



Submission to the University of Tasmania independent review of the *End-of-Life Choices (Voluntary Assisted Dying) Bill 2020* for the benefit of the Tasmanian Parliament

Catholic Health Australia (CHA) is the peak body for all Catholic health and aged care services in Australia. CHA is the largest non-government provider of health, community and aged care services in Australia. The Catholic Health and Aged Care sector is comprised of eighty hospitals (public and private), representing more than 10,000 hospital beds, 25,000 residential aged care beds, 36,500 consumer of home and community care, 7,000 aged care residential units and employing more than 84,000 staff.

CHA not-for-profit providers promote the ministry of health care as an integral element of the mission and work to fully provide health care to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

Medicine's longstanding Hippocratic ethic governs the care that CHA members provide to patients and residents. Catholic providers put into practice the ancient commitment of the medical profession to cure where possible, to care always and never intentionally to inflict death. CHA's position is consistent with the Australian Medical Association¹ and the World Medical Association².

Our clinicians are trained to provide effective symptom and pain management and to respect patients' decisions (or, if they are not competent, their substitute decision-maker's decisions) to forgo treatments that are too burdensome or medically futile (and in doing so, our clinicians act in accordance with the needs and preferences of patients).

The Catholic health sector believes that every human life has equal value. Our ethic of medical care embodies the notion that human dignity is inherent and inviolable. Care and accompaniment during end of life, of patients and their families is best practice and should be available to all.

CHA appreciates the opportunity to provide a submission to the University of Tasmania Voluntary Assisted Dying Panel and sets out its concerns below:

Increased risk of abuse: CHA queries how the State can protect and prevent people from having their lives ended unwittingly or unwillingly. The possibility of wrongful death increases, having a life unwittingly or unwillingly

¹ <https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016>

² <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/>

ended, because a prognosis may not be correct as to the trajectory of a disease. A life may be ended prematurely. There are no effective safeguards to detect coercion and abuse as factors leading to a decision to choose Voluntary Assisted Dying (VAD). All of these are likely to increase the risk, not reduce them. The absence of VAD would ensure higher levels of safety against this risk. Analysis of the Victoria legislation by Paul Santamaria QC confirms this increased risk³.

Overseas experience: As has been demonstrated by a recent ruling of the High Court of Germany, limitations on VAD are arbitrary and can easily be extended to any citizen who at any time and for whatever motive chooses such means⁴. We have also seen that in Belgium and Holland the scope for who is eligible for VAD has widened, in part through legislative change and in part by expansion of the criteria for acceptable reasons for access to VAD⁵.

Protections for medical practitioners: CHA supports provisions that provide legal protection for registered health practitioners who choose not to assist patients with VAD. However, CHA also believes that such protections must be extended to organisations that choose not to offer VAD. No hospital is required to offer a full range of services. For example, some do not offer maternity services, some do not offer in-patient psychiatric care. In this same way organisations should not be expected to offer VAD.

Patient autonomy: In relation to a person's autonomy, including autonomy in respect of end of life choices, we believe that all good health care should respect the autonomy of patients. Patient autonomy is always to be respected in decisions about healthcare. Respect for autonomy is problematic when VAD is part of a continuum of healthcare. The norm of clinical care requires the capacity for the patient, their family and care team to work toward a plan for therapeutically effective treatments, including planning for end of life care. CHA believes that every person should be supported in making informed decisions about their medical treatment, and should have access to information about medical treatment options, including comfort and palliative care and treatment. However CHA queries how the Parliament can deliver on this where there is unequal access for every citizen to all medical/clinical care necessary for their treatment, including high quality specialised palliative care. This effectively means VAD potentially becomes a forced choice and one likely to be offered or chosen because there is a perception or reality that there is no alternative and no choice.

Quality of life principles: CHA finds the references to "quality of life" and "dignity" principles in the Bill problematic given that they could be used to suggest there are degrees of dignity influenced by the arbitrary assessment of quality of life. For example, that those who are unable to speak or feed themselves have less quality of life or less dignity than others.

End of life options: All good medical care should openly encourage discussion about end of life care options. All patients should be informed of the right to refuse non-beneficial treatment and treatments which will be overly burdensome or likely to be futile. This standard applies in all medical settings today. CHA believes the introduction of VAD will limit those conversations. The challenge that legislators face is how to improve that conversation, not stymie it.

³<https://www.catholiclawyers.com.au/Portals/1/Victoria's%20Assisted%20Suicide%20Legislation.pdf?ver=Wv4PrnXJ3p1zJdLeSOEcDw%3d%3d>

⁴ Bundesverfassungsgericht; Press Release No. 12/2020 of 26 February 2020. Judgment of 26 February 2020 2 BvR 2347/15, 2 BvR 2527/16, 2 BvR 2354/16, 2 BvR 1593/16, 2 BvR 1261/16, 2 BvR 651/16

⁵ Dutch Supreme Court rules doctors can euthanize dementia patients. catholicnewsagency.com/news/dutch-supreme-court-rules-doctors-can-euthanize-dementia-patients-31228.; and, Peter Kurti (2018) *Euthanasia: Putting the Culture to Death*. Connor Court Publishing. Brisbane.

Protections: CHA is very concerned about the need for provisions to protect people who may be subject to abuse or coercion. It is the role of legislators to ensure the bill has the most stringent of protections. There is already a well-documented history of elder abuse in this country and the abuse and coercion of people with disabilities.

Speed of process: With regards to the speed of the assessment and referral process CHA queries how the Parliament can safeguard against doctors forming common cause. Given the very short time frame between first request, first assessment and second request and referral, how can the Parliament prevent two doctors from forming common cause to agree to assess and review each other's cases and fast track the process?

The Commission: It would appear that the role of the Voluntary Assisted Dying Commission is limited to record keeping. CHA queries why the Commission's remit should not be broadened to include safeguarding functions that better detect instances of coercion and abuse.

Palliative Care: High-quality palliative care that treats the person holistically is still under-resourced in Tasmania. Recommendations made by a Parliamentary Inquiry into palliative care in 2017 have not been acted upon⁶.

CHA believes that good medical care requires that patients are presented with a full range of treatment options and are assisted to understand the implications of proposed treatment plans. Effective choice cannot be maintained if Tasmanians do not have equal access to palliative care.

The PM Glynn Institute's report, *A snapshot of palliative care services in Australia (2020)*⁷, articulates how problematic this inequity is in the context of VAD legislation:

"Considered strictly from a public policy perspective, there is a major argument to be made against the legalisation of assisted dying or euthanasia when access to palliative care for those at the end of life or suffering from life-limiting illnesses is neither universal nor equitable. This is especially so when the case for euthanasia and assisted suicide is advanced on the grounds of choice and autonomy.

If in some places and for some people there is no effective access to palliative care, it is difficult to see how a genuine choice is offered to a suffering person by giving them the option of assisted dying. If the choice is between assisted dying on the one hand, and the absence of effective pain and symptom control and accompaniment by family and carers on the other, it is a false choice and one which it is unjust to offer."

⁶ [https://www.parliament.tas.gov.au/ctee/house/Reports/Report%20-%20Inquiry%20into%20Palliative%20Care%20in%20Tasmania%20\(TABLED\).pdf](https://www.parliament.tas.gov.au/ctee/house/Reports/Report%20-%20Inquiry%20into%20Palliative%20Care%20in%20Tasmania%20(TABLED).pdf)

⁷ https://www.acu.edu.au/-/media/feature/pagecontent/richtext/about-acu/institutes-academies-and-centres/pm-glynn/_docs/palliativecare_report_a4_oct_11_singlepages.pdf