charity ABN 48 000 026 219

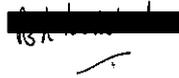
We have enormous sympathy for those who endure suffering at the end of their life. We also believe wholeheartedly in the benefits of high quality palliative care. Greater investment in palliative care research, education, training and services in a range of settings for all Australians is essential. This is where our attention and resources must be directed. To commit to killing, even on a person's voluntary request, detracts from this need and fails our most vulnerable.

We urge you not to support this Bill and would welcome the opportunity to discuss this important topic further.

Yours sincerely,



Dr Stephen Judd
Chief Executive
HammondCare



Prof Roderick MacLeod
Senior Palliative Care Physician
HammondCare

About HammondCare

HammondCare is an independent Christian charity specialising in dementia and aged care, palliative care, rehabilitation and older persons' mental health.

Regarded nationally and internationally as one of Australia's most innovative health and aged care providers, HammondCare offers hospital care, residential care and community services.

Dr Doug Bridge
BMedSc(Hons), MBBS(WA), FRACP, FRCP, FACHPM, DTM&H
Consultant Physician
Clinical Professor, School of Medicine and Pharmacology,
University of Western Australia
Provider number 18895AF

East Fremantle Medical Centre
██████████, East Fremantle 6158
Tel ██████████

11th September 2017

The Hon. Greg Donnelly
Parliament House
Macquarie Street
Sydney
NSW
2000

Dear Mr Donnelly,

My name is Douglas Bridge and I am writing to you regarding the Voluntary Assisted Dying Bill 2017 that is expected to be introduced into the Legislative Council on 14th September. Although I live and work in Western Australia I, along with many others who practice specialist palliative medicine across Australia, are watching closely the developments in your state and Victoria regarding the proposed euthanasia and physician assisted suicide legislation. Outcomes in these two large jurisdictions are likely to have an impact on what happens in other states and territories, including my own, as similar bills come before them in due course.

Earlier this year in March a piece that I wrote entitled "Palliative care, euthanasia and physician assisted suicide" was published in the Medical Journal of Australia publication Insight. The piece was co-signed by 32 colleagues who, like myself, practice in the field of specialist palliative medicine. Attached for your reference is a copy of the article. The following link will take you to the publication itself where you can access information, publications and documents cited in the piece <https://www.doctorportal.com.au/mjainsight/2017/10/palliative-care-euthanasia-and-physician-assisted-suicide/>. I encourage you to, if you can find the time, to go to the links in the article and read through the source material. I believe that you will find the material both informative and helpful.

If you would like to discuss in more detail any matters raised in the Insight piece or indeed anything related to the forthcoming debate on the bill, do not hesitate to contact me on (08) ██████████ or by email: ██████████

Yours sincerely



Doug Bridge
Dr Douglas Bridge, BMedSc (Hons), MBBS, FRACP, FRCP, FACHPM, DTM&H
Emeritus consultant, Royal Perth Hospital
Clinical Professor, School of Medicine and Pharmacology, University of Western Australia
Consultant Physician, WA Country Health Service
Past President, Chapter of Palliative Medicine, Royal Australasian College of Physicians

Palliative care, euthanasia and physician assisted suicide

IN his opinion piece in *MJA InSight*, Professor Emeritus Ian Maddocks proposes an integration of palliative care, euthanasia, and physician assisted suicide (EPAS). As palliative care practitioners, we know this supposed common ground is both a contradiction in terms and contrary to sound medical practice.

From our experience of caring for people who are ill and vulnerable, legalising EPAS is unnecessary and unsafe.

Despite its inevitability, dying is not a popular topic for discussion in Australia today. In the words of American surgeon Dr Atul Gawande, we have “forgotten that we are mortal”. Death is not a medical or pharmacological event. It remains instead a profound mystery and the natural end of the complex journey of life. It is universal yet unique, personal but communal. It affects us all.

Dying can be traumatic, terrifying and painful for the patient, and challenging for the grieving family. In the face of inevitable death, some patients are willing to explore improbable alternative therapies, or burdensome or experimental treatments that may have a very low success rate. If people insist that “everything be done”, they are likely to die in the medically confronting environment of an intensive care unit, possibly prolonging the process of dying itself.

Good palliative care helps patients and families avoid both overtreatment and neglect of treatment. It enhances patient autonomy and decision-making capacity by improving symptom control and empowering patients to participate in their care. We affirm the patient’s right to choose their therapy; decline futile therapy; choose the place of dying; choose who should be present; receive the best possible relief of symptoms, even, on rare occasions, deliberate palliative sedation (not terminal sedation); and refuse to prolong the dying process. Ideally, this should be readily available for all those with life-limiting illness.

Autonomy does not include the right to demand that a clinician kills the person. Contrary to public opinion, the use of therapeutic doses of analgesia or sedation in order to relieve difficult and intractable discomfort does not hasten death and is not a form of euthanasia. Appropriate end of life prescribing of analgesia is simply good clinical practice when the patient is actively dying.

Supporting people when they are dying is utterly different to intentionally causing them to die. What Professor Maddocks calls “a single effective intervention” is in fact an act of killing.

The term “voluntary assisted dying” conceals the true nature of what is proposed in the bill before the Victorian parliament. The patient’s dying is not assisted; rather, a doctor is required to kill the patient or to help the patient commit suicide. The word “voluntary” attempts to emphasise the patient’s autonomy. Ironically, EPAS legislation weakens patient autonomy by devaluing the final stages of life. Further, overseas experience has shown that supposed safeguards within these laws do not effectively guard the autonomy of those most vulnerable to the extension of these laws.

In an attempt to make EPAS publicly acceptable, its proponents sanitise the language, using euphemisms such as “voluntary-assisted dying” and “go gentle”. However, the inconvenient truth remains that at the heart of EPAS, the action of the doctor is to end a patient’s life or assist patients to kill themselves. This has profound ramifications for all health professionals. “Do not kill” has been a core ethical principle of every civilisation and the practice of medicine; we violate it at society’s peril.

Quality health care manages the causes of patients’ distress rather than ending life. In our experience, requests to terminate life prematurely are uncommon and often a cry for help. Such requests rarely spring from uncontrolled pain, but rather from despair, a sense of loss of control, or fear of being a burden to others. Evidence shows that a person’s desire for hastened death changes over time and reduces when care is good. It is illogical and immoral to even consider euthanasia legislation before ensuring there is universal access to palliative care. The 1990 World Health Organization definition states that palliative care affirms living and dying as a normal process, and “neither hastens nor defers death”. Likewise, after extensive research and consultation, the Australian and New Zealand Society for Palliative Medicine (ANZSPM) issued a position statement on EPAS in 2013.

This statement affirmed that:

- the discipline of palliative medicine does not include the practice of EPAS; and
- ANZSPM opposes the legalisation of EPAS.

In the Netherlands, often quoted as a euthanasia success story, so many doctors have refused to kill their patients that the government has established mobile euthanasia teams to perform EPAS across the country. Doctors in Canada are increasingly requesting to be removed from “assisted dying” lists. The legalisation of EPAS results in great harm to vulnerable individuals, families, the community and health professionals.

Paradoxically, it is in dying naturally that many people find healing and realise what is truly important in their lives. They may experience profound personal growth and family reconciliation. Indeed, as Canadian surgeon, Professor Balfour Mount, who coined the term “palliative care” wrote: “It is possible to die healed”.

We write as an informal network of Australian and New Zealand practitioners in palliative care. We do not represent any particular organisation, institution or philosophy. Some of us have practised palliative medicine for more than 30 years. We acknowledge that death, like birth, can be distressing and messy. We are deeply concerned at the increasingly determined attempts to legalise the practice of EPAS.

We believe that these attempts may be sincere and well meaning, but unfortunately are based on ignorance and misunderstanding. The first step towards a clear understanding of the issues is to use clear, unambiguous terminology. Irrespective of whether EPAS is legalised in Australia or New Zealand, EPAS has no part in the ethical and professional practice of palliative medicine.

Professor Douglas Bridge is an Emeritus consultant at Royal Perth Hospital, clinical professor in the University of Western Australia’s School of Medicine and Pharmacology, a consultant physician with WA Country Health Service, and is past president of the Chapter of Palliative Medicine, Royal Australasian College of Physicians. He writes on behalf of the following cosignatories:

Dr Simon Allan, Arohanui Hospice, New Zealand
Dr Megan Best, University of Sydney, University of Notre Dame, NSW
Dr Mil Chan, North Adelaide, SA
Dr Louis Christie, Orange Health Service, Palliative Care Service, NSW
Professor Richard Chye, St Vincent's Clinical School, University of NSW
Dr Maria Cigolini, Royal Prince Albert Hospital, Chis O'Brien LifeHouse, University of Sydney, NSW
Professor Katherine Clark, North Sydney Cancer Centre, Royal North Shore Hospital, University of Sydney, NSW
A/Professor Josephine Clayton, HammondCare, University of Sydney, NSW
Professor Sinead Donnelly, University of Otago, Victoria University of Wellington, New Zealand
Dr Derek Eng, University of Western Australia
Dr Anthony Herbert, Lady Cilento Children's Hospital, QLD
Dr Annmarie Hosie, University of Technology Sydney, NSW
Dr Suharsha Kanathigoda, Canberra, ACT
Dr Martin Kennedy, Lady Davidson Private Hospital, Calvary Hospital, NSW
Professor David Kissane, Monash University, VIC
Dr Amanda Landers, University of Otago, New Zealand
Dr Lynn Lim, Royal Prince Alfred Hospital, Chris O'Brien LifeHouse, NSW
Professor Melanie Lovell, HammondCare, University of Sydney, NSW
Professor Roderick Macleod, HammondCare, University of Sydney, NSW
Dr Yvonne McMasters, palliative medicine specialist and activist, NSW
A/Professor Natasha Michael, Cabrini Health Monash, University of Notre Dame, VIC
Dr Wendy Muircroft, Southern Adelaide, SA
Professor Ian Olver, Sansom Institute for Health Research, University of South Australia
Dr Riona Pais, Royal Prince Alfred Hospital, University of NSW
Dr Lawrie Palmer, University of Adelaide, SA
Dr Laura Pearce: South Coast, NSW
Professor Jane Philips, University of Technology Sydney, NSW
Professor Peter Ravenscroft, University of Newcastle, NSW
CNC Joan Ryan, Royal Prince Alfred Hospital, Chris O'Brien LifeHouse, University of Sydney, NSW
Dr Merlina Sulistio, Cabrini Health, VIC
Dr Sarah Thompson, HammondCare, NSW
Dr Sarah Wenham, Broken Hill Hospital, NSW

Plunkett Centre for Ethics

A joint centre of St Vincent's Hospital and Australian Catholic University

Victoria Street
Darlinghurst
NSW 2010

Phone: 02 [REDACTED]

Email: [REDACTED]

12 September 2017

The Hon. Greg Donnelly, MLC

Parliament House

Macquarie Street

SYDNEY NSW 2000

Dear Mr Donnelly

I am writing to you about the **Voluntary Assisted Dying Bill 2017 (Public Consultation Draft)**. May I draw your attention to some things about it.

Misnomer

First, a note about the name of the Bill. Competent and humane doctors *regularly* help their patients to die in comfort and with dignity. So the name of this Bill is a misnomer. Competent and humane doctors treat pain and physical suffering (which can *always* be done successfully *if* the doctor is properly trained and if he or she is *really* prepared to respond to the needs of each patient). This is a Bill to legalize, in certain circumstances, doctors assisting their patients to commit suicide. Whatever your views on this Bill, I do hope that you will not allow yourself to be taken in by its name. That name is intended to *hide* what is really proposed.

Lack of access to palliative care in NSW

You will be aware of the recent report from the Audit Office of the state of palliative care in NSW. Amongst its dismaying findings is the fact that NSW does not have in place a policy to ensure monitoring of *access* to competent palliative care. No wonder just about everyone has a story about how his or her relative or friend had to suffer pain and discomfort as they died. The problem is that, in NSW, some people receive excellent care as they approach death, other people miss out (and thus die badly). This is a disgrace. We should not even *consider* whether to authorize doctors to help people commit suicide until we can

truthfully say that everyone in NSW has a *genuine chance* to receive competent and humane end of life care.

Confuses medical problems with social problems

The Bill would allow a doctor to provide assistance in suicide to a person '*suffering from a terminal illness, who is experiencing severe pain, suffering or physical incapacity to an extent unacceptable to the patient*'. But please notice that this wording deliberately conflates two very different kinds of suffering: pain and physical discomfort (which are *medical* problems) and 'existential' suffering: loneliness, fear of being a burden, etc. (which are *social* problems).

If the patient's suffering is physical, that always *should* be (and always *can* be) relieved, either *directly* or *indirectly*. In the vast majority of cases, physical suffering can be relieved directly, by means of pain relief. In a very small number of cases, physical suffering can be relieved only by indirect methods, such as lightly sedating the patient. Physical suffering *can* be relieved, and we need to get that message across to the people of New South Wales.

However, in all the jurisdictions which have legalized assistance in suicide and euthanasia, people who request this service suffer not from pain but from such things as loneliness and the fear of being a burden on others. The data from Oregon reveals this to be the case there, and it is notoriously true in the Netherlands. We should not licence doctors to help people to commit suicide in these circumstances: we should address the underlying problems: inadequately trained doctors, lack of access, etc.

The paradox of 'safeguards'

The Bill is attended by a series of 'safeguards'. But the 'safer' one tries to make the scope of such legislation, the sooner it will be challenged as 'unfair'. If this Bill were to be passed, it would soon be claimed that the 'benefit' it offers should be made available *much more widely*. A future Parliament would be (and, arguably, should be) put under pressure to deal with 'inequality' of access. For instance, the unfairness of making this 'benefit' available only to those who request it, and denying it from those who have lost that capacity to request it, will be obvious to all.

You will have noted that, in what I have said, I have not drawn on religious premises. Though some will denigrate my views as 'attempting to impose her religious beliefs on others', this debate has nothing to do with religion and everything to do with good public policy in New South Wales.

Yours sincerely



Bernadette Tobin PhD
Plunkett Centre for Ethics

13th September 2017

Dear The Hon. Greg Donnelly
Parliament House
Macquarie Street
Sydney NSW 2000

My name is Ghauri Aggarwal. I am an Associate Professor and Head of Department, Palliative Care at a major teaching hospital in Sydney. I have been a Palliative Care Physician for the last 22 years. I have also been involved in the development and teaching of palliative care in the Asia Pacific region over the last 12 years. I am currently Co-Vice Chair of the Asia Pacific Hospice and Palliative Care Network (APHN). APHN is a non-government organisation that works to promote access to quality hospice and palliative care for all in the Asia Pacific region.

The purpose of my letter is two-fold. First, to provide you with a copy of APHN's position statement, ratified at its recent July 2017 annual general meeting held in Singapore, regarding the deliberate ending of life. Attached for your reference is a copy of the position statement. It is addressed to all Members of Parliament in Australia because it specifically took into account that parliamentary debates regarding proposed physician-administered euthanasia and physician-assisted suicide were expected in the coming months. The position statement dated 1st August 2017 is signed by Associate Professor Cynthia Goh, Chair, Asia Pacific Hospice and Palliative Care Network.

Second, I would like to make some specific comments about why the *Voluntary Assisted Dying Bill 2017* that is coming before the NSW Parliament shortly should be opposed.

I care for patients at the end of their life in acute hospital, inpatient unit and home settings. The care we provide is delivered with compassion and professional expertise not just to our patients but also their families and carers. Critical to the care of patients, who feel inherently vulnerable, is developing a relationship with them that is based on absolute trust. Only through this absolute trust can one come to understand each person's unique suffering and provide them with the care that they deserve. Laws that facilitate physician-administered euthanasia and physician-assisted suicide unquestionably strike at the heart of that delicate relationship between doctor and patient; a relationship based on absolute trust.

I wish to also express my ongoing concern regarding what is, in my view, a general lack of understanding in the community, media and the Parliament itself about what palliative care is, and is not. Many myths abound regarding palliative care. Perhaps those of us involved in palliative care professionally have to accept some responsibility for those myths still having some currency in 2017. Nevertheless, I strongly urge you to inform yourself about modern palliative care practices. I would be pleased to provide you with information if that would assist.

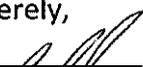
I would like to also comment on the impact of the proposed legislation on the medical culture in this state. The principle of "do no harm" has been, is and always will be at the very heart of what we do as medical practitioners. It is intrinsic to our vocation. It is deceitful to suggest, as some do, that the proposed legislation would have a negligible impact on the way medicine is practised in this state. The reality is that if such a proposal became law the very nature of the conversations that doctors have with their patients regarding dying and therapeutic options would be profoundly altered in a negative way. The conversations and practices that the proposed legislation would not just validate but legalise are at complete odds with the current practice of medicine in New South Wales, and indeed Australia.

The other issue I wish to comment on is the matter of so-called safeguards and protections in the proposed legislation. Having practised palliative medicine for 22 years I have witnessed the utter vulnerability that people often find themselves in as they approach the end of their life. One can easily see how an individual could be susceptible to influence or pressure from others to consider or make a decision regarding ending their life.

Thank you for taking the time to read my letter. If you have any particular questions regarding what I have raised, do not hesitate to contact me on

[REDACTED]

Yours sincerely,


[REDACTED]

Associate Professor Ghauri Aggarwal
Palliative Medicine Physician
FRACP, FACHPM, FFPMANZCA



ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK
Linking palliative care in Asia and the Pacific

1 August 2017

The Asia Pacific Hospice and Palliative Care Network promotes access to good-quality hospice and palliative care for all in the Asia Pacific region. We value every moment of life and do not support any action that has the intention of shortening a person's life. Restoring dignity and enhancing quality of life is the basis of palliative care.

We do not support the deliberate ending of life and we view with concern moves in certain jurisdictions in the region to legalise physician-administered euthanasia and physician-assisted suicide. Licensing doctors to administer or supply lethal drugs to seriously-ill patients has no place in the practice of health care. Such moves devalue the dying and undermine society's responsibility to protect its most vulnerable members.

Australia and New Zealand are acknowledged leaders in fostering palliative care development in the Asia Pacific region. In much of this region, pioneers are struggling to establish good end-of-life services in the face of little political and financial support. Eighty percent of the world's dying has little or no access to morphine for pain relief.

The United Kingdom, Australia and New Zealand have been ranked as the top three countries worldwide in the 2015 Economist Quality of Death Index. The eyes of the world are on these nations and on how they discharge their responsibilities to dying people.

For those of us trying to improve end-of-life care, licensing doctors to provide or administer lethal drugs to patients poses serious risks of sabotaging efforts around the globe to convince governments that pain relief and good end-of-life care are basic human rights.

The Asia Pacific Hospice and Palliative Care Network appeals to you therefore to recognise your responsibilities on the world stage when considering any proposed legislation before you.

Yours faithfully

Associate Professor Cynthia Goh
Chair, Asia Pacific Hospice Palliative Care Network

15th September 2017**All correspondence to:**

Sydney Institute of Palliative Medicine,
Gloucester House
Royal Prince Alfred Hospital,
Missenden Road
Camperdown, NSW 2050
Australia

Telephone: 61 2 9515 8793
Fax: 61 2 9515 6768

EMAIL: SIPM@sswahs.nsw.gov.au

The Hon. Greg Donnelly
Deputy Opposition Whip in the Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

Executive Committee**Chairperson**

A/Prof Ghauri Aggarwal
Concord Hospital

Committee

Dr Jan Marce Davis
St George Hospital

Dr Jennifer Wiltshire
Liverpool Hospital

Dr Melanie Lovell
Greenwich Hospital

Dr Sally Greenaway
Westmead Hospital

Janeen Foffani

Royal Prince Alfred Hospital
Email: janeen.foffani@sswahs.nsw.gov.au

Consultants to SIPM:

Prof J Norelle Lickiss
Sydney, Australia

Dear Mr Donnelly,

We, the executive of the Sydney Institute of Palliative Medicine (SIPM), are writing to you to express our serious concerns regarding the *Voluntary Assisted Dying Bill 2017*. The bill as we understand is expected to be debated in the Legislative Council shortly.

Our organisation has for some years played a significant role in the development of palliative medicine as a clinical science and specialist medical field in New South Wales, Australia and internationally. Its activities include registrar training, conducting annual symposia and participating in various international and humanities programs.

As co-ordinator of the palliative medicine training network across the state, SIPM is particularly concerned about how this bill, if passed into law, would impact on both the future development of palliative medicine and how palliative care is practised in this state. It is well recognised that palliative care services in this state are seriously under-resourced. In many parts of New South Wales, there is no access to a palliative medicine physician. People living in those areas need urgent access to expertise in palliative and end of life care.

Current training and the medical ethics that underpin palliative care are directed at providing the best care possible to patients at the end of their life. The legal framework that the bill would establish is specifically designed to create engagements with patients that are anathema to our profession. We are concerned about the impact of such a law on individual patients specifically and society in general. We believe that such a law would have a negative impact on the practice of palliative care in New South Wales.

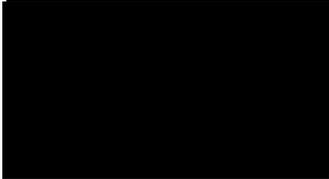
It is our view that the proposed legislation will compromise greatly the ability of palliative care specialists to deliver good end of life care to patients. In a most fundamental way it interferes with both the relationship and trust between doctor and patient. This can only compromise the ability of doctors to provide the best advice and care to patients experiencing suffering and pain. We submit that if the law is changed to permit doctors to end life, it will alter society's attitude towards the medical profession in a most profound way. Citizens will come to question, if not potentially fear, the very individuals who they believed were professionally trained to care for them.

Palliative care can achieve good symptom control in the overwhelming majority of patients. It is our view that so-called voluntary assisted dying is not necessary for symptom relief. It is our observation that distress increases symptom burden and that a focus on death, as happens when euthanasia is considered, increases distress and hence increases pain, breathlessness and other symptoms. In our repeated experience, focusing on living well rather than dying, improves people's wellbeing.

We would strongly urge each Member of Parliament to look closely at the proposed legislation and take into account our concerns with regards to the negative impact on society, the future practice and discipline of Palliative Medicine and safety of the vulnerable patients for whom we are entrusted to care for.

If there are any matters raised that you would like to discuss further please contact A/Prof Ghauri Aggarwal via email ([REDACTED]) or phone 02 [REDACTED]

Yours faithfully,



A/Prof Ghauri Aggarwal
Chair, SIPM

Yours faithfully,



Dr Jan Maree Davis
Education lead

Yours faithfully,



Dr Jennifer Wiltshire

Yours faithfully,



A/Prof Melanie Lovell

Yours faithfully



Dr Sally Greenaway



The Hon. Greg Donnelly MLC
Parliament House
Macquarie Street
Sydney, NSW 2000

Dear Mr Donnelly,

Palliative Care New South Wales (PCNSW) is the peak body for Palliative Care in this state. We represent a broad membership that consists of specialist clinicians, nurses and allied health professionals, as well as volunteers and members of the general public who have an interest in Palliative Care.

I am writing to you on behalf of our membership which has expressed great concern regarding some misconceptions about Palliative Care in relation to the Public Consultation Draft *Voluntary Assisted Dying Bill NSW 2017*. As the peak body, PCNSW has a responsibility to its members and the broader Palliative Care community to participate in any public discussions relating to Palliative Care, and both comment on and critique any proposed physician assisted suicide and euthanasia legislation.

PCNSW wishes to take this opportunity to explain our position on physician assisted suicide and euthanasia and address some of the misconceptions in the general community regarding both the meaning and purpose of Palliative Care. We wish to also invite you to meet with a representative from Palliative Care NSW to discuss the implications and expected impacts of the proposed legislation on Palliative Care across NSW.

PCNSW is affiliated with the national peak body for Palliative Care, Palliative Care Australia. The following link will take you to Palliative Care Australia's Euthanasia and Physician Assisted Suicide position statement.

http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2015/08/20160823-Euthanasia-and-Physician-Assisted-Suicide-Final.pdf.

It is important to clarify the following points:

- The practice of Palliative Care does not include physician assisted suicide or euthanasia;
- Palliative Care does not intend to hasten or postpone death; and
- When aligned with a person's wishes, withdrawing or refusing life sustaining treatment (including withholding artificial hydration) or providing medication to relieve suffering, do not constitute physician assisted suicide or euthanasia.

Consultation

In drafting this Bill there has been no specific consultation with Palliative Care NSW. This is concerning when you consider the detailed body of knowledge and expertise that is held by the sector in dealing with end of life care and support. We believe that there needs to be more consultation involving the broader medical and health sector, as this issue is not confined to Palliative Care.



Palliative Care
NEW SOUTH WALES

Palliative Care New South Wales
PO Box 487 Strawberry Hills, NSW 2012
P 02 9206 2094 F 02 9281 0157
E info@palliativecarenewsw.org.au
W palliativecarenewsw.org.au
ABN 67 231 950 900

At what cost?

A recent report by the NSW Auditor-General highlighted significant shortcomings in the strategic oversight of Palliative Care in this state <http://www.audit.nsw.gov.au/publications/latest-reports/palliative-care>. This remains the case, notwithstanding the State Government's recent announcement to increase funding to the sector. Access to Palliative Care is not yet equitable across geographic boundaries or on prognosis. There is also poor death literacy within the community at large. In repeated community surveys, many people do not know or understand what Palliative Care is, yet, this bill assumes that the same people have the required knowledge to make informed choices about physician assisted suicide and euthanasia.

The Voluntary Assisted Dying Bill 2017

The Bill itself contains a range of shortcomings, deficiencies and gaps that PCNSW have identified in its submission to the working group. On the basis of these and the matters mentioned above, it is the position of PCNSW that the Bill should not be supported.

We believe that discussion and collaboration are the best approach for grappling with an issue that would so fundamentally change the way society deals with dying and death. We would therefore like to invite you to meet with a representative of Palliative Care NSW to discuss any questions that you may have.

To assist with the arrangement of a meeting, please contact Palliative Care NSW on (02) [REDACTED] or email Megan Burke at [REDACTED].

Yours sincerely,

A large black rectangular redaction box covering the signature area.

Linda Hansen
Executive Officer
Palliative Care NSW

15th September 2017



The Hon. Greg Donnelly MLC
Deputy Opposition Whip in the Legislative Council
Parliament House
Macquarie Street
SYDNEY NSW 2000

greg.donnelly@parliament.nsw.gov.au

Dear Mr Donnelly,

I am writing to you as the President of the NSW Society of Palliative Care Medicine (NSWSPM) to express our strong opposition to the Voluntary Assisted Dying Bill 2017. We are implacably opposed to any laws that would facilitate physician assisted suicide or euthanasia. Attached for your reference is a copy of NSWSPM's position statement regarding these matters.

We wish to also express our ongoing concerns regarding how the popular media has, and continues to, misrepresent and misinterpret the practice of specialist palliative medicine. This includes spurious reports that a "standard" practice of specialist palliative medicine is the "inappropriate use of opioids to hasten death" and of "using opioids to effect euthanasia by stealth". Such reports are completely untrue. The standard of care that is applied is to prescribe opioids in direct proportion to symptoms being treated and are only used to manage pain and/or shortness of breath. Such proportionate use has been shown not to hasten death. Any other suggestions are both misleading and false. Any doctor who acted beyond this approach by, for instance, intentionally prescribing doses of morphine disproportionate to the symptoms, would be practising outside this profession's agreed standard of care.

We respectfully request that you take into consideration the matters we have raised when deliberating on the Voluntary Assisted Dying Bill 2017.

If you have questions regarding what is contained in the position statement or any other matters, please contact me on (02) [REDACTED] or (02) [REDACTED]

Yours sincerely,

Dr Jan Maree Davis FRACP FACHPM
President, NSW Society of Palliative Medicine



NSW Society Position Statement on Euthanasia

There is currently extensive debate in our community concerning the legislation of euthanasia. The question of whether it is ever right for a doctor to deliberately administer drugs to patients, whether this be directly (euthanasia) or indirectly (physician-assisted suicide), with the intention of bringing about their death, is a difficult moral and ethical challenge. This paper represents the views of a group of palliative medicine practitioners, who, by virtue of the nature of their work, are in the position to contribute to the discussion concerning appropriate care for terminally ill and dying patients.

Support for euthanasia developed in the context of expanding medical technology where the prolongation of life at all costs was often the goal of treatment. More recently there has been a focus on people's desire to control the nature and timing of their own death. Debate regarding euthanasia has now become confused with ethically disparate issues such as the right to refuse futile treatment, and the right to receive adequate pain control.

The term euthanasia should be reserved for the deliberate and direct action taken by a doctor with the primary intention of terminating a patient's life in order to relieve suffering. If euthanasia is performed at the patient's request, it is voluntary, otherwise it is non-voluntary. The terms 'active' and 'passive' euthanasia are ambiguous and confusing and so should be avoided. Physician-assisted suicide, the situation where the doctor takes no direct action to end the patient's life but merely assists the patient by providing the means (usually in the form of medication and advice), distances the doctor from the consequences of his actions, but we can find no moral or ethical differentiation between this and euthanasia as the intention and outcome are the same.

A change in the law regarding euthanasia is not necessary. Modern palliative care is aimed at improving the quality of life of patients with active, progressive, far advanced disease. Care focuses on relief of symptoms, alleviation of psychological and spiritual suffering and supporting the patient/family unit in the final stage of life which can be a time of tremendous personal growth. Setting goals for treatment and making ethical decisions is part of that care, and at times will involve making the decision to withhold or withdraw life-prolonging treatment in the face of progressive disease and/or the burden of treatment. Such acts should not be confused with euthanasia. Extraordinary treatment, including that which could potentially shorten life, may be necessary to relieve pain or other symptoms causing serious physical or psychological distress. The provision of such treatment is not euthanasia as the goal in these situations is to relieve symptoms, not to end the person's life. It needs to be clearly understood that good palliative care does not generally have a life-shortening effect.

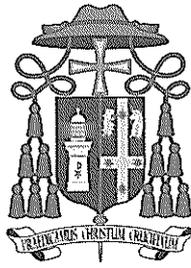
It is acknowledged that there is the occasional case in which suffering is so extreme that the termination of a patient's life seems to be the most compassionate solution, but that does not make it morally correct to act in this way. Such situations are exceedingly rare in light of recent advances in symptom control and ultimately suffering is an existential rather than a medical problem.



Research indicates that requests from dying patients for euthanasia are uncommon, and often dissipate after symptom control is established⁽¹⁾. The current penetration rate of palliative care services in Australia is unknown, but it is unlikely that even half of the dying patients in this country receive access⁽²⁾. Any discussion of euthanasia and physician-assisted suicide is inappropriate while this problem of access to palliative care services exist for dying patients and their families. Feeling a burden on others is highly associated with distress to patients at the end of life as well as the wish to hasten death (Chochinov et al. Dignity in the terminally ill: a cross-sectional, cohort study. *Lancet* (2002) vol. 360 (9350) pp. 2026-30

Legalisation of euthanasia is dangerous. We believe it is a fallacy to suppose that with the legalisation and social acceptance of euthanasia, burdensome patients would not be subtly pressured to request termination of their lives, or that we would continue to resist the extension of euthanasia to those unable to request or consent to termination of their lives (particularly in a climate of budgetary constraints). The Dutch experience as seen in the Rummelink Report shows that legislation does not restrict the administration of euthanasia to those who request it. We are committed to the care of the dying and believe that there is a need to recognise the right of competent adults to refuse treatment and to be offered all treatment possible to relieve suffering. We oppose unequivocally the legalisation of assisted suicide and euthanasia.

1. Glare P, Tobin B, Requests for Euthanasia, Proceedings of the Australian Bioethics Society, 1994.
2. NSW Palliative Care Working Party Report, NSW Health 1993.



We proclaim a crucified Christ
1 Cor 1.23

The Hon Greg Donnelly MLC
Deputy Opposition Whip in the Legislative Council
Parliament House
6 Macquarie Street
Sydney NSW 2000

Tuesday, 19 September 2017

Dear Mr Donnelly,

The Voluntary Assisted Dying Bill 2017 to be introduced into the NSW Legislative Council this Thursday 21 September strikes at the heart of respect for the dignity and rights of vulnerable people. Despite the promise of safeguards, international experience shows that such legislation places people, especially the elderly, people with disabilities and those with existing mental health issues, in an explicitly life-threatening situation.

Two key issues which the NSW Government has itself identified as areas in which significant problems exist are **palliative care** and **elder abuse**.

The conclusion to the Executive Summary of the *Planning and evaluating palliative care services in NSW* report begins with a most telling statement:

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.

How then can the NSW Parliament in conscience even begin to consider a Bill that would legalise assisted suicide? It is imperative that the focus of the Parliament remain on adequately resourcing and managing the State's palliative care system so as to better meet the physical, emotional and spiritual needs of the sick and dying.

Most Rev Peter A Comensoli
Bishop of Broken Bay

Caroline Chisholm Centre, PO Box 340, Pennant Hills, NSW 1715, Australia

• Tel: (+61 2) [REDACTED] • Fax: (+61 2) 9847 0201 [REDACTED] • www.dbb.org.au

Our concern should be to eliminate unnecessary suffering rather than eliminating people.

The recent report *Elder Abuse in NSW* notes the concern of Dr Brown of the Australian Association of Gerontology that:

... public debates around older people as **economical social burdens or as bed-blockers**, for example, are both inaccurate and derogatory and, more importantly, they reinforce ageist perceptions in the community, in families and older people themselves—the **perception that older people are somehow worthless and burdens**.

How will the escalation of elder abuse currently being seen in NSW play out in an environment where decisions as to the mental, physical or emotional incapacity of an elder are left to a guardian, legal representative or hospital board who see the elderly as 'economic social burdens' and who have recourse to assisted suicide or euthanasia legislation?

This is a very dangerous Bill. We must ensure that our only concern is that every member of our society knows with certainty that they will always be treated with the dignity, concern and professionalism which are the hallmarks of the NSW health care system. I urge you to oppose this Bill.

I would be happy to discuss these matters further with you and attach a leaflet setting out my key concerns.

Yours sincerely,

A black rectangular redaction box covers the signature of the sender.

Most Rev Peter A Comensoli
Bishop of Broken Bay

The true mark of our humanity is witnessed in the steadfast care we give to those we love as they are dying. The New South Wales Parliament is likely to consider a private members Bill to legalise euthanasia and assisted suicide. If this is accepted it would radically abandon our deep human commitment not to deliberately take someone's life.

Human dignity is honoured in living life, not in taking it. It is right to seek to eliminate pain, but never right to eliminate people. Euthanasia and assisted suicide represent the abandonment of those who are in greatest need of our love, care and support.

Take action

Now is our time to act. Talk to your family and friends about the dangers of euthanasia and the false messages that are around. Write to your Member of Parliament about the need for more funding so everyone can have access to palliative care.

Sign the petition rejecting the legalising of euthanasia and assisted suicide. Get involved!

HOPE

HOPE: Preventing Euthanasia & Assisted Suicide (Inc.)

PO Box 229, Marden SA 5070

info@noeuthanasia.org.au

1300 284 317



facebook.com/NOEuthanasia/

noeuthanasia.org.au

Authorised by Paul Russell,

Tower 2, Level 5, 121 King William Street Adelaide SA 5000

HOPE: Preventing Euthanasia & Assisted Suicide (Inc.)

REFERENCES

1 Lerner, B and Caplan, A, Euthanasia in Belgium and the Netherlands: On a Slippery Slope? JAMA Intern Med. Published online August 10, 2015. doi:10.1001/jamainternmed.2015.4086.

Do you know
the facts?

noeuthanasia.org.au

What euthanasia is

Voluntary euthanasia is when a doctor injects a patient with a lethal dose of drugs at the patient's request.

Assisted suicide (what some call 'voluntary assisted dying') is when a person takes a lethal dose of drugs that has been given to them by a medical practitioner, or **other nominated person**, sometime earlier.

Both **voluntary euthanasia** and **assisted suicide** are the deliberate ending of someone's life.

What euthanasia is not

Euthanasia is not turning off a life support machine or ending other treatments regarded as futile or burdensome.

Euthanasia is not giving a patient pain relief as they are dying. Effective pain management, provided as part of good palliative care, is simply good medical practice, and should always be encouraged.

True compassion

Those whom we love – our family and friends – long for our accompaniment and care as they are dying, not the deliberate hastening of their death.

They deserve the commitment of our government to provide appropriate medical and community support, wherever it is needed; not state-approved killing or state-supported suicide.

The best way to care compassionately for people at the end of their life is to affirm their value when they are most vulnerable, to encourage people to discuss their end-of-life care before they need it, and to petition governments to invest in palliative care, respite care and support for carers.

Undermining our healthcare system

Our healthcare system exists to provide the best possible medical help. We place enormous trust in the integrity of doctors and nurses to provide healing and care. To legalise euthanasia or assisted suicide would be to undermine that trust.

Good medical care is not about lethal injections or lethal prescriptions. They cannot be made safe, they do not promote the dignity of sick and vulnerable people, and they undermine real patient autonomy, implying that a person's life might be no longer worth living.

Once the fundamental principle to do no harm and never to kill is removed from medical practice, the integrity of our healthcare system is seriously compromised.

No Consensus, little support, failed guarantees

Those who advocate for legalising euthanasia and assisted suicide often make four assertions:

1. That it is an idea whose time has come.

What they fail to say is that there is no consensus among the medical fraternity to support this claim. Both the Australian Medical Association and the Australian and New Zealand Society of Palliative Medicine are opposed to euthanasia and assisted suicide, and the pressure placed on the medical profession to move away from healing.

2. That it is supported in a growing number of countries.

This, too, is not the case. There are many more countries that have rejected legalising euthanasia in recent years (including the UK, New Zealand, and the last 43 attempts in the USA alone, to name a few) than have accepted it. The vast majority of countries in the world do not support legalised euthanasia, and very few are actively considering it.

3. That safeguards can be put in place to protect abuses.

Again, this is simply not the case. In countries where euthanasia has been legalised, there has been pressure to expand the original 'restrictive' legislation, either in law, in practice or both, to accept more and more grounds to euthanise people, sometimes even without their explicit consent.

4. That no one should have to endure a hard death, therefore other options should be provided.

This is perhaps the hardest claim to respond to. However, effective pain management is now an ordinary part of good palliative medicine. Certainly, better training is needed for medical practitioners and greater resources provided for patients wherever they live. There are effective ways of accompanying people as they are dying that do not involve killing them.





Anglican Church Diocese of Sydney

ST. ANDREW'S HOUSE SYDNEY SQUARE NSW 2000
ALL CORRESPONDENCE TO:
QVB POST OFFICE NSW 1230

TELEPHONE: (02) [REDACTED]

20 September 2017

The Hon. Greg Donnelly MLC
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr Donnelly,

Re: NSW Voluntary Assisted Dying Bill 2017

The Anglican Church has consistently and publicly opposed moves to legalise euthanasia in NSW and elsewhere in Australia.

In light of the proposed *NSW Voluntary Assisted Dying Bill 2017*, I thought it would be helpful if all Members of the Legislative Council were aware of our objections to this Bill in principle and in its detail.

1. All life is precious in God's sight and deliberately ending a human life is wrong. Many people of faith in NSW, both Christian and of other faith traditions, oppose this legislation as contrary to their beliefs.
2. Respect for human life is not just a religious value, but a foundational value for all societies. The value and dignity of each person is not diminished by age, disease, dependence or disability.
3. The euphemism 'assisted dying' masks the fact that this Bill allows for the prescribing of medication which the patient may take with the purpose of ending their life (assisted suicide) or the administration of medication by a doctor or other nominated person to end the patient's life (euthanasia). We find the use of euphemistic language in this debate unhelpful and confusing for the community.
4. Legislating suicide as a means of reducing suffering sends a negative message to our community, especially in view of the current suicide rate in Australia, where around 8 people end their lives each day. Why is our parliament encouraging the legalisation of suicide in this group of people?
5. In several overseas jurisdictions with legal euthanasia, there has been a significant widening of the criteria for inclusion, exposing vulnerable members of society to abuse, including children, the depressed, those who are mentally incompetent and the elderly. The legislation of the US State of Oregon is held up as a safe model to follow in Australia, but their Act requires physicians to give minimal information about their cases and there are no enforcement provisions to ensure that every case is reported. In addition, in many of these jurisdictions, it is not pain but psychosocial factors such as loss of autonomy that prompt requests. If so, we should improve end of life care and provide psychosocial support, not legalise 'assisted dying'.
6. In view of the recent findings of the NSW and Federal Government enquiries into the extent of elder abuse in Australia, the introduction of 'assisted dying' is very dangerous.

7. 'Assisted dying' is contrary to the goals of medicine and medical ethics. It endangers the important trust relationship between patients and carers. Doctors are not trained to end the lives of their patients nor should they be involved with this practice.
8. Palliative care is effective in the majority of cases to manage pain and suffering among the terminally ill, providing an ethical and safe way to comfort those who suffer. Increasing access to high-quality palliative care would be a more effective way of improving end of life care. The Attorney General's report on Palliative Care in NSW shows the need for much more work to be done to improve services.
9. Euthanasia and assisted suicide is marketed as a means to a safe and peaceful death, but in Oregon up to 25% of cases involve complications, such as a patient vomiting up the tablets or waking up after taking them.
10. Even though a large part of the public is apparently in favour of legalising euthanasia, this level of support is not reflected in those at the end of life. The number of patients requesting euthanasia at the end of life has been estimated to be less than 1% after palliative care has commenced.
11. It has been reported that a euthanasia law is needed to control the alleged current incidences of euthanasia performed by doctors. However, current legislation can address this issue, as it is medical negligence. Moreover, it is highly unlikely that the existence of doctors who are acting unlawfully will be curtailed by further legislation, further increasing the risks of abuse.

Summary

As a community, we are rightly concerned about the suffering which those with terminal illness may face. Yet this legislation opens the way for state-sanctioned killing which may lead to abuse and expansion beyond its original intent. This Bill puts vulnerable people at risk for the sake of a small number of people who are insisting on autonomy at the end of life. This is intolerable.

Legalisation to allow euthanasia and assisted-suicide is unnecessary as there are safer and better ways to improve end of life care for people in NSW. Palliative care provides a legal, effective, holistic and ethical option for helping people with terminal illness. The Attorney-General has told us that there are many ways that Palliative Care can be improved. That should be our first priority.

Recommendations

We call upon you and all other Members of the Legislative Council -

- to acknowledge the dignity of human life and the gift of life,
- to call assisted-dying by its correct name – assisted suicide,
- to reject the false notion that assisted dying represents a right or a dignified death,
- to recognise the social, ethical and medical consequences of this new legislation, and
- to further improve access to high quality palliative care to ensure that all people will be able to die with appropriate care and support.

On behalf of the Anglican Church in Sydney and the NSW Council of Churches, I ask you to please give pause to any support you might have had for this Bill, and **vote against it**.

Yours sincerely,


Glenn N Davies

Archbishop of Sydney
President of the NSW Council of Churches



Speaking the truth in love

Eph 4:15

21 September 2017

The Hon. Greg Donnelly
Parliament House
Macquarie Street
NSW 2000

Dear Mr Donnelly,

Re: Bill to allow euthanasia and assisted suicide

I write to express grave concern regarding the *Voluntary Assisted Dying Bill 2017* that has been introduced into the New South Wales Parliament.

As the largest non-government provider of health care and palliative care services in our community, Catholics have been privileged to walk with many Australians during the last stage of their life journey and to endeavour to make it as peaceful, positive and supported as possible. This has helped us to understand why state sanctioned killing is a bad idea.

I understand why some people want this Bill. It's often because someone they've known and loved has suffered greatly in dying, or they're exhausted from caring for someone who's dying only very slowly. While I empathise with these reasons, death, like life, is rarely free from all pain and grief. Death and dying are fundamental human experiences which touch us all deeply and reflect the profound truth of our dependence upon – and need for – each other.

This challenges us as a society to think about what 'a good death' means and how our community responds to the elderly, frail, disabled and dying. However well-meaning, giving people a lethal dose is not an answer. In particular, euthanasia will **fundamentally change** the nature of the medical profession and our society, and lead to an **increased vulnerability** for those who most need our support.

Fundamental changes to the medical profession and society

Euthanasia empowers doctors rather than patients: in the end lawyers and especially doctors (medical and psychological) will have to decide 'who' is better off dead or 'who we are better off with' dead.

The doctor-patient relationship is built upon trust. Voluntary euthanasia undermines this. Do we want our hospitals and doctors assessing which patients should live and die? Do we want them gradually desensitised to neglect and killing? Do we want medical students trained to administer lethal doses? Do we want a person's own family member or friend to help them to commit suicide when they are depressed and vulnerable and to have to live with it afterwards?

Most Rev. Anthony Fisher OP, DD BA LIB BTheol DPhil
Archbishop of Sydney

Polding Centre, 133 Liverpool Street, Sydney NSW 2000, Australia

The medical community itself is split on this matter.ⁱ Many doctors don't want their profession to be associated with killing, which is why the Australian Medical Association does not support these laws.ⁱⁱ

The defining aspect of our law is that human life is to be protected, that human rights are universal, and that there are no exceptions to our homicide laws. But legal euthanasia would designate two classes of citizens: those whose lives are inviolable; and those whose lives can be taken (e.g. the terminally ill, the disabled). The first purpose of law is to protect the innocent and vulnerable and that's a big part of why Australians oppose state-sanctioned killing even of criminals. The prohibition on killing is a cornerstone of law, and society and protects each one of us impartially, equally.ⁱⁱⁱ

Loss of dignity and increased vulnerability for those in need

Since my recovery from Guillain-Barré Syndrome last year, I have a more personal understanding of suffering. I have been weak and vulnerable. I spent five months in hospital, gradually repairing my nerves and rebuilding my wasted muscles, learning again to walk, climb stairs, use cutlery, write. I have experienced suffering and the humiliation of total dependence, which makes those suffering from debilitating and terminal illnesses especially vulnerable to pressure from others. If we class the frail, elderly, and disabled as expendable, the community is likely to do less for them and leave them feeling worthless and pressured into choosing euthanasia. In turn, people's lives are put at risk.

We all want to relieve suffering and respect autonomy; but surely we can find ways of doing so that don't involve killing or putting the vulnerable at risk. If reducing suffering is our big concern, we should ensure universal access to high quality palliative care and the best possible pain relief and support, rather than a supposed quick end.

For these reasons and others, I urge you and your fellow Members of Parliament to uphold that human life is inviolable and to continue to support the common good of our community by opposing this Bill.

I would be happy to meet with you to discuss this matter further.

Yours sincerely



Most Rev. Anthony Fisher OP, DD BA LIB BTheol DPhil

Archbishop of Sydney

ⁱ Lauren Day, "Doctors divided over voluntary assisted dying legislation in Victoria". *ABC News*, 21 August 2017 <http://www.abc.net.au/news/2017-08-21/doctors-divided-over-voluntary-assisted-dying-legislation/8827204>

ⁱⁱ Australian Medical Association Position Statement on Euthanasia and Physician Assisted Suicide 2016 <https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016>

ⁱⁱⁱVE in Quebec, Belgium, Luxembourg & Holland; PAS in Switzerland, Oregon, Washington, Vermont, Montana & New Mexico.

The Hon. Greg Donnelly MLC
Deputy Opposition Whip in the Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

21 September 2017

Dear Mr Donnelly

Proposed NSW legislation on assisted dying

We are writing to you on behalf of the Australian and New Zealand Society of Palliative Medicine (ANZSPM) with regard to the proposed draft NSW legislation on assisted dying. Our purpose is to inform you of the published views of our members with respect to euthanasia and physician assisted suicide.

ANZSPM is a specialty medical society that facilitates professional development for its members and promotes the practice of palliative medicine, in order to improve the quality of care for people with life threatening illness. Our members are medical practitioners who provide care for people with a life-threatening illness and include palliative medicine specialists, palliative medicine training registrars and other doctors such as general practitioners, oncologists, haematologists, intensivists, psychiatrists and geriatricians. Ninety-three (93) of our members are currently based in NSW, out of nearly 500 members across Australia and New Zealand.

ANZSPM has published a *Position Statement on Euthanasia and Physician Assisted Suicide*, produced following a survey of our members to ensure that the statement is reflective of member views, with the most recent review in late 2016. The Position Statement is available on the ANZSPM website: www.anzspm.org.au (also **attached** for reference).

Key points in the ANZSPM Position Statement that we wish to draw your attention to are:

- There remain significant deficits in the provision of palliative care in Australia, including in NSW as highlighted in the recent NSW auditor-general report (<http://www.audit.nsw.gov.au/publications/latest-reports/palliative-care>).
- ANZSPM advocates, and its members deliver, excellent quality care for people living with life threatening illness by proactive assessment, treatment and prevention of physical, psychological, social and spiritual concerns; and support for caregivers.
- For people who are requesting assisted dying, particular care is needed to ensure that access to high quality care that addresses symptom control and other issues, including specialist palliative medicine referral, is available.
- According to international best practice, the discipline of Palliative Medicine does not include the practices of euthanasia or physician assisted suicide.

- ANZSPM does not support the legalisation of euthanasia or physician assisted suicide, but recognises that ultimately these are matters for government to decide having regard to the views of the community and, critically, informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.

Key recommendations:

The proposed legislation fails to address that the pressing need is to address those deficits in palliative care, that have far reaching and serious negative impacts on the quality of life and decision-making for people at the end-of-life and their carers. We commend the NSW Government for the recent investment of \$100M in palliative care services, which is aimed to improve confidence and choice for people at the end of life, but more is needed.

We are concerned that the legislative proposal will divert attention away from the larger problem of service gaps for the broader population of people currently receiving end-of-life care in NSW, for whom the priority is access to high quality palliative care and support.

ANZSPM calls on the NSW Government and Members of the Legislative Council to continue to urgently focus their attention on health reform and investment which will immediately strengthen palliative and end-of-life care including:

- remedying shortages in the palliative care workforce (including in the specialist medical, nursing and allied health fields),
- ongoing training for the generalist health workforce,
- policy directions which support and value advance care planning and patient preference,
- initiatives to support high quality palliative care regardless of setting (hospitals, community, residential aged care) to ensure improved access to high quality care for all people with life threatening illness, and
- increased carer support including opportunity for quality respite care to address the important issue of the sense of being a burden which is a concern held by many people at the end of life.

We would appreciate the opportunity to meet with you in person to discuss these critical matters further. Please contact Simone Carton (Chief Executive Officer) on [REDACTED] or by email [REDACTED] to arrange a meeting.

Yours faithfully,

[REDACTED]
Prof Meera Agar
President

[REDACTED]
Simone Carton
Chief Executive Officer

Encl.

ANZSPM Position Statement on the Practice of Euthanasia and Physician Assisted Suicide

Position Statement

The Practice of Euthanasia and Physician Assisted Suicide

Preamble

As the peak body for Palliative Medicine in Australasia, the Australia and New Zealand Society of Palliative Medicine (ANZSPM) has prepared this position statement reflecting the majority view of its members. ANZSPM acknowledges that, as with the diversity of opinion in the general and medical communities across Australia and New Zealand, there are divergent views on euthanasia and physician assisted suicide within its membership.

At the date of approval of this document, it is acknowledged that the practices of euthanasia and assisted suicide are illegal acts in both Australia and New Zealand, although these practices remain on the political and legislative agenda in several jurisdictions.

Background

ANZSPM is a specialty medical society that facilitates professional development and support for its members. ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with palliative diagnoses, and support their families.

ANZSPM members are medical practitioners. They include Palliative Medicine Specialists, doctors training in the Palliative Medicine discipline, General Practitioners (GPs) and doctors who are specialists in other disciplines such as oncology.

In preparing this statement, ANZSPM acknowledges:

- (a) the Australian Medical Association Position Statement *Euthanasia and Physician Assisted Suicide* published in November 2016;
- (b) the New Zealand Medical Association Position Statement *Euthanasia* approved 2005; and
- (c) the *Euthanasia and Physician Assisted Suicide Position Statement* published by Palliative Care Australia and updated August 2016.

Statement

1. Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.¹ In accordance with best practice guidelines internationally,² the discipline of Palliative Medicine does not include the practices of euthanasia or physician assisted suicide. ANZSPM activities are limited to the Palliative Medicine discipline.
2. ANZSPM does not support the legalisation of euthanasia and physician assisted suicide, but recognises that ultimately these are matters for government to decide having regard to the will of the community and, critically, informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.
3. If these practices are legalised in the Australasian context, ANZSPM endorses international guidelines reaffirming that they are not part of best practice palliative care. ANZSPM will continue to advocate for and, through its members, deliver good quality care for the dying, and this does not include the practice of euthanasia or physician assisted suicide.
4. Patients have the right to refuse life sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia.
5. Good medical practice mandates that the ethical principles of beneficence and non-maleficence should be followed at all times. The benefits and harms of any treatments (including the provision of medically assisted nutrition and/or hydration) should be considered before instituting such treatments. The benefits and harms of continuing treatments previously commenced should be regularly reviewed. Withholding or withdrawing treatments that are not benefitting the patient, is not euthanasia.
6. Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia.

¹ WHO (2002) <http://www.who.int/cancer/palliative/definition/en/>. Accessed on 11 October 2009

² Such as the European Association for Palliative Care's White Paper on standards and norms for hospice and palliative care in Europe: part 1, *European Journal of Palliative Care*, 2010, 17(1): http://www.eapcnet.eu/LinkClick.aspx?fileticket=uW_JGKKvpZl%3d&tabid=167

7. Palliative sedation for the management of refractory symptoms is not euthanasia.³
8. Requests for euthanasia or assisted suicide should be acknowledged with respect and be extensively explored in order to understand, appropriately address and if possible remedy the underlying difficulties that gave rise to the request. Appropriate ongoing care consistent with the goals of Palliative Medicine should continue to be offered.
9. When requests for euthanasia or assisted suicide arise, particular attention should be given to gaining good symptom control, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. depressive disorders and poorly controlled pain). In such situations early referral to an appropriate specialist should be considered.^{4 5}
10. Despite the best that Palliative Care can offer to support patients in their suffering, appropriate specialist Palliative Care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.
11. ANZSPM acknowledges the significant deficits in the provision of palliative care in Australia and New Zealand, especially for patients with non-malignant life limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations and those from culturally and linguistically diverse backgrounds.
12. ANZSPM advocates for health reform programs in Australia and New Zealand to strengthen end of life care by remedying shortages in the palliative care workforce (including in the specialist medical, nursing, and allied health fields), ensuring improved access to appropriate facilities and emphasising the role of advance care plans and directives.
13. ANZSPM advocates for increased carer support for respite care to decrease the sense of burden for many patients at the end of life.

³ <http://www.biomedcentral.com/1472-684X/9/20>, European Association for Palliative Care (EAPC) framework for palliative sedation: an ethical discussion, Accessed 8/3/2013.

⁴ Breitbart W. Suicide risk and pain in cancer and AIDS patients. In: Chapman CR, Foley KM, eds. Current and Emerging Issues in Cancer Pain: Research and Practice. New York, NY: Raven Press; 1993:49-65.

⁵ Chochinov HM, Wilson KG. The euthanasia debate: attitudes, practices and psychiatric considerations. Can J Psychiatry. 1995;40:593-602.

Definitions

Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.⁶

Palliative Care as defined by the World Health Organization⁷ is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care provides relief from pain and other distressing symptoms; it

- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Enhances quality of life, and may also positively influence the course of illness; and
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.⁸

Assisted suicide is the act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intractable suffering, in order that that person can use that means to commit suicide. If the person who dies performs the last act, assisted suicide has occurred.⁹

⁶ Pallipedia: <http://pallipedia.org/glossary/term.php?id=196>. Accessed on 11 October 2009

⁷ WHO (2002) <http://www.who.int/cancer/palliative/definition/en/>. Accessed on 11 October 2009

⁸ Adapted from International Task Force on Euthanasia www.internationaltaskforce.org/definitions.htm. Accessed 11 October 2009

⁹ Adapted from the International Task Force on Euthanasia www.internationaltaskforce.org/definitions.htm. Accessed 11 October 2009



CATHOLIC HEALTH Australia

26 September 2017

Dear Member of the Legislative Council,

Deep Concerns raised by New South Wales proposed legislation on voluntary assisted dying

Catholic Health Australia (CHA) is reaching out to you on behalf of your local health and aged care specialists to express concerns raised by New South Wales proposed legislation on voluntary-assisted dying (VAD).

CHA is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10% of hospital based healthcare in Australia. Catholic services provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly.

Our hospital members and associated clinicians are gravely concerned about the misleading assertions made by the proponents of VAD around public support for this legislation.

There is a significant lack of safeguards in place with respect to VAD to address the needs of vulnerable people including the disabled community, those affected by mental illness, and people who live in rural and remote communities. Those suffering from terminal illness are particularly vulnerable to the abuse and exploitation that this legislation could introduce. Practical concerns that have yet to be adequately addressed include:

- the regulatory mechanisms for procurement of lethal self-administered pharmaceuticals;
- responsibility for the financial costs of implementing, funding, and reporting VAD;
- access to services in regional and rural areas, particularly the availability of palliative care as the preferred alternative; and
- reporting considerations including the monitoring of VAD incidence.

Within the medical community, clinicians across all disciplines remain divided on this issue. Historical ethical traditions in medicine are strongly opposed to taking life. For instance, the Hippocratic Oath states, "I will not administer poison to anyone where asked," and I will "be of benefit, or at least do no harm." Linking VAD to the practice of medicine could harm both the integrity, and the public's image, of the profession.

There is a great deal of uncertainty and unanswered questions surrounding VAD. With current disciplines dedicated to relieving pain and suffering so severely underfunded and under resourced, there is reasonable concern that this could have unintended consequences that those unable to access these supports would be pressured towards VAD. Additionally, it is CHA's view that the New South Wales healthcare system is not currently equipped or otherwise adequately resourced to provide equitable access to the necessary professionals with the appropriate skillsets capable of facilitating a properly informed decision by an individual to pursue VAD.

CHA members are concerned that the community voice has not been adequately considered in the discussions surrounding VAD. There is a small but vocal percentage of the community strongly supporting this legislation that have received a great deal of media attention, however the experience of our members has been quite different, having encountered notable confusion and indecision within society surrounding this issue. It is essential to ensure that the community has been adequately informed and all voices heard before any consideration of the implementation of legislation, which has long-lasting and potentially injurious consequences.

Marginalised groups such as non-English-speaking Australians, the elderly and frail, prisoners, homeless, mentally and physically disabled, those living alone without supportive families, Aboriginal and Torres Strait Islander peoples, and individuals susceptible to elder and other forms of abuse are particularly vulnerable subsets of a group already rendered vulnerable by advanced terminal disease. For these individuals, susceptibility to mixed messaging and misinformation around treatment options and the value of such interventions is already problematic. Special care needs to be taken by palliative practitioners and other health professionals to ensure a compassionate, individualised response is provided to inform individuals from these demographics.

CHA and our members, who are providing hospital care for over 10% of Australians, remain vehemently opposed to VAD, object to the politicisation of what constitutes appropriate care for those at end-of-life and implore you to talk to clinicians to gain an understanding of this issue.

CHA feels this is an example of legislation being passed without adequate thought given to process and implementation considerations. Our members in New South Wales have been seeking to meet with politicians interested to gain a deeper understanding of this issue. If you would like to talk to someone, we are happy to introduce you to palliative care physicians who can speak of their first hand experiences in caring for those at the end of their life and who can discuss these matters and concerns in greater detail. Please contact Emma Hoban chahealthpolicy@cha.org.au and this can be arranged.

Thank you for your time.

Yours sincerely,



Suzanne Greenwood LLM LLB FAIM MAICD MCHSM
Chief Executive Officer

www.healthprofessionalssayno.info

The Hon. G. J. Donnelly
Parliament of New South Wales
Macquarie Street
SYDNEY NSW 2000

Dear Mr Donnelly,

Regarding: Voluntary Assisted Dying Bill 2017

I am writing on behalf of 101 Palliative Care health professionals who are concerned and opposed to the present euthanasia and physician assisted suicide bills before the Victorian and New South Wales parliaments.

For some time, one strategy of the proponents of the bills has been to downplay, obfuscate and corrupt the intentions and effectiveness of Palliative Care. The aim of the strategy seems to be to create fear in listeners that Medical, Health Care and Palliative Care professionals cannot help people with terminal illness, increase or prolong peoples' suffering and, conversely, that Palliative Care hastens patients' death in a covert way.

This letter has been written to refute these claims, to present a factual account of Palliative Care, to call for rejection of medically assisted suicide legislation, and increased commitment to Palliative Care services in Victoria and New South Wales, in order to address the needs of those nearing their last years of life.

These bills are a most serious threat to the wellbeing and safe care of people with terminal illness, and to those with severe, chronic and disabling conditions, who may feel they have become a burden to others. Both the NSW Auditor General's report on Palliative Care service provision and the Victorian enquiry into end of life choices have both emphasized the need to address inequity and shortfalls in service, and for better service delivery.

Yours sincerely,



Dr Maria C Cigolini MBBS(Syd) FRACGP FACHPM Grad.DipPallMed(Melb)
Clinical Head **RPAH Department of Palliative Medicine**
Clinical Lecturer **University of Sydney**
Sydney Cancer GH6, Royal Prince Alfred Hospital
Missenden Road, Camperdown, NSW 2050 Australia
Tel 02 [REDACTED]

An Open Letter to Members of Parliament by Australian Palliative Care Professionals

We, the undersigned Australian Palliative Medicine professionals, do not support the introduction of medically assisted suicide or euthanasia in the states of Victoria and New South Wales. We are also writing to address claims made about Palliative Care by assisted suicide advocates, including Mr Andrew Denton, to the public and in the media. We do not intend this response as an attack on Mr Denton, and wish him well with a good recovery in his present illness.

We work every day with people who are seriously ill and dying, to support them and their families and carers when burdened by their illness or condition, and in their time of need.

Although the standard of Australian Palliative Care services, whether in the home or in the medical setting, are currently rated second in the world, this is not widely known in our community, and these services and our care are not well understood.

Our work is a good news story that should provide the public with great confidence.

Instead, in the current debates on euthanasia and assisted suicide, we frequently observe that public confidence in Palliative Care is being actively and deliberately undermined. Assertions include that Palliative Care doctors either cannot or will not relieve suffering and that assisted suicide, and in some cases euthanasia, is needed to address this.

This is simply false.

Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering.

This is not just a 'pharmacological oblivion' as some have claimed. It is the careful management of pain and other severe symptoms through individualised medication plans at therapeutically recognised doses, and with dignified

personal care, delivered by experienced doctors, nurses and allied health workers. Family and carers are also supported with emphasis on a holistic approach.

No one is abandoned and everyone can be assisted or supported in some way.

Mr Andrew Denton also claimed at the recent 'Communities in Control 2017 Conference' in Victoria, that because Catholic thinking holds that suffering can sometimes be of benefit to the person, Catholic Health Care service providers and Palliative Care professionals are deliberately under-medicating symptomatic patients at the end of life. This false assertion implies that professionals in these services are deciding that their patients should experience pain and suffering because it is somehow good for them.

It is contrary to fact that any Palliative Care service or its employees, of any faith or secular belief, would behave this way. The approach to Palliative Care across all Australian and New Zealand services is held to professional standards, with rigorous and transparent quality control and benchmarking, contributing to our high world ranking.

One has to question the targeting of services and professionals providing the majority of the care and support of those who are terminally or chronically ill, and their families.

Ironically, Mr Denton and others simultaneously claim that Palliative Medicine sets out to end peoples' lives in the guise of giving pain relief. Both claims are false. Research has shown beyond doubt that therapeutic doses of opioid medications and sedatives in palliative care settings do not shorten life.

The often-repeated claim that Palliative Care professionals purposely shorten the lives of patients with medication and other practices is untrue, and risks discouraging terminally ill and vulnerable patients from seeking the assistance of Palliative Care, or from taking the very medication which would ease their pain.

As defined by the World Health Organisation and re-stated by the Australia and New Zealand Society of Palliative Medicine, the discipline of Palliative Care aims "to improve the quality of life of patients and families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual."

Good end of life care, supported by the skills and expertise of Palliative Care professionals, also enhances a person's choices, including the individual's choice to refuse life-prolonging, or other medical treatments unacceptable to that individual.

All Australians should have the confidence that their care and support in their time of need will be defined by this approach, and not by the ill-advised and erroneous observations of those who are rushing to legalise assisted suicide.

For the sake of public confidence, we ask that all sides of the current debate respect the role of Palliative Care services and the dedication and competence of all the professionals that staff them.

If assisted suicide or euthanasia laws are ever considered by our parliaments, that consideration should not be based on the false belief that we cannot assist or support those with pain and suffering in a professional and ethical manner.

If there is a problem facing Palliative Care in Australia it is that access to high quality services is not yet universal. We therefore warmly welcome the commitment of the New South Wales government to provide an additional \$100M to the sector focussing on rural and regional service delivery. We call on the Victorian Government to support the call by Palliative Care Victoria for \$65M recurring funding to assist the service to provide care for those in need.

It would be unethical for any state jurisdiction in Australia to move to legalise for assisted suicide or euthanasia whilst many ill, aged and disabled Australians cannot yet access the support that they need. Such a move would not enhance choice, but instead reduce choice around the care and support for those in real need.

We call all legislators to recommit to Palliative Care and the other services needed to better benefit all Australians, and not to let the agendas of others undermine more pressing Health Care and Community Service priorities.

Signatories

(101 in total)

Dr Maria Cigolini MBBS FRACGP FACHPM GradDipPallMed, Palliative Medicine Specialist, NSW

A/Prof Leeroy William BSc (Hons) MBBS MSc FACHPM, Palliative Medicine Physician, VIC

Dr Megan Best PhD BMed(Hons) MAAE ClinDipPallMed, Palliative Care Doctor, NSW

Prof Douglas Bridge BMedSc(Hons) MBBS FRACP FRCP FACHPM DTM&H, Palliative Physician, Past President RACP AChPM, Lecturer, WA

Prof Peter Ravenscroft MD FRACP FFPANZCA FACHPM, Palliative & Pain Medicine Physician, NSW

Prof Geoffrey Mitchell MBBS PhD FRACGP FACHPM, GP & Palliative Medicine Specialist, QLD

Prof Roger Woodruff MBBS FRACP FACHPM, Clinical Head, Lecturer, Board Member IAHP, VIC

Dr Simon Allan ONZM MB ChB MD FRACP FRCP(Edin) FACHPM, Palliative Medicine Physician, President of RACP AChPM

Prof Roderick MacLeod MNZM MB ChB MMedEd PhD FACHPM FRCGP, Palliative Medicine Physician, NSW

Ms Odette Waanders CEO Palliative Care, VIC

Dr John Malcolm BA MB BS PhD Grad.DipMed(Pain Management) FAFPHM FRACP FACHPM, Palliative Medicine Physician, NSW

Prof Ian Olver AM Professor of Transitional Cancer Research, Oncologist, Director, Dean Health Sciences, SA

Dr Adrian Dabscheck MBBS FRACP FACHPM, Palliative Medicine Physician, VIC

Prof Jennifer Philip MBBS FRACP FACHPM, Palliative Medicine Physician, VIC

Dr Scott King MBBS FRACGP FACHPM AFRACMA, Palliative Medicine Specialist, VIC

A/Prof Eleanor Flynn, MBBS BEd MTheol DipGerMed FRACGP FRACMA, Palliative Care Doctor, VIC

Prof Katherine Clark, MBBS MED PhD FRACP FACHPM, Palliative Medicine Physician, NSW

Dr Helen-Anne Manion OAM, MBBS DipPallMed(UWCM) FACHPM, Palliative Medicine Physician, Director of Dying at Home Program, NSW

Dr Martina Welz MBBS FRACP, ClinDipPallMed GradCertPallCare, Geriatrician & Palliative Medicine Specialist, VIC

Dr Paul Molina Chavez MBBS DRANZCOG FRACGP DipPalMed, General Practitioner & Palliative Care Doctor, VIC

Dr Sivakumar Subramanian, MBBS MSc MRCP, Palliative Medicine Physician, VIC

Dr Grace Walpole MBBS FRACGP FACHPM, Palliative Medicine Specialist, VIC

Prof David Kissane MBBS MPM MD FRANZCP FACHPM FAPM, Psychiatrist/ Psychoncologist, VIC

Dr Maria Pisasale MBBS BHA FACHPM FRACMA AFCHSE, Palliative Medicine Physician, VIC

Dr Merlina Sulisto BMedSc MBBS FRACP FACHPM, Palliative Medicine Physician, VIC

Dr Barbara Martin MBBS, FRCOG, FACHPM, Palliative Medicine Specialist, VIC

Ms Jeanette Moody RN Health Sector CEO, Palliative Care, VIC
Dr Hilary Stiel MBBS Hons MPHTM, RACP, Palliative Medicine Advanced Trainee, VIC
Ms Brigitte Karle RN, Clinical Nurse Educator Palliative Care, NSW
Ms Suzanne Sara RN, Palliative Care in Aged Care Liaison Nurse Specialist, NSW
Dr Yvonne McMaster Retired Palliative Medicine Specialist and Palliative Care Activist, NSW
Prof Melanie Lovell MBBS, PhD, FRACP, FACHPM Palliative Care Physician, Clinical Head, NSW
Prof Jane Philips RN PhD FACN, Palliative Nursing Professor. Lecturer, Researcher, NSW
A/Prof Josephine Clayton MBBS PhD FRACP FACHPM, Palliative Medicine Physician, Research Head, Lecturer, NSW
Dr Wendy Muircroft MBChB MRCGP DipPallMed MBHL FACHPM, Palliative Medicine Specialist, SA
Dr Peter Coleman MBBS BSc FRACGP, Palliative Care Doctor, NSW
Dr Alan Oloffs FRACP FACHPM MD BSc, Palliative Medicine Physician, Clinical Head, NSW
Dr Martin Kennedy MBBS FAFRM FFPANZCA FACHPM, Palliative Medicine Specialist, Director Rehabilitation & Aged Care, NSW
Dr Mary Stavralopoulou MBBS FRACGP, General Practitioner working with cancer patients, VIC
Dr Derek Eng MBBS FACHPM, Palliative Medicine Specialist, WA
Dr Dipti Mittal MBBS FRACP FACHPM, Palliative Medicine Physician, NSW
Dr Tanya Maya Jones, BSc BMBS FRACGP ClinDipPallMed, Palliative Care Doctor, NT
Dr Laura Pearce MSc, MBChB, FACHPM, Palliative Physician, Clinical Head, NSW
Dr Louis Christie FACEM FACRRM ClinDipPallMed, Palliative Care Doctor, NSW
Dr Helen Lord MB BS MPH FACHPM Palliative Medicine Specialist, TAS
Dr Frank Formby, MBBS, FACHPM, Palliative Medicine Specialist, TAS
Dr Amy Chow, MBChB FRACGP FACHPM, Palliative Medicine Specialist, NSW
Dr Alice Phua MBBS FACHPM, Palliative Medicine Specialist, WA
Ms Elizabeth Harris, BS RN, Clinical Nurse Specialist Palliative Care, NSW
Dr Anthony Herbert MBBS FRACP (Paed) FACHPM, Paediatric Palliative Physician, QLD
Dr Graham Grove MBBS Hons FRACP FACHPM BTh, Palliative Medicine Physician, QLD
Prof Peter Joseph AM FAMA FRACGP, Past President or Member RACGP/AMASA/AHEC, Dep. Chair CPMC Chair NHMRC Organ Transplant, Lecturer, Rural Medicine, SA
Dr Paul Kleinig, Palliative Care Consultant, BAppSc(OccTher) BMBS FRACP FACHPM, Palliative Medicine Physician, SA
A/Prof Timothy Kleinig, PhD FRACP MBBS (Hons) BA, Lecturer, Neurologist, SA
Dr Joseph V Turner, MBBS BMedSc(Hons) PhD DRANZCOG FRACGP FARGP FACRRM, Lecturer, UNE, UQld, UNSW
Dr Debra Louise Chandler, FRACGP, GP working in Palliative Care, TAS
Dr Riona Pais MBBS FRACP FACHPM, Palliative Medicine Physician, NSW
Dr Lynn Lim MBBS FRACP, FACHPM, Palliative Medicine Physician, NSW
Dr Philip Lee MBBS, FRACGP, GradDipPallMed, Palliative Medicine Physician, NSW
A/Prof Joel Rhee BSc(Med) MBBS(Hons) GCULT PhD FRACGP, General Practitioner working in Palliative Care, NSW
Ms Linda Hansen CEO Palliative Care, NSW

Dr Hong Nguyen MBBS BMedSci FRACGP, GP working in Palliative Care, VIC
Ms Kara Jacobs BPhy APAM, Palliative Care Physiotherapist, QLD
Dr Yamin Myat Aye MBBS FRACP FACHPM, WA
Ms Sara Karacsony RN Clinical Nurse Specialist Supportive & Palliative Care, NSW
Ms Teresia Matsveru RN Clinical Nurse Consultant, Palliative Care, NSW
Dr Aki Ghani MBBS FRACP FACHPM, Palliative Medicine Physician, QLD
Dr Anil Tandon MBBS FRACP FACHPM, Palliative Medicine Physician, WA
Dr Andy Hart MBBS FRACP FACHPM, Palliative Medicine Physician, WA
Dr Sue Colen MBBS FRACGP, Palliative Care Doctor, QLD
Dr Christine Drummond MBBS MMed FACHPM, Palliative Medicine Specialist, SA
Dr Sarah Wenham, MB ChB MRCP FRACP FACHPM, Palliative Medicine Physician, NSW
Dr Dorit Lesterhuis-Vasbinder MD(Netherlands) DipPalMed, Aged Care Physician and Palliative Care Doctor, WA
Dr J Ralph McConaghy MBBS DRACOG FRACGP MPHIC MMed FACHPM AFRACMA, Palliative Medicine Specialist, QLD
Dr Katherine Allsopp MBBS BSc(Med) FRACP FACHPM, Palliative Medicine Physician, NSW
Dr Sarah Thompson MBBS FRACGP FACHPM, Palliative Medicine Physician, NSW
Dr Clare Zachulski BSc MBBS FRACP, Palliative Medicine Specialist, NSW
Dr Shawna Koh BSB MBChB FRACP FRChPM, Palliative Medicine Physician, NSW
Dr Rebecca Strutt, MBBS FRACP FACHPM, Palliative Medicine Physician, NSW
Dr Philip Redelman, MBBS FRACGP FACHPM, Palliative Medicine Specialist, NSW
Dr Zujaj Quadri MBBS FRACP FACHPM, Palliative Medicine Physician, NSW
Dr Timothy To BSc MBBS FRACP FACHPM Palliative and Geriatric Medicine Physician, SA
Dr Jusveer Rakhra MBChB FRACP DCH, RACP Paediatric Palliative Medicine Trainee, NSW
Dr Mary McNulty MBBS FACHPM, Palliative Medicine Specialist, WA
Dr Ann Taylor MBBS FRACP FACHPM, Palliative Medicine Physician, SA
Dr Shawna Koh, BSB MBChB FRACP FRChPM, Palliative Physician, NSW
Dr Wing-Shan Angela Lo FRACP FACHPM Palliative Medicine Consultant, NSW
Dr Wendy Falloon B.MedSci MBBS DAUK FANZCA, Anaesthetist/Pain, TAS
Ms Lorraine Mitchell BA Social Work, Palliative Care Social Worker, NSW
Mr Danny Ford BA BTh MA, Pastoral Care Coordinator Health Sector Palliative Care, NSW
Ms Carol Robertson BA Social Work, Palliative Care Social Worker, NSW
Dr Elise Maehler MBBS FRACGP ClinDipPalMed, RACP Palliative Medicine Trainee, NSW
Dr Peter Roach MBBS FRACGP, RACP Palliative Medicine Trainee, NSW
Dr A Sarah Dunlop MBBS, RACP Palliative Medicine Trainee, WA
Dr Kim Caldwell MBBS MRCP RACP Palliative Medicine Trainee, NSW
Dr Amanda Vo MBBS, RACP Palliative Medicine Advanced Trainee, VIC
Dr Sharon Heng, MBBS, RACP Palliative Medicine Advanced Trainee, VIC
Dr Andrew Ng MBBS RACP Palliative Medicine Advanced Trainee, VIC
Mr Stephen Calder Pastoral Care Palliative Care Coordinator Health Sector, NSW
Dr Wei Lee MBBS FRACP RACP Palliative Medicine Trainee, NSW
Dr Gregory Barclay MBBS FRACGP FACHPM, Palliative Medicine Specialist, NSW

3rd October 2017

The Hon Greg Donnelly MLC
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr Donnelly

Re: NSW Voluntary Assisted Dying Bill 2017

I write today to express the concerns and objections of the NSW and ACT Baptist Association with regard to the Voluntary Assisted Dying Bill that was introduced into Parliament on 21st September.

We acknowledge and grieve for the distress and pain that is sometimes experienced by people at the end of life, and those who care for them. Our resolve is to work alongside others to support them with love, compassion and effective practical and palliative care.

However, we believe that life is God's gift and that our task is to protect and nurture life to the best of our ability. I therefore wish to express our opposition to this Bill, based on this foundational belief and the points outlined below:

1. The introduction of Assisted Dying undermines society's value for life.
 - a. We believe the value of life is not diminished by age, productivity or illness.
 - b. We urge that the terminally ill must be cared for and valued, not abandoned to death.
 - c. While we recognise that many who support this Bill have a well-intentioned desire to relieve the pain and suffering of the terminally ill, the strong insistence on the free choice and autonomy of a small number of individuals must always be weighed against the common good. In this case, we strongly believe that Assisted Dying introduces ethical shifts into our society that are contrary to the common good.
 - d. The legislation, even with included safeguards, represents a fundamental altering of criminal law to allow one person to play a part in ending the life of another. This is a dangerous shift away from the belief that we do not kill each other, even for reasons of mercy and compassion.
 - e. Promoting assisted suicide as a valid choice for people will undermine the significant and important work that is being done to prevent suicide.

2. The introduction of Assisted Dying creates significant risks for the most vulnerable in our society.
 - a. The notion that some lives are not worth living puts the most vulnerable in our community at risk. It reinforces a notion that some lives are more valuable than others.
 - b. There is a growing concern about elder abuse in our society. This Bill increases the potential for family members or carers to seek personal gain by applying pressure to the elderly to end their life.
 - c. We are concerned at the potential for significant widening of the parameters for who is eligible for Assisted Dying. This has occurred in a number of jurisdictions where similar Bills have been introduced. For example, in Belgium, what started as an intention to relieve physical suffering in terminally ill adults has resulted in a situation where euthanasia for sick children has now been legalised. Once a society passes over the boundary that says we do not assist people to kill themselves (assisted suicide), or actually kill them (euthanasia), where logically can it draw the line in the sand? In truth the line has already been crossed and to claim otherwise is being disingenuous.
 - d. We do not believe that the safeguards included in the Bill will be successful in preventing the pressuring of individuals at the end of life.

3. The introduction of Assisted Dying is contrary to the goals of medicine, and undermines the relationship of trust between patients and medical practitioners which is vital to the success of our health care system.
 - a. The Bill not only constitutes a fundamental change to the nature and goals of medicine, it also places what we believe is a significant and inappropriate burden on medical practitioners to ensure that no other party is benefiting from the patient's death.

We join you in seeking a respectful and compassionate response to end of life care. However, we urge that the response to suffering at the end of life be **focused on improving the quality and investment in palliative care**, rather than the introduction of a legislative framework that legalises assisted suicide and euthanasia.

We believe in an approach taken by organisations such as aged care provider BaptistCare, which provides a model of care that enhances quality of life by recognising the journey of individuals living with life-limiting illnesses. We also believe that Australian's need greater access to accurate information about palliative care and end-of-life care options.

Palliative care focuses on symptom relief, the prevention of suffering and improvement of quality of life. Palliative care supports a natural and dignified death for patients and provides support for family and colleagues. It is a solution that strengthens (rather than undermines) the foundational value we place on human life in our society.

I urge you to consider these objections, and the objections of many community groups who agree that the legalisation of Assisted Dying is unnecessary. In light of these objections, I urge you to oppose the current Bill and to join those in our movement and beyond in calling for greater investment into palliative care.

Yours sincerely



Rev Dr Steve Bartlett
Director of Ministries
NSW & ACT Baptist Churches

e. [Redacted]
p. 02 [Redacted]

From: Project Officer <[REDACTED]>
Sent: Tuesday, 3 October 2017 5:43 PM
To: Greg Donnelly
Subject: Voluntary Assisted Dying Bill 2017

Categories: Green Category



The Hon. Greg Donnelly MLC
Parliament House
Macquarie Street
Sydney NSW 2000

NSW Voluntary Assisted Dying Bill 2017

Dear Mr Donnelly

I am the Director of the L J Goody Bioethics Centre in Perth, Western Australia, one of a national network of ethics centres which for the last 30 years has provided advice to the public and private health sectors right around Australia. I write at this time to ask that you **do not support the *Voluntary Assisted Dying [VAD] Bill*** currently before your Parliament.

My reasons are as follows:

Fundamental Problem with VAD Legislation

1. When Australia abandoned capital punishment decades ago, it made a considered commitment to uphold a universal principle which stands at the heart of every civilised society, namely the absolute prohibition on one citizen intentionally killing another for any reason. Were the NSW Parliament to legislate VAD, it would be proposing the creation of a first and irreversible breach in a principle essential to the safety and security of the people of New South Wales. And this breach once created could not be contained in practice.
2. An inevitable effect of legislating VAD, even for a very narrowly-defined cohort in the first instance, is that other people who do not belong to that cohort come to view their exclusion from it as discriminatory. They then seek to be included among those to whom the legislation applies – and then another group claims discrimination. And so it goes: *“Once you introduce rights to one group of people, it is a political inevitability that others will soon demand to have those rights extended to them in the name of equality. Anything less than this incremental extension of rights is surely discrimination, is it not?”*^[1]
3. Parliament – were it to make an initial breach in the universal prohibition on killing – would have no logical reason to refuse to extend its reach further and further. Indeed, regardless of any statutory restrictions in an initial VAD law, no Parliament can guarantee that a future Parliament will not remove or vary the restrictions. The only way to prevent the inevitable spread of VAD is not to cross this particular Rubicon in the first place. I respectfully submit that Parliament should not, for any reason or in any circumstances, legislate a breach in the universal prohibition on one person intentionally killing another.

The VAD Bill

4. The Bill requires a patient seeking VAD to be 'suffering from a terminal illness' [S.9 (2)(c)] causing severe pain, suffering or physical incapacity [S.9 (2)(e)]. Research into the reasons people opt for VAD reveals that 'treatment of severe pain' is almost never the primary reason.
5. The *Oregon Death with Dignity Act* report for 2016 notes "*the three most frequently mentioned end-of-life concerns were losing autonomy (89.5%), a decreasing ability to participate in activities that make life enjoyable (89.5%), and loss of dignity (65.4%).*"^[2]
6. Nurses working in hospices in Oregon report that pain and pain control rated tenth in major drivers of desire for VAD among hospice patients after "*desire to control the circumstances of death, the wish to die at home, loss of independence or fear of such loss, and loss of dignity or fear of such loss*".^[3]
7. A *2017 Position Paper* from the American College of Physicians, while acknowledging pain and nausea to be significant factors, notes that other major drivers of VAD include "*psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based on hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically.*"^[4]
8. None of these drivers of VAD are medical conditions, and none require medical treatment.
9. One way or another, these are all expressions of a person's psychological desire to take control of the manner and timing of their own death. They represent, first and foremost, an exercise of the common law right of autonomy or self-determination. They all can be managed effectively with appropriate ongoing psychological counselling and social support, and by better access to state-of-the-art palliative care which includes these services. Providing all citizens in New South Wales with better access to these supports, especially equal access to palliative care for people living in rural and remote areas of the State, will be a more effective way to meet the real end-of-life decision-making needs of all NSW citizens.
10. The key question then is whether that citizen's decision has been made validly. This is not properly a medical but a legal matter. For that reason, I submit that VAD properly belongs within the purview of the legal profession, not the medical profession.

Disability

11. Disabled, aged and other vulnerable persons have every right to feel very nervous about the VAD Bill. British actress and disability advocate Liz Carr said recently: "*Whilst supporters of assisted suicide claim that the opposition of disabled people is irrelevant because these bills are only intended for terminally ill people, the top five reasons given by those using the Oregon assisted suicide law all relate to the experience of disability: "loss of autonomy" (91%), "less able to engage in activities" (89%), "loss of dignity" (81%), "loss of control of bodily functions" (50%) and "feelings of being a burden" (40%). Assisted suicide laws are, at their core, about disability.*"^[5] (emphasis added)

Depression

12. Many persons seeking VAD suffer from depression: studies identify rates as high as 40.9% and 58.8%.^[6] Depression is generally understood to invalidate a patient's informed consent for almost all medical treatments – except of course depression itself. The effect of depression on validity of consent to VAD does not seem to figure in the VAD Bill.

Suicide

13. Jurisdictions which have legislated VAD usually experience increased suicide rates: the rate in Oregon in 2010 was 35% higher than the national average, while the suicide rate in the Netherlands has increased by a similar percentage over the last decade. This creates a dilemma: can Parliament credibly seek to lower the suicide rate in NSW if it introduces a practice which will increase the rate of suicide? To put it otherwise: if all suicides are tragic, how can some suicides be considered good – and indeed, authorised by the State?

For all of these reasons I most sincerely urge you : **please do not support the Voluntary Assisted Dying Bill 2017 when it is debated in Parliament.**

Faithfully

Rev Dr Joseph Parkinson STL PHD MAICD
DIRECTOR
L J Goody Bioethics Centre
[REDACTED]
Mt HAWTHORN WA 6016

T [08] 92 [REDACTED]
F [08] 9242 4067
E [REDACTED]
W www.bioethicsperth.org.au

References

- ¹ Liz Carr (2017). "It's about people like me": disabled and dead against euthanasia." Online at <https://www.mercatornet.com/careful/view/its-about-people-like-me-disabled-and-dead-against-euthanasia/20276>
- ² Oregon Death with Dignity Act. Data Summary 2016. Online at <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf>
- ³ Linda Ganzini MD et al (2002). Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide. *New England Journal of Medicine* 2002; 347:582-588. Online at <http://www.nejm.org/doi/full/10.1056/NEJMsa020562#t=article>
- ⁴ Sulmasy et al (2017). Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. *Annals of Internal Medicine* 10.7326/M17-0938. Published online at Annals.org 19 September 2017.
- ⁵ Carr (2017).
- ⁶ Debra Vermeer (2017). Euthanasia: Quebec, Dutch, Belgian and Oregon laws a 'mess'. News Weekly February 11, 2017. Online at <http://newsweekly.com.au/article.php?id=57566>

Disclaimer

The information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. If you are not the intended recipient of this message you are hereby notified that any use, review, retransmission, dissemination, distribution, reproduction or any action taken in reliance upon this message is prohibited. If you have received this email in error, please notify us immediately by return email or telephone (08) 9242 4066 and destroy the original message. Any views expressed in this message are those of the individual sender and may not necessarily reflect the views of the organisation.

Please consider the environment before printing this email

^[1] Carr (2017).

^[2] *Oregon Death with Dignity Act. Data Summary 2016*. Online at <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf>

^[3] Linda Ganzini MD et al (2002). Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide. *New England Journal of Medicine* 2002; 347:582-588. Online at <http://www.nejm.org/doi/full/10.1056/NEJMsa020562#t=article>

^[4] Sulmasy et al (2017). Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. *Annals of Internal Medicine* 10.7326/M17-0938. Published online at Annals.org 19 September 2017.

^[5] Liz Carr, "It's about people like me": disabled and dead against euthanasia." Online at <https://www.mercatornet.com/careful/view/its-about-people-like-me-disabled-and-dead-against-euthanasia/20276>

^[6] Vermeer (2017).

LIVES WORTH LIVING

We embrace disability as a valid identity

3 October 2017

The Hon. G. J. Donnelly
Parliament of New South Wales
Macquarie Street,
SYDNEY, NSW 2000

An open letter to members of Parliament

Dear Mr Donnelly,

Stories from the disability rights community

I write on behalf of a coalition of organisations to provide you with a booklet that speaks to the deep and genuine concerns held by many people with disability about euthanasia laws that are before your parliament. We are all people with disabilities with a stake in these issues.

There are a range of views on this issue, including amongst people with disability and we'd encourage you to consult across the community and with genuine Disabled Peoples Organisations.

No matter your views on this issue, we'd invite you to pause and read the personal witness in the attached booklet to gain insight and understanding into how some of us feel about an issue that goes to the core of our existence and our rights.

Our position is not what you might have been told. We are not religious. We are not politically motivated. What we are is worried that euthanasia is being pushed through Parliaments without listening to our voices and reaching a genuine understanding of the disability rights position.

Our key objections are these:

The Bills before Parliament do not even *mention* the rights of people with disability under article 10 of the United Nations Convention on the Rights of People with Disability which was signed by Australia and ratified with bipartisan support. This says that:

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

On any objective measure, we simply *don't* enjoy these rights on an equal basis with others when it comes to assisted suicide. The playing field is rigged against us.

For a start, it's unfair and unjust to "offer" people like me euthanasia when we face barriers in accessing preventative, primary and tertiary healthcare which place us at risk of preventable illness, including life-threatening illnesses.

continues on page 2

We ask how Parliaments can even consider legalised euthanasia when our people can't even get yearly health checks or basic screening for the cancers that kill us?

Back in 2003 a community advocacy group, Access for All Alliance, undertook a survey of all general practices around Australia to identify which provided access to adjustable-height examination beds. The survey showed that of the 3,553 response there were just over 14,000 fixed-height examination beds and only 719 adjustable-height examination beds. An open letter from the Human Rights Commission found that in many situations patients, particularly women with disability, do not get a service *at all* because of the inaccessibility of fixed-height examination beds. One woman had not had a pap smear *for 10 years* because her doctor could not transfer her on to the fixed-height examination bed.

Eight years later the National Disability Strategy reports very little sustained and meaningful improvement in our access to healthcare. While the National Disability Insurance Scheme (NDIS) is starting to make a difference in specialist supports, it won't fix the health system.

Don't pass a euthanasia law that gives up on us. Pass a law to mandate disability access to screening against the secondary diseases that kill us.

People with disability are at risk of suicide due to depression, abuse and neglect and economic inequality. On almost every measure we are a vulnerable community on a par with Aboriginal and Torres Strait Islander people; LGTBIQ people and women and yet there is no meaningful suicide prevention work for people with disability and our deaths are regarded as a merciful release.

Your Parliament should invest in disability supports, mental health services and suicide prevention rather than creating a path to end our lives.

We have cause to be concerned about perverse outcomes if euthanasia is adopted in Australia. In some countries where it has been introduced euthanasia has been offered to people with mental illness, people with dementia, twin brothers who were deaf, and even a woman with severe tinnitus. A number of these countries have better safety nets in Australia and still people with disabilities are falling into the net of euthanasia.

Our challenge to advocates of voluntary euthanasia who insist that here in Australia it would "never be about someone like you", would be to ask you to specifically, totally and permanently rule us out. The legislation before you does not do this and we'd ask you to oppose it.

Parliaments across Australia have come together to do a wonderful thing by supporting the National Disability Insurance Scheme. We thank you. But most people with disability are still not covered by the scheme; there are gaps and many people are lost in transition. Older people, such as many in the generation affected by polio, are still not covered.

Australia should continue to choose the high road of investment in disability supports, paving gaps and making our lives worth living over time, not sanctioning our suicides.

In a toxic climate, where people with disability are described as burdens; abuse is rampant; we lack access to healthcare and we are vulnerable to financial, social, physical and sexual abuse it's no wonder some of us want to die.

The question facing Parliament is whether it's right, fair, a real choice or offered on an equal basis.

We say it isn't and invite you to choose a better way – to vote no to euthanasia and invest in measures that offer us a chance of a decent life, not a quick death.

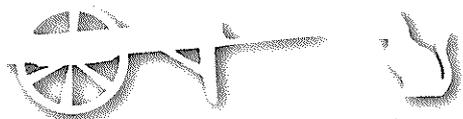
Thank you for accepting our stories and considering this letter and you can also contact me directly via [REDACTED] or [REDACTED]

Regards

[REDACTED]

Craig Wallace
Convenor
Lives Worth Living

NOT DEAD YET
The Resistance


Rage Against the Dying

*Please help us to
live and not to die*

NOT DEAD YET
The Resistance

LIVES WORTH LIVING



Rage Against the Dying

We want to talk about assisted suicide and euthanasia from the perspective of disabled people. We believe that this is a lethal form of discrimination and that we are the people who are very likely to die from the result of mistakes and abuse.

We have information and personal experience of having a degenerative disability. We understand that we don't have the right to live often; we live in poverty, we don't have support and we really believe that we need to do something to speak about those issues and many other issues, because our voices are not being heard. We're fighting against a very big and powerful lobby which is mostly comprised of non-disabled people who are afraid of being like us.

*This booklet includes testimony from some of
Australia's leading disability advocates.*

"I have watched family members die over and over again, and because we have this information, this is something that's really, really concerning to us that we know that people will die under this (proposed legislation), and we hear these stories every single day."

"So what I'm asking is that before you take steps to make sure that people can die with dignity, as we hear so often, that you first make sure that everyone has the same opportunity to access health services and live a life free from discrimination, whether that be systemic, attitudinal, or environmental."

"You cannot introduce adequate safeguards when in a myriad of ways people with disability are told we are a burden on society, on family, on friends, and that it would be best if we just weren't here anymore, that this would be a selfless thing to do."

"This (assisted suicide) has always been put in terms of individual rights, but it's not, it's putting more power in the hands of the state and it's putting more power in the hands of medical professionals, it's not really about empowering individuals."

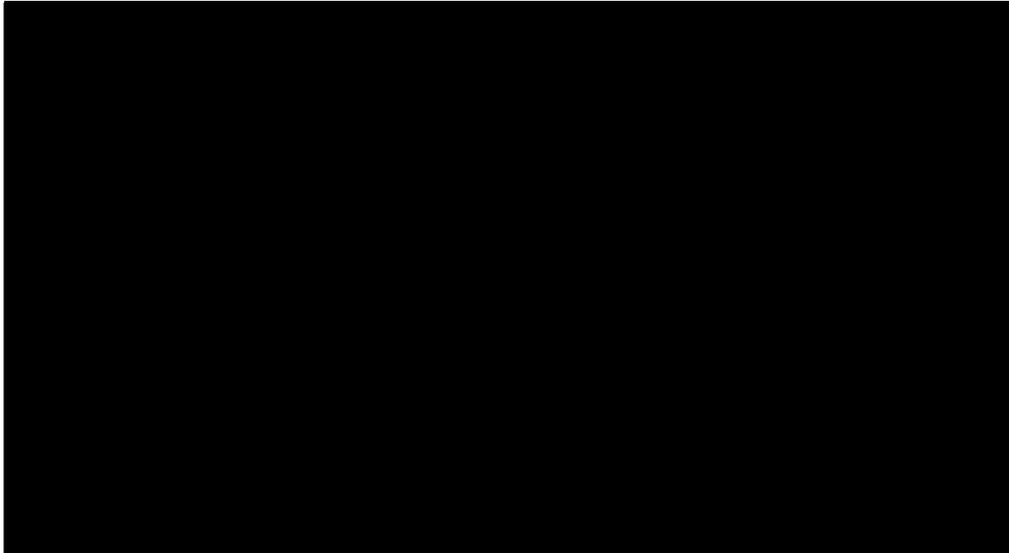


“Disability and assisted suicide is incredibly inappropriate when put together.

...we think the whole idea is actually really rude and inappropriate. It's being marketed as something that's about death with dignity, and the idea of dignity is really problematic for us because a lot of us don't go to the toilet in the same way that other people do and it's not something about us being less dignified.”

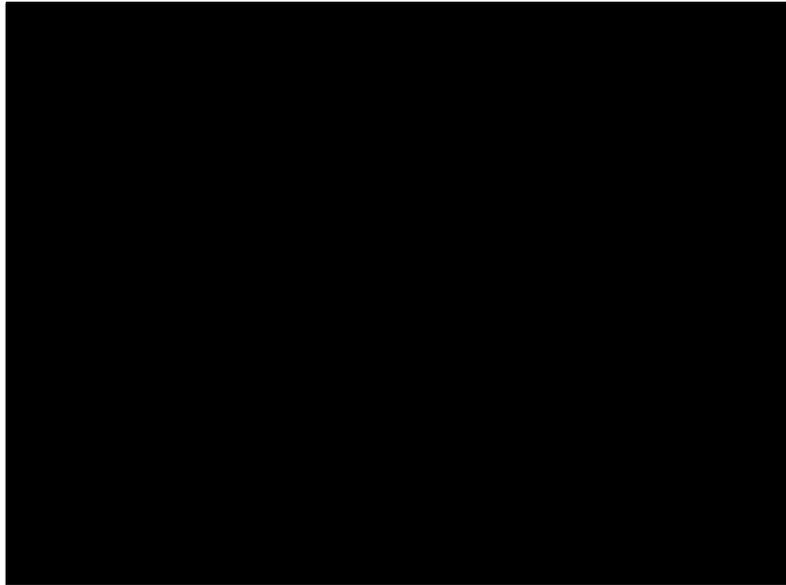
“Those issues around the narrative that our lives are tragedies is a really, really big issue for us and they're the things that I don't think non-disabled people know.”

“I have watched family members die over and over again, and because we have this information, this is something that's really, really concerning to us that we know that people will die under this (proposed legislation), and we hear these stories every single day.”



“Please consider your decision from all angles and all perspectives, you have the power to decide whether people live or die. Please don’t take that lightly. And it isn’t only people with cancer who cannot access treatment and services, people with disability don’t always have the same access to preventative health services as everyone else, a lot of the time this is because of lack of access.”

“So what I’m asking is that before you take steps to make sure that people can die with dignity, as we hear so often, that you first make sure that everyone has the same opportunity to access health services and live a life free from discrimination, whether that be systemic, attitudinal, or environmental.”



“This legislation gives more power to the medical profession and the lives of people with disabilities. It enables doctors to make decisions about what is “suffering”. Doctors are presumed to be impartial assessors of “intolerable” “suffering” but they bring with them their own personal biases as well as the bias of the medical profession regarding what is ‘normal’ and what is ‘suffering’ and what is worth living.

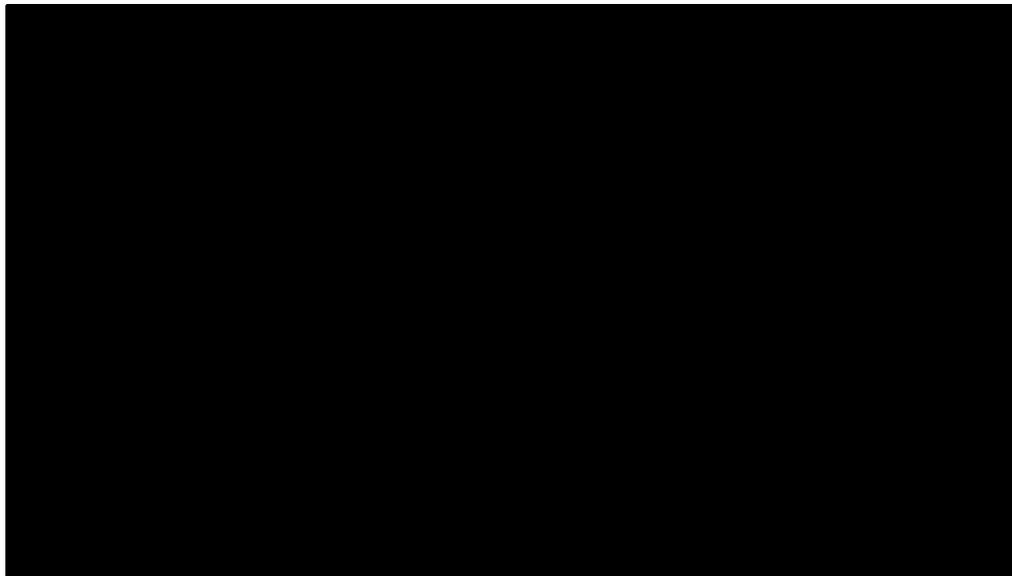
You cannot introduce adequate safeguards when in a moment people with disability are told we are a burden on society, our friends, and that it would be best if we just weren't here. This would be a selfless thing to do.

None of this occurs in a vacuum - in a logical, medical vacuum. Our choices are intrinsically influenced by the kinds of supports available in their lives. This issue is being framed around individual choices for people with disabilities our choices are already limited. Ensuring we have supports to live and live well. we are on

Anonymous testimony

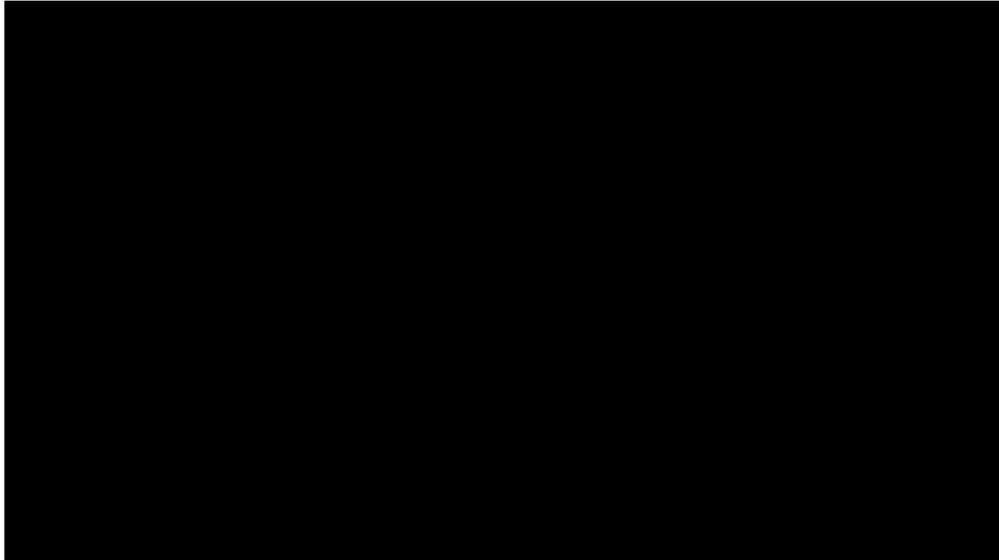
“In my experience — as a person with a lifelong terminal condition, and a transplant recipient who was given 12 months to live while on the waiting list — there are no clear lines around ideas of choice, of dignity, of pain, of coercion, even of suffering. My thoughts and decisions at that time were bound in confusing mixtures of fatigue, medication, anxiety, hope and guilt. Concern for those closest to me and their burden of care was constantly in my thoughts.

Cultural attitudes to terminal illness are underpinned almost entirely by a benign pity, and our default discourse both reflects and reinforces this: unbearable, helpless, without hope, suffering, inevitable, tragic, incurable. These are the words I have heard my whole life to describe my life and prospects. They also, without coincidence, form the technical language of qualifying criteria for the euthanised. Until our culture can stop defining my life — my healthy, thriving life — with the same terms as it uses to justify reasons to choose death, I will not feel safe from social and internalised coercion to make free choices. Until we look deeply at our attitudes to disability and terminal illness, I do not yet feel ready to have this legislation imposed upon me.”



"I'm not seeing a huge difference around the type of language around those what are conventionally understood as suicides and tragic (and we should have tried to stop them and if only) and the kind of language around this kind of death and this kind of suicide (assisted suicide)."

"This (assisted suicide) has always been put in terms of individual rights, but it's not, it's putting more power in the hands of the state and it's putting more power in the hands of medical professionals, it's not really about empowering individuals."



My concerns about euthanasia are that legalising suicide by people with disability will create a raft of subtle personal, emotional, practical and financial incentives for disabled people to take our own lives. When people talk about choice they do so in the absence of understanding about the profound barriers and attitudes that disabled people face which restrict our choices in the here and now.

How can we talk about 'choice' for disabled people to die when people can't even access the basic screening and preventative medicine that would prevent us managing our conditions or even developing diseases like cancer?

It's also problematic that the deaths of people with disability are so often minimised. Violence against people with disability is endemic and the homicides of disabled children by their parents are sometimes portrayed as a welcome release for all concerned rather than murder. For most groups of people in the community, like young people, LGBTIQ people or isolated farmers, suicide is treated as a tragedy which needs to be prevented. Yet there is almost no suicide prevention work in the disability community. There is almost no work done to support people who acquire a disability to say 'things can get better' with the right supports and access.

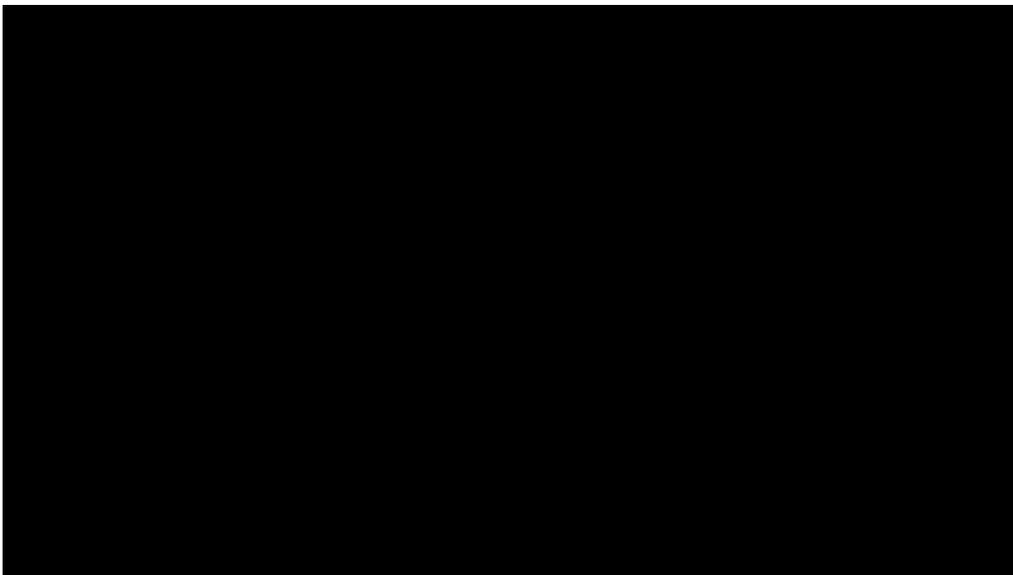
Craig Wallace continued

I'm a lifelong atheist and human rights activist for people with disability who has come to this position after much consideration. It's really unsophisticated to try and suggest disabled people are being manipulated in the debate. It's a patronising view that suggests we're gullible and incapable of reaching an independent viewpoint. Privileged people who don't live the lives of disabled people in the firing line need to start listening to the real fears and concerns we have about the spread of euthanasia and why these are grounded.

"It is significant that none of the legislation we have seen to date names specific conditions which are covered by euthanasia and instead uses terms like 'intolerable suffering' or 'terminal illness'. Well, most of us have gone through periods where our disabilities have seemed intolerable and many disabilities shorten the life span. Where euthanasia has been introduced it has expanded to cover people who are deaf, depressed and have disability. There is also a historical context of euthanasia as a tool for eugenics which few people mention but still feels very close to us today.

In a world which regards disability as a financial 'burden' and where we continue to be socially, economically and physically oppressed by inaccessible environments, I'm simply not prepared to hand power over the lives of disabled people to carers, doctors, politicians and professionals. I don't trust the safeguards. I don't believe they'll keep people safe and we've got good reason to be sceptical."

The late Stella Young was spot on when she said we don't need death with dignity till we have lives with dignity.



“Opposition to these bills is usually marginalised as being religious and that’s very useful to do if you don’t want to listen to it, but actually if we want to introduce a bill like this, we have to listen to all sides of course, and we have to not diminish their view.”

“I have met with disabled people all over the world in this issue. Why does it involve us? Because it’s very easy to shut up disabled people, and go: this is not about you. This is about terminally ill people. In the public perception, in the media, and in medical terms there is such a fine line between disability and terminal illness, that we become one in the same.”

“I feel that even the risk of getting it wrong in one case is too much. What strikes me as bizarre is that in terms of something like capital punishment we don’t have that for that same reason and that’s a much higher degree of accountability. We have an investigation, a court case, police involvement, and still there are miscarriages of justice. We want to check is that person of sound mind, not being coerced, whatever all of the safeguards we’re gonna put in, and we have that happening with two doctors with limited time.”

“Coercion is not about being dragged to your death. Coercion is worse than that usually. It’s usually social coercion, and it looks in the form

Liz Carr continued

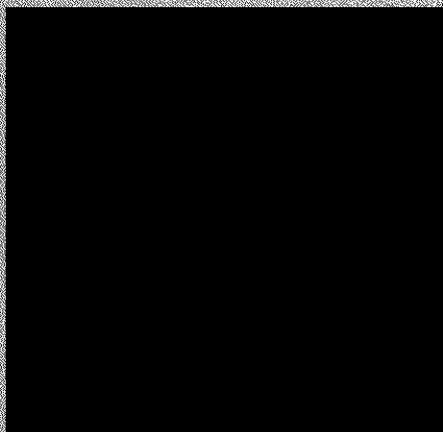
of you decide yourself, because life's so poor, but that's not always physical or mental. It can often be because you've not got the support you need or because you're with a family that you don't want to burden; and even if they say you're not a burden, the fact that you've got the kids to look after or you've got work and you've got life, you can feel that. How do we unpack all of that?"

We are a collective of Australian people living with disabilities who are concerned about assisted suicide and euthanasia legislation.

We are affiliated, internationally with groups across the globe who share our concerns.

We only have small voices. We don't have major media machines and we don't have a large lobby behind us. That's why you need to listen closely because we are the people that will be affected by this legislation through mistakes and abuse.

Please listen and understand our concerns and, please, vote NO to the Voluntary Assisted Dying Bill!



"Before we can talk about death with dignity, we need to ensure that all people, regardless of age or disability, can live with dignity. We're not there yet!"

Stella Young

NOT DEAD YET
The Resistance

LIVES WORTH LIVING



Rage Against the Dying

**SPEECH TO THE NATIONAL PRESS CLUB CANBERRA
WEDNESDAY 23 AUGUST 2017**

AMA PRESIDENT, DR MICHAEL GANNON

Euthanasia and Physician Assisted Suicide

Last year, we released an updated Position Statement on Euthanasia and Physician Assisted Suicide.

It came at a time when a number of States, most notably South Australia and Victoria, were considering voluntary euthanasia legislation.

There was an expectation in some quarters that the AMA would come out with a radical new direction. We didn't.

The AMA maintains its position 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. This is not euthanasia.

Doctors have an ethical duty to care for dying patients so that they can die in comfort and with dignity.

We are always there to provide compassionate care for each of our dying patients so they can end the last chapter of their lives without suffering.

We believe that governments must do all they can to improve end of life care for all Australians.

They must properly resource palliative care services and advance care planning, and produce clear legislation to protect doctors who are providing good end of life care in accordance with the law.

Of course, euthanasia is a matter for society and its Parliaments.

However, if new legislation does come into effect, doctors must be involved in the development of the legislation, regulations, and guidelines.

We must protect doctors acting within the law, vulnerable patients, those who do not want to participate, and the wider health system.

The AMA recognises that good quality end of life care can alleviate pain and other causes of suffering for the overwhelming majority of people.

There is already a lot that doctors can ethically and legally do to care for dying patients experiencing pain or other causes of suffering.

This includes giving treatment with the intention of stopping pain and suffering, but which may have the secondary effect of hastening death.

I reiterated all of this yesterday in an address to 40 MPs in Victoria, imploring them to legislate protections according to this 'doctrine of double effect'.

Bills in South Australia and Tasmania have been defeated. I encourage politicians in Victoria to 'put the horse before the cart' and focus on the everyday issues in end of life care.

Our position does not appeal to everyone, least of all high profile euthanasia campaigners and their enthusiastic supporters in the media.

We also have members who differ in their view.

But our position, supported by the overwhelming majority of our Federal Council, is supported by the bulk of the medical profession.

There are medical, ethical, and moral responsibilities at the heart of the doctor-patient relationship, and we all take them and our oath, the Declaration of Geneva, very seriously indeed.

I am sure that Members are closely following developments in Victoria. I commend the Upper House Committee Report and the process that informed it. The response to the Report was to prioritise Recommendation 49 and focus on Euthanasia/Physician Assisted Suicide.

Similarly a lot of advocates on both sides of this important social issue have focused on Points 3.1 and 3.3 in our statement, forgetting that E-PAS represents a very small part of a much wider discussion on End of Life care and how we can improve it.

I understand that the decision which awaits you all will be a difficult and challenging one. The process to develop the Federal AMA position last year was also at times vexed. What I will emphasise is that the survey of members which informed and underpinned the AMA position showed generally that those doctors who regularly deliver end of life care to patients are those that have the greatest opposition to E-PAS. These are the doctors who perhaps not only see the dangers such legislation could bring to the community, especially vulnerable groups like the aged and those with disabilities. These are also the doctors who know what can be done now to bring comfort and dignity to those who are dying if they are adequately supported by good legislation and adequate resourcing of palliative care services.

These are the very positive things that you, as Members of Parliament, can advocate for to genuinely improve the end of life care for the whole New South Wales community.

AMA New South Wales is responsible for advocacy in your state and I have sent their President, Professor Brad Frankum a copy of this correspondence. Of course with proposals for Euthanasia/Physician Assisted Suicide live in your state, in Victoria and Western Australia (not to mention recently defeated bills in Tasmania and South Australia), this is very much a national issue and I would be happy to address any of your individual or collective concerns.

Thank you for your invitation.

Yours sincerely

Michael Gannon

On Fri, Oct 6, 2017 at 8:55 AM, Tammy Tsimbrikas <[REDACTED]> wrote:

Dear Dr Gannon,

See attached for your attention a copy of a letter from myself regarding the *Voluntary Assisted Dying Bill 2017* that is currently before the NSW Legislative Council.

I look forward to your response in due course.

Yours sincerely,

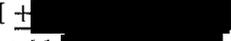


Greg Donnelly MLC

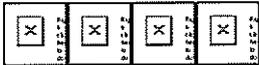
Parliament of New South Wales

--

**Dr Michael Gannon
President
Australian Medical Association**

 **E** 
 **M** 
T +61 
F +61 2 6270 5499
W www.ama.com.au

 **BARTON ACT 2600**
PO Box 6090 KINGSTON ACT 2604



IMPORTANT: This message may contain privileged and confidential information that is the property of the intended recipient. If you are not the intended recipient, you should not disclose or use the information contained in it. If you have received this email in error, please notify us immediately by return email and delete the document. Copying or disseminating any of this message is prohibited.
Any views expressed in this message are those of the individual sender and may not necessarily reflect the views of the Australian Medical Association unless indicated otherwise. Before opening or using attachments check them for viruses and defects.

Euthanasia and Physician Assisted Suicide

2016

1. Good quality end of life care and the relief of pain and suffering

1.1 Doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity.

1.2 Doctors should understand that they have a responsibility to initiate and provide good quality end of life care which:

- strives to ensure that a dying patient is free from pain and suffering; and
- endeavours to uphold the patient's values, preferences and goals of care.

1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.

1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life.¹

1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or physician assisted suicide simply because they are unable to access this care.²

1.6 As a matter of the highest priority, governments should strive to improve end of life care for all Australians through:

- the adequate resourcing of palliative care services and advance care planning;
- the development of clear and nationally consistent legislation protecting doctors in providing good end of life care;¹ and
- increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia.

2. Patient requests for euthanasia and physician assisted suicide

2.1. A patient's request to deliberately hasten their death by providing either euthanasia or physician assisted suicide should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and/or poorly controlled clinical symptoms. Understanding and addressing the reasons for such a

¹ The AMA supports nationally consistent legislation which holds that a doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under a medical practitioner's supervision, incurs no civil or criminal liability by administering or prescribing medical treatment with the intention of relieving pain or distress:

- a) with the consent of the patient or the patient's representative; and
 - b) in good faith and without negligence; and
 - c) in accordance with the proper professional standards;
- even though an incidental effect of the treatment may be to hasten the death of the patient.

A doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under the doctor's supervision, is under no duty to use, or to continue to use, life sustaining measures which are of no medical benefit in treating the patient if the effect of doing so would be merely to prolong life.

² Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering. Physician assisted suicide is where the assistance of the doctor is intentionally directed at enabling an individual to end his or her own life.

request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.

2.2 If a doctor acts in accordance with good medical practice, the following forms of management at the end of life **do not** constitute euthanasia or physician assisted suicide:

- not initiating life-prolonging measures;
- not continuing life-prolonging measures; or
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

3. AMA position on euthanasia and physician assisted suicide

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.

3.2 The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide.

3.3 The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.

3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:

- all doctors acting within the law;
- vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
- patients and doctors who do not want to participate; and
- the functioning of the health system as a whole.

3.5 Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.

3.6 Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

Reproduction and distribution of AMA position statements is permitted provided the AMA is acknowledged and that the position statement is faithfully reproduced noting the year at the top of the document.

For Those Who Are Undecided: Reflections on the Voluntary Assisted Dying Bill
By Anna Walshⁱ

In the next fortnight, you will vote on the Voluntary Assisted Dying bill. For those undecided, but whose conscience is troubled by the concept that eliminating a patient in order to eliminate their pain should be part of medical practice, this short note reviews the basic ideology and facts underpinning euthanasia and physician-assisted suicide.

The arguments for euthanasia and physician-assisted suicide focus on very human concerns. That such acts could be contemplated in a profession that abides by the maxim, 'first, do no harm', is justified by the assurance that it will be restricted to terminally ill patients, where there is no treatment for suffering that the patient finds acceptable.

This justification presupposes that persons with terminal illnesses who suffer terrible pain and suffering will make use of good quality palliative care and yet still find it wanting. The state, it is argued, is obliged to interfere with the practice of medicine in order to find a solution for the good of society.

The presupposition is worth testing. In Oregon, where physician-assisted suicide has occurred for 20 years, statistics demonstrate that pain relief is not the primary reason people request this service. Instead, the statistics show that most people have anticipatory fears about loss of autonomy and dignity, and being less able to enjoy life's activities.ⁱⁱ

When pain is the issue, palliative care physicians have the means to control pain. Far from placing sanctity of life over quality of life, treatment administered to control the pain that accompanies terminal illness but has the foreseeable consequence of shortening the patient's life has long been justified on the basis of 'double effect reasoning.'

Central to double effect reasoning is the *intention* of the physician.ⁱⁱⁱ The reasoning process prohibits a physician from performing any act where the intention is to hasten death so as to avoid suffering. The cause of death must be the disease process itself, and the physician's action that contributes to death must be good or neutral.

However where a person's death is imminent, adequate pain relief that includes the unintended but foreseeable consequences of hastening death is permissible and consistent with the ends of medicine. But prescribing and administering lethal substances in order to end the patient's life runs afoul of double effect reasoning and the law.

The above logic forms the counterpoint argument to characterizations of euthanasia and physician-assisted suicide as a continuum of medical care. Whilst respect for the patient's autonomy is a *prima facie* principle that physicians must respect, physicians as moral agents should not use their skills to kill. It is, in effect, a moral absolute.

The normative ethical theory that justifies the bypassing of double effect reasoning and permits both the direct and indirect killing of a patient is a form of utilitarian consequentialism. For the consequentialist, the nature of the act itself is irrelevant to whether it is permissible. What matters is the end result and the end justifies the means.

For the consequentialist, the physician's intention is irrelevant. It involves an artificial distinction that fails to provide clear guidance. However whether or not treatment is available to effectively control pain is not the issue for them. Rather, it is the ability to choose not to have to suffer in the future.

The fear of 'legislative creep', where permitting one kind of action increases the tendency of further ethical encroachment, is dismissed as scaremongering. The bill is purported to be modeled on Oregon's *Death with Dignity Act*, which has remained stable in terms of being confined to terminally ill adults who self administer the lethal substance.

Great pains are taken to distinguish the Oregon framework from Belgium and other European countries that have undeniably succumbed to legislative creep. Like Oregon, legislation enacted in Belgium was initially confined to terminally ill adults, however today it encompasses incurable physical and mental illness and terminally ill children.^{iv}

However, unlike Oregon, this bill is not restricted to physician-assisted suicide, but extends to the concept of the direct killing of the patient by a physician or nurse where the patient is physically incapable of administering the lethal substance to him or herself. Thus, this bill already demonstrates 'legislative creep' from the model it is derived from.

It is not irrational to be concerned about legislative creep. Once killing a terminally ill patient on the basis of their fear of suffering and loss of dignity is justified by society and normalized in the law, why should it be restricted to the terminally ill adult? Suffering – and fear of suffering – can occur at any time in one's life, for a multitude of reasons.

Permitting only the terminally ill who meet specific criteria to access physician-assisted suicide could be discriminatory. Additionally, if it is accepted as a cure for suffering, arguments can be made that it would be unjust not to provide this service to those who are perceived to be suffering but nevertheless lack capacity to make decisions.

Without moral absolutes, medicine becomes a rudderless ship, sailing in whatever direction the patient directs. Unless it is made available to everyone who is suffering, rules governing euthanasia and physician-assisted suicide are arbitrary and open to challenge. Whilst Oregon has resisted the 'twitch on the thread', far many more have not.

Ultimately, the point of difference between the palliative care physician's control of pain using double effect reasoning and this bill is the intention underlying the physician's action. Intention changes the nature of the act even where the consequences are the same. Intention acts as a restraining hand in the preservation of professionalism and integrity.

Whilst you should listen to the narratives of people who have witnessed family members die a painful death, it is not inappropriate to dig deeper into those stories. Also take the time to understand how palliative care physicians help the terminally ill, and how patient outlooks change upon receiving quality palliative care services.

Physician-assisted suicide and euthanasia are moral and medical issues. Putting aside the emotion that accompanies this discussion, your vote should be cast for an ideology you believe will best serve the medical profession, that will produce good fruit in terms of its consequences, and that promotes the kind of values you believe will help society flourish.

¹M. Bioethics (Harvard), LL.M (Syd), LL.B (Hons), B.Nurs (Hons).

² Oregon Death with Dignity Act: 2015 Data Summary

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>.

³ See, eg, Daniel Sulmasy and Edmund Pellegrino, 'The Rule of Double Effect' (1999) 159 *Archives of Internal Medicine* 545, 545.

⁴ European Institute of Bioethics, 'Analysis of the Seventh Report of the Federal Commission for Euthanasia Control and Evaluation to the Legislative Chambers (for the years 2014-2015)' [www.http://eib.com](http://eib.com).

From: The Hon. John Watkins AM <[REDACTED]@au>
Sent: Monday, 9 October 2017 7:30 AM
To: Greg Donnelly
Subject: NSW Voluntary Assisted Dying (VAD) Bill 2017

Follow Up Flag: Follow up
Flag Status: Flagged

[Voluntary Assisted Dying \(VAD\) Bill 2017](#) | [View in Browser](#)



5 October 2017

Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr Donnelly

NSW Voluntary Assisted Dying (VAD) Bill 2017

Calvary is writing to you to share some particular and critical concerns we have identified with respect to the proposed legislation.

Calvary has 130 years of providing care for the terminally ill and, whilst we provide a wide range of person-centred services across all age groups and across the health, aged and community sectors, the core of our mission and our major specialisation is in palliative and end of life care.

Given this experience and expertise of providing quality care to the vulnerable, tailored to their individual needs and goals, we submit we are well-placed to provide advice on the matter of voluntary assisted dying.

We encourage you, if you are supportive of the legislation, at least to consider these very important matters – as outlined below.

1. The Bill establishes a process for VAD but with *insufficient appreciation of the*

clinical care context. The Bill focuses on individual autonomy without adequately addressing the context in which end of life decisions are made, and the significant role of family and carers in particular. The role clinicians in the event of complications, or if the substance is ineffective, has not been sufficiently considered.

2. Clause 18 (1) (a) of the legislation requires that 'in the medical practitioner's opinion, the patient is suffering from a terminal illness' defined in Clause 4 as "an illness that will, in reasonable medical judgment, result in the death of the person suffering from the illness within the next 12 months." **Determining how long a person has to live is not an exact science** and is a challenge even for the most qualified doctors. At one year, the margin for error in prognostication significantly increases and many clinicians would find it this a difficult assessment to make. Patients are at risk of ending their life when they could potentially have several more years to live.
3. Calvary is most concerned, however, at the **lack of information about the proposed clinical regimen that will apply, including its known complications, safety and effectiveness.**

The Bill does not specify the regimen or drugs that would be used. The normal process for the introduction of a new treatment or clinical intervention would require this information prior to approval.

Overseas experience shows us that sometimes things don't go smoothly in the VAD process.

Without a clear understanding of what drugs will be used and how complications, including vomiting, fitting, and failure to die will be managed and until the proposed protocols are approved by the relevant medical colleges, it is premature to proceed with the Bill.

As these clinical risks have not been presented, and cannot be presented until the regimen and protocol are known the community cannot fully understand what we are being asked to agree to.

I draw your attention to our [position paper](#) which discusses Calvary's concerns in more detail. Appended to our paper is an example of the clinical process used in Canada for intravenous medications for medical assistance in dying.

In an issue of such importance, and in the context of many differing values, we believe that all the relevant information should be available ahead of the decision.

Again, we encourage you, if you are supportive of the legislation, at least to consider these very important matters.

Please contact [Sue Hanson](#), National Director of Clinical Services on (02) [REDACTED] to discuss this letter.

Yours sincerely

[REDACTED]

The Hon. John Watkins, AM
Chair of Calvary



Calvary

Continuing the Mission of the Sisters of the Little Company of Mary

Founded in 1885 by the Sisters of the Little Company of Mary, Calvary is a charitable, not-for-profit, Catholic health care organisation.

Our mission is to provide quality, compassionate health care to the most vulnerable, including those reaching the end of their life.

We're responsible for over 12,000 staff and volunteers, 15 Public and Private Hospitals, 17 Retirement and Aged Care Facilities and a national network of Community Care Centres.



Hospitality



Healing



Stewardship



Respect

You can find us on



[Unsubscribe](#) [Forward to a friend](#)

© Little Company of Mary Health Care Ltd 2017
135 King Street, Sydney NSW

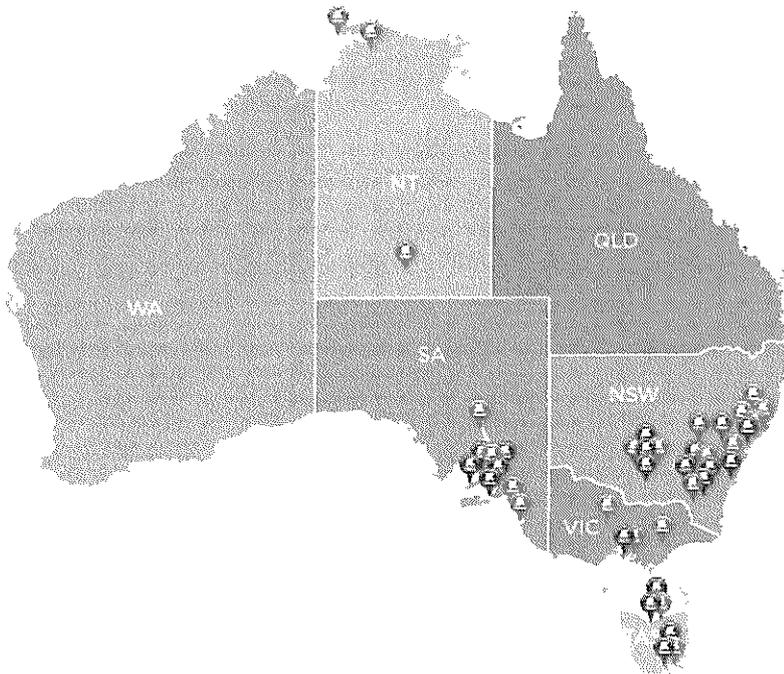
5 October 2017

Voluntary Assisted Dying Bill 2017 (NSW)

Calvary's Position

Calvary's role in the NSW Community

Since the establishment of Calvary in 1885, with the arrival of the Sisters of the Little Company of Mary in Australia, Calvary has become well known for the provision of health care to the most vulnerable, including those reaching the end of their life. With more than 12,000 staff and volunteers, 15 public and private hospitals, 17 retirement and aged care facilities, and a national network of Community Care centres. We operate across six states and territories within Australia.



Calvary Health Care Kogarah public hospital in Kogarah, NSW is recognised as a leader in Specialist Palliative Care. We provide Specialist Palliative Care Services and Rehabilitation Services to the local St George and Sutherland Shire regions and extensive Community Health Services to the St George region.

We are one of the largest sub-acute hospitals in NSW serving approximately 12,500 patients per year.

We provide palliative care as an inpatient service, at home or in residential care facilities. A person can be admitted for pain and symptom management, respite care or end of life care.

We use a team approach to address the needs of patients and their families. Our care is coordinated with other services and is focused on the whole person. We help patients to achieve their goals and improve their quality of life.

Calvary Mater Newcastle public hospital in Waratah, NSW, is the major cancer care centre for the Hunter New England Local Health District, delivering more than 320,000 occasions of outpatient services and in excess of

Level 12, 135 King St, Sydney NSW 2000 · GPO Box 4121, Sydney NSW 2001 · P: 02 9258 1700
www.calvarycare.org.au

Page 1 of 14

16,000 inpatient treatments per year. Calvary Mater Newcastle is also home to a world renowned research facility. Staffed by leading researchers in oncology, toxicology, psychiatry and palliative care, we are affiliated with major universities and colleges and international research partners.

We provide Palliative Care as an inpatient service, at home or in residential facilities. Patients can be admitted for pain and symptom management, respite care or end of life care.

Calvary Riverina Hospital in Wagga Wagga, NSW, provides a range of services to the Riverina community including Calvary Riverina Surgicentre, our award winning Drug and Alcohol Centre, and Maternity and Women's Health Services.

The Mary Potter Palliative Care Unit provides inpatient palliative care services and support to public and private patients. This service is supported by a multidisciplinary team of nursing, medical and allied health practitioners who provide much needed specialist care to patients who are nearing end of life. We provide specialist palliative care for acute patients and, as a member of the Palliative Care Alliance, have established links with hospice and home-based community palliative services for both public and private patients.

Calvary Retirement Communities operates 873 aged care beds and 272 independent living units across 14 sites in NSW, including at Ryde in Sydney, in the Hunter Region and in Newcastle.

Calvary Community Care has been supporting people in their own homes and communities throughout NSW for over twenty years. We deliver a range of aged care, disability and other support services that enable independence, improve social connections and promote positive health and well-being.

Calvary's position – fundamental questions outstanding

Calvary does not support the passage of this legislation. Calvary accepts that there are a plurality of views on the subject of voluntary assisted dying. Calvary will not, however, participate if the legislation is passed.¹

Calvary cannot support the notion that assisting a person to commit suicide, or to end their life directly and intentionally, is an expression of care. We strive to eliminate suffering but not the people who are experiencing the pain or physical incapability.

Clause 9 of the Bill establishes the conditions for eligibility "to request assistance from medically qualified persons to voluntarily end their own lives".

¹ Calvary has reviewed the [Royal Australasian College of Physicians' \(RACP\) feedback](#) in response to the NSW Parliamentary Working Group on Assisted Dying's (PWGAD) Draft *Voluntary Assisted Dying Bill 2017*. Calvary agrees with the comments made on pages 4-10 of the RACP submission. Some of these comments have now been addressed by those are sponsoring the private member's Bill.

9 Request for assistance to voluntarily end life

- (1) An eligible person may request a registered medical practitioner for assistance to end the person's life in accordance with this Act.
- (2) A person is *eligible* to make a request under this section if:
 - (a) the person is at least 25 years of age, and
 - (b) the person is an Australian citizen, or a permanent resident of Australia, and is ordinarily resident in New South Wales, and
 - (c) the person is suffering from a terminal illness, and
 - (d) the registered medical practitioner to whom the request is made (referred to in this Act as the *primary medical practitioner*) has informed the person that, in the practitioner's opinion, the person is suffering from a terminal illness, and
 - (e) as a consequence of the terminal illness, the person has been experiencing severe pain, suffering or physical incapacity to an extent unacceptable to the person.
- (3) The primary medical practitioner must not be a close relative of the person who makes the request.
- (4) A request under this section is referred to in this Act as a *request for assistance*.
- (5) A person who makes a request for assistance is referred to in this Act as the *patient*.

Clause 18 (c) further requires that the medical practitioners involved have formed the opinion

- (c) there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure.

And Clause 19 requires the primary medical practitioner to provide certain information to the patient

19 Information to be provided by primary medical practitioner

- (1) The primary medical practitioner must, after conducting an examination under this Part, provide the following information to the patient in writing:
 - (a) information relating to the nature of the illness and its likely course,
 - (b) information relating to the medical treatment, including palliative care, counselling and psychiatric support and measures for keeping the patient alive, that might be available to the patient,
 - (c) information relating to the consequences of the administration to the patient of an authorised substance, including the risk and possible adverse consequences of the administration not resulting in the death of the patient,
 - (d) information relating to the right of the patient to rescind a request for assistance,
 - (e) any other information required by the regulations.
- (2) If the patient is unable to read the written information, the primary medical practitioner must also provide the information to the patient orally.
- (3) In addition, the primary medical practitioner must offer to refer the patient to a palliative care specialist. The patient is not required to accept the offer of referral.
- (4) The patient must, after receiving information and offer of referral under this section, indicate to the primary medical practitioner that the decision to request the assistance still stands.

Considering the effect of these clauses in their totality, Calvary submits that the following scenario is permitted under the proposed Bill.

A person aged 25, suffering from an illness which in reasonable medical judgment could result in their death within the next 12 months, who says to a medical practitioner, "I am experiencing severe pain, suffering or a physical incapacity to an extent unacceptable to me," can lawfully be assisted to die.

Determining how long a person has to live is not an exact science and is a challenge even for the most qualified doctors. At one year, the margin for error in prognostication significantly increases and many clinicians would find it this a difficult assessment to make. Patients are at risk of ending their life when they could potentially have several

more years to live.

Under this legislation we could fail as a community to offer a person with a terminal illness the chance to live the life remaining to them as fully and as richly as possible. Such an outcome, Calvary submits, is not in the interests of the common good. The passage of this Bill may implicitly suggest to the community that the State of NSW places greater value on facilitating the death of a person whose suffering is great than on investing in treatments, care and social support mechanisms which could help them live a longer life with less pain and suffering.

Without easy access to quality pain management (palliative care), a social safety net and good community support systems, some people may request physician assisted dying as they feel they have no other choice. This is especially so for people who live in rural, regional and remote areas and for people from culturally and linguistically diverse communities who have less access to palliative care services. People with little support from family, who are socially isolated and with access to limited economic resources may also come to believe it is better that they die rather than seek help to live with less suffering.

We do not believe that this legislation contains adequate safeguards to protect vulnerable populations, especially those with incurable cancer, progressive neurological illness, the aged, the infirm, and people who live with disability. These groups of people can experience high rates of depression and isolation. The risks that this legislation poses for the majority of these human beings are great.

The Bill does not specify the regimen or drugs that would be used.

Calvary has deep concerns with respect to the **lack of information** about the proposed clinical regimen for voluntary assisted dying in the draft legislation; including any reference to the known complications, safety and effectiveness, let alone how risks would be managed.² Clause 6 defines an “authorised substance” as “a substance that is declared by the regulations to be an authorised substance for the purposes of this Act or that belongs to a class of substances so declared.” This is not a matter that should be left to regulation.

Calvary has identified significant issues of implementation, unaddressed in the Bill which should be discussed, clarified, debated and ultimately provided for in legislation. This factual information, if provided, would enable legislators better to assess whether the clinical regimen is safe, respects human dignity and is consistent with the value of compassion. Both the rationale for and efficacy of the proposed legislation depend on the means, the mode and the manner by which a person obtains their own death. **If the clinical regimen is unsafe, gives rise to complications or is ineffective, the legislation will fail to achieve its stated intention and will put people in NSW at risk.**

These are threshold issues which cannot be left to be resolved in the six months between the passing and

² The the Australian and New Zealand College of Anaesthetists made a similar point in their submission to the Ministerial Advisory Panel in Victoria. On page 16 of the College’s submission, they state:

“There must be disclosure in the legislation of the type, dose and formulation of the lethal dose of medication to be administered and of the alternative methods that may be used if the patient is unable to self-administer or ingest or absorb the lethal dose of medication.”

See http://www.anzca.edu.au/documents/anzca_voluntary-assisted-dying-submission-report_2.pdf accessed on 10 August 2017.

commencement of the legislation (*per* Clause 2 of the Bill). These are issues to be resolved before the law is introduced.

Threshold issues which need to be addressed before legislating

Calvary agrees with three observations made by the Royal Australasian College of Physicians (RACP) and submits that the revised Bill has not addressed these concerns, namely that

- the Bill conveys a legal process, with little understanding of the clinical care context. This is apparent in the sections covering assisting persons, prognosis, suffering and physician opinion,
- the Bill is heavily based on individual autonomy and does not adequately address the context in which end of life decisions are made, and the significant role of family and carers,
- the process for preparation of a Bill of this nature has not been undertaken in a sufficiently robust manner.³

In addition to the ethical questions which have been ably raised with Members of Parliament and the NSW community by our sister Catholic health and aged care services and religious leaders, Calvary has concerns about two (2) key or threshold questions.

1. What lethal substance will people use to end their own lives (bring about their own deaths)?
2. Who will assist them (to die) and how will this be done?

The answers to these questions are threshold concerns which we believe should be thoroughly explored and addressed before legislation is enacted and not left to be sorted out later.

1. What lethal substance will people use to end their own lives?

The draft Bill does not specify the regimen or drugs that would be used. Clause 6 states

6 Authorised substances

An authorised substance is a substance that is declared by the regulations to be an authorised substance for the purposes of this Act or that belongs to a class of substances so declared.

Assisted suicide is not a simple procedure with 100% effectiveness. Accordingly, we raise the following issues:

- What drug is proposed for oral ingestion in NSW?
- Is the drug pharmaceutically available? Who will dispense it?
- Will the Commonwealth Government (through the TGA) allow the drug to be imported and dispensed?
- Will the drug be on the PBS?
- If not on the PBS, what will be the fee to access it?
- Who will credential this scope of practice?
- What are the known risks and complications?

³ RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017 page 2 accessed at <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf> on 20 September 2017.

Before legislation is enacted, it is important that the community has information about the proposed lethal substance, how it will be sourced, its efficacy, the risks and benefits.

International reports have identified that complications of medically assisted dying are under-reported, however in those countries where assisted dying or euthanasia have been legalised there are reports of patients vomiting under sedation, having seizures, of people who wake up having taken medications they expected would end their life and patients who take up to four days to die after the administration of lethal drugs.⁴

In some cases oral drugs fail to be effective and have to be followed by intravenous drugs directly administered by clinicians. Until the protocols that will be used to undertake medically assisted dying have been shown incontrovertibly to be 'safe' and effective the legislation is premature. Safeguards in the legislation are not the same as having safeguards in place to ensure the safe introduction of clinical practices in accordance with existing standards. The latter should be our first priority.

If the substance is not effective in bringing about the death of the person through self-administration or administration by their nominee, what are the obligations of clinicians in this situation?

The Bill is not clear. Clause 29 (3) purports to protect a medical practitioner and a health care facility operators if s/he

- (a) provides the assistance, or
- (b) is a designated health practitioner and administers an authorised substance to the patient, or
- (c) prepares, sells, possesses or supplies an authorised substance to be administered to the patient in accordance with a request for assistance under this Act, or

⁴ See for example, Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA*. 2016;316(1):79–90. doi:10.1001/jama.2016.8499; accessed at <http://jamanetwork.com/journals/jama/article-abstract/2532018> on 10 August 2017. Problems and complications are discussed on page 86 as follows:

There are no flawless medical procedures; all procedures and interventions can have complications. Determining the rate of problems and complications related to euthanasia and PAS has been challenging because of definitions and the lack of witnesses. For several years, Oregon reported no complications. Between 1998 and 2015 (average number of deaths per year, 55), Oregon reported absence of data on complications for 43.9% of cases, no complications for 53.4% of cases, and regurgitation of medication in 2.4% of cases as the sole complication. The state reported that between 2005 and 2012, 6 patients (0.7%) regained consciousness after ingesting the lethal medications but paradoxically does not classify this as a complication. The median time between ingestion of barbiturate and death was 25 minutes, but the range extends to 104 hours—more than 4 days. The number of prolonged deaths—those taking longer than a day—is not reported in Oregon. In Washington state, for 2014 and 2015 combined, the data are less complete. For the 292 reported cases, 1.4% of patients regurgitated the medications, and 1 patient experienced a seizure. It is unclear if any patients in Washington state regained consciousness. Only 66.8% of patients died in less than 90 minutes, while the range extends to 30 hours. A comprehensive 2000 study of problems and complications in 649 Dutch cases (prior to the actual legalization) revealed a higher frequency of problems with PAS than with euthanasia. Technical problems with PAS, such as difficulty swallowing, occurred in 9.6% of cases, and complications such as vomiting or seizures occurred in 8.8% of cases. In 1.8% of PAS cases, patients awoke from coma and in 12.3% of cases time to death was longer than anticipated or the patient never became comatose. For euthanasia, 4.5% of cases had technical problems, such as inability to find a vein for injection, and in 3.7% of cases patients had complications such as vomiting, or myoclonus. In 0.9% cases patients awoke from coma, and in 4.3% of cases time to death was longer than expected or the patient did not become comatose. These data are 16 years old, and 13 years of legalization may have reduced the complication rate. There are no data from other countries, including Belgium, on problems or complications with euthanasia or PAS.

- (d) refuses or fails to provide life-saving measures to the patient at any time while a request for assistance is in force in relation to the patient under this Act, or
- (e) is present when the assistance is provided by the primary medical practitioner, or when an authorised substance is self-administered by the patient or administered to the patient by a designated health practitioner, or
- (f) destroys an unused authorised substance (under the supervision of the primary medical practitioner if the person is not the primary medical practitioner) or possesses the substance for that purpose, or
- (g) does any thing required or permitted under Part 4.

Calvary submits that the Bill is not clear enough. If the substance is not effective in bringing about the death of the person through self-administration or administration by the designated practitioner, the obligations of clinicians in this situation are uncertain and open to multiple interpretations.

Calvary agrees with the Royal Australasian College of Physicians (RACP).

There are serious risks that outcomes may not always be certain and may be the opposite to what was intended. Possible scenarios include:

- *A medical practitioner in attendance when the patient ingests and the lethal dose of medication has not been effective*
- *A medical practitioner in the Emergency Department receiving a patient who has ingested the medication but it has not resulted in the death of the patient – moreover, if there is uncertainty as to whether the patient intended to die, health professionals would be obliged to provide life saving interventions*
- *A medical practitioner in the Emergency Department receiving a patient who has ingested the medication and the family request treatment because they do not agree with their decision to end their life*
- *A paramedic called to a patient who has ingested the medication but it has not been effective*
- *A paramedic called by the family to a patient who has ingested the medication because the family do not agree with their decision to end their life.*

Clear guidelines would have to be developed to assist and protect all individuals involved in the above scenarios before, during and afterwards.⁵

Whether the outcome of the legislation under consideration is effective and safe will depend heavily on a thorough analysis and understanding of the efficacy and risks of the proposed lethal substance(s). What are they?

In addition, people will need answers to other questions they have.

- Will the assisted dying procedure (pre and post care) have an item number? If not, who will then pay for

⁵ RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017 page 11 accessed at <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf> on 18 September 2017.

the assessments required? The individual or the state? Who will pay for access to a psychiatrist, which is compulsory?

- Who pays for the administering of substance when it is taken?
- If the state of commonwealth government is paying, how many medical, psychiatric or psychological assessments can you have? If you have one assessment, then withdraw your request only to make a new request at another time, can you have other assessments? Or will access be capped?

The most recent version of the Bill attempts to ensure that the patient who is seeking to access the lethal substance understands some of the risks and complications.

For instance, clause 5 (2) of the Bill states

- (2) A *designated health practitioner* is a registered medical practitioner, or a nurse, whose registration under the Health Practitioner Regulation National Law in the relevant health profession is endorsed under that Law as being qualified to administer, obtain, possess, prescribe, sell, supply or use a substance included in Schedule 8 to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* of the Commonwealth.

Clause 13 of the Bill states

13 Standards for provision of assistance

In providing assistance to a patient under this Act, a primary medical practitioner is to be guided by appropriate medical standards and such guidelines, if any, as are prescribed by the regulations, and must consider the appropriate pharmaceutical information about any authorised substance to be given or administered to the patient.

And finally, Clause 19 (1) (c) requires the primary medical practitioner to provide the patient with information in writing “relating to the consequences of the administration to the patient of an authorized substance, including the risk and possible adverse consequences of the administration not resulting in the death of the patient.”

While this is a step in the right direction, Calvary submits that these clauses are no substitute for informing the community as a whole, **before legislation is enacted**, about the proposed lethal substance, how it will be sourced, its efficacy and all the risks associated with this substance.

2. Who will assist patients (to die) and how will this be done?

The legislation is structured on the basis that self-administration of the lethal dose is the norm. If a person cannot self-administer, a medical practitioner can administer the substance. Clause 5 of the Bill states:

5 Provision of assistance

(1) A primary medical practitioner *assists* or *provides assistance* to end a patient's life if the medical practitioner does any of the following for the purpose of, or in connection with, ending the patient's life:

- (a) prescribes and prepares an authorised substance for the patient,
- (b) gives an authorised substance to the patient for self-administration,
- (c) if the patient is physically incapable of self-administering a lethal dose of an authorised substance—administers the substance to the patient or gives the substance to a designated health practitioner for administration to the patient.

(2) A *designated health practitioner* is a registered medical practitioner, or a nurse, whose registration under the Health Practitioner Regulation National Law in the relevant health profession is endorsed under that Law as being qualified to administer, obtain, possess, prescribe, sell, supply or use a substance included in Schedule 8 to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* of the Commonwealth.

(3) A *designated health practitioner* does not include any person who is a close relative of the patient.

The premise behind the proposed legislation is that it is an individual's right, and is being proposed for a small minority of the population. It is expected that the majority of people who request VAD will do so in terms of concerns relating to independence, dignity, fear of being a burden rather than issues related to symptom management.

There has not been a *targeted* consultation with the health sector, who will be responsible for overseeing and administering this system change; nor the Commonwealth who have responsibilities for aged care services, primary care, policy leadership for palliative care and workforce training.

Calvary believes that the VAD legislation amounts to a sweeping societal reform that is being introduced without understanding all the consequences.

Some of the consequences which need further thought may be summarised as follows:

- A 48 hour cooling-off period (proposed in Clause 12) is far too short given the nature of the decision being made.
- Clause 18 (1) (a) of the legislation requires that 'in the medical practitioner's opinion, the patient is suffering from a terminal illness'. Clause 4 of the Bill states: "A terminal illness is an illness that will, in reasonable medical judgment, result in the death of the person suffering from the illness within the next 12 months." As the *RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017* points out, determining how long a person has to live is not an exact science and is a challenge even for the most qualified doctors. At one year, the margin for error in prognostication significantly increases and many clinicians would find it this a difficult assessment to make. Patients are at risk of ending their life when they could potentially have several more years to live.⁸
- There is very poor death literacy within the community. Most people don't know what palliative care is, even fewer people have completed advance care plans, yet with this legislation the people of NSW will be expected to make informed choices about accessing VAD.
- The proposed legislation is silent on families being involved in the decision making process. As a specialist palliative care provider, Calvary deals with conflict within families and the decision making process at the end of life on a frequent basis. How is this to be managed?

⁸ "Being confident of a 12 month lifespan on an individual basis is very difficult. As expressed in a recent systematic review, accurate forecasting is (nearly) impossible for a number of reasons explained below. Prognostication is generally a variable skill not only affected by patient factors but also level of clinician experience, duration of relationship with the patient and whether it is done by an individual or a multidisciplinary team. It is based on statistical data which will only apply on average. Therefore if a certain group of patients have a 12 month expectation of life, a significant proportion will die before this time and a significant proportion afterwards. Studies are also heterogeneous. Most studies have been in the cancer population and there are studies in the non-cancer population where forecasting is even more inaccurate. As described in the review, there are also varying types of estimates (continuous, categorical, and probabilistic) and of the three estimates, probabilistic "may be slightly more accurate than categorical or continuous". The Bill is using the least accurate method to draw judgments which are uncertain in nature. Studies show that clinicians are more likely to overestimate than underestimate survival."
RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017 page 4 accessed at <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf> on 18 September 2017.

- As a society we are making every effort to counteract suicide, yet we are now proposing legislation that would recognise that some suicides are acceptable and that health professionals will assist in that process. We already know the impact that suicides have on families and those close to the individual.
- Rigorous care needs to be taken in determining how the vulnerable will be protected; legislation needs to take **into account signs of risk factors for the coercion or abuse of persons who are dependent on the care of others** – such as family violence, substance abuse, gambling addiction and mental health issues.
- The legislation needs to be make clear who will be responsible for providing family support, counselling and conflict mediation, bereavement counselling for people choosing VAD.

Doctor-Patient and Patient-Hospital and Clinician-Clinician Relationships

- The VAD legislation potentially changes the role of the doctor in our society. By asking our doctors to participate in this process we are potentially **undermining the patient/family trust; not just in doctors but our health care system.**
- **What is the potential impact on the access of vulnerable populations to health services?** Will they be further marginalised through fear of a system that is perceived to support gravely ill people to end their lives?
- Nearly 50% of deaths occur in a hospital. Will patients be able to access assisted dying in a hospital setting? What are the implications for both public and private hospitals? How will health services deal with other patients who object? What safeguards are needed for staff? Similar concerns will arise in aged care settings.
- How will health workers work side by side with each other if there is difference in opinion? One colleague is willing to participate in assisted dying work, the other is not. How does this affect the team? Will this be detrimental to patients? What skills will be needed to manage this?

Issues related to good end of life care

Access to palliative care is not universal nor equitable across the state. Under the proposed legislation patients are to be made aware of what palliative care is available to them and offered a referral. What happens if someone lives where palliative care is not available? What is the approach that will be taken? How will people meaningfully engage with any palliative care options? What if the primary and secondary medical practitioners have little knowledge about or experience of the practice of palliative care?

Concluding remarks

As a significant provider of health care in NSW, we raise these concerns with you because of the ramifications of proceeding with legislation before all the major questions have been answered. In particular, it is important to know and to have evaluated the efficacy and risks of the lethal substance which will be used. It is important to know exactly what will be involved if a doctor is to assist another person to end their own life.

Calvary submits that it is not in the public interest to proceed with the legislation. Given the social significance of the proposed law, good public policy development suggests that all the major questions are addressed before enacting legislation.

The Hon. John Watkins, AM
Board Chair
5 October 2017

Appendix



Information for intravenous medications for Medical Assistance In Dying

This document is to provide background information. It is recognized that care may be modified to meet the best interests of the individual patient. The following medications are to be administered by the physician on the Intervention Team.

It is recommended that a "Do Not Disturb" sign be placed on the door to the patient's room and that all cell phones and pagers of staff participating in the procedure are either turned to silent mode or left with a colleague to decrease the potential for interruptions during the procedure.

1. Intravenous access

The importance of reliable intravenous access is emphasized to ensure successful uninterrupted administration of all the medication.

For central lines or peripherally-inserted central catheters (PICC):

- Site is secured
- Blood can be withdrawn
- Saline 10cc flush is given with little or no resistance
- Gravity set flows freely

For peripheral lines:

- Size 20G or larger (18G, 16G)
- Site is secured
- Saline 10cc flush is given with little or no resistance. There is no evidence of interstitial flow, swelling around the site, or pain throughout the duration of the flush
- Gravity set flows freely
- Consider a second peripheral intravenous line if there is a history of difficult access, "blown" IVs, intravenous chemotherapy, or if the primary IV is 20G or smaller

2. Intravenous setup

Intravenous setup includes a 1L bag of Ringers Lactate or Normal Saline connected to a free-flowing gravity set connected directly to the IV catheter.

Because of noisy alarms, temperamental tubing sets and a machine-dictated delay in diagnosing compromised or interstitial venous access, electronic pumps and electronic pump sets are not recommended.

All other intravenous infusions should be discontinued to avoid backflow of medications.

Run IV at 50-100mL/hr until time of injection, and then run "wide-open."

3. Medications

- The pharmacy department will prepare two complete kits including all pre-filled syringes labeled as described below. The kits will be dispensed from the pharmacy department by a pharmacist to a member of the MAID team on a patient-specific basis pursuant to a prescription from the intervention physician that has been verified by a pharmacist.
- Physician to administer all medications completely, sequentially and rapidly as detailed below with minimal or no delay between syringes.
- If a gravity set is not used consider flushing with 10mL of saline after every syringe.
- Midazolam 10mg (1mg/mL = 10mL). Use 10mL syringe. Label as **Syringe A: midazolam**
For deep sedation/coma
Consider Advising those who are present that the patient may gasp following administration of this medication.
Inject over 10 seconds
- Lidocaine 2% 100mg (20mg/mL = 5 mL). Use 5mL syringe. Label as **Syringe B: lidocaine**
Necessary for peripheral venous access only
For reduction of discomfort on injection of propofol
Inject over 5 seconds
- Propofol 1000mg (10mg/mL = 100mL). Use two 50mL syringes. Label as **Syringe C: propofol and Syringe D: propofol**
For induction of coma, myocardial depression, respiratory depression, and vasoplegia
Warn the patient that there may be some discomfort on injection, and that the goal of lidocaine is to relieve this but some patients may still experience pain. Consider advising those who are present that after the injection is completed an assessment of awareness will be completed.
Inject each syringe continuously and promptly over 30 seconds
After completing the injections, check eyelash reflex and whether there is any response to verbal stimulus. If there is no response to stimuli then proceed to injection of rocuronium.
- Rocuronium 200mg (10mg/mL = 20mL). Use 20mL syringe. Label as **Syringe E: rocuronium**
For muscle paralysis

Consider advising those who are present that cardiac arrest can occur up to 20 minutes after respiratory arrest has occurred. In other words, the patient's heart may continue to beat for some time after the procedure is complete. Inject promptly over 5 seconds

Rocuronium should always be administered after propofol, even if respiratory and/or cardiac arrest has already occurred with propofol alone.

A minimum of time should elapse between the administration of midazolam, lidocaine and propofol, i.e. these should be administered in a short sequence.

Painful stimuli (e.g. sternal rub, trapezius squeeze, pressure on orbital bone or nailbed) should be avoided as these may cause distress to those who are present, and are likely unnecessary.

Should there be a response to stimuli, do not administer rocuronium. Instead, administer a further:

- o Midazolam 10mg (Syringe 1)
- o Propofol 1000mg (Syringes 3 and 4)

Then check for response to stimuli. If there is none, then administer rocuronium 200mg (Syringe 5)

- o Bupivacaine 0.5% plain (5mg/mL = 80 mL). Use 2x 50mL syringes. Label as Syringe F and G: bupivacaine

For inducing asystole

Inject continuously and promptly over 30 seconds per syringe

It is anticipated that all of the pre-filled syringes will be used for each patient. For whatever reason should this not be the case (e.g. patient changed their mind to proceed) ensure all unused pre-filled syringes are returned to the pharmacy department for proper tracking and disposal.

Step	Syringe Label	Drug	Rate of administration
1	Syringe A	Midazolam	Over 10 seconds
2	Syringe B	Lidocaine	Over 5 seconds
3	Syringe C	Propofol (1 of 2)	Over 30 seconds
4	Syringe D	Propofol (2 of 2)	Over 30 seconds
5	<i>confirm coma achieved</i>		
5b	If still responding to stimuli, administer second set of midazolam and propofol from second kit		
6	Syringe E	*Rocuronium	Over 5 seconds
7	Syringe F	Bupivacaine (1 of 2)	Over 30seconds
8	Syringe G	Bupivacaine (2 of 2)	Over 30 seconds

* Rocuronium should only be administered once coma is ascertained

The Australian Family Association
PO Box 1522, Castle Hill NSW 1765
E [REDACTED]
P [REDACTED]
W family.org.au

The Hon. Greg Donnelly MLC
Parliament House
Macquarie Street
Sydney
NSW 2000

Dear Mr Donnelly,

The Australian Family Association (AFA) is a not-for-profit, voluntary, and (non-party) political organisation with the objective of strengthening and supporting the family. The AFA is concerned with social issues, policies and laws which have an impact upon the family.

It is the view of the AFA that, if passed, the *Voluntary Assisted Dying Bill 2017* would:

- Place vulnerable patients, including elderly patients and patients with disabilities at great risk.
- Radically undermine the doctor-patient relationship which is built upon trust.
- Conflict directly with policies for preventing suicide and send the dangerous message to people suffering depression and mental illness that suicide can be a valid choice.

Please find enclosed a list of 30 assisted suicide and euthanasia bills that failed to be passed into law after they were introduced in legislatures in various states in the US in 2017. It appears that as the aftermath of the legalisation of assisted suicide and euthanasia in locations such as the state of Oregon, The Netherlands and Belgium has become apparent, legislators in other jurisdictions both in Australia and overseas are increasingly opposing moves to legalise these practices. A particularly noteworthy example is the resounding defeat in 2015 of a bill seeking to legalise assisted suicide in the United Kingdom. The bill was voted down in the House of Commons 330-118.

It should also be noted that on September 7th of this year the highest court of New York, the New York Court of Appeals, rejected a lawsuit that sought to permit "aid in dying". The five participating judges ruled unanimously that physician assisted suicide is illegal. The judges' unanimous opinion cited the fact that the state has legitimate reasons for outlawing the practice, including to protect vulnerable patients from pressure to end their lives.

Australian palliative care services are among the very best in the world and we must ensure that all people who are approaching the end of their life in New South have access to excellent palliative care rather than assisted suicide and euthanasia.

Yours sincerely,

[REDACTED]
Joseph Carolan
NSW Secretary
The Australian Family Association

9th October 2017

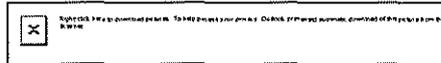
30 Assisted Suicide and Euthanasia Bills that Failed to be Passed into Law in 2017 in the United States

	State	Bill	Details	Failure
1	Oklahoma	Oklahoma Death with Dignity Act (HJR 1009)	Joint resolution to enable a referendum on physician assisted suicide	Died in committee
2	North Carolina	End of Life Option Act (HB 789)		Stalled in committee killing it for this session
3	New York	Medical Aid in Dying Act (S.3151/A.2383)		Did not come to a vote
4	New York	End of Life Option Act (A.3598)		Stalled in committee
5	New York	Senate Bill 2045	Bill to permit physicians to prescribe a lethal dose to patients with a terminal illness.	Main sponsor withdrew support
6	Delaware	End of Life Option Act (HB 160)		Did not come to a vote
7	Rhode Island	Lila Manfield Sapinsley Compassionate Care Act (HB 5468)		Sponsor of the bill requested it be postponed effectively killing it this session
8	Oregon	Senate Bill 893	Bill to extend euthanasia and assisted suicide to mentally incompetent people	Died in committee
9	Oregon	Senate Bill 494	Bill to extend euthanasia and assisted suicide to mentally incompetent people	Died in committee
10	Mississippi	Death with Dignity Act (SB 2283)		Died in committee
11	Utah	End of Life Options Act (HB 76)		Tabled in the House Health and Human Services Committee on a 9 to 3 vote, which effectively ended its progress this session
12	Tennessee	SB 1378, HB 1394	Bill to legalise assisted suicide	Withdrawn
13	Maryland	Senate Bill 354	Bill to authorise a patient to request "aid in dying"	Withdrawn
14	Maryland	Richard E. Israel and Roger "Pip" Moyer End-of-Life Option Act (HB 370)		Sponsors withdrew bill citing lack of support
15	Wyoming	Death With Dignity Act (HB 122)		Bill drafted but not introduced
16	New Mexico	End of Life Options Act (SB 252/HB 171)		Defeated in Senate 22 - 20

	State	Bill	Details	Failure
17	Indiana	End of Life Options Act (SB 273/HB 1561)		Died in committee
18	Nebraska	Patients Choice at End of Life Act (Legislative Bill 450)		Stalled
19	Connecticut	An Act Concerning Aid In Dying For Terminally Ill Patients (HB 6024)		Died in committee
20	Connecticut	An Act Concerning the Option to Die With Dignity (HB 6238)		Died in committee
21	Kansas	Death with Dignity Act (HB 2120)		Died in committee
22	Arizona	Death with Dignity Act (HB 2336/SB 1512)		Died in committee
23	Iowa	Iowa End of Life Options Act (Senate File 215/House File 299)		Died in committee
24	Missouri	Missouri Death with Dignity Act (HB 524)		Died in committee
25	Missouri	Death with Dignity Act (HB1222)		Stalled
26	Hawaii	Medical Aid in Dying Act (SB 1129)		Deferred by House committee effectively killing it for this session
27	Alaska	Terminally Ill: Ending Life Option (HB 54)		Stalled in Committee
28	Maine	An Act to Support Death with Dignity (LD 347)		Defeated in House 85-61
29	Nevada	Senate Bill 261	Bill to permit the prescription of a lethal substance.	Died in committee
30	Minnesota	End-of-life Options Act 2017 (HF 1885/SF 1572)		Referred to committee effectively killing it for this session

Greg Donnelly

From: St Vincent's Health Australia <[REDACTED]>
Sent: Tuesday, 10 October 2017 2:17 PM
To: Greg Donnelly
Subject: A message from St Vincent's on NSW's assisted suicide legislation



10 October 2017

Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr Donnelly,

Re: NSW's assisted suicide legislation

We write regarding legislation that was recently introduced into the NSW Parliament to legalise physician-assisted suicide.

St Vincent's Health Australia is the largest non-profit provider of health and aged care services in Australia. You may know us best through our **St Vincent's Hospitals**, public and private, located in Sydney's Darlinghurst.

St Vincent's has deep expertise in providing end-of-life and palliative care.

We established Australia's first dedicated service for the terminally ill at St Vincent's almost 130 years ago. It's now the largest palliative care facility in NSW, serving a population of 350,000 people, both in the inpatient and community setting, which sees around 700 new patients every year.

It is from this deep experience that we raise serious concerns about NSW's proposed assisted suicide model.

We believe there are too many unworkable practical issues associated with the legislation for it to go ahead. There are also no guarantees in its safeguards.

For example, under the NSW model, an individual can access assisted suicide if they are judged to have a terminal illness that will result in death within 12 months. Forecasting a terminally ill person's death is not an exact science. Evidence shows that doctors find it very difficult to diagnose how long someone has to live.

At 12 months, the margin for error significantly increases and most clinicians

would find it an almost impossible assessment to make. It's also much longer than is available in overseas jurisdictions. If the NSW legislation passes, patients could end their life when they have more than a year to live; robbing them of the opportunity to reconsider their situation which could have improved over time, particularly if accessing high quality palliative care.

Indeed, under the bill, NSW patients accessing assisted suicide may never know the benefits of palliative care because there is no requirement for a person to genuinely engage with one of its specialists, only for the patient's primary practitioner to make an offer of referral.

There is also nothing in the bill that addresses possible coercion in any significant way. Pressure or coercion can be discrete. Any monitoring is unlikely to detect manipulations such as family members encouraging patients to undergo assisted suicide for ulterior motives.

Nor has the likelihood of 'doctor shopping' – in the event of a patient receiving an unfavourable assessment – been addressed. Patients seeking to suicide under the NSW bill are not required to have an established therapeutic relationship with either of the two assessing medical practitioners.

Finally, no assisted suicide regime is completely safe. Every system of assisted suicide or euthanasia around the world has experienced errors or had its safeguards manipulated.

We recognise that many MPs and members of the community have arrived at a position of support for assisted suicide after the difficult death of a loved one, friend or constituent. We respect and acknowledge how these events are likely to have affected peoples' views. We are also sensitive to the wishes of terminally ill patients – and their families – to be able to exercise choice and die without pain and with dignity. How could we not? Those are some of the very tenets of quality palliative care.

We also acknowledge that too many people in NSW die painful and undignified deaths.

But to a large degree that's because thousands of people struggle each year to access high quality palliative care which would give them the chance to die pain-free.

It's estimated that around 6000 people in NSW miss out on receiving palliative care each year who would benefit.

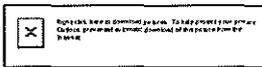
Our current hospital and community systems and staff do not have the infrastructure or education to support the many people who are not able to access palliative care services to die in peace.

The answer to this challenge is to ensure all health professionals are comfortable and resourced to provide palliative care so that all people in NSW can access its benefits, not introducing an untested system with all its inherent risks and uncertainties. The NSW Government's recent announcement of an additional \$100m investment in palliative care services over the next four years is an excellent start to addressing this problem.

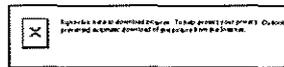
We would warmly welcome the opportunity to meet with you to share our clinical experiences in this area. Alternatively, A/Professor Anthony Schembri, St Vincent's Hospital Sydney's CEO, would be pleased to assist in a briefing and/or visit to our palliative care services where you could meet our dedicated clinicians and hear their views.

Your office can contact Mr Paul Andrews on 02 [REDACTED] or [REDACTED] to arrange.

Yours sincerely



Mr Toby Hall
Group Chief Executive Officer
St Vincent's Health Australia



Clinical Professor Richard Chye
Director of Supportive & Palliative Care
St Vincent's Hospital Sydney

St Vincent's Health Australia Limited | Level 22, 100 William Street, East Sydney, NSW 2010
Australia

[Unsubscribe greg.donnelly@parliament.nsw.gov.au](mailto:greg.donnelly@parliament.nsw.gov.au)

[Update Profile](#) | [About our service provider](#)

Sent by paul.andrews2@svha.org.au



11 October 2017

Dear Member of the Legislative Council,

Objection to the Proposed bill to legalise Voluntary Assisted Dying in NSW

We write as the representative body of Catholic hospital providers in NSW to express our concerns regarding the legislation to introduce voluntary assisted dying (VAD) which is currently before the Legislative Council. Our members are some of the longest-serving health and hospital service providers in NSW, and Australia, and provide over half of all palliative care received by Australians.

We do not support the proposed bill. We believe it compromises the inherent value of the person and erodes trust in the medical profession. The proposed legislation also creates serious risks for patients and undermines the provision of effective, day-to-day healthcare.

Palliative care in Australia is currently chronically underfunded and under resourced. As identified in the August 2017 report released by the NSW auditor-general on palliative care services, NSW Health's approach to planning and evaluating palliative care is not effectively coordinated with no comprehensive monitoring and reporting on services and outcomes. If passed, this legislation will threaten the provision of palliative care through resourcing an alternative instead of improving the current system to meet community need.

We believe this legislation will have the unintended consequence of undermining the value of palliative care for those at the end of life. Some patients may access assisted suicide without fully understanding how palliative care can provide a dignified and respectful death. We are particularly concerned that vulnerable people – such as Indigenous people or elderly people – may no longer access palliative care, mistakenly fearing it will hasten their death, and will forego its benefits.

Our health care organisations are committed to providing the best possible, evidence-based, compassionate care to all members of society. It is our belief that the proposed legislation will inhibit the capacity of clinicians to do this, and overturns the overarching principle that has underpinned the medical community for centuries of "do no harm". Should assisted suicide become legal, our hospital providers will not participate in any scheme that facilitates killing either by assisted suicide or euthanasia.

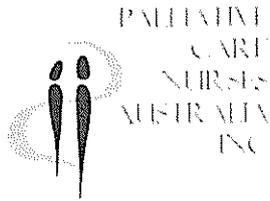
The legislation in its current form raises too many questions to be considered safe and equitable. We would warmly welcome the opportunity for clinicians from our organisations to meet with you, to discuss our concerns and share their clinical experiences in this area. Clinicians who care for the dying in their end of life can ably assist to answer queries you may have on the challenging topic of how Australians experience death. Your office can contact Emma Hoban at [REDACTED] should you wish to arrange any private briefing.

Thank you for your time.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Suzanne Greenwood", is written over a black rectangular redaction box.

Suzanne Greenwood LLM LLB FAIM MAICD MCHSM
Chief Executive Officer



11 October 2017

The Hon. Greg Donnelly MLC
Deputy Opposition Whip in the Legislative Council
Parliament House
Macquarie Street
SYDNEY NSW 2000
greg.donnelly@parliament.nsw.gov.au

Dear Mr Donnelly,

I am writing to you as President of the Palliative Care Nurses Australia Inc (PCNA) and in relation to the Voluntary Assisted Dying Bill 2017 that was introduced to the New South Wales Parliament on 21 September 2017.

PCNA is a national member based organisation for nurses working with people who are living with and dying from a progressive life limiting illnesses and their families. The vision of PCNA is to promote excellence in palliative care nursing for our community, through leadership, representation and professional support. The World Health Organization (2002) definition of palliative care underpins our work.

PCNA has been following the current societal, academic and parliamentary debate in Australia on the topic of legalisation of euthanasia and assisted suicide for people living with a life limiting illness who are experiencing suffering. Euthanasia and physician assisted suicide are currently illegal in all Australian states and territories. The NSW Voluntary Assisted Dying Bill 2017 states that it aims to provide a legislative framework for the rights of terminally ill persons to request and receive assistance to end their lives voluntarily and to provide protection for persons providing such assistance and sets up safeguards against possible abuse of the right recognised by the Bill. If passed, this Bill will directly affect nurses working in palliative care and consequently, we feel it important to bring to your attention the beliefs of our organisation and members.

Palliative Care Nurses Australia believes that:

- Palliative care does not include the practice of euthanasia or assisted suicide; and that the intent of palliative care is to neither hasten or postpone death;
- Nurses play a key role in minimising the person's suffering and maximising their function and access to support and comfort. Optimal palliative care nursing involves:
- advocating for and ensuring all Australians have access to palliative care in accordance with their needs;



- impeccable assessment and management of the physical, psychological, socio-cultural and spiritual needs of the person and their family in accordance with the best available evidence;
- discussing and supporting a person's choices to withhold or withdraw treatments where the potential harm outweighs possible benefit or is against their expressed wishes;
- considering the complex and multi-dimensional nature of suffering and acting to prevent and alleviate it where possible by seeking and utilising the best available evidence and interdisciplinary advice;
- respectfully and compassionately acknowledging a person's desire to die statements or requests to hasten death in the context of a life limiting illness, and seek to understand the origins of the request; whilst acknowledging that for a small proportion of people pain, distress and/or suffering can persist despite the provision of best palliative care;
- responding to a person's request to hasten death in accordance with: the law, professional codes of conduct, ethical health care principles, best available evidence, and the unique needs of the person and their family; and
- fostering informed and respectful communication with patients, their families, other health care professionals and the wider community about death, dying and end of life care, including the topic of euthanasia and physician assisted suicide.

We would encourage all members to consider our position against the practice of euthanasia or assisted suicide when debating the Voluntary Assisted Dying Bill 2017 in Parliament on 12 or 19 October 2017.

Should you wish to discuss our views further, please feel free to contact our office on 07 [REDACTED] to arrange a suitable time.

Yours sincerely

[REDACTED]

Jane Phillips PhD RN
PRESIDENT

Definitions

Palliative Care as defined by the World Health Organization (2002) is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care provides relief from pain and other distressing symptoms, and:

- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Euthanasia is a physician (or other person) intentionally killing a person by the administration of drugs, at that person's voluntary and competent request (EAPC, 2015).

Physician assisted suicide is a physician intentionally helping a person to terminate their life by providing drugs for self-administration, at that person's voluntary and competent request (EAPC 2015).

References:

ANZSPM 2013 position statement euthanasia and assisted suicide
<http://www.anzspm.org.au/c/anzspm?a=da&did=1005077>

PCA position statement (last updated August 2016) voluntary euthanasia and assisted suicide
http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2015/08/20160823-Euthanasia-and-Physician-Assisted-Suicide-Final.pdf

Krikorian, A. et al., (2012). Suffering and distress at the end-of-life. *Psycho-Oncology* 21 (8): 799-808.

Radbruch, L., et al., Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. *Palliative Medicine*, 2015,
<http://www.eapcnet.eu/LinkClick.aspx?fileticket=28Vb6Oln9SQ%3D>

WHO 2002. Palliative Care Definition. World Health Organisation, Geneva. Viewed online 2/2/16
<http://www.who.int/cancer/palliative/definition/en/>

We write to you on behalf of our network to send you a unified statement opposing the legalisation of euthanasia and physician assisted suicide and the present Bills presented in the NSW and Victorian Parliaments.

In health care, by far the majority position is against such Bills by those at the coal-face, who provide care and support of those with significant life limiting or burdensome illness.

Unfortunately, the voice of this majority is often silenced, downplayed or undermined by a loud minority and the media representations of the opposing view.

This statement represents the voice of the many nurses, allied health, doctors and others in healthcare involved with providing the real care for vulnerable and burdened individuals, and their families. We know what can be achieved with dignified and holistic care and support. Advocacy in government should be to provide such holistic care in an equitable way and facilitate appropriate support for its vulnerable citizens.

In a very short time the website designed to provide a voice for health care professionals has gathered almost 400 signatories and continues to grow daily by word of mouth alone, without publicity.

We ask you to listen to our concerns and to examine with clarity the significant pitfalls and dangers in the evidence against such legislation, and vote against euthanasia and physician assisted suicide.

On behalf of the www.healthprofessionalsay.info Network,
Yours Sincerely,

Dr Maria C Cigolini

MBBS(Syd) FRACGP FACHPM Grad.DipPallMed(MELB)
Clinical Director **Department of Palliative Medicine**
Royal Prince Alfred Hospital, SLHD
Senior Lecturer **University of Sydney, NSW**

████████████████████

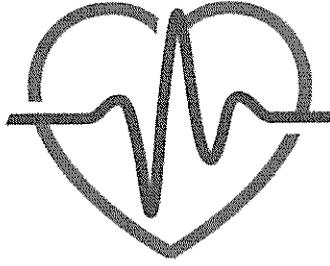
&

A/Prof Leeroy William

BSc(Hons) MBBS MRCP MSc FACHPM
Palliative Medicine Specialist **Monash Health, Eastern Health**
Adjunct Associate Professor **Monash University, Melbourne, VIC**

████████████████████

Please do not hesitate to call us for further information or discussion



Health Professionals Say No!

WWW.HEALTHPROFESSIONALSSAYNO.INFO

We endorse the views of the World Medical Association that physician assisted suicide and euthanasia are unethical, even if made legal. We endorse the Australian Medical Association position that " doctors should not be involved in interventions that have as their primary intention the ending of a person's life."

We also endorse the World Health Organisation definition of Palliative Care, which has been re-affirmed by the Australia & New Zealand Society of Palliative Medicine. that Palliative Care aims to deliver impeccable holistic and person centred care without the aim of foreshortening life.

We are committed to the concept of death with dignity and comfort, including the provision of effective pain relief and excellence in Palliative Care.

We uphold the right of a patient to decline treatment.

We know that the provision of pain relief, even if it may unintentionally hasten death of the patient, is ethical and legal. Equally the withdrawal or withholding of futile treatment in favour of Palliative Care is also ethical and legal.

We believe that crossing the line to intentionally assist a person to suicide would fundamentally weaken the doctor-patient relationship, which is based on trust and respect. The power of the clinician/patient relationship cannot be over-estimated.

We are especially concerned with protecting vulnerable people who can feel they have become a burden to others, and are committed to supporting those who find their own life situations a heavy burden. We believe such laws would undermine the public perception of the dignity and value of human life in all its different stages and conditions. Government focus should be on the compassionate and equitable provision of Social Services, Health Care and Palliative Care.

Doctors and Healthcare Professionals are not necessary for the legalisation or practice of assisted suicide. Their involvement is being sought only to provide a cloak of medical legitimacy. Leave doctors, nurses and allied health to focus on saving lives and providing real care and support for those who are suffering.

Sent by Dr Maria Cigolini & A/Prof Leeroy Williams
On Behalf of 393 Health Care Professionals

Prof David Kissane, MBBS MPM MD FRANZCP FACHPM FAPM, Clinical Head Psychiatry, Lecturer, Psychoncologist, VIC
Dr Roger Woodruff MBBS FRACP FACHPM, Oncologist/Palliative Medicine Physician, Clinical Head, Lecturer, Board Member IAHP, VIC
Dr Maria Cigolini, MBBS FRACGP FACHPM Grad.DipPallMed, Palliative Medicine Specialist, Clinical Head, Lecturer, NSW
Dr Megan Best, PhD, BMed(Hons), MAAE, ClinDipPallMed, Palliative Care Doctor, Research Fellow, Lecturer, NSW
Prof Rod Macleod, MNZM MB ChB MMed FACHPM FRCGP, Palliative Medicine Specialist, Clinical Head, Lecturer, Health Sector Head, NSW
Ms Suzanne Greenwood, LLM LLB FAIM MAICD MCHSM, Health Sector CEO, ACT
Prof Doug Bridge, BMedSc (Hons) MBBS FRACP FRCP FACHPM DTM&H, Palliative Medicine Physician, Clinical Head Lecturer, WA
Prof John Murtagh AM, MD BSc BEd FRACGP DipRCOG, Prof of General Practice, VIC
Prof Ian Oliver, MD, PhD Professor, Director Health Research, Lecturer, Health Sector Leader, SA
Dr Peter Coleman, MBBS BSc FRACGP, Palliative Care Doctor, NSW
Dr Peter Ravenscroft, MD FRACP FFPANZCA FACHPM, Palliative & Pain Medicine Physician, NSW
Dr John Buchanan, MBBS MMed DPM FRACP FRANZCP, Psychiatrist, Clinical Leader, VIC
Dr Martin Kennedy, MBBS FAFRM FFPANZCA FACHPM, Palliative Medicine Specialist, Director Rehabilitation & Aged Care, NSW
Dr Marion Harris, MBBS FRACP, Medical Oncologist, VIC
Dr Louise Halliday, MBBS FRACGP, General Practitioner, NSW
Dr John Quinlan, FAFRM MA(Ethics), Rehabilitation Specialist, Medical Ethicist, NSW
Assoc/Prof Charbel Sandroussi, MBBS MMed, FRACS, Cancer Surgeon, Clinical Head, Lecturer, NSW
Assoc/Prof Josephine Clayton, MBBS PhD FRACP FACHPM, Palliative Medicine Physician, Research Head, Lecturer, NSW
Prof Melanie Lovell, MBBS, PhD, FRACP, FACHPM Palliative Care Physician, Clinical Head, NSW
Dr Anthony Herbert, MBBS FRACP FACHPM B Med Sci, Researcher, Lecturer, Director of Paediatric Palliative Care Service, QLD
Dr Kate Smyth, MBBS FANZCA, Consultant Anaesthetist, NSW
Prof Peter Joseph, AM FAMA FRACGP, Past President or Member RACGP/AMASA/AHEC, Dep.ChairCPMC, ChairNHMRC Organ Transplant, Lecturer, Rural Medicine, SA
Prof Katherine Clark, MBBS MED PhD FRACP FACHPM, Clinical Conjoint Prof University of Sydney, Clinical Director Pall Care, NSW
Dr Patricia Chan, MBBS, MMed (Clin Epi), PhD, NSW
A/Prof Timothy Kleinig, PhD FRACP MBBS (Hons) BA, Neurologist, Clinical Head, Lecturer, SA
Dr Joseph V Turner, MBBS BMedSc(Hons) PhD DRANZCOG(Adv) FRACGP

FARGP FACRRM, Rural Medicine, Lecturer. NSW, QLD
A/Prof Leeroy William, BSc (Hons) MBBS MRCGP MSc FACHPM, Palliative
Medicine Specialist, Lecturer, VIC
Dr Angela Chang, MBBS FRACGP General Practitioner, NSW
Assoc/Prof Joel Rhee, BSc(Med) MBBS(Hons) GCULT PhD FRACGP, General
Practitioner, Lecturer, NSW
Dr Alan Oloffs, FRACP FACHPM MD BSc, Palliative Medicine Physician, Head
of Supportive and Palliative Care, NSW
Dr David Bell, MBBS, FRACP, Oncologist, NSW
Dr James Gallagher, BMed BmedSci FRACS, Surgeon, NSW
Dr Rosemary Isaacs, MBBS FFCFM (RCPA) FRACGP, Forensic Physician, NSW
Prof Louise Bauer, AM, BSc(Med), MBBS (Hons), PhD, FRACP, FAHMS,
Paediatrician, Professor and Head of Child & Adolescent Health, Lecturer, NSW
Dr Scott King, MBBS, FRACGP, FACHPM, AFRACMA, Clinical Director of
Palliative Care, VIC
Prof Geoffrey Mitchell, Professor of General Practice and Palliative Care,
Lecturer, QLD
Dr John McEnroe, OAM MBBS FRACGP, General Practitioner, VIC
Prof Graeme Clark, AC FAA FRS FTSE MS FRCS (Edin,Eng) FRACS (Hon)
FRCS (Hon) MD, Academic, Surgeon, Lecturer, VIC
Dr Shirley Prager, MBBS FRANZCP, Psychiatrist, VIC
Dr Mirrilee Back, MBBCh UK FRCGP, General Practitioner, VIC
Dr Louis Christie, FACEM FACRRM ClinDipPallMed, Palliative Care Doctor,
NSW
Dr Derek Eng, MBBS FRACP FACHPM - Palliative Care Physician, WA
Dr Paul Kleinig, B.App.Sc(OccTher) MBBS FRACP FRACHPM, Palliative Care
Physician, SA
Dr Robert Claxton, FRACS FRCS FRCSEd, Admin Head of Surgery, NSW
Dr Russell Clark, AM FRACP DTM&H, Director Geriatric Medicine, Senior Lecturer,
NSW
Dr Diane Grocott, MBBS FRANZCP, Psychiatrist, VIC
Dr Catherine Hollier, MBBS FRACGP General Practitioner, NSW
Dr Riona Pais, MBBS FRACP FRACHPM, Palliative Medicine Physician, NSW
Dr Lynnette Yap, MBBS FRACGP MPHIC, General Practitioner, VIC
Dr Tanya Maya Jones, BSc BMBS FRACGP ClinDipPallMed, Palliative Care
Doctor, NT
Dr Sarah Wenham, MB ChB MRCP FRACP FACHPM, Palliative Medicine
Physician, Clinical Head, NSW
Dr Mary Stavralopoulou, MBBS FRACGP, General Practitioner, VIC
Dr Stephen Shiny, MBBS, Palliative Medicine Advanced Trainee, VIC
Dr Peter Roach, MBBS, FRACGP, Palliative Medicine Advanced Trainee, NSW
Dr Peter Finlayson, MBBS BSc(Med) MHA FRACMA FACRRM AFACHSM, Rural
Medicine Doctor, NSW
Dr Kevin Eng, MBBS FRACGP, General Practitioner, WA
Prof Patrina Caldwell, MBBS FRACP, Paediatrician and Lecturer, NSW
A/Prof Mel Cusi, MBBS, FACSP, FFSEM (UK), PhD, Associate Professor, NSW
Prof Gerald Fogarty, MBBS FRANZCR PhD, Radiation Oncologist, Clinical Head,
Lecturer, NSW
A/Prof Paul Wrigley, MBBS MMed PhD FANZCA FFPANZCA, Pain Medicine
Physician, NSW

Dr Elizabeth Brown, MBBS FRACP, Respiratory Physician, NSW
 Dr David Holford, MBBS DipRACOG MPHTM, General Practitioner NSW
 Dr Wendy Falloon, B.MedSci MBBS DA (UK) FANZCA, Consultant Anaesthetist, TAS
 Dr Michael Stone, B Med Sc MBBS(Hons) MMed PGDipEcho FANZCA FFPMANZCA, Pain Medicine Physician, NSW
 Dr Kim Caldwell, MBBS MRCP, Palliative Medicine Advanced Trainee, NSW
 Dr Hong Nguyen, MBBS BMEDSCI FRACGP, General Practitioner, VIC
 Dr Alice Phua, MBBS FACHPM, Palliative Care Consultant, WA
 Prof Philip Siddall, MBBS PhD FFPMANZCA, Conjoint Professor and Specialist Physician in Pain Medicine, NSW
 Dr Hoa Pham, MBBS FRACGP, General Practitioner, WA
 Ms Elizabeth Harris, BS RN, Clinical Nurse Specialist Palliative Care, NSW
 Dr Shawna Koh, BS MBChB FRACP FRChPM, Palliative Physician, NSW
 Dr Debra Louise Chandler, MBBS FRACGP, General Practitioner, TAS
 Dr Angela Wang, MBBS, FRACGP, General Practitioner, NSW
 Dr Ivan Stratov, MBBS FRACP PhD, Infectious Diseases Physician
 Ms Jacqui White, Bachelor Social Work, Masters Womens Health, VIC
 Dr Adrian Dabscheck, MBBS Grad.DipPallMed, Cert Clinical Teaching, Palliative Medicine Specialists, VIC
 Ms Janette Moody, Health Sector CEO, VIC
 Ms Rachel Davy, RN, Registered Nurse and Midwife, NSW
 Dr Lynn Lim, MBBS FRACP FACHP, Palliative Medicine Physician, NSW
 Ms Kylie Draper, RN(Div1), Registered Nurse, VIC
 Dr Helen Lord, MB BS MPHIC FACHPM, General Practitioner and Palliative Medicine Specialist, TAS
 Dr Judith McEinery, MBBS FACHPM, Palliative Medicine Specialist, QLD
 MS Mary Beaumont, RN, Registered Nurse, VIC
 Dr Same Younan, MBBS FRANZCP, Psychiatrist, NSW
 Ms Mary Ticinovic, M Psychology(Clin) BPsychology(Hons), Psychologist, NSW
 Mr Andrew Goff, RN Dip.Nursing Dip.Specialist Palliative Care, VIC
 Dr Kenneth Simpson, MBBS, MRACGP, General Practitioner, NSW
 Ms Helen Morris, EN, Nurse, VIC
 Dr Susan Armstrong, MB BS, General Practitioner, NSW
 Dr Brett Hurley, MBBS, Resident Medical Officer, NSW
 Dr Mark Morton, MBBS FRACP, General Physician, SA
 Ms Justine O'Connell, Qualified Sonographer, NSW
 Ms Patricia Wesslink, B Nursing, Grad.CertICU Nursing, Registered Nurse, QLD
 Ms Randa Abdelsayed, BSc MPsychology & MAPS, Psychologist, NSW
 Ms Angela Rudock, BachPsychology BachHumanServices, Psychologist, VIC
 Dr Judith Nall-Bird, MSc MBBS DCH FRACGP, General Practitioner, NSW
 Mr Andrew Sloane, MBBS, ThD/Lecturer and Ethicist, NSW
 Dr Jillian Collins, MBBS, General Practitioner, NSW
 Dr Hayley Thomas, BSc, MBBS, DCH, General Practitioner, QLD
 Ms Ainsley Poulos, Ba App Sc (Speech Pathology), Speech Pathologist, NSW
 Ms Kia Foord, RN, Nurse Practice Manager, NSW
 Dr Lucy van Baalan, B.Med FRACGP FAMAC, General Practitioner, NSW
 Dr Thomas Sing, MBBS, RANZCR, Radiologist, NSW
 Dr Stephanie Kirk, BMed, Medical Practitioner, NSW
 Dr Kelly Peterson, MBBS HlthSc(Hons) Dip.CH, Medical Practitioner, NSW

Dr Laura Dunstan, BMed/MD, BSc(Hons), Medical Practitioner, NSW
 Dr David Kardachi, B.Med.,B.Sc(Hons), Medical Practitioner, NSW
 Dr Lachlan Dunjey, MBBS FRACGP DOBstRCOG, Genial Practitioner, WA
 Dr My Le Trinh, MBBS FRACGP DCH, General Practitioner, NSW
 Dr Irmgard Pascoe, B.Med FRACGP, General Practitioner, NSW
 Dr Alice Lac, MBBS (Hons) FRACP, Geriatrician, VIC
 Dr Margaret Graham, MBBS FRANZCP, Psychiatrist, VIC
 Dr Patricia Treston, MBBS MPHc FACHPM, Palliative Medicine Specialist, QLD
 Dr Keith Hogan, MBBS FRACP FACHPM, Palliative Physician, VIC
 Dr James Wong, MBBS, FRACP, Cardiologist, NSW
 Ms Rebecca Spring, Medical Student, NSW
 Ms Tamara Kronk BNSc RN, Nurse, QLD
 Dr Kim Boaz, MD, Resident Medical Officer, VIC
 Dr Phillips Harris, MBBS FRACGP DCH, General Practitioner, SA
 Dr Giselle Kidson-Gerber, MBBS, FRACP, FRCPA, Pathologist, NSW
 Dr Richard Lord, MBBS FRACGP DRANZCOG, General Practitioner, TAS
 Ms Alice Kean, Medical Student, SA
 Dr Vincent Lee, MBBS, FRACGP General Practitioner, QLD
 Ms Caroline Early, B Pharmacy, Pharmacist, SA
 Dr Christopher Benness, MBBS MD FRCOG FRANZCOG CU, Gynaecologist, NSW
 Dr James Zhang, MBBS PHD Student Conjoint Lecturer, NSW
 Dr Annette Britton, MBBS, FRACP, Geriatrician, NSW
 Dr Simon Gerber, BScMed MBBS (Hons) FRACGP, General Practitioner, NSW
 Dr John Best, BMed FACSEP, Medical Practitioner, NSW
 Dr Peter Barclay, MBBS FRACGP, General Practitioner, NSW
 Dr Andrew Browning, FRCOG FRANZCOG (Hon), Gynaecologist, NSW
 Dr Rebecca Ling, MBBS GP Registrar, NSW
 Dr Zoe Willett, MBBS, BMedSci, Medical Practitioner, NSW
 Dr John Wenham, MB ChB DCH DRCOG DipHSM MRCGP FRACGP, Rural Medicine, NSW
 Dr Eve McClure, MBBS, FRACP, Geriatrician, NSW
 Dr Joanna Barlow, MBBS DPM FRANZCP, Psychiatrist, NSW
 Dr Rhys Morgan, MBBS (Hons) FANZCA FRACS BMin, Consultant Anaesthetist, QLD
 Dr Ian Jones, MBBS FACRRM DipRACOG, Rural Medicine, General Practitioner, VIC
 Ms Cathy Hayes, RN, Nurse, VIC
 Dr Rachel Chan Moy Fat, BMed MD, Medical Officer, NSW
 Ms Christine Ferguson, RN, Nurse, VIC
 Dr Julian Chew, B.MedSci (Hons) MBBS FRACGP, General Practitioner, NSW
 Mr Danny Ford, Health Service Pastoral Care Coordinator, NSW
 Dr Paul Mercer, MBBS FRACAP DIPRACOG, General Practitioner, QLD
 Dr Aet Jaosoo Lees, BSc(Med) MB,BS, MD FRACP BA, Endocrinologist, NSW
 Dr William Warr, MBBS FRACGP FASMF, General Practitioner, VIC
 Dr Nicole Hutchins, MBBS, Resident Medical Officer, TAS
 Dr Bruce Hayes, MBBS FRACP MPH&TM, Physician, Public Health, QLD
 Ms Joanne Jarlett, Health Service Chaplain, VIC .
 Dr Janine Morrow, MBBS, GP Registrar, QLD

Ms Lois Lois Haultain, BA (Hons), Senior Healthcare Pastoral Care Coordinator, NSW

Ms Amanda Cox, Occupational Therapist, NSW

Ms Kate Willis, MBBS BAppSc (Physiotherapy), Physiotherapist, Medical Practitioner, NSW

Dr Ross Simpson, MBBS FRACGP, General Practitioner, NSW

Ms Sue Love, Health Service Cahplain, NSW

Dr Geoffrey Francis, MB BS DObstRCOG FRACGP, General Practitioner, VIC

Dr Christopher Bennes, MBBS MD FRCOG FRANZCOG CU, Gynecologist, NSW

Dr Mary McNulty, MBBS FACHPM, Palliative Medicine Specialist, WA

Mr Jo Manouk, BMin.GradDipCounselling,Health Service Pastoral Care Coordinator, NSW

Dr Nancy Nicholas, MBBS, General Practitioner, VIC

Dr Jane Taylor's, MBBS, Medical Practitioner, ACT

Dr Yi-An Neoh, MBBS FRACGP, General Practitioner, SA

Dr James Ward, MBBS, B Lib Stud ThC, Medical Practitioner, NSW

Mr Grant Murray, Health Service Pastoral Care, NSW

Dr Lesleigh Sands, MBBS FRACGP, General Practitioner, QLD

Ms Debbie Johnson, Health Services Pastoral Care Co-Ordinator, NSW

Dr Yvonne McMaster, MBBS FACHPM, Palliative Medicine Doctor and Network Leader, NSW

Dr Ester Koh, MBBS FRACGP, General Practitioner, VIC

Dr David Knight, MB BS FRCOG FRANZCOG FRACGP, General Practitioner, ACT

Dr Andrew Hart, MBBS FRACP FACHPM, Palliative Medicine Physician, WA

Dr Nathan Grills, Public Health Physician, VIC

Dr Ann Taylor, MBBS FRACP FACHPM, Palliative Medicine Physician, SA

Dr Rena Ng, MBBS, Resident Medical Officer, NSW

Dr John York, MD FRACP FRCP.Grad.Dip.Couns. Physician, NSW

Dr Michael Peterson, MB BS (Hons) DRACOG, General Practitioner, NSW

Mr Tony McGriffin, Medical Student, QLD

Dr Amanda Howard, BMBS FRACGP DRANZCOG DCH, General Practitioner, ACT

Ms Hannah Watts, Medical Student, WA

Ms Vichaya Champreeda, Medical Student, VIC

Dr Anil Tandon, MBBS FRACP FACHPM, Palliative Medicine Physician, WA

Mr/Rev Peter Archer, Ordained Pastoral Health Care Officer, NSW

Ms Meredith Hatcher, Physiotherapist/Healthcare Pastoral Care Officer, NSW

Ms Judy Douglas, RN, Nurse, NSW

Dr Hugh Pearson, MBBS, Resident Medical Officer, NSW

Dr Sara Fraser, MBBS, Senior Health Officer, QLD

Dr John Oakley, MBBS, General Practitioner, NSW

Dr Nathan Combs, MBBS, GP Register, General Practitioner, WA

Dr Andrew Browning, FRCOG FRANZCOG (Hon), Gynecologist, NSW

Dr Henry Vo, BMed MD BSc(Med)Hons, Medical Practitioner, NSW

Dr Lawrence Simpson, OAM MD BS FCCP FRACS, Thoracic Surgeon, VIC

Dr Richard Shawyer, MB BS MTH, Medical Practitioner, VIC

Ms Donna Hanlan, Health Sector, Pastoral Care Coordinator, NSW

Dr Sylvia Leung, MBBS Dip Paed FRACP FHKAM (Paed) FHKCPaed.

Paediatrician, NSW
 Dr Doug Utley, MB BS FRACGP, General Practitioner, VIC
 Dr Gerald Gleeson, STB MA PhD, Health Sector Bioethicist, NSW
 Dr Phillip Andrew, BSc (Hons) MB BS (Hons) FRACGP FACTM FWACP, General Practitioner, Tasmania
 Mr Richard Travender, Adv Dip Past.Ministry Grad.Counseling, Pastoral Care Coordinator Aged Care and Palliative Care, NSW
 Ms Liane Lee, BPharm GradDipEd, Educator, Pharmacist, WA
 Dr Christopher Williams, MBBS DCH, GP Registrar, VIC
 Dr Corey Cunningham, MBBS FRACGP FACSEP, Exercise and Sports Medicine Physician, NSW
 Ms Kerrie Jackson, Health Care Sector pastoral Care Coordinator, NSW
 Dr Lucy Woodhouse, BachelorMedicalStudies MD, General Practice Registrar, NSW
 Dr Jade Schroers, MBBS, Physician Trainee/Registrar, NSW
 Dr Cheuk Lam, Medical Student, NSW
 Dr Anmarie Hosie, RN PhD, Palliative Care Nurse, Researcher and Educator, NSW
 Dr Richard Wong, MB BS BSc(Med) FRACGP DCH DRANZCOG, General Practitioner, QLD
 Dr Alesion Walsh, MBBS FRACGP, General Practitioner, VIC
 Ms Anna Baker, Registered Midwife/Registered Nurse, QLD
 Dr Alice Schroers, MBBS, Intensive Care Senior Resident Medical Officer, NSW
 Dr Michelle Huang, MBBS, General Practice Registrar, NSW
 Mr Richard Sadig, Medical Student, NSW
 Dr Felicity Wild, MBBS, General Practitioner, WA
 Dr Mark Yates, FRACP, Geriatrician, VIC
 Dr Peter Selvaratnam, PhD(MedAnatomy) FACP, Physiotherapist, VIC
 Dr Winnie Chen, MBBS, GP Registrar, NT
 Dr Jane Thompson, MBBS DipObs, General Practitioner, VIC
 Dr Isabelle D'Souza, MBBS FRACGP, General Practitioner, WA
 Dr Terrence Middleton, MBBS DipRACOG FRACGP, General Practitioner, WA
 Dr Stephanie Isaac, BMedSc(Hons) Univ. Medal, MD, Medical Intern, NSW
 Dr Ruth Redpath, FRCS FRCR DMedSci(Hons), Oncologist, VIC
 Ms Joanna Blades, Medical Student, WA
 Dr Joseph Thomas, MBBS MD FRANZCOG CMFM DDU, Gynecologist, QLD
 Dr David Sturrock, MBBS FRANZCP, Psychiatrist, NSW
 Dr Paul Neeskens, MBBS, General Practitioner, QLD
 Dr Roger Steer, MBBS, General Practitioner, VIC
 Dr Thalia Shuttleworth, MBBS FRANZCO, Ophthalmologist, NSW
 Dr Bernadette Wilks, MBBS, Anaesthetics Registrar, VIC
 Dr Jill Howard, MBBS, GP, QLD
 Dr Michael Shanahan, MBBS FRACS, WA
 Dr Robert Pollnitz, MBBS FRACP, Paediatrician, SA
 Dr Yong Yau Paul Chia, MBBS FRACP, General Physician, Lecturer, TAS
 Dr David Ven Gend, MBBS FRACGP, DipPallMed, Senior Lecturer in Pall Med, QLD
 Dr Julene Haack, MBBS(Hons1) Dip RANZCOG FRACGP, General Practitioner, QLD
 Dr Lee-Anne Gray, MBBS, Intern, WA

Dr Ruth Highman, MBBS BA(Psych) FACRRM FRACGP, ED SMO, WA
 Dr Catherine Hollier, BMed FRACGP, General Practitioner, NSW
 Fr John Daffy, M.B B.S FRACP, Physician & Director of Infectious Diseases, VIC
 Dr Eamonn Mathieson, MBBS FANZCA, Specialist Anaesthetist, VIC
 Dr Theo Shemansky, MBBS FRACGP B App Sci (Pod), QLD
 Dr Andrew FC Taylor, MBBS FRACP MD, Gastroenterologist, VIC
 Dr Daniel Mealey, MBBS, Medical Registrar, NSW
 Dr Frederick Peter Denton, MBBS(Melb) FRACS, Surgeon, VIC
 Dr Michael Plunkett, MBBS FRACGP, General Practitioner, VIC
 Dr Patricia Newell, MB ChB FANZCA, Anaesthetist, VIC
 Dr Adrian Thomas, MBBS, FRANCOG, Obstetrician, VIC
 Dr Xavier O'Kane, M.B.B.S. MA (Bioethics), General Practice Registrar, VIC
 Dr Michael Christie, MB BS FRACGP, General Practitioner, VIC
 Dr T John Martin AO, MD DSc FRACP FRCPA FAA FRS, Emeritus Professor of
 Medicine, VIC
 Dr Dr Roheela D'Cruz, MBBS FRACGP MPH GAICD, General Practitioner, VIC
 Dr Kameel Marcuz, MBBS FANZCA, Anaesthetist, VIC
 Dr Stephen Parnis, MBBS DipSurgAnat FACEM FAICD FAMA, Emergency
 Physician, VIC
 A/Prof Edward O'Sullivan, MBBS FRACP, Peri-operative Physician, VIC
 Dr Elvis Seman, MBBS FRANZCOG EUCOGE FRCOG NFPMC PhD, Head of
 Urogynaecology, Lecturer, SA
 Dr Catherine Madigan, Clinical Psychologist, VIC
 Dr Milton Micallef, MBBS BA(Hons) BSc, Medical Registrar, NSW
 Ms Catherine Mannering, Med Student, VIC
 Dr Simon Donohoe, EMBBS FRACS, Cancer Surgeon, VIC
 Dr Antonio De Sousa, MBBS, General Practitioner, VIC
 Prof Eugene Haydn Walters, Public Health Physician, Lecturer, VIC
 Dr Douglas Randell, MBBS FRACGP, ACT
 Dr Heather Manning-Down, MB BS DPM FRANZCP Dip Crim, Psychiatrist, VIC
 Dr Susan Newton, BMed GradDipPallMed MProfEthics FACHPM, Lecturer and
 Palliative Medicine Specialist, NSW
 Dr Elizabeth Ravenscroft, MB BS FRACP FRCP, Paediatrician, NSW
 Dr Rimino Guerriero, MBBS FRCS FRACS General Surgeon, SA
 Dr Mark Hobart, MBBS, General Practitioner, VIC
 Dr Normal Hohl, MBBS FRACGP FAFPHM DTM&H CTH, General Practitioner,
 QLD
 Dr Judith McEniery, MBBS FACHPM, Palliative Medicine Specialist, QLD
 Dr Susan Belperio, MBBS(Hons) FANZCA, Anaesthetist, SA
 Dr Graham Toohill, MBBS FRACGP Dobs.RCOG D.RANZCO&G DTM&H,
 General Practitioner, VIC
 Dr Jonathan Baré, MBBS FRACS(orth) FAOA, Orthopaedic Surgeon, VIC
 Dr Steven Zebic, MBBS, Medical Practitioner, VIC
 Dr Ann-Marie Diggins, MB ChB FRACGP, General Practitioner, VIC
 Dr Rosemary Wong, MBBS MD(Melb) FRACP GradDipDiv(ACT) GAICD,
 Endocrinologist, VIC
 Dr Andrew Hughes, FRACGP FACRRM, General Practitioner, QLD
 Dr Albert Matti, MBBS, Medical Practitioner, SA
 Dr Mary Walsh, MBBS FRACGP, General Practitioner, VIC
 Dr Ibrahim Yacoub, MBBS FANZCA, Anaesthetist, VIC

Dr Geraldine Fenn, MBBS FRACGP, General Practitioner, VIC
 Dr Dunne Brian, MBBS, Medical Practitioner, VIC
 Dr Lucia Murnane, MBBS FRACGP DCH GradDipBioethics, GP Ethicist, VIC
 Ms Faye Tomlin, RN, Nurse Practitioner, QLD
 Dr Sam Phillips, MBBS, Medical Practitioner, VIC
 Dr Catherine Crowley, MBBS(Hon) DipCHGCut, Medical Practitioner, NSW
 Dr Ian Haines, MBBS, FRACP, FACHPM, Palliative Medicine Physician, VIC
 Dr Yi-An Neoh, MBBS RACGP, General Practitioner, SA
 Dr Ian Denness, MBBS DCH DSCCA GradDipDiv FRACGP, General Practitioner, NSW
 Dr Teem-Wing Yip, BA BMBS MPH FACRRM FAFPHM, Public Medicine Physician, NT
 Dr. KAM Andrew Kok Foo, MBBS(Qld), FRACR, Radiologist, WA
 A/Prof Patrina Caldwell, MBBS FRACP, Paediatrician, Clinical Leader, Lecturer, NSW
 Dr Richard Chittleborough, MBBS FRACGP, General Practitioner, SA
 Dr Jereth Kok, FRACGP MBBS, General Practitioner, VIC
 Mr Pascale Van der Beken, RN, Clinical Nurse Specialist, NSW
 Dr James Quinn, MBBS FRACGP, General Practitioner, VIC
 Dr Olivia Perrotti, BA MBBS, General Practice Registrar, NSW
 Ms Marion Gall, Nursing Assistant, QLD
 Dr Andrew Gan, MBBS BMedSci FRACGP, General Practitioner, VIC
 Dr Johnny Khoury, MBBS BSc(Med) FRACGP DCH DRANZCOG, General Practitioner, Lecturer, NSW
 Dr Anthony Obeid, MBBS, Medical Practitioner, NSW
 Dr Danielle Li Danielle, BMedSci MBBS, Emergency Medicine Registrar, NSW
 Ms Helen Morris, EN, Nurse, VIC
 Dr David Anderson, MBBS FRACGP MPH, General Practitioner, VIC
 Ms Barbara Page, RN HNE(Health) MHC, Nurse Specialist, NSW
 Prof George Mendz, MSc PhD, Lecturer, Research Head, NSW
 Ms Kristen Green, Medical Student, VIC
 Dr Michael Knight, MBBS FRACS (Orth), Orthopaedic Surgeon, VIC
 Dr William Linden Hall, MDSc BDS, Dental Surgeon, VIC
 Ms Alicia Smith, Cardiac Sonographer, NSW
 Dr Dimitios Papadopolous, MBBS (Hons) DipPaed FRACP, Paediatrician, NSW
 Ms Natalie Grey, BA, BSc(Hons) MPharm, Pharmacist, Clinical Head, TAS
 Dr Davina Fang, MBBS FRACGP, General Practitioner, VIC
 Ms Elizabeth Kinsey, MPsych DipAppliedPsych (Health), Psychologist, VIC
 Dr Siba Sulaeman, Emergency Medicine Physician, VIC
 Dr Jane Tehan, MBBS(Hons), Geriatric Medicine Registrar, VIC
 Ms Yin Chung, RN, Nurse, NSW
 Ms Donna Purcell, MBBS, General Practitioner, QLD
 Dr David Crosbie, MBBS FRACP FCICM, Intensivist, VIC
 Ms Anastasia Fantini, RN, Nurse, TAS
 Dr Catherine Croagh, MBBS FRACP MD MPH, Gastroenterologist, VIC
 Mr Christopher Langan-Fox, BA(Psychology) BA(Hons) MSc, Psychologist, TAS
 Ms Elizabeth Aguilera, Occupational Therapist, NSW
 Dr Sally Troedel, FANZCA MBBS Anaesthetist, Anaesthetist, VIC
 Ms Maria Sparshott, RN, Nurse, NSW
 Dr Ruella D'Cruz, MBBS, Emergency Medicine, Registrar, NSW

Ms Valerie Wee, EN, Nurse, NSW
 Dr John Vidovich, MBBS FRACS FRCS(Eng), Vascular Surgeon, VIC
 Dr Dean Everard, MBBS(Hons) FRACP, Geriatrician, Clinical Head, Lecturer, VIC
 Ms Krystyna Kidson, M.Psych (Clin) Hons, MIAC, Psychologist, NSW
 Dr Willaim Kennett, MBBS MRCP, Palliative Medicine Advanced Trainee, NSW
 Ms Joanne Kissane, RN, Nurse QLD
 Dr Caroline Dowling, MBBS, FRACS , Urologist, VIC
 Dr Catherine Peterson, MBBS FRACGP, General Practitioner, SA
 Dr Natasha Hamilton, MBBS, Paediatric Advanced Trainee, TAS
 Dr Genevieve Hamilton, MBBS FRACGP BBiomedSci BSci(Hons), General Practitioner, VIC
 Ms Ruth Dukes, Credentialed Mental Health Nurse, QLD
 Dr Teresa Leung, MBBS FRACP FRCPA, Haematologist, VIC
 Dr Michael McCaffrey, MBBS, Medical Practitioner, SA
 Dr William Edwards, MB BS DIP ANAT MS FRACS FAORTHA, Surgeon, VIC
 Dr J Philip Joseph, MAFP FRACGP Dip.PallMed, Palliative Medicine Specialist, VIC
 Dr Brian Fernandez, MBBS, Medical Resident, NSW
 Mr Michael Sparshott, Radiographer, NSW
 Dr Peter Ferwerda, MBBS, Medical Practitioner, VIC
 Ms Helen Holley, BSc Dip Physiotherapy, Physiotherapist, NSW
 Ms Kathleen Airey, BSSc (Pastoral Care), Health Sector, QLD
 Dr Jessica Costa-Pinto, MBBS, FRACP, Paediatrician, VIC
 Ms Mia Villatora, Neuropsychotherapist, NSW
 Dr Sarah Heynemann, MBBS BMedSci, Medical Oncology Registrar, VIC
 Mr Martin Carolan, PhD, Radiation Oncology Medical Physicist, NSW
 Ms Frances Beaumont, RN, Nurse, QLD
 Dr Wam En Chang, MBBS,FRACGP; General Practitioner, Medical Educator, VIC
 Dr Simon Tong, MBBS FRACGP DRANZCOG, General Practitioner, VIC
 Dr Simonil Mehta, MBBS FRACGP, general Practitioner, NSW
 Dr Sarah Tedjasukmana, MBBS BScAdv)(Hons I) DCH, GP Registrar, NSW
 Dr Alan Dobson, MBBS FRACGP Dip.ORCOG DCH, General Practitioner, VIC
 Dr Crystal Durell, MBBS FRACGP, General Practitioner, WA
 Dr Juliet Seedhouse, MBBS, Medical Practitioner, QLD
 Dr Nyree O'Connor, MBBS FRACGP, General Practitioner, VIC
 Dr Peter Seha MBCh FRACGP, General Practitioner, QLD
 Dr Pieter Pretorius, MBBS FRACGP, General Practitioner, VIC
 Dr Thinus van Rensburg, BSc MBChB FRACGP FACRRM, General Practitioner, ACT
 Dr Philip Cohen, MB BS, GP Registrar, SA
 Dr John Deery, MBBS, General Practitioner, ACT
 Dr Berbar Shiu, MD FRACGP, General Practitioner, VIC
 Dr Catherine Bailey, MBBS FRACP, Physician, NSW
 Dr Kristin Richardson, MBChB FRACGP GCHPE, General Practitioner, Medical Educator, NSW
 Dr Lorraine Abderson, FRACGP MBChB, General Practitioner, WA
 Dr Carol Booth, B Med BA(hon) LLB, Lawyer, General Practitioner, NSW
 Dr Elizabeth Thomas, MBBS MBioeth FRACP, Physician, Bioethicist, VIC
 Dr Megan Graieg, MBBS, Medical Practitioner, WA
 Dr Emily Isham, MBBS BMedSci MIPH DRANZCOG, General Practitioner, TAS

Dr Nathan O'Dea, MBBS, BSc(Hons). Medical Oncology CMO. NSW
 Dr Christopher Ford, MBBS FRACGP BPastoral Care BHSci(Public Health) Rural
 General Practitioner, VIC
 Dr Lin Hickey, MBBS FRACGP, General Practitioner, QLD
 Dr Carli Weatherhead, BMedSci (Hons) MBBS DCH DRANZCOG, General
 Practitioner, VIC
 Dr Verity Nicholson, MBBS BMedSci, Anaesthetics Registrar, VIC
 Dr Natalie Morgan, MBBS (Hons), Senior Paediatric Registrar, VIC
 Dr Madeleine de Haan, MBBS FRACGP, General Practitioner, VIC
 Dr Leanne Cole, MBBS, General Practice Registrar, VIC
 Dr Michael Tong, BSc (Hons) DipB&M BMedSc(Hons) BMed DCH DTM&H
 FRACGP, General Practitioner, NT
 Dr Norah Stan-Bishop, MBBS DCH, Medical Practitioner, WA
 Dr Eleanor Sharland, MBBS (Hons) FRACGP, General Practitioner, WA
 Dr Maurice Easton, MBBS FRACP, Paediatrician, VIC
 Dr Jocelyn Lowinger, MBBS, Medical Practitioner, VIC
 Dr Karen Gwee, MBBS FRANZCP, Psychiatrist, VIC
 Dr Manoj Obeyesekere, MBBS MRCP FRACP FHRS MD, Cardiologist, VIC
 Dr Wilson Chong, MBBS BMedSc(Hons) DCH FRACGP, General Practitioner,
 VIC
 Dr Albert Matti, MBBS Mast Med Dip Child Health Bsc(Hons), SA
 Dr Damir Culic, Dental/Oral Surgeon, SA
 Dr Raymond Yeow, BA MBBS MBA(Exec) FIAA, Health Sector, NSW
 Dr Carol Ierace, MBBS DRANCOG General Practitioner, SA
 Dr Peter Barker, MBBS FRACGP DipRANZCOG DPD FRCRRM, VIC
 Dr Sharon Martin, BNSc BMBS FRACGP, General Practitioner, SA
 Dr Vincent Lee, FRACGP MBBS BPharm, General Practitioner, QLD
 Prof Margaret Somerville, AM FRCS DCL Professor of Bioethics, Samuel Gale
 Professor of Law Emerita, Professor Emerita Faculty of Medicine, Founding
 Director Emerita Centre for Medicine Ethics and Law, McGill University Montreal
 Canada, NSW
 Dr David McIlroy, MBBS MD MClInEpi FANZCA, Specialist Anaesthetist, VIC

Dear Mr Donnelly,

I write to express my opposition to the *Voluntary Assisted Dying Bill 2017* currently before the NSW Parliament. Euthanasia/physician assisted suicide (E/PAS) is exceedingly difficult to monitor and regulate, and the proposed legislation will put vulnerable members of the community at serious risk of coercion and manipulation.

The legislative and regulative means by which governments seek to protect patients are referred to as “safeguards”. Proponents of the bill have argued that safeguards will protect vulnerable persons from abuses of the law. Yet overseas experience overwhelmingly suggests that safeguards fail to protect patients from coercion and distress at the end of life. E/PAS is poorly monitored in the Benelux region of Europe, and some patients have received E/PAS under duress or without valid consent.¹ Safeguards have failed even in jurisdictions to which the so-called “conservative” NSW E/PAS bill has been compared, such as the US state of Oregon. Crucial details of cases of assisted suicide in Oregon go unreported in a significant minority of instances.

Furthermore, E/PAS laws arbitrarily distinguish between patients on the basis of the presence or absence of a terminal illness, and this distinction is vulnerable to convincing philosophical critiques. One Canadian ethicist, for example, recently argued that there is no morally relevant difference between the suffering experienced by patients with a terminal illness and those who experiencing other forms of refractory suffering (such as patients who are healthy but feel their life is worthless).² That is to say, we should provide euthanasia to competent patients who wish to see their life ended for non-medical reasons. Legislators will inevitably be subject to public pressure once the practice of E/PAS has become normalised in society, and it will be difficult to resist calls to further expand the law.

The reality is that there is no truly “safe” safeguards regarding E/PAS legislation. The common good will not be served by supporting the proposed legislation; in fact the very opposite would be the case. Accordingly, I encourage you to vote against the *Voluntary Assisted Dying Bill 2017*.

Yours sincerely,

Xavier Symons
BA(Adv)(Hons), MA (Res)
Research Associate, Institute for Ethics and Society, UNDA
Bioethicist, Austin Health Human Research Ethics Committee
Deputy Editor, www.bioedge.org

¹ Kenneth Chambaere, Luc Deliens *et al.* “Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey”. *Canadian Medical Association Journal* 2010 Jun 15;182(9):895-901.

² Xavier Symons and Udo Shuklenk. “Viewpoints: Should euthanasia be available for people with existential suffering?” *The Conversation* 6th July 2017.

'ASSISTED DYING: DON'T GO THERE'

Professor Theo Boer

16th July 2014

In 2001 The Netherlands was the first country in the world to legalise euthanasia and, along with it, assisted suicide. Various 'safeguards' were put in place to show who should qualify and doctors acting in accordance with these 'safeguards' would not be prosecuted. Because each case is unique, five regional review committees were installed to assess every case and to decide whether it complied with the law. For five years after the law became effective, such physician-induced deaths remained level - and even fell in some years. In 2007 I wrote that 'there doesn't need to be a slippery slope when it comes to euthanasia. A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia.' Most of my colleagues drew the same conclusion.

But we were wrong - terribly wrong, in fact. In hindsight, the stabilisation in the numbers was just a temporary pause. Beginning in 2008, the numbers of these deaths show an increase of 15% annually, year after year. The annual report of the committees for 2012 recorded 4,188 cases (compared with 1,882 in 2002). 2013 saw a continuation of this trend and I expect the 6,000 line to be crossed this year or the next. Euthanasia is on the way to become a 'default' mode of dying for cancer patients.

Alongside this escalation other developments have taken place. Under the name 'End of Life Clinic,' the Dutch Right to Die Society NVVE founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or send the patient away. On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic. The NVVE shows no signs of being satisfied even with these developments. They will not rest until a lethal pill is made available to anyone over 70 years who wishes to die. Some slopes truly are slippery.

Other developments include a shift in the type of patients who receive these 'treatments'. Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now

sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades.

Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting towards considering them rights, with corresponding duties on doctors to act. A law that is now in the making obliges doctors who refuse to administer euthanasia to refer their patients to a 'willing' colleague. Pressure on doctors to conform to patients' (or in some cases relatives') wishes can be intense. Pressure from relatives, in combination with a patient's concern for their wellbeing, is in some cases an important factor behind a euthanasia request. Not even the Review Committees, despite hard and conscientious work, have been able to halt these developments.

I used to be a supporter of the Dutch law. But now, with twelve years of experience, I take a very different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort? Before those questions are answered, don't go there. Once the genie is out of the bottle, it is not likely to ever go back in again.

Theo Boer has been a Member of a Regional Review Committee since 2005. For the Dutch Government, five such committees assess whether a euthanasia case was conducted in accordance with the Law. In the past nine years, Prof. Boer has reviewed almost 4,000 euthanasia cases. The views expressed here represent his views as a professional ethicist, not of any institution.

Euthanasia and physician-assisted suicide: focus on the data

We should aim at improving the care of dying patients

Modern debates about legalising euthanasia and physician-assisted suicide (PAS) in Great Britain and the United States began in the late 19th century.¹ Legislation was periodically proposed only to be defeated until, in 1942, Switzerland decriminalised assistance in suicide for cases when there were no “selfish motives”.² In 2002, euthanasia was legalised in the Netherlands and Belgium, then in Luxembourg in 2009, and most recently, in 2015 in Colombia and in 2016 in Canada.³ PAS, but not euthanasia, has been legalised in five US states. In Oregon, PAS was legalised by popular referendum in 1997. In addition, in 2009, Washington State legalised PAS by referendum and Montana by court ruling; Vermont in 2013 and California in 2015 also legalised PAS by legislation.⁴

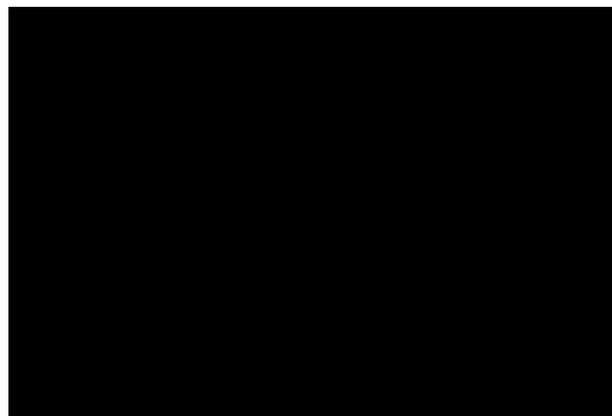
Debates about legalisation of euthanasia and PAS continue in a number of countries and states. On both sides, there are many claims and counterclaims that may not cohere with our empirical understanding. To ensure evidence-based discussions and policy formulation, it is important to consider three major points regarding the practices of euthanasia and PAS.

First, euthanasia and PAS are rarely used, even in countries where these interventions are legal and have been used for more than a decade.⁵ Since the 1980s, euthanasia and PAS were permitted and not prosecuted in the Netherlands if certain safeguards were followed, and they were finally legalised in 2002. Yet, according to the latest data from 2010, dying patients have requested euthanasia in only about 6.7% of all deaths.⁵ In a similar manner, in Belgium, only 6% of all deaths have a request for euthanasia or PAS.⁶ However, not all requests are honoured; in the Netherlands, just 45% of requests are granted, and in Belgium this rate rises to 77%.⁵⁻⁷

Moreover, few deaths are caused by euthanasia or PAS. The most recent study from 2014 suggests that in the Netherlands 3.8% of deaths are by euthanasia or PAS, most of which — about 92% of the 3.8% — are by euthanasia, and in Belgium, only 4.6% of all deaths are by these interventions.⁵ After 17 years of legalisation, in Oregon in 2014, only 0.3% of all deaths occurred by PAS,⁷ and in Washington State only 0.24% of deaths were by PAS.⁸

Not only are these interventions rarely requested, they are predominantly used by patients with cancer. Even though cancer accounts for less than 25% of deaths in high income countries, about 75% of all euthanasia and PAS cases occur in patients who have cancer.³⁻⁶ Few occur in patients with neuro-degenerative diseases, such as amyotrophic lateral sclerosis.³⁻⁶

These data mean that the claim that legalising euthanasia and PAS will help solve the problem of poor end-of-life



care is erroneous. Euthanasia and PAS do not solve the problem of inadequate symptom management or improving palliative care. These interventions are for the 1% not the 99% of dying patients. We still need to deal with the problem that confronts most dying patients: how to get optimal symptom relief, and how to avoid the hospital and stay at home in the final weeks. Legalising euthanasia and PAS is really a sideshow in end-of-life care — championed by the few for the few, extensively covered by the media, but not targeted to improve the care for most dying patients who still suffer.

Second, pain is not the primary reason why people seek euthanasia or PAS. It is commonly thought that patients in excruciating and unremitting pain would want these interventions. Many healthy people believe that pain would be the reason why they may want them; however, evidence suggests otherwise. Patients who request and receive euthanasia or PAS infrequently experience pain; similarly, few patients in pain actually want euthanasia or PAS. Two decades ago, research with patients who had cancer or HIV showed that those who were interested in euthanasia or PAS were not those experiencing pain.⁹ This has been confirmed multiple times; for instance, the data from the state of Oregon in the US, which has followed patients who have requested and used PAS for 17 years now, show that fewer than 33% of patients are experiencing — or fearing — inadequate pain control.⁵ Even in Australia, when for a brief moment seven patients were given euthanasia in the Northern Territory, none had uncontrolled pain.¹⁰

If not pain, then what motivates patients to request euthanasia and PAS? Depression, hopelessness, being tired of life, loss of control and loss of dignity. These reasons are psychological — they are clearly not physical pain — and are not relieved by increasing the dose of morphine, but by antidepressants and therapy. In the states of Oregon and Washington, the reasons for wanting PAS were: 90% of patients reported loss of autonomy, 90% were less able to engage in activities that make life enjoyable and 70% declared loss of

Ezekiel Emanuel

University of
Pennsylvania,
Philadelphia,
PA, USA

mepchari@
upenn.edu

doi: 10.5694/mja16.00132

Online first 24/04/17

dignity^{5,6} — depression and hopelessness are not listed and are not included in the reporting list. Likewise, in the Netherlands, the main legal requirement is “extreme physical or mental suffering,” and patients’ reasons are classified in this manner, making it hard to know whether the reasons are physical symptoms of depression. However, when researchers from the Netherlands — who were convinced that the main rationale was pain — interviewed patients who requested euthanasia, they found that few of the ones using euthanasia were experiencing pain, but most were depressed.¹¹

The importance of psychological suffering as patients’ rationale for requesting euthanasia and PAS indicates that these interventions are less like palliative care and more like traditional suicide condoned and assisted by the medical community. The main drivers of traditional suicide are psychological problems. Despite the importance of psychological suffering as the main motivator, few physicians in the jurisdictions where euthanasia and PAS are legal receive psychiatric consultation. Indeed, in the states of Oregon and Washington, less than 4% of patients who had PAS had a psychiatric consultation.⁵⁻⁷ In Belgium, where an independent physician needs to be consulted for non-terminal cases, in 42–78% of cases that physician is a psychiatrist. Since psychological reasons dominate, one would think that requiring psychiatric evaluation would be a reasonable safeguard before providing euthanasia or PAS. Therefore, we need to think very differently about what drives people to want euthanasia. The picture most people have of patients who are writhing in uncontrolled pain despite morphine is simply wrong.

Third, many people believe euthanasia and PAS are flawless, quick and painless. This belief is common but mistaken. No medical procedure — even simple ones like blood draws — is flawless; every medical procedure has

problems and complications. Euthanasia and PAS are no exceptions. According to a study in the Netherlands from 2000, 5.5% of all cases of euthanasia and PAS had a technical problem and 3.7% had a complication. An additional 6.9% of cases had problems with completing euthanasia or PAS. Technical problems, including difficulty finding a vein and administering oral medications, occurred in 4.5% of euthanasia cases and in 9.8% of PAS cases. Moreover, 3.7% of euthanasia cases and 8.8% of PAS cases had complications, such as nausea, vomiting and muscle spasms. Overall, an additional 1.1% of patients who had euthanasia or PAS did not die but awoke from coma.¹² The data suggest that the common view of euthanasia and PAS as quick, flawless, and painless ways to die is unrealistic.

When considering this evidence, the case for legalising euthanasia and PAS looks less compelling. They will not improve the care of many dying patients, they are not helping people in pain and enduring inadequately treated physical symptoms, and are far from quick and flawless. What is then the great impetus to legalise interventions to end lives for a small minority of patients who are depressed, worried about losing autonomy and being tired of life?

We should end the focus on the media frenzy about euthanasia and PAS as if it were the panacea to improving end-of-life care. Instead, we need to focus on improving the care of most of the patients who are dying and need optimal symptom management at home.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

© 2017 AMPCo Pty Ltd. Produced with Elsevier B.V. All rights reserved.

References are available online at www.mja.com.au.

- 1 Emanuel EJ. The history of euthanasia debates in the United States and Britain. *Ann Intern Med* 1994; 121: 793-802.
- 2 Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003; 326: 271-273.
- 3 Deliens L, van der Wal G. The euthanasia law in Belgium and the Netherlands. *Lancet* 2003; 362: 1239-1240.
- 4 Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada and Europe. *JAMA* 2016; 316: 79-90.
- 5 Onwuteaka-Philipsen BD, Brinkman-Stoppelenburg A, Penning C, et al. Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. *Lancet* 2012; 380: 908-915.
- 6 Chambaere K, Vander Stichele R, Mortier F, et al. Recent trends in euthanasia and other end-of-life practices in Belgium. *N Engl J Med* 2015; 372: 1179-1181.
- 7 Oregon Public Health Division. Oregon Death with Dignity Act annual reports, 1999–2016. *Oregon Health Authority*; 2016. <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> (accessed Mar 2017).
- 8 Washington State Department of Health. 2014 Death with Dignity Act report: executive summary. Washington, DC: DOH; 2015. <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2014.pdf> (accessed Mar 2017).
- 9 Emanuel EJ, Fairclough DL, Daniels ER, Clarridge BR. Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists and the public. *Lancet* 1996; 347: 1805-1810.
- 10 Kissane DW, Street A, Nitschke P. Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *Lancet* 1998; 352: 1097-1102.
- 11 van der Lee ML, van der Born JG, Swarte NB, et al. Euthanasia and depression: a prospective cohort study among terminally ill cancer patients. *J Clin Oncol* 2005; 23: 6607-6612.
- 12 Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, et al. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med* 2000; 342: 551-556. ■



RESEARCH NOTE, Oct 2017: The Gendered Risks of Euthanasia and Assisted Suicide*

Background

The question of whether or not to legalise euthanasia and assisted suicide is again being debated in Australia, specifically in the states of Victoria and New South Wales where bills were tabled on 20 and 21 September 2017, respectively. Despite the continuing debate around the globe, only a handful of jurisdictions have legalised the practices. In keeping with this trend, South Australia rejected a euthanasia bill in November last year.

What are Euthanasia and Assisted Suicide?

'Euthanasia' is the intentional killing of a patient, whereas 'assisted suicide' is suicide effected with the assistance of another, both with the intention to relieve suffering. They may be accomplished by active steps, usually the administration of a lethal drug, or passively, for example by deliberately withholding treatment.

Euthanasia and assisted suicide are distinct from a situation where extraordinary or disproportionate means of sustaining a patient's life are withheld or rejected (i.e. high risk surgery for a patient dying of cancer). In this situation the intention is to reject or withdraw the burdensome treatment, not to kill the patient.

Euthanasia and assisted suicide are similarly distinct from a situation where a patient is given medication in order to alleviate their suffering, even if this *risks* hastening their death. Here the intention is to *alleviate the patient's suffering* via the medication, not to *kill* them via the medication.

General Concerns around Instituting Euthanasia and Assisted Suicide as Standard Medical Practices

- The **normalisation of suicide** and what facilitating it in some instances but not others says about the different value society places on certain lives.
- The **risk of coercion or pressure** from partners, other family members, health professionals and the patient themselves if they have come to feel like a burden on others.
- The **risk of non-voluntary euthanasia**, when euthanasia is performed on a person who does not have the capacity to make the decision themselves, and **involuntary euthanasia**, when euthanasia is performed against a person's will. Both have occurred in jurisdictions where euthanasia is legalised (Cohen-Almagor, 2003).
- The **future expansion of the conditions for eligibility** as demonstrated overseas (aka 'bracket creep'). Laws that once required a patient to have a terminal illness and to be over a certain age now allow euthanasia and assisted suicide for certain minors, psychosocial conditions, disability, and for those who are simply tired of life.
- The **fallibility of medical diagnoses/prognoses** and the potential for a person's life to be mistakenly ended based on inaccurate medical information.
- The **diminished capacity of patients** who are facing terminal illness and experiencing severe suffering and the question of whether or not they are able to give truly informed consent to their lives being ended.
- The potential **adverse impact on palliative care development** when it is less burdensome, both economically and socially, to end a patient's life.
- The ability of physicians to end the lives of their patients **fundamentally changes the nature of the physician-patient relationship** from one of healing and pledging to "do no harm" to one where physicians may take their patients' lives. This may damage the relationship of trust and care between physicians and their patients and ultimately undermine the integrity of the medical profession.

* Much of this research note is based on an article by Dr Katrina George titled, 'A Woman's Choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide'. Dr George was a former director of Women's Forum Australia.

Why Women May be Uniquely Vulnerable to Euthanasia and Assisted Suicide Laws

There is a growing body of feminist academic literature that raises concerns about the rights and wellbeing of women and the impact that sex and gender may have on decisions regarding the end of life (see Wolf, 1996; Raymond, 1999; Canetto & Hollenshead, 2000; Parks, 2000; Platt, 2000; Allen, 2002; George, 2007; Callahan, 2015). Gender responsive healthcare is important and if there is the potential for gendered risks in legalising euthanasia and assisted suicide, then this requires public acknowledgement and further empirical research (Graham & Prichard, 2013: 17). Some possible gendered risks of euthanasia and assisted suicide include:

1. **Women tend to live longer than men** and are thus more likely to develop diseases and disabling conditions that motivate the desire for euthanasia and assisted suicide. They will also be more likely to experience the discrimination and abuse faced by the elderly in our society, which could be a further motivating factor in the request for euthanasia and assisted suicide. The Australian Law Reform Commission's report on elder abuse recognised that women are significantly more likely to be victims than men and that neglect of older women could be as high as 20% (ALRC, 2017: 37).
2. **Women are also more likely to experience the death of a partner or spouse** due to their relative longevity, and to be deprived of this support and companionship in older age. A 2013 Australian study found that living alone is an important predictor of suicide in older adults (De Leo, 2013). A 2016 American study found that loneliness was a key motivation behind euthanasia and assisted suicide requests of patients with "psychiatric" disorders in the Netherlands (Kim, 2016: 362). 70% of the cases reviewed were women and 76% were 50 years or older (Kim, 2016: 362). One woman in her 70s "without health problems" said she experienced life without her husband who had died one year earlier, as a "living hell" and "meaningless" (Kim, 2016: 364).
3. **Women have less economic resources when they are older** (Herald Sun, 2017), the time when decisions about euthanasia and assisted suicide are most likely to occur. This entrenched economic disadvantage limits their options for care and means they are more likely to face other adversities such as homelessness, being unable to leave violent relationships due to financial insecurity and the general struggles associated with financial hardship, all of which could influence a decision for euthanasia or assisted suicide. Women also receive less care assistance from family members than men and are more likely to have to pay for assistance even if their spouse or partner is still around (Roscoe, 2001: 444). Such economic disadvantage disproportionately affects women and there is evidence that it does influence requests for euthanasia and assisted suicide (Emmanuel, 1998: 510).
4. **Women are arguably more self-sacrificial and less assertive than men**, whether by nature, socialisation or simply in terms of society's ideals about femininity (Callahan, 2015: 112; George, 2007: 18-22). They may thus be more likely to decide for euthanasia and assisted suicide to spare their loved ones the burden of caring for them, or to be persuaded that their life is unworthy of other's care and their family's resources. There is evidence that the fear of being a burden influences some patients in their decisions for euthanasia and assisted suicide (George, 2007: 21). In a study of assisted suicides where the majority of cases were women, the fear of being a burden was a prominent reason for deciding for death (Canetto & Hollenshead, 2000). The ethic of self-sacrifice was summed up by a friend of one of the suicides who said: "She felt it was a gift to her family, sparing them the burden of taking care of her" (Canetto & Hollenshead, 2000: 180).
5. **Women demonstrate a stronger preference for more structured, passive methods of suicide, with significant physician participation** (George, 2007: 7), and it is clear that increasing numbers of women decide to die when offered the more passive options of euthanasia and assisted suicide (George, 2007: 25). The rate of assisted death by women in the Netherlands, Oregon and elsewhere is nearly four times that of the usual female self-inflicted suicide rate (George, 2007: 25). One explanation for this might be that decisions for euthanasia and assisted suicide fit in with cultural expectations of women as passive and compliant, and play out gender expectations of subordination and dominance in a profession where physicians are still predominantly male (George, 2007: 23-27). One study has warned that the structure and passivity of euthanasia and assisted suicide "will create a sense of obligation on the part of a woman, especially one who subscribes to stereotypic sex roles to complete a physician-assisted death towards which she may be initially ambivalent" (Kaplan, 2002: 42).

6. **Women are more likely to attempt suicide than men as they are more prone to psychological problems such as depression** (The Guardian, 2015). Men are more likely to die by suicide due to the fact that they often use more violent methods such as hanging or suffocation, whereas women tend to use nonviolent means, such as overdosing (The Guardian, 2015). However, if euthanasia and assisted suicide are enshrined into law, women's preference for more passive methods of suicide coupled with their higher tendency to attempt suicide could have a harmful compounding effect on women's decisions to die. This may already be evident in the 2016 American study reviewing euthanasia and assisted suicide cases of patients with psychiatric disorders in the Netherlands, in which 70% of the cases reviewed were women (Kim, 2016).
7. **Female euthanasia and assisted suicide need to be considered within the context of pervasive male violence against women, particularly against intimates** (George, 2007: 15). Research indicates striking similarities between the broader patterns of male violence against women and at least one form of assisted death: 'mercy killing' (George, 2007: 15). There is a higher incidence of female mercy killings, mostly by men, who are most often the woman's partner, often without consent from the female victims (George, 2007: 15-18). Mercy killing reflects gendered patterns of violence in that the incidence and demographics of mercy killing match those of male violence against women generally (George, 2007: 18). It is also characterised by the same themes of domination, possessiveness and control which characterise other killings of women by men (George, 2007: 18). The prevalence of violence against women in Australia (particularly intimate partner violence) is concerning, with at least one woman a week being killed by a partner or former partner, and one in three Australian women having experienced physical violence since the age of 15 (Our Watch). Thus, before legalising euthanasia and assisted suicide, it is vital that we understand the dynamics at work and whether the dynamics underlying other forms of gendered violence and unbalanced power relationships that result in the deaths of women, may sometimes also underlie female euthanasia and assisted suicide (Wolf, 1996: 284-285).
8. **Women's historical and ongoing experience of power imbalance and gender domination could 'play out' in a clinical relationship** and influence their decision for euthanasia and assisted suicide (George, 2007: 25). The medical profession is traditionally paternalistic and still predominantly male, and a male physician's cooperation with a woman's request for euthanasia or assisted suicide could reflect entrenched sexism and gender roles (George, 2007: 25). Similarly, women's preferences for more structured, passive deaths at the hands of their (more often than not) male physicians could be an indication of gender dynamics at play (George, 2007: 27). One example of possible gender dynamics at play in the clinical relationship is in a study of euthanasia and assisted suicide in the United States (Meier, 1998: 1195). Relative to men, women died in circumstances where their requests were less likely to be explicit, less likely to be at their personal request and more likely to be initiated by family members or partners (George, 2007: 6).
9. **The majority of high profile euthanasia and assisted suicide cases are female** (George, 2007: 1, 25). Given the persistence of gender stereotypes and inequality, this raises the question of whether women are being used to portray euthanasia and assisted suicide because it "seems right" that women would passively and compliantly sacrifice themselves to prevent being a burden on their loved ones (whether consciously or not). It also raises concerns as to what kind of influence such media portrayal could have on women's decisions to request euthanasia and assisted suicide, and whether such depictions of women could be self-fulfilling.
10. **Autonomy and choice is often the principal argument used for euthanasia and assisted suicide but these insights challenge the presumption that women who decide for euthanasia and assisted suicide are always exercising autonomy** (George, 2007: 18). Biological factors, structural inequalities, disparities in power, social and economic disadvantage and cultural stereotypes that may underlie the decisions of some women are gender distinctive and challenge the rhetoric of choice (George, 2007: 2, 8). Even if there were no greater incidence of women deciding for euthanasia and assisted suicide, the reasons for their decisions could suggest a lack of autonomy (George, 2007: 2). By legitimising and increasing access to methods of suicide which appeal to women, the risk is that for some women a legalised regime will compound oppressive socio-cultural influences and facilitate the last of many non-choices (George, 2007: 33).

Further Information

For further information please contact Ms Rachael Wong, Director of Research, Policy and Advocacy, Women's Forum Australia, M: [REDACTED], E: [REDACTED]

References

- Allen, F. (2002) 'Where are the Women in End-of-Life Research?' *Behavior Change* 19(1): 39-51.
- Australian Law Reform Commission (ALRC) (2017) Elder Abuse – A National Legal Response (ALRC Report 131).
- Callahan, S. (2015) 'A Feminist Case Against Self-Determined Dying in Assisted Suicide and Euthanasia' *Feminism & Psychology* 25(1): 109-112.
- Canetto, S., & Hollenshead, J. (2000) 'Gender and Physician-Assisted Suicide: An Analysis of the Kevorkian Cases, 1990Q1997' *Journal of Death and Dying* 40(1): 165-208.
- Cohen-Almagor, R. (2003) 'Non-Voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives' *Issues in Law and Medicine* 18(3): 239-257.
- De Leo, D. et al (2013) 'Suicides in Older Adults: A Case-Control Psychological Autopsy Study in Australia' *Journal of Psychiatric Research* 47(7): 980-988.
- Emanuel, E.J et al (1998) 'The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians' *Journal of the American Medical Association* 280(6): 507-513.
- George, K. (2007) 'A Woman's choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide' *Medical Law Review* 15(1): 1-33.
- Graham, H., & Prichard, J. (2013) 'Voluntary Euthanasia and 'Assisted Dying' in Tasmania: A Response to Giddings & McKim' Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014 Submission 20 – Attachment 1.
- Herald Sun (2017) 'Wendy Tuohy: Women Still Burdened by Economic Disadvantage' (7 March 2017) <http://www.heraldsun.com.au/news/opinion/wendy-tuohy/wendy-tuohy-women-still-burdened-by-economic-disadvantage/news-story/f2d380ba1713222f06676f46998c03f1> (Accessed 12 October 2017).
- Kaplan, K.J et al (2002) 'Suicide, Physician-assisted suicide and Euthanasia in Men Versus Women Around the World: The Degree of Physician Control' *Ethics and Medicine* 18(1): 33-48.
- Kim, S.Y.H. (2016) 'Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014' *Journal of the American Medical Association: Psychiatry* 73(4): 362-368.
- Meier, D.E. et al (1998) 'A National Survey of Physician-Assisted Suicide and Euthanasia in the United States' *New England Journal of Medicine* 338(17): 1193-1201.
- Our Watch, 'Understanding Violence: Facts and Figures' <https://www.ourwatch.org.au/Understanding-Violence/Facts-and-figures> (Accessed 12 October 2017).
- Parks, J. (2000) 'Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of Women's Death Requests' *The Hastings Centre Report* 30(1): 30-36.
- Platt, M. (2000) 'Assisted Suicide: Devaluing Disabled Life' *The American Feminist* 6(4): 12-13.
- Raymond, D. (1999) "'Fatal Practices": A Feminist Analysis of Physician Assisted Suicide and Euthanasia' *Hypatia: A Journal of Feminist Philosophy* 14(2): 1-25.
- Roscoe, L.A. et al (2001) 'A Comparison of Characteristics of Kevorkian Euthanasia Cases and Physician-Assisted Suicides in Oregon' *Gerontologist* 41(4): 439-446.
- The Guardian (2015) 'Why are Men More Likely Than Women to Take Their Own Lives?' (21 January 2015) <https://www.theguardian.com/science/2015/jan/21/suicide-gender-men-women-mental-health-nick-clegg> (Accessed 12 October 2017).
- Wolf, S. (1996) 'Gender, Feminism and Death: Physician-Assisted Suicide and Euthanasia' in Wolf, S. (ed.) *Feminism and Bioethics: Beyond Reproduction* Oxford University Press: New York (pages 282-317).



FACT SHEET: The Gendered Risks of Euthanasia and Assisted Suicide

1. **Women tend to live longer than men** and are thus more likely to develop diseases and disabling conditions, or to experience elder abuse and discrimination, both of which could motivate the desire for euthanasia and assisted suicide. In terms of elder abuse, women are significantly more likely to be victims than men.
2. **Women are also more likely to experience the death of a partner or spouse** due to their relative longevity, and to be deprived of this support and companionship in older age. Studies have found that loneliness is an important predictor of suicide and a key motivation behind euthanasia and assisted suicide requests.
3. **Women have less economic resources when they are older**, the time when decisions about euthanasia and assisted suicide are most likely to occur. This entrenched economic disadvantage limits their options for care and means they are more likely to face other financially-related adversities, all of which could influence a decision for euthanasia or assisted suicide. Women are also more likely to have to pay for care than men.
4. **Women are arguably more self-sacrificial and less assertive than men** and may thus be more likely to decide for euthanasia and assisted suicide to spare their loved ones the burden of caring for them, or to be persuaded that their life is unworthy of other's care and their family's resources. There is evidence that the fear of being a burden influences some patients in their decisions for euthanasia and assisted suicide.
5. **Women demonstrate a stronger preference for more structured, passive methods of suicide, with significant physician participation** and it is clear that increasing numbers of women decide to die when offered the more passive options of euthanasia and assisted suicide.
6. **Women are more likely to attempt suicide than men** as they are more prone to psychological problems such as depression. If euthanasia and assisted suicide are legalised, this, coupled with women's preference for more passive methods of suicide could have a harmful compounding effect on women's decisions to die.
7. **Female euthanasia and assisted suicide need to be considered within the context of pervasive male violence against women, particularly against intimates.** Research indicates striking similarities between the broader patterns of male violence against women and at least one form of assisted death: 'mercy killing'. There are more female mercy killings, mostly by men, who are most often the woman's partner, and they are characterised by the same themes of domination, possessiveness and control as other gender-based violence.
8. **Women's historical and ongoing experience of power imbalance and gender domination could 'play out' in a clinical relationship** (where the medical profession is traditionally paternalistic and still predominantly male) and influence their decision for euthanasia and assisted suicide.
9. **The majority of high profile euthanasia and assisted suicide cases are female.** Given the persistence of gender stereotypes and inequality, this raises concerns as to why this is the case and what kind of impact the media coverage of such cases has on women's decisions for euthanasia and assisted suicide.
10. **These insights challenge the presumption that women who decide for euthanasia and assisted suicide are always exercising autonomy.** A legalised regime could in fact compound oppressive socio-cultural influences and facilitate the last of many non-choices for some women.

For further Information or a more detailed research note, please contact Ms Rachael Wong, Director of Research, Policy and Advocacy, Women's Forum Australia, M: [REDACTED] E: [REDACTED]

The Hon. Greg Donnelly MLC
Deputy Opposition Whip in the Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000



19 October 2017

Dear Mr Donnelly,

We are writing to express opposition to the *Voluntary Assisted Dying Bill 2017* currently before the NSW Parliament. The Institute for Ethics and Society is a research institute whose role includes providing advice and commentary in the fields of political, legal and medical ethics and their practical application and integration into relevant current day social issues. We have grave concerns about the proposed legislation.

Bills proposing the legalisation of physician-assisted suicide and euthanasia (if the person cannot take the medication themselves) represent a serious risk to vulnerable people due to the inability to legislate in a way that avoids abuse.

The proposed model would require two doctors to agree to a person's request for a prescription for a lethal dose of medication to be used to end the person's life. To do so the doctors essentially need to agree that the person would "be better off dead" or at least that it is reasonable for a person in that position to consider that he or she would be better off dead.

DEFINITIONS: We find that the current public debate lacks clarity regarding what does and does not constitute euthanasia and assisted dying. Euthanasia describes an act where a doctor intentionally ends the life of a person by the administration of drugs, at that person's voluntary and competent request. Physician-assisted suicide describes the situation where a doctor intentionally helps a person to commit suicide by providing drugs for self-administration, at that person's voluntary and competent request. In the latter situation, the doctor is distanced from the act, but from a moral perspective, it is the same as euthanasia; the doctor's motivation and intention are the same, as is the outcome. **Euthanasia is NOT simply identical to:** turning off life support, stopping life-prolonging treatment, or using (therapeutic) pain-killers and sedatives at the end of life. In these situations the aim of the action is not to kill the patient, but to cease futile treatment, reduce suffering and allow an underlying disease to progress to natural death. Given their focus on the relief of pain and the cessation of futile treatment, these are good medical practices which are already legally and ethically permissible choices in end of life care.

RISKS OF EUTHANSIA LEGISLATION

1. Euthanasia can legitimises suicide as a solution to life's problems. In jurisdictions where euthanasia and physician-assisted suicide (EPAS) are legal, unassisted suicide rates are also rising. Since Australia is already confronting a suicide crisis, with over 8 people per day taking their lives, we should not introduce government-sanctified suicide as well.
2. Euthanasia changes one of the most basic tenets of our society, that we do not kill one another, even for reasons of mercy and compassion. This is a fundamental value that recognises that all human life should be respected; all innocent lives will be protected by the state; and all lives are worth living.
3. Legislators have proposed introducing EPAS as part of standard medical practice, in an attempt to confer medical legitimacy on the practice. However euthanasia is fundamentally opposed to the foundational imperative of medical ethics: 'First, do no harm'; and hence it should not be aligned with the doctor's activity in the role of healer. Such an alignment is a risk to the doctor-patient relationship, which is based on trust.
4. Debate about the legalization of euthanasia is not debate about the failure of medicine or the failure to address physical suffering. The timing of the debate makes this clear, given that today we have more medical treatments available than at any other time in human history. Indeed, we know that in places where EPAS is legal, psychosocial reasons, such as fear of the future, fear of losing control of one's life or losing a sense of autonomy, are prominent motivators for requesting EPAS. This suggests that the way to ease public distress about dying would be to provide more psychosocial support for dying people, by increasing the availability of palliative care and the multidisciplinary support that accompanies it. Furthermore, research shows that most euthanasia requests are a cry for help, misinterpreted by doctors, rather than an actual desire to be killed. Commentators in Oregon, USA, have reported cases of this misinterpretation leading to action to hasten death.
5. In all jurisdictions where EPAS has been legalised, abuses have been documented. These include the following:
 - Allowing EPAS for people who have untreated depression. However, a desire for hastened death is often a symptom of depression which should be treated rather than providing the person with suicide pills. Generalist psychologists are not trained to diagnose depression.
 - Allowing EPAS for people who feel coerced into requesting it when it is not what they really want. There is no way to protect against a sick person's perception that they are a burden to their carers, whether the carers overtly indicate this or not. Furthermore, a recent report on Elder Abuse in NSW noted that abuse and forms of coercion are frequent, and that financial abuse from a family member is the most common form.
 - Allowing EPAS for people who are not mentally competent. Assessing mental competence is a complicated procedure that requires significant time investment and expertise. Australian

psychiatrists have recognized their inability to definitely establish mental competence in one consultation.

- Allowing EPAS to occur without independent supervision to ensure that lethal medications are taken voluntarily.
- Extending EPAS to other categories of patient over time on the grounds that the right to EPAS cannot be limited to particular persons because judgements of suffering can only be made on a subjective basis.
- Allowing EPAS to persons who do not qualify for access to EPAS under the law on the basis of claims that assessing prognosis (i.e. how long a person has to live) is notoriously difficult to do with any precision.

NONE OF THESE ABUSES CAN BE AVOIDED UNDER THE CURRENT LEGISLATION.

EPAS is advertised as a way to a peaceful death, but research shows that up to 25% of cases of EPAS involve complications such as vomiting up the pills and swallowing the vomit, and waking up after a period of being unconscious. Research indicates that palliative care is a much more reliable way of ensuring a peaceful death.

Supporting literature can be provided on request.

Despite the rhetoric about the inclusion of safeguards, there are no genuine safeguards regarding E/PAS legislation. Furthermore, if our society is unhappy with end of life care at the moment, it is both unwise and unethical to consider legalising assisted dying before palliative care is universally accessible in this state. The common good will not be served by supporting the proposed legislation; in fact the very opposite would be the case. Accordingly, we encourage you to vote against the *Voluntary Assisted Dying Bill 2017*.

Yours sincerely,



Prof. Sandra Lynch
Director | Institute for Ethics and Society
The University of Notre Dame Australia
L1, 104 Broadway (PO Box 944), Broadway NSW 2007