

VOLUNTARY ASSISTED DYING BILL 2021

Legislative Assembly Second Reading Debate – copied from Hansard 25 November 2021

Mr STEPHEN BALI (Blacktown) (11:04): I contribute to debate on the Voluntary Assisted Dying Bill 2021. I thank all members for their respect and courtesy in dealing with these difficult issues. I understand that the member for Sydney, who has been in the Chamber for most of the debate, and many others will be discussing amendments to the bill. I thank the many people who have been in contact either with me or my staff on this issue. We have heard many accounts of personal suffering and its harrowing effects. I welcome the Premier's commitment to improving palliative care services, and I hope we can do that in a whole-of-Parliament way. This debate raises many complex issues and emotions and also brings one's own mortality into question and brings up the meaning of life. The role of euthanasia in society has been actively debated since the 1800s. Generations of scholars, religious scholars, ethicists, and sociologists, along with the scientific community, have debated the various definitions of euthanasia. In 1826, Dr Karl Marx defined euthanasia as that science:

... which checks oppressing features of illness, relieves pain, and renders the supreme and inescapable hour a most peaceful one.

That definition has become the modern definition of palliative care. More recently, Moira Camilleri stated that:

The goal of palliative medicine is emancipation, the freeing of the dying person's consciousness from the domination of pain. The goal of euthanasia is death.

We have heard proponents of the bill clearly redefine the debate to say that euthanasia has nothing to do with palliative care and that the bill's focus is on the right to choose death with dignity under pre-defined conditions. The way death occurs or the administration of death is a difficult issue when developing statutes and laws. I do not believe that anyone in this House would deny a patient's relief from suffering based on the mistaken belief that the administration of palliative care will not only provide pain relief but also shorten life. That concept is already accepted in law. The modern common law precedent in the United Kingdom was established in *Crown v Adams* in 1957 with the principle that:

... if the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.

The bill will put into law a person's right to voluntarily seek euthanasia under restricted circumstances. One reason for that is based on the potential fear that if a doctor is involved, they could be prosecuted. No doctor has ever been prosecuted for murder in Australia for performing active voluntary euthanasia. Proponents of the bill would argue that we must codify voluntary euthanasia into law to ensure that no doctor can be prosecuted for participating in the act of euthanising someone. But what is the state of play in Australia? Kuhse, Singer, Baume, Clark and Rickard undertook substantial academic research into end-of-life medical practices in Australia and compared them to those in the Netherlands. The study was published in the *Medical Journal of Australia* in 1997. The authors' findings were staggering. They found that:

The proportion of all Australian deaths that involved a medical end-of-life decision were: euthanasia, 1.8% ... ending of patient's life without patient's concurrent explicit request, 3.5%; withholding or withdrawing of potentially life-prolonging treatment, 28.6%; alleviation of pain with opioids in doses large enough that there was a probable life-shortening effect, 30.9%. In 30% of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient's life, of which 4% were in response to a direct request from the patient. Overall, Australia had a higher rate of intentional ending of life without the patient's request than the Netherlands.

Essentially, that study found that Australian law had not prevented doctors from practising euthanasia or from making end-of-life decisions. The difference in the rates of euthanasia between Australia and the Netherlands were not statistically significant. However, the rates of intentionally ending life without an explicit request from a patient were significantly higher in Australia than in the Netherlands. In 22.5 per cent of all Australian deaths, doctors withheld or withdrew treatment from patients with the explicit intention of ending life without the patient's explicit request. That evidence demonstrates that choice is available and that there are no prosecutions in Australia.

The challenge for legislators is not to treat this issue as a two-dimensional binary code of "yes" or "no" to voluntary assisted dying under predetermined guidelines but to deal with how the medical profession is held

to account. Many members have referred to their personal experiences, local surveys they have conducted or discussions they have had with their communities when coming to their decisions. Of the couple of hundred people who emailed my office, approximately two-thirds were against the bill. I accept the backdrop of general surveys across the country that show the majority of people accept the concept of euthanasia. However, as I said before, this Parliament is not just voting on a general concept but on the implementation and administration of voluntary end-of-life decisions.

I thank all those who have sent in their personal testimonies. All members of this place have seen, read and cried through those traumatic stories of loved ones who have suffered. The act of dying or the prospect of pain is one of the greatest fears that a person can face. Watching someone we care about or love dying wreaks emotional havoc on our thoughts for the rest of our lives. Those stories cannot be ignored. Unfortunately, I too have watched close family members go through immense suffering and pain prior to their deaths. My mother was struggling with cancer but somehow managed to get out of her hospital bed, put on a cheery face and be here for my inaugural speech. Her Westmead Hospital specialists, whilst nice and empathetic, were quick to discuss quality of life and end-of-life options rather than to explore the various treatments that might be available elsewhere. On a recommendation from a friend we had to go to St Vincent's Hospital to gain valuable additional valuable treatment.

My father died of at least seven brain tumours that were not picked up, also by Westmead Hospital, until the last month of his life. My sister-in-law died of motor neurone disease, which has been discussed often in this debate. Once again, doctors just wanted to manage quality of life or end-of-life issues rather than discuss alternative treatments. Thankfully, my brother and his partner wanted to try whatever was available, and hopefully in doing so improved treatment knowledge for others with motor neurone disease. My mother-in-law died in a nursing home incident when she was incorrectly fed with a tube and the food emptied into her lungs. Doctors could not help her and she died in hospital after seven days. No-one was ever charged over the incident. I understand the pain and anguish that family members go through when helping a loved one through their final months and days. I have serious reservations about the bill regarding the protections it will afford the medical profession without accountability. I seek an extension of time. [*Extension of time*]

My anecdotal evidence is clear: The nursing and medical fraternity are not perfect. If a patient lives in western Sydney or in a regional area, unfortunately doctors and specialists are more ready to have the conversation with them about end-of-life processes than aggressive or modern alternative treatments. A study by Kuhse, Singer, Baume, Clark and Rickard identified that in 1.6 per cent of all Australian deaths, the attending doctor felt that the end-of-life decision "was clearly the best one for the patient" or "discussion would have done more harm than good". In Australia 36.5 per cent of all deaths occurred through intentionally ending a life without the patient's consent by either the administration of drugs or by withholding or withdrawing treatment, which is significantly higher than the 19.5 per cent of deaths in the Netherlands. This bill will allow two doctors to make an end-of-life assessment, yet they will not have to be a patient's treating doctor or a specialist experienced in the illness. I am not sure if that is truly a safeguard.

In summary, we are legislators and are not participating in a survey on the concept of euthanasia. Academic studies show clearly that euthanasia is practised more in Australia, including in New South Wales, than in the Netherlands. No-one in Australia has ever been prosecuted for euthanasia. The bill will allow doctors who have a predisposition to end-of-life procedures to participate in the counselling and decision-making of patients, when the evidence is clear that a significant number of deaths in Australia occur when a doctor makes the end-of-life decision and does not even inform the family or patient. People have free will and, unfortunately, some will exploit that for inappropriate reasons. The bill will not eliminate elder abuse or other forms of coercion. It must also focus on holding the medical profession accountable rather than providing doctors with immunity from their actions. For those reasons I do not support the bill in its current form.