

## VOLUNTARY ASSISTED DYING BILL 2021

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

**Ms ROBYN PRESTON (Hawkesbury) (16:30):** I acknowledge the wise counsel of Dr McGirr, the member for Wagga Wagga and thank him for his speech. I oppose the Voluntary Assisted Dying Bill 2021. I particularly focus on one of the real advances in modern medicine in our lifetime, which has been in palliative care. The Australian and New Zealand Society of Palliative Medicine [ANZSPM] in its November 2021 position statement on the practice of euthanasia and physician-assisted suicide, makes a number of observations that are very pertinent to our consideration of this bill. The statement notes that:

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.

This means that this society is made up of experts in the care of those for whom this bill proposes the intentional ending of life by administration of a lethal poison as an appropriate response. The statement declares:

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.

In accordance with best practice guidelines internationally, the discipline of palliative medicine does not include the practices of euthanasia and physician-assisted suicide. The Australian and New Zealand Society of Palliative Medicine does not support the legislation of euthanasia and physician-assisted suicide. ANZSPM's position, based on the expertise and experience of its members, is that good quality care for the dying does not include the practice of euthanasia or physician-assisted suicide. Helpfully, the statement that clarifies that certain good medical practices in end of life care are not euthanasia or physician-assisted suicide, because they do not, unlike the measures to be authorised by this bill, involve acts done for the purpose of intentionally ending a person's life.

These good medical practices, which are not euthanasia or physician-assisted suicide, and would not be covered by this bill's definition of voluntary assisted dying, include the refusal of life-sustaining treatments by the patient, withholding or withdrawing treatments that are not benefitting the patient, treatment that is appropriately administered to relieve symptoms and has a secondary and unintended consequence of hastening death and palliative sedation for the management of refractory symptoms. I note that all these end-of-life practices are already lawful in New South Wales and this bill has no effect one way or the other on their legality. The ANZSPM statement also comments on an appropriate response when a patient requests euthanasia or physician-assisted suicide. The requests for euthanasia or physician-assisted suicide should be acknowledged with respect and be extensively explored to understand and be appropriately addressed, and if possible, remedy the underlying difficulties that gave rise to the request. Appropriate ongoing care, consistent with the goals of palliative medicine should be continued to be offered.

When requests for euthanasia or physician-assisted suicide arise, particular attention should be given to gaining good symptom control, especially for those symptoms that research has highlighted may commonly be associated with a serious and sustained desire for death; for example, depressive disorders and poorly controlled pain. In such situations, early referral to an appropriate specialist should be considered. This is what the experts in end-of-life care recommend. If this bill is passed, this wise, caring approach will be overridden by a clumsy, ill-thought-out approach that will put a person expression of a desire to help and a desire for help to end their life, on a conveyor belt towards death by lethal poison.

When a palliative medicine specialist who, in accordance with this statement and with the views of his profession on what is not good medical practice to end-of-life care, will not participate in providing euthanasia or physician-assisted suicide or has a patient who requests euthanasia or physician-assisted suicide, he or she will be legally required by clause 21 of the bill to give the patient the information approved by the Health Secretary by gazette notice for the purposes of this section. If the palliative medicine specialist considers his or

her objection to prescribing a lethal poison for a patient to be a matter of conscience required by his professional obligation to engage in good medical practice, then he or she must hand over this information as soon as the request is made by the patient. In any case, if he or she decides to refuse the request to prescribe and perhaps administer a lethal poison to the patient, the patient must be given the information within two business days.

The gazetted information, under the corresponding law in Western Australia, is a 16-page booklet or a 17 minute audio file outlining the legal processes. It prominently features contact details for the Western Australian Voluntary Assisted Dying Statewide Care Navigator Service. The only care offered by these navigators is assistance to suicide or death by administration of a lethal poison. This compulsory provision of suicide facilitation information by a palliative medical specialist, indeed by medical practitioners to a patient with suicidal ideation, cuts right across the wise and compassionate measures recommended in the statement. This includes advice that 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; for example, depressive disorders and poorly controlled pain. In such situations, early referral to an appropriate specialist definitely should be considered.

Palliative medicine specialists treat an expressed desire for death as a possible symptom of a depressive disorder that may well respond to expert treatment. The bill will require medical practitioners to treat such an expressed desire as the first step in a bureaucratic legalistic process that starts with handing the patient the official Voluntary Assisted Dying Care Navigator Service, which can be gazetted under clause 185 of this bill and ends with their death by lethal poison. The ANZSPM statement properly notes that a desire for death, driven by poorly controlled pain, should be responded to by referral to an appropriate specialist to address the pain control. The bill disturbingly undermines the important message palliative care experts are striving to instil throughout the medical and health care sector. Where pain and other symptoms associated with a life limiting illness, whether terminal or otherwise, are not able to be adequately managed by the primary care practitioner, then a referral to a palliative care service must be made.

Clauses 10 and 28 seem to be premised on a patently false assumption that every medical practitioner is well enough informed about palliative care to be legally entrusted with the duty of informing a person expressing a desire for death, including where it is related to concern about inadequate pain control, about the palliative care and treatment options available to the person and the likely outcomes of the palliative care and treatment options. The reality is that palliative care is a specialist discipline of medicine which, like many areas of medicine, is constantly improving and about which many GPs and specialists in other areas of medicine, will simply not be sufficiently up to date with. They will not be informed or experienced to convey an accurate and comprehensive

account of the palliative care options and their likely outcomes to a person.*[Extension of time]*

We should be doing our utmost as quickly as possible to bridge the gap between Aboriginal and non-Aboriginal residents in New South Wales when it comes to life expectancy and access to health care. When the Queensland Parliament recently passed its Voluntary Assisted Dying Bill, respected indigenous leader Noel Pearson was not among those who cheered its passage. He cited Yawuru man and WA Senator Pat Dodson's comment that:

Where First Nations people are already overrepresented at every stage of our health system, it is irresponsible to vote in favour of another avenue to death. Paving the way for euthanasia and assisted suicide leaves First Nations people even more vulnerable, when our focus should be on working collectively to create laws that help prolong life and restore their right to enjoy a healthy life.

People losing hope should not be a reason for voluntary assisted dying. The fear of losing autonomy as one works through their illness should not be a reason for voluntary assisted dying. Many organisations exist to prevent people from dying, to give them hope, to give them dignity and to give them a sense of independence. Those organisations assist the elderly, work towards suicide prevention and protect people's mental health. Organisations such as Lifeline, Salvation Army, Beyond Blue, Lifeline Harbour to Hawkesbury, Way Ahead, Wesley Mission, Everymind, Reach Out Australia, Mission Australia, Suicide Prevention Australia and churches of all denominations all conduct a vitally important role in protecting human life over death. Numerous other

organisations, including religious organisations and individuals outside the scope of organisations, work tirelessly to assist people to overcome anything adverse in their life; they defend their life, not assist their death.

Events like RUOK and movements such as Hope4U are there solely to keep people existing. These good organisations and individuals in our community prioritise life over death. How can we legislate in support of death over life? We must not encourage an early death and assist anyone with dying. Rather, we must assist them with living. In every disastrous situation we face, whether it be times of war, pandemic, natural disaster or other catastrophic events, we put everything on the line to save lives. We invest in the safety, dignity and health of the person in need, regardless of their physical or mental situation, pain or quality of life. It is our responsibility as a Government to protect life, not to extinguish it. Protecting the right to life and the vulnerable should be the first and central priority of all governments and all people.

Our State went to extreme measures, some of which were considered undignified, to save people from dying from the COVID-19 virus. It cost this State \$1 billion per week to protect lives, small businesses, to support our students, staff and those with mental health issues. We shut down businesses, schools, nursing homes and elective surgery. Our freedoms were stripped. We could not visit our loved ones, travel, dine, attend funerals or visit places of worship. It was all to protect people from succumbing to the virus and dying. How is it that we have members in this place who would dismiss that approach and support a bill that would make it legal to extinguish a life? It does not make sense to me.

The argument that New South Wales needs to fall into line with other States could not be further from the truth. We should be the standout State. We do not need a copycat approach to something as important as this issue. There is nothing dignified about committing suicide, nor is there anything undignified about not deciding the time and circumstances of your death to circumvent the realities and adversities of life, which can be dealt with by advancements in the medical field and palliative care. I conclude by reiterating the opinion of Premier Dominic Perrottet that if the bill is passed, it will open a door that no-one will close.