Calvary | Little Company of Mary Health Care Ltd

Hospitality
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28 January 2022

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

Response to Supplementary <u>Question Three to Dr Rachel Hughes</u> from Legislative Council Law & Justice Committee *Voluntary Assisted Dying Bill 2021* (NSW) per Mark Green

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

Supplementary Question

3. In evidence provided to the inquiry hearing on 8th December, Ms Penny Hackett, President, Dying With Dignity NSW said:

> "The key feature of this law is choice. It is voluntary and no-one is compelled to be involved. Those who oppose VAD laws are not required to use them or to participate in the process." (Hansard, page 3)

Can you please comment on what the actual meaning of the word "choice" is, as generally understood by the population at large and in the specific context of medico-health decision making?

Response

Calvary makes the following observations about "choice" and "choices":

Choices to accept treatments

It has always been the case – in Calvary and many other services – that the dying person is free to decide whether or not to accept any further treatment. Treatment has *always* been voluntary. And, one of the noblest activities of hospitals and the medical profession has been to assist such patients as they are dying.

It is perfectly lawful for a medical practitioner, in appropriate cases, to administer drugs to a dying patient with the intention of relieving that patient's pain and suffering, even though the practitioner knows, or even expects, <u>but does not intend,</u> that the patient's life may be shortened. These are distinctions with very important differences.

Moreover, there is no duty upon medical practitioners to prolong the life of a dying patient. It is bad medical practice to provide treatments that offer no realistic possibility of helping a dying person or which are burdensome for such a patient.

There will be people who can be assessed as having freely given informed consent to a medical practitioner to provide them with and/or administer the VAD substance. For people in this category, the Bill offers sufficient protections. But they are not the ones who really need protection. *Legislation of this type is to be considered by reference to the public good and the public good should not be compromised to the advantage of a limited* *group of people.*

Capacity to make informed choices

Many people approaching death lose the capacity to make any such informed choice. Both depression and the onset of dementia cause confusion and a willingness to go along with the suggestions that those closest to the dying person may wish to make.

As many legal practitioners who works in the area of probate, administration and guardianship know, the involvement of the relatives of the dying person in testamentary matters can be malign. The law reports contain innumerable cases where courts have found that the dispositions of a dying person were not free and informed but resulted from pressure being placed on the dying person by those who stand to profit from his or her death. There will be more cases, not less, as life expectancy increases as it has profoundly over a generation. The temptations placed before potential beneficiaries who observe their expected patrimony being eaten up by long term care will be considerable. The pressure can be very subtle and, as the testator who is subject to this legislation approaches death, the ability to give free and informed consent diminishes rapidly.

The capacity of medical practitioners to know whether a person is making a free choice

The critical decisions to be made under the Bill - for example, as to whether the patient has a terminal illness, is suffering intolerably on account of that illness, has requisite decision-making capacity, whether their decision is voluntary, and their consent is informed as to the nature and finality of the consequences of their action – **all of these matters are evaluated by medical practitioners.**

However several of these matters, particularly whether the decision has been made free from pressure or duress, are not necessarily medical judgments at all. They are more usually regarded as forensic decisions to be made on the basis of evidence and inquiry, not impression or assumption.

The Bill requires doctors to have acquired a certain level of professional qualification, but it does not require them to *know* the patient or to have had any prior consultative *relationship* with the patient. The Bill does not require the doctors to be specialist or experienced in the illness or disease from which the person is suffering.

Positive duty

So how is it to be determined that a particular person's decision is truly voluntary and not caused, or contributed to, by pressure, duress or manipulation? In truth, the Bill requires no active inquiry into the existence of these matters. *Provided that no evidence or circumstances of pressure or duress is otherwise apparent to the doctors*, that is all that is required for the doctors to conclude that the person is acting without pressure or duress. In other words, the inquiry is not proactive, but reactive. The Bill would appear to impose no duty on the doctor(s) to prepare notes of what he or she observed at the time the decision of eligibility is made, in terms of the absence of pressure or duress.

There is no positive duty of inquiry on the part of the doctor. Nor is the doctor required to consult with the patient's own GP who might be expected to know the personality of the patient, past expressions of wishes when diagnosed with a terminal illness, or the dynamic within the patient's own family. The complexity of inquiries needed to be undertaken to decide whether a person is subject of undue influence, pressure or duress is the subject of much research. The Bill enables, but stops short of, requiring the coordinating practitioner and the consulting practitioner to have regard to the person's existing medical history. This means an assessment of eligibility can be made without any attempt at obtaining that history.

It is not realistic for two doctors, who may know nothing about the patient, the patient's personality, family relationships or the possibility of past and present elder abuse by family members of the patient to arrive at a sufficiently informed decision on a sometimes vexing matter when, before a judge, such an inquiry will often take a significant period of time to determine safely.

Minimum Changes

At the very least, the Bill could be amended to ensure that a person's own GP is consulted by the two VAD doctors and that the latter must obtain the patient's medical history before any assessment of eligibility is undertaken by them. The Bill should also be amended to require the VAD doctors to record the reasons relied upon by them in concluding that the person is eligible to access VAD. This would not be an onerous obligation - doctors do very little without recording matters in clinical notes.

Concluding Remarks

To say that VAD laws are “voluntary and no-one is compelled to be involved” is simply not accurate.

Even though the Bill ascribes the right for residential aged care facilities to opt out of providing voluntary assisted dying at the facility they must still allow access to VAD practitioners from the first assessment right up to administration of a lethal substance. This imposition infringes the rights of the people working, living and being treated at our members’ facilities. People who have intentionally sought to join a community providing compassionate care, free from any intentional taking of life, would be exposed to VAD. This exposure could be as a bystander (for example, witnessing someone undertaking VAD) or by unintentional participation in the practice (for example, through being handed a lethal substance). The VAD laws are not voluntary for these people.

Choice cannot be defined simply as freedom to act without coercion. Such a definition fails to take into account whether (i) the patient has access to other options and (ii) their circumstances which may limit their access to these options.

The Bill also neglects adequately to address the issue of coercion, which is of particular concern in the case of elderly patients. Our society is aware of the prevalence of elder abuse; almost 40 per cent of people living in residential aged care experienced some form of abuse or neglect, according to the Royal Commission into Aged Care Quality and Safety. This law should not have the effect of heightening the risk of such elder abuse.

It is also worth noting that the VAD training for medical practitioners under the Victorian scheme, takes only six hours to complete online. This is hardly adequate training to enable any person or any practitioner to identify the subtle forms of coercion. https://www.health.vic.gov.au/patient-care/health-practitioner-information It should not be presumed that any doctor who applies to be a participant in the scheme is well-versed in identifying when a human being may be being influenced or coerced.

Finally, the Bill references the rights of people in rural and remote areas to have equal access to VAD; **but people living in rural and remote areas do not have equal access to palliative care currently**. To enshrine a right equitable access to VAD without an analogous guarantee of palliative care access is **no choice**. Regional and remote Australians experience higher morbidity and mortality rates and poorer access to healthcare services. Often they need to travel long distances to access healthcare. If VAD presents their only opportunity to die at home with their loved ones in their communities, that is not a state of affairs commensurate with a voluntary choice.

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For more information

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