Calvary | Little Company of Mary Health Care Ltd

Hospitality
Healing
Stewardship
Respect

28 January 2022

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

Response to Supplementary Question One to Mark Green and 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

1. In evidence provided to the inquiry hearing on 13th December, Dr. Danielle McMullen, President, Australian Medical Association (NSW) said:

> "We would undertake that the requirement for two separate doctors to both consult with the patient about their reasoning, intent and illness and to discuss with them all options available to them for their care, including voluntary assisted dying... ." (Hansard, page 5)

In evidence to the inquiry hearing on the same day Dr. Cameron McLaren, appearing as a private individual from Victoria said:

> "I underwent the training [Voluntary Assisted Dying training] for two reasons: I did not want a patient for whom I had cared throughout their journey with cancer to have to seek external providers that they chose to pursue this option [Voluntary Assisted Dying]; secondly having been educated in medicine with a strong focus on patient-centred care, I felt that my opinion... ." (Hansard, page 67)

In evidence to the inquiry hearing on the same day Dr. Greg Mewett, Palliative Care Physician, Grampians Regional Palliative Care Team, Ballarat Health Services, Victoria said:

> "My final comments would be that I find this [Voluntary Assisted Dying], as a palliative care doctor, patient-centred care... ."
>
> and
>
> "Palliative care is a style of care which, near the end of life, VAD is one type of choice in that care – they are not mutually exclusive." (Hansard, page 69)

In evidence to the inquiry hearing on the same day Associate Professor Charlie Corke, Acting Chair, Voluntary Assisted Dying Board, Victoria said:

> "I note that Dr. McLaren and Dr. Mewett both talked of patient-centred care. Really, the way in which we deliver health care can be considered as patient-centred care or medical-centred care or perhaps as legally-centred care or religious-centred care. There is a whole load of different ways we look at the way we deliver

> care. But, fundamentally, I think patients are wanting patient-centred care rather than any of those other options." (Hansard, page 71)

Can you please comment on the implications for the professions of medicine and nursing and the overall medical, health and aged/residential care ecology of New South Wales by describing Voluntary Assisted Dying, as provided for in the *Voluntary Assisted Dying Bill 2021*, as "care" or "patient-centred care"?

Response

Calvary's earlier submission

We refer to our submission dated, 22 November 2021.

Calvary agrees with Dr Natasha Moore who writes,

> For an early death to be on the table – legally and medically sanctioned – it changes the "table" for everyone. The evidence from other jurisdictions suggests that adding it to the mix does not leave other elements unaffected: the resources available for palliative care; the patient-doctor relationship; family dynamics at the end; our understanding of dementia, disability, suffering in general. And as is so often the case, it's the already vulnerable who have most to fear.

Uncertainty and fear mandate comprehensive information provision and symptom management. The unmet need and distress is highly complex and VAD legislation simply does not and cannot address this.

There will be changes to the care ecology of NSW if VAD is introduced.

There are challenges arising from a culture which allows doctors and health care staff to present, suggest and offer VAD as a choice. Whilst doctors may consider that they are being objective and impartial by presenting patients with all the options, the suggestion of VAD may be taken by patients as a negative value judgement on the worth of their lives and it may contribute to making them feel like a burden.

Understanding care and 'patient-centred care'

Patient-centred care must be understood in the context of the *raison d'être* of healthcare: the healing of and caring for the sick.

The risk of the approach articulated in the question and in some of the quotes which are included as part of the question is a *commodified view of healthcare* in which satisfying the wants of the consumer are the sole objective. That is outside the bound of medicine as traditionally practised and is not patient-centred care as we have understood this concept until now. Moreover we tend to speak about person-centred care rather than patient-centred care. The former expression focuses on the subject who has an inherent dignity as a human person and who is viewed holistically.

In the fourth quote in Question 1, patient-centred care and "religious-centred" care are set up as opposing views. This is, of course not the case at Calvary.

We acknowledge and respect the dignity of every person who seeks our care. We listen to each person and to those who care for them. We seek to involve each person in care tailored to their needs and goals. Each person's wellbeing inspires us to learn and improve. We complement compassionate clinical care with dedicated spiritual and emotional support; particularly when people are searching for meaning and purpose at vulnerable moments in their lives. The recognition of the innate dignity of each person influences all of our decision-making and informs the manner in which we look after the people who seek our care.

The purpose of the Bill is "to provide for, and regulate access to, voluntary assisted dying for persons with a terminal illness; to establish the Voluntary Assisted Dying Board; and to make consequential amendments to other Acts." Schedule 1 defines voluntary assisted dying (VAD).

> ***voluntary assisted dying*** means the administration of a voluntary assisted dying substance and includes steps reasonably related to the administration.

This is a purely technical act. Calvary does provide person-centred care. We do not regard VAD as healthcare but as a form of euthanasia.

On 9 December, 2021 one of our patients wrote

> I am dying. I've never done it before, I have no idea of what I'm going to face and this unknown is very daunting
>
> Where do I turn to for help, who can help me with the unique experience of having to face my own death, fully knowing it is imminent?
>
> Mentally and emotionally I'm dealing with an enormous amount
>
> My wife and family are also going through this experience and they need help dealing with it as well
>
> Where do I go for information to help demystify the great unknown of facing my own death?
>
> This is where I hope Palliative Care can help me, help me with all of this; and the things I haven't even thought of yet
>
> I hope Palliative Care can ensure I'm comfortable as I can be, as informed as I can be, my loved ones are also considered in this situation and they make the whole process as easy as possible and help reduce the stress of the whole issue.

There is nothing in the VAD Bill which responds to the questions:

> Where do I turn to for help, who can help me with the unique experience of having to face my own death, fully knowing it is imminent?
>
> Where do I go for information to help demystify the great unknown of facing my own death?

This is what a patient-centred (or better person-centred) care seeks to do. We are first and foremost teachers and guides.

Conclusion

When our patients or residents are dying, we strive to ensure that they do so in comfort and with dignity.

Consistent with our ethic of care, Calvary will not provide or administer a lethal substance to someone in our care. This position is consistent with the Hippocratic Oath and is shared by the Australian Medical Association and the World Medical Association – that is to do no harm.

Relieving suffering is a primary concern of good medical and clinical practice – as is improving the wellbeing of every person with a life-threatening illness and supporting their families in the process.

To relieve suffering is not to expedite someone's death, but rather to provide high quality care that relieves pain, alleviates stress and cares for the individual so that they can live as fully as possible to the very end of their lives.

A person who is facing their death is entitled to the same care as every other human being who is experiencing mental ill health, social isolation, the sense of being a burden, loss of meaning and loneliness.

No one should need to take their own life because of these things.

As we stated in our submission:

> There is a risk that a VAD culture may undermine such a message by making the value of the lives of people living with a terminal illness conditional on their own appraisal. Doubt and/or existential suffering is often part of the journey. The fact that a person is experiencing this kind of suffering does not take away from the value of their lives.

The profound and complex communication skills of a clinician in the face of this suffering broaden medicine from the purely technical to the deeply personal. This is critical.

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For more information

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