28 January 2022

Hon. Wes Fang, MLC
Committee Chair, Legislative Council
Standing Committee on Law and Justice

Response to Supplementary Question Two to Mark Green and Question Five to Dr Rachel Hughes from Legislative Council Law & Justice Committee *Voluntary Assisted Dying Bill 2021* (NSW)

We refer to the above subject. Calvary submits the following response to the question from the Committee.

Supplementary Question

2. Assuming the *Voluntary Assisted Dying Bill 2021* is passed by the New South Wales Parliament in its current form, including:

- Clause 9 (and related provisions) – Registered health practitioners may refuse to participate in voluntary assisted dying; and
- Part 5 – Participation

what do you say will be the specific impact on residential facilities and health care establishments operated by your organisation?

Response

Clause 9

9 Registered health practitioner may refuse to participate in voluntary assisted dying

(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—

(a) participate in the request and assessment process,

(b) prescribe, supply or administer a voluntary assisted dying substance,

(c) be present at the time of the administration of a voluntary assisted dying substance.

(2) Subsection (1) does not limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in the subsection.

The schedule provides a definition of registered health practitioner.

> ***registered health practitioner*** means a person registered under the *Health Practitioner Regulation National Law* to practise a health profession, other than as a student.

Calvary submits that many people who are responsible for the care of people in our residential facilities and health care establishments are not registered health practitioners as defined by Clause 9. In particular those who provide substantive care to residents in our residential homes are not all registered health practitioners. This Bill does not afford them any protection if they have a conscientious objection. They cannot refuse to be involved in the VAD process. Whilst Clause 89 (2) purports to offer this group of staff some rights such as registered health practitioners have, Clause 89 (3) has the effect of neutering or gelding Clause 89 (2).

Clause 9 needs to be amended and broadened to cover all who provide care including staff and others in community and residential care settings. This will provide comfort to many of our carers who will have no legal recourse under the Bill if they are asked to be present at the time of the administration of a voluntary assisted dying substance in one of our homes. Clause 9 (1) (c) would give them that protection and enable them to continue to work in the residential facility in good faith.

Some on the Committee may argue that clauses in Part 5 of the Bill (as presently constructed) will not require any particular staff member of a residential facility to be present during the administration of a voluntary assisted dying substance.

The Committee needs to bear in mind, however, that Commonwealth Law, the *Aged Care Act*, the Charter of Rights, quality and safety standards and all the other supporting delegated legislation impacts of the way care is delivered in a residential facility. A provider may not be able to simply stand aside and allow the VAD substance to be in a permanent resident's care without some supervision to protect and uphold the rights of other residents to be kept safe.

During the lead up to a *self-administration* process (under Clause 97), a Provider continues to have obligations if something goes wrong, if harm is being done or has become aware of circumstances which suggest that to continue the process would be wrong. Accordingly a provider may need to monitor the process and therefore to ask staff to be present throughout the administration process, or parts thereof, in ways some individuals may feel is a violation of their conscience.

If Clause 9 applies to them, these staff will have greater confidence in speaking up to say that they do not want to participate or be present in the process because they cannot. This is important. Many of the staff who work in residential facilities need their jobs and do not have the level of experience nor the level of training available to a registered health practitioner.

Part 5 – Participation

Division 3 of Part 5

Division 3 of Part 5 is unacceptable as presently written. *If the effect* of these Clauses is to allow persons who are not medically responsible for the care of the patient in the health care establishment (who is admitted under the care of a particular admitting doctor, surgeon or physician) to interfere in the management of that patient's care, this is neither in the public interest nor does it advance the practice of safe and quality care. Our hospitals cannot allow persons who are not credentialed under our hospital bylaws to operate in our hospitals. We would simply lose our accreditation.

The situations Division 3 is trying to protect are already addressed in present practice. If a patient, presently admitted to a hospital, needs to access another service not provided in that the hospital, as soon as the patient is stable they are transferred, discharged or granted an appropriate period of leave to obtain the services sought. Given that the length of stay in a hospitals is generally short, we submit Division 3 is both unnecessary and, for the reason proffered in the above paragraph, misconceived.

We submit that the clauses could be redrafted to give effect to what is present practice and clarify that the effect of

the Division is not and cannot be to override the leadership in care of a credentialed admitting doctor.

Division 2 of Part 5

Clause 88 defines deciding practitioner.

> In this Part—
>
> ***deciding practitioner***, for a decision about a person, means—
>
> (a) the person's coordinating practitioner, or
>
> (b) if the person's coordinating practitioner is not available—another medical practitioner nominated by the person.

Calvary submits that for the purposes of the Division, the deciding practitioner should be the person's usual medical practitioner or if that person is not available—another medical practitioner nominated by the person.

Decisions about a person's suitability for transfer to receive another service are best made by the practitioner who has a therapeutic relationship with the person, who knows the person, understands any comorbidities the person is experiencing, other treatments the person is receiving and make the requisite judgments about the appropriateness of transfer – or otherwise.

Sub-clause (4) of Clauses 93-97 directs the decision making process of a deciding practiioner. The weighting is focused on whether there would be adverse affect on the person's access to VAD. Given the definition of deciding practitioner, there would appear to be an inbuilt bias.

The application of **Subdivision 3** will be most problematic for faith based organisations – like Calvary – and services which do not facilitate VAD.

Non-participating residential aged care providers must not be forced to provide or to oversee the administration of the VAD substance in their homes. As noted above, Clause 89 (2) of the Bill ostensibly offers this protection. However Clause 89 (3) effectively takes away or eliminates the protections offered by Clause 89 (2) by making the protection subject to Divisions 2 and 3 of the Bill.

Under this Bill, organisations like Calvary, may clearly state, under Clause 98, that the entity does not provide, *at a residential facility services associated with voluntary assisted dying, including access to the request and assessment process or access to the administration of a voluntary assisted dying substance*. The effect of Subdivision 3, and Clause 97(2) in particular, is to force the entity's participation in the very thing they have said they will not do.

What is the overarching public interest at play here? Does VAD have a status greater than any other service – human or medical – which many residential facilities do not provide? After the legislation is enacted and comes into operation people, for whom VAD is an important requirement could surely select a residential care facility which is supportive of VAD.

Calvary submits that if Subdivision 3 is to remain in the Bill, sub-clause (2) could be amended so that it applies to permanent residents living in the entity's residential facility before the Act comes into operation. After the Act comes into operation sub-clause (3) could apply to permanent and non-permanent residents alike.

It is submitted that this is in the public interest because it better respects the values and ethos of faith-based organisations and a plurality of views and desires in the community.

As previously stated, In the same environment and indeed in the same room may reside a person or people who do not want to be associated with any form of euthanasia. As Calvary stands aside to allow their fellow resident to take the VAD substance, how are we to deal with those other people's rights, beliefs, fears, anxiety and even anger that we have allowed this to happen in their home without their consent? How do we explain to them that we are upholding principle 4(k):

> All persons have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

This person might say, this act has violated my sanctuary and left me with grief and suffering I did not expect to have

to bare at this point in my life.

Finally, permanent and non-permanent residents should be required to inform their residential care provider that they are applying for VAD. Residential aged care providers can be informed, without compromising their conscientious objection, if they are not forced to participate in the process.

Concluding Remarks with respect to Division 2 of Part 5

The Bill as it presently stands exposes care providers, their staff and other patients/residents at aged care facilities to significant risk.

The Bill seeks to offer choice in end-of-life matters, but if it passes in its present form it appears neither to protect nor respect the choice of people in aged care facilities who don't want anything to do with assisted dying.

The effect of Division 2 of Part 5 doctors to access any aged care service and use its facilities for the purpose of assisted dying. A doctor can do this without informing the institution involved.

This impacts upon the duty of care we owe our residents at aged care facilities. It creates an unacceptable level of risk to other residents, as well as the safety and wellbeing of our employees.

In aged care facilities who do not want to participate in VAD, the Bill could expose workers in these facilities to handling lethal drugs and the euthanising of vulnerable people with whom they have a caring relationship.

It could also cause severe distress by exposing other residents in shared accommodation to assisted dying taking place.

In a climate post Royal Commission into Aged Care, which exposed challenges facing the elderly, these are risks that could be better mitigated.

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For more information

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