

VOLUNTARY ASSISTED DYING BILL 2021

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

Mr ALISTER HENSKENS (Ku-ring-gai—Minister for Families, Communities and Disability Services) (11:03): Today we debate the highly emotional topic of the circumstances, if any, that people in the future should be able to lawfully terminate their life with the authority of the State of New South Wales. Like many members of the House, I supported and voted in favour of legalising abortion, but today I raise serious concerns about the proposed piece of legislation—the Voluntary Assisted Dying Bill 2021. Today we are engaged in a debate about competing views on how to best manage the pain of terminally ill patients. If a majority of the House is in favour of euthanasia instead of palliative care, we must, in my opinion, come to grips with an important challenge: How can we protect the vulnerable patients covered by the legislation?

Despite the labels that will be put by commentators on each side of the debate, many speakers, like me, will not bring a religious objection to the bill. For the purpose of speaking on the bill today, I randomly consulted, individually, a large number of local medical specialists and doctors who were not associated with either side of the debate. Those included a medical oncologist, a clinical haematologist, two palliative care specialists, a neurological specialist, two psychiatrists, a pain specialist, a joint palliative care and pain management physician treating cancer patients and a general practitioner with a large cohort of elderly patients. With the assistance of the Australian Embassy in the Netherlands, I spoke with a former senator and architect of that country's euthanasia legislation introduced in 2001, a doctor who performs the termination of patients in that country as well as doctors and representatives in New South Wales associated with the voluntary assisted dying group.

I have listened to my constituents and I have met constituents for and against the legislation. I have heard their sometimes very emotional stories about the loss of a loved one, and I have read the emails sent to my office. The communicated views of people in my electorate is evenly divided between those who support and oppose the bill. My reservations about the bill are entirely pragmatic and are based on the expert medical advice that I received and my 27 years of legal experience as a practising barrister and solicitor, prior to entering the Parliament. The bill is the first piece of legislation since the abolition of capital punishment that will allow a person to intentionally end the life of another human being without any legal punishment or sanction. Any legislation that results in the lawful ending of a person's life must be well-drafted and carefully scrutinised because any weakness in the legislation can result in new and unintended consequences.

I begin with a consideration of the coordinating and consulting medical practitioners under the legislation. The coordinating and consulting medical practitioners do not have to be the treating doctors of a patient. They do not need to know the patient. They do not even need to speak to the patient's treating doctors, and they do not need any special knowledge whatsoever of the disease that the patient is suffering. An immediate cause for concern is that the second consulting doctor is appointed by the first consulting doctor. Every pretence to an independent review is destroyed by the manner of the second doctor's appointment under the legislation. Unlike in Victoria, neither of the two doctors needs to be a specialist in a relevant area. The doctors under the bill may choose to consult a third doctor who is a specialist in a particular area. However, strangely, there is no obligation for the coordinating and consulting practitioners to follow the specialist advice.

In discussions with a broad range of medical practitioners, the advice I received is that in almost all cases, excluding perhaps motor neurone disease, it is impossible to accurately predict a terminal patient's likely date of death until about two or three weeks from the patient's actual death, when the patient starts to exhibit certain changes physically, emotionally and physiologically that point to an impending death. The central plank of the bill, the idea that a person can be accurately assessed to have six or 12 months to live, is a medical fallacy in almost all cases.

People with serious terminal medical conditions by definition are vulnerable. When a vulnerable person is tricked, coerced or misled into signing a contract, there are various legal mechanisms to overturn or change the contract. However, as with capital punishment, euthanasia is not like signing a contract. Errors with euthanasia process are irreversible, so the process has to be robust. The Ageing and Disability Commission Annual Report 2020-2021 revealed that of the more than 4,000 allegations of elder abuse across the State, 68.3 per cent were for financial or psychological abuse, mainly to prevent or restrict access to families and prevent or restrict access to support and services.

Since becoming an MP, I have spoken to people working with seniors in my electorate who have told me about elderly people eating cat or dog food while living in their own home because of coercive family control over their finances or an absence of family financial support. 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 family members to end their life earlier than the patient wants. According to the Royal Commission into Aged Care Quality and Safety, in 2019-20 alone there were 5,718 reported allegations of assault in aged-care settings across Australia. KPMG estimated up to 39,000 other such instances were unreported. As a society, we do not always treat our senior citizens well. Proposed section 16 (1) (g) purports to exclude from eligibility any persons acting "because of pressure or duress". But these forces are often imperceptible to the point of being impossible to identify.

As a consequence, the patient may be legally assisted to die by the coordinating and consulting medical practitioners without the rigorous assessment of any third party. Many of the people with terminal illnesses whom this legislation concerns can have assets that are valuable. This gives a motivation for people to encourage them to end their lives against their will. One of the great challenges of legislation like this is how can vulnerable people be protected from the manipulation or the greed of those around them or implied pressure or an expectation that they should go early to provide money to their family through an inheritance. It is very important to understand that there is no obligation under this bill on anybody to consult with close family members about their patient's decision-making capacity, whether they are under duress or acting voluntarily, before the doctor's decision to allow a person to be killed.

That means the first time that you may find out that your mother, for example, was considering dying under this proposed law is when you get the phone call to tell you that she is dead. Close family members should know in advance that there is a proposal to lawfully kill their loved ones and be given the opportunity to assess the voluntary nature of the decision and the reasons behind it. My wonderful 90-year-old mother was recently hospitalised. She still lives independently, with the support of my sisters and brothers. She was recently taken to the hospital with an apparently serious medical condition and, because of COVID-19 restrictions, no family member could attend the hospital to be her advocate with the doctors and to understand the medical advice that was being given to her. It was quite clear that the doctors who were treating my mother had no idea of my mother's cognitive abilities.

My mother was understandably, given her age, only able to pass on to our family limited details of the medical advice she was receiving directly from the doctors. This is a good example of the limitations of unfamiliar doctors making assessments about an unfamiliar patient. No real harm was done in my mother's case because it occurred in a context where all of my family were trying to keep my mother alive and well, and to ensure she was receiving the best medical treatment possible. But imagine this same situation in circumstances where there was a manipulative family member controlling the flow of information who was keen on an early inheritance. Greater scrutiny is required for those kinds of decisions that can give rise to family disagreement. Under this bill, none of the family needs to be informed or involved.

The bill has completely inadequate processes to protect vulnerable, terminally ill patients from being exploited or coerced in order to receive an inheritance or for other reasons. It goes against all life experience that clause 6 (2) of the bill presumes, as it does, that all terminally ill patients have the capacity to understand all the information and advice given to them about assisted dying, and it presumes that the patient has decision-making capacity. [*Extension of time*]

It is very easy to understand that a patient may be bamboozled under this legislation when the whole process can occur as quickly as within five days. In certain circumstances, the process can even be fewer than five days under proposed section 49 (1). This is particularly of concern when people who are given a diagnosis of a terminal medical condition go through five stages of grief and will be more likely to want to die after the initial diagnosis than later on. Yesterday a Victorian specialist told me of how one of his patients was coerced to end their life by a child who lived overseas and wanted the death of their parent to coincide with the child's visit to Australia. This caused incredible grief for the spouse of the patient, who felt that valuable and painless months with their partner had been taken away. If this can happen under the similar Victorian legislation, then it will happen under this legislation.

As I have said already, a legal criterion for eligibility under the bill is that a person must be diagnosed with at least one illness that will, on the balance of probabilities, cause death within six months or 12 months for a neurodegenerative condition. It is very difficult to support a law, which at its heart, is based on a criterion that is only a guess by doctors without any scientific basis as to the length of a patient's life. Opinions based on

guesswork are incredibly dangerous, especially when the consequence is that a person will die and may be robbed of time with their loved ones. Under the Dutch model, every euthanasia death is investigated by an assessment committee, which is constituted by a lawyer, a doctor and an ethicist. Oversight is critical to compliance with process, and more and better oversight is needed within this bill.

In his second reading speech, the member for Sydney argued that legislation of this kind is beneficial for and will reduce suicide rates because people are currently suiciding who could have used the processes under this bill. But the evidence actually shows the opposite. Suicide rates go up in jurisdictions after legalising euthanasia, not down. People may suicide as a consequence of psychological pain. The legalising of death under this bill for people because of subjective psychological pain is unwelcome. Former Prime Minister Paul Keating alluded to this by saying that with euthanasia a line is crossed that should not be crossed.

Medical journal articles reviewing relevant jurisdictions have found that when societies legalise euthanasia, rates of non-euthanasia suicides go up, not down. That is what has happened in the United States, the Netherlands and Canada, and the early data from Victoria is consistent with an increase. The normalisation of ending a life because of pain through euthanasia will undo some of the good work we have been doing to deal with mental ill-health in our community. It is a major concern that legalising euthanasia will lead to an increase in non-euthanasia suicide.

The member for Sydney in his speech cited a Palliative Care Australia estimate, which he said suggested that 4 per cent of patients are beyond the help of palliative care. Those figures are based upon a single university study. The report actually states that only between 0.5 per cent and 2 per cent of palliative care patients report severe distress after starting palliative care but just before death. A medical oncologist in my electorate, who treats over 2,000 cancer patients a year together with other specialists, have told me that nobody needs to be in pain if they receive proper palliative care, including, in some cases, treatment for psychological pain. They have told me that there have been enormous advances in palliative medicine in the past 20 years.

In conclusion, if it is the will of this Parliament to pass this legislation, it should do so with amendments to deal with the issues that I have raised. This legislation has a central role for doctors, but many members of the medical profession do not want this law. If this bill is passed, there will almost certainly be an increase in the number of suicides in our community. This legislation will lead to a slippery slope of normalising euthanasia—like in the Netherlands, where 20 years after the introduction of euthanasia, one in 25 of all deaths for any reason is by euthanasia. I find it hard to accept that in each and every case assisted dying will be truly voluntary when I have spent over 25 years appearing in legal cases where people have complained about being misled, deceived or coerced into doing something they have regretted. The supporters of this legislation put the word "voluntary" to their name but they cannot guarantee that dying will be voluntarily in every case. I fear we are about to commence a history in our State of coerced or involuntary dying. If that happens in just one case, it is one case too many.