

VOLUNTARY ASSISTED DYING BILL 2021

Legislative Assembly Second Reading Debate – copied from Hansard 12 November 2021

Mr EDMOND ATALLA (Mount Druitt) (14:07): I make a contribution in opposition to the Voluntary Assisted Dying Bill 2021. The bill would give individuals with a terminal illness the opportunity to end their lives prematurely, despite medical advances over the past decade which have made a big difference to cause a rethink about voluntary assisted dying. The bill as it currently stands removes more of the protections that were present in the 2017 bill, which was rejected by the New South Wales Parliament in 2017. I give examples of the protections that have been removed. In the 2017 bill two doctors independent of each other needed to sign off on a patient's death; the 2021 bill removes the independence previously required. In the 2017 bill at least one doctor needed to be a specialist in the illness the patient is suffering from; the 2021 bill removes the specialist requirement. In the 2017 bill, doctors needed to meet and examine a patient in person. The 2021 bill allows a doctor to sign off on a patient's death via telehealth. The 2017 bill required a mandatory psychological assessment of a patient. The 2021 bill does not require any mental health assessment. The 2017 bill required mandatory reporting to the Coroner. The 2021 bill removes that requirement.

Given that the New South Wales Parliament rejected a much stricter bill in 2017, it is unthinkable that just four years later MPs would consider passing a much more dangerous bill. Our focus should be on resourcing rather than looking for a shortcut to end people's lives because of the shortfall in palliative care, particularly in regional New South Wales. The State currently has 91 full-time equivalent palliative care specialists, equivalent to 1.1 palliative medicine specialists per 100,000 people. To meet Palliative Care Australia's benchmark of two full-time specialist palliative medicine physicians, New South Wales needs to double its current number of palliative care doctors. The shortfall of available palliative care significantly affects regional New South Wales. However, there is also a lack of palliative care in major hubs.

For example, Westmead Hospital, which serves a population of 1.85 million and has almost 1,000 beds, has no dedicated palliative care unit, and nor does Nepean Hospital. Despite strong lobbying from my colleagues in this place and from the residents of the area, Westmead Hospital remains without any palliative care services. Former Deputy Premier of New South Wales the Hon. John Watkins made the following comments in relation to the Voluntary Assisted Dying Bill 2021:

The idea that supporting euthanasia is progressive, and opposing it is conservative, is obsolete. In fact, any thoughtful progressive should be worried about where the rush towards voluntary assisted dying is taking us. The critical factor that's changed over the past decade is medical science, primarily in the field of palliative care. New treatments like intrathecal care and nerve blocking are enabling people with life-ending conditions to achieve a quality of life inaccessible last century.

One reason people resort to voluntary assisted dying is the level of pain endured, leaving them with the idea of voluntary assisted dying rather than living with pain. Recent medical advancements in medical procedures by trained pain specialists can block the pain signal and alleviate the pain experienced by the patient. However, these procedures are expensive and only a tiny fraction of the population have access to modern palliative care. If someone is among the privileged few who is very wealthy, lives in the right area or has great health insurance, they can get access to life-extending, modern palliative treatments. Mr Watkins continued:

But if you are poor, live in the wrong area and have no health insurance, your chances of accessing modern palliative care is close to nil. If you are offered any end-of-life care—and there's no guarantee you will be—it will look far more like the 20th century model than the modern possibilities. Surely any compassionate government in 2021 should be pushing for the average person to get modern palliative care long before they get access to death.

Effective palliative care is the alternative to voluntary assisted dying. Persons die in pain only when palliative care services are not adequately funded. Funding palliative care in the regions is more important than funding suicide for persons who are unable to receive palliative care.

The majority of doctors do not support assisted suicide. Health Professionals Say No, a group of over 1,000 doctors—many of whom practise in New South Wales—believe euthanasia can never be made safe. In recent years it has become apparent that elder abuse and the risk of elder abuse are increasing threats in Australia. If an individual is unable to take care of themselves or has reduced decision-making capabilities and/or financial

management issues, their vulnerability to being pressured into euthanasia by family members or others responsible for their care increases. The 2015 parliamentary inquiry into elder abuse in New South Wales revealed shocking accounts of abuse. The committee chair, the Hon. Greg Donnelly, MLC, wrote:

Within the context of the many priorities that governments juggle, abuse of older people can be overlooked, perhaps because elder abuse tends to be hidden away. Perhaps it is because of the ageism that exists in our culture, that allows us to disrespect our elders and tacitly accept disempowerment as an inevitable outcome of frailty. Perhaps it is too threatening for many of us – because we ourselves will one day be old and frail – to see this abuse for what it is: exploitation of and in some cases violence towards people who are vulnerable, people who in many cases are the least able to protect and defend themselves.

Elder abuse can take many forms, from subtle emotional pressure to direct coercion. In the case of a vulnerable person experiencing a terminal illness, the interests of the suffering person and the beneficiaries of their estate are in direct conflict. The beneficiaries, who are usually family members, have a strong financial incentive to expedite the release of assets that might flow from a will. The interests of the suffering persons are protected when they are relieved of any emotional pressure or sense of guilt for still being alive and holding up the financial benefit that they will provide when they die to the people they love. It is a complex, emotional situation that is very difficult to manage through a regulatory regime.

It would be recklessly negligent of the New South Wales Parliament to legalise euthanasia and assisted dying in the State before putting in place a system to effectively address the scourge of elder abuse. If we cannot tackle elder abuse, there is no reason to believe we can adequately safeguard against the abuse of our vulnerable elderly when it comes to euthanasia and assisted dying. The last attempt to legislate euthanasia in New South Wales excluded people with mental illness; this bill does not. I seek an extension of time. [*Extension of time*]

There is a strong risk that dying people with mental illness will activate the assisted dying process as a result of their mental infirmity rather than a decision solely relating to their primary medical condition. The evidence from overseas jurisdictions shows that the demand for access to euthanasia for those with mental illness has increased dramatically. This bill does not offer any protections to vulnerable Indigenous people. Indigenous people do not support assisted dying because it goes against their spirituality, and they feel threatened by it. That was a key reason the euthanasia legislation in the Northern Territory was overturned. Former Prime Minister Paul Keating made the following comments regarding the Victorian legislation that this bill is modelled on, as reported in *The Sydney Morning Herald* on 19 October 2017:

There is probably no more important issue in contemporary bioethics or a more serious ethical decision for our parliaments than that raised by the Voluntary Assisted Dying Bill 2017 being debated this week in the Victorian Parliament. Under this bill, conditions and safeguards are outlined that will allow physicians to terminate the life of patients and to assist patients to take their own life. This is a threshold moment for the country. No matter what justifications are offered for the bill, it constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human.

I believe if we work to lower the cost of quality-of-life medication and palliative care assistance, fewer individuals will feel that they are a burden on their family and will not feel the necessity to end their lives.

I stand in solidarity with the Australian and New Zealand Society of Palliative Medicine in its recommendations to not introduce assisted dying. Instead, it makes recommendations to direct more funding and resources into palliative care and carer support workforces, to increase funding for the generalist health workforce and to support initiatives that provide high quality of life palliative care. I share its concerns that the bill, and the resulting legislation, will turn attention away from the larger problem of service gaps, and therefore less funding will be given to the much-needed network for quality-of-life care. Proponents of the New South Wales VAD bill are nothing more than political Pharisees if they support saving lives under COVID-19 and suicide prevention, but not under the proposed VAD bill. I call on my colleagues to vote against the bill, and better fund quality palliative care instead.