Calvary
Little Company of Mary Health Care Ltd

Hospitality
Healing
Stewardship
Respect

22 November 2021

Wes Fang, MLC
Committee Chair, Legislative Assembly
Standing Committee on Law and Justice

Submission to the Legislative Council Law & Justice Committee *Voluntary Assisted Dying Bill 2021* (NSW)

Introductory Remarks

Calvary has a 136 year history. Providing care to people who are reaching the end of their life has been our specialty in NSW since our beginnings on 4 November 1885. On 5 November 2021, Calvary took responsibility for 55 residential care services previously operated by Japara. Many of these services are located in NSW as the map below illustrates.

In 2020/21, Calvary cared for 1,084 residents and 9,719 clients. We had 115,282 emergency admissions, 205,380 hospital admissions and cared for 554, 986 outpatients.[i] We care for many people who experience vulnerability and we care for many people as they die.

Calvary is concerned that the legalisation of Voluntary Assisted Dying in NSW, while ostensibly benefiting the small percentage of people who want this option, poses a greater unintended but foreseeable risk to people living with significant vulnerability.

In addition, while our capacity as a State to provide palliative and end-of-life care, particularly in regional, rural and remote areas, is at best inconsistent, people cannot be said to have equitable access to quality needs-based care as they approach and reach the end of their lives.[ii] Despite experiencing higher levels of morbidity and mortality, people living in rural and remote areas have poorer access healthcare, including palliative care services. Pain management, medication management, staff knowledge and training are critical ingredients of an effective palliative care service.

By legalising VAD, do we really address this inequity? And if we do not address this existing inequity, are we offering any semblance of a real choice to people who are living with a serious and potentially very frightening disease to find a way to live as fully as they can until they die?

> *"It's a forked tongue that says life is dispensable in some circumstances and not others. I respect that the views of many who desire these laws are formed through suffering and loss, as are mine. I don't have all the answers, but a good start would be to generously fund palliative care in Australia. Politicians have told me it's expensive. Maybe, but I'd ask what price a life?"*

Gemma Tognini[iii]

Who We Are

Calvary is a charitable Catholic not-for-profit organisation with over 18,000 staff and volunteers, we have a national network of 14 public and private hospitals, 72 residential care and retirement communities and 19 community care service centres. Calvary operates across seven states and territories within Australia. We provide aged and community care, acute and sub-acute health care; and specialist palliative care and comprehensive care for people in the final stage of life.

In NSW we operate:

- 21 residential care and retirement communities;
- 2 public hospitals (Calvary Health Care Kogarah and Calvary Mater Newcastle);
- 1 private hospital (Calvary Riverina Hospital, encompassing also a Surgicentre and a Drug and Alcohol Centre); and
- a network of home care services in Sydney, Hunter New England and Wagga Wagga.

Founded on 4 November 1885 by the Sisters of the Little Company of Mary, our mission is to provide quality, compassionate health care to the most vulnerable, including those reaching the end of their life.

Full details of the extent of our footprint and the services we operate in NSW are set out in the graphic which follows.

Our NSW Locations

Hunter Newcastle

- **Calvary Cessnock Retirement Community,** Cessnock
- **Calvary Cooinda Retirement Community,** Singleton
- **Calvary Ephesus Retirement Community,** Lambton
- **Calvary Mater Newcastle,** Waratah
- **Calvary Mt Carmel Retirement Community,** Maitland
- **Calvary Muswellbrook Retirement Community,** Muswellbrook
- **Calvary Nazareth Retirement Community,** Belmont
- **Calvary St Francis Retirement Community,** Eleebana
- **Calvary St Joseph's Retirement Community,** Sandgate
- **Calvary St Luke's Retirement Community,** Cooks Hill
- **Calvary St Martin de Porres Retirement Community,** Waratah
- **Calvary Tanilba Shores Retirement Community,** Tanilba Bay
- **Calvary Tours Terrace Retirement Community,** Hamilton South

Sydney

- **Calvary Bayview Gardens,** Bayview
- **Calvary Brighton-Le-Sands,** Brighton-Le-Sands
- **Calvary Corymbia,** Belrose
- **Calvary Health Care Kogarah,** Kogarah
- **Calvary Henley Manor,** Doonside
- **Calvary Ryde Retirement Community,** Ryde

Other Regions

- **Calvary Albury and District,** Glenroy
- **Calvary Community Care,** Sydney, Taree, Riverina, Hunter/Newcastle, Forster, Lakelands
- **Calvary Riverina Hospital,** Wagga Wagga includes Calvary Riverina Drug and Alcohol Centre, and Calvary Riverina Surgicentre
- **Calvary St Paul's Retirement Community,** Taree
- **Calvary The Brelsford,** Coffs Harbour
- **Calvary The Mariner,** South West Rocks

● Community Care
● Hospitals - Private
● Hospitals - Public
● Retirement Communities

Calvary

Our Concerns

> *". . . illness and dying involve suffering, and we don't know how to eliminate it entirely.*
>
> *Assisted dying legislation takes one kind of death and aims to make it easier. It's a deeply sympathetic goal. It also opens the door to new kinds of suffering and abuse, unintended but not unforeseeable.*
>
> *So, the question cannot be: how do we eliminate suffering? The law can't do that. The question must be: what kind of society are we? What are our bedrock values? And who do they advantage – or disadvantage – the most?"*

Dr Natasha Moore[iv]

Who is disadvantaged?

Without the insulating effects of high quality health care access and support, people from vulnerable and marginalised groups are left completely exposed to the unintended consequences of the Bill. As a society, we must legislate with a view to protecting the vulnerable and most disadvantaged in our society.

First Nations Peoples experience a much higher burden of disease and live shorter lives than their non-Indigenous counterparts. Existing mistrust of the health care system will only be exacerbated by the introduction of a practice so radically at odds with cultural practice.

In the eyes of our First Nations Peoples, dying holds particular significance. Their ancient culture recognises the inherent interconnectedness between people. Their strong connection to Family and Country enables to see more clearly that even the expression of individual autonomy occurs in relation to other people and that at a societal level this means the right to do something must be weighed up against the impact on the others. Many Elders have expressed concern at the introduction of VAD in other states and much is lost by not listening to their insights and wisdom.

> *"First Australians live shorter lives. Their babies are more likely to die of preventable diseases. They watch their friends, cousins and siblings prematurely end their own lives. They have had their hearts broken too often when there is a 'death in custody' because of misjudgement, prejudice or ignorance as their culture faces power and authority. One simply cannot bear witness to this reality – where First Nations are overrepresented at every stage of our health and criminal justice systems - and put forward another avenue to death."*

Patrick Dodson, Yawuru man[v]

Ageism and the Royal Commission

We recently provided evidence to the Royal Commission into Aged Care Quality and Safety on palliative care in aged care.[vi] One of our nurse practitioners, Mr Joshua Cohen, made some observations about palliative care and pain management in residential care which we submit are relevant more generally. We quote directly from the Commission's report:

> Mr Joshua Cohen, a palliative care nurse practitioner, explained that the most important aspects of palliative care in aged care are adapting the care to the individual and the family, and keeping the care recipient at the centre of that care. However, pain management in residential care is often difficult because of the care setting and the absence of staff knowledge in how to manage the medications and the pain. Training is also essential.[vii]

Older people are often dehumanised in our society, viewed through an entirely economic lens as a financial burden. The Final Report of the Royal Commission into Aged Care Quality and Safety highlighted how much needs to be done to protect older people. According to the most recent report of the Victorian VAD Review Board, the average age of a person accessing Voluntary Assisted Dying in Victoria was 72 years old.[viii]

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.[ix]

Australians are living longer than ever before and the aged care sector is facing an ageing population with increasing frailty. By 2058, the number of Australians aged 85 and over will increase to more than 1.5 million; more than twice the current number.[x]

Following the implementation of MAID in Canada, a similar coincidence was noted. Dr Bridget Campion stated,

> *I think it is an amazing coincidence that, as cash-squeezed governments are facing a tidal wave of aging baby boomers, MAID has become legalized. My guess is that, sometime after the summer 2020 review, the next round of public consultations will consider MAID and the question of substitute decision-making—of having others make decisions for persons unable to make or voice their own choices. My fear in all of this is that as we place our focus on people who wish to have assistance in dying, we will fail persons who wish to have assistance in living.*[xi]

Fear of Dying

We fear death and dying. A natural reluctance to address our mortality often adds much confusion and existential suffering to people who are dying and their families. Many people do not understand the physiological process of dying and they do not understand the administrative processes surrounding dying. They can be overwhelmed and unsure of their options. 70% of Australians want to die at home, but only 14% have that privilege.[xii] Many people fear a medicalised death and, without provision of community care services, VAD could seem like their only option. Family members of people who are dying are often deeply distressed and the need to provide them with comprehensive support and an understanding of what happens when someone is dying. They are understandably distressed by parts of the dying process which doctors and health care professionals might term 'normal'.

Calls for better palliative care access by VAD opponents do not represent attempts to shift the goal posts. Australians die at home only half as much as people in the United States, Canada and New Zealand. In Australia, dying is medicalised and highly institutionalised, with about 50% of Australians dying in hospital and another 30% dying in residential care.[xiii] Access to palliative care is patchy and dependent on factors such as location and financial ability. Legalising VAD is not a solution to these challenges; nor is, Calvary hopes, anyone proposing that VAD has a future as the pathway of 'choice' to enable the vast majority to die at home.

Even so, suffering and dependence on other people cannot be completely eliminated from the end-of-life experience. One of the major arguments in favour of VAD is intolerable suffering; and intolerable suffering comprises part of the eligibility criteria in the Bill. A person must be experiencing suffering that "cannot be relieved in a way that the person considers tolerable" (clause 26 (3) (a)). A 2014 study from the Netherlands on the relationship between requests for VAD and unbearable suffering noted that unbearable suffering did not seems to be a dominant motive in requests for VAD. No difference in unbearable symptoms was noted between persons who requested VAD and those who did not.[xiv]

Gemma Tognini states that the desire for VAD is more about our need for control than choice. It springs from a desire to be in complete control, from cradle to grave, without being forced to rely on others.

> "Like many, Dad fretted that he was a burden on us. We lied and said of course he wasn't. One evening I was helping Mum get him changed. He was heavy with fluid and difficult to manoeuvre.
>
> He cracked gags as I yanked his shorts back up over his remaining leg and his bare behind, but in his eyes I saw a frail old man who knew that wasn't really how it was supposed to be. It might sound strange but there was a gift in bearing that burden. One I'm still unwrapping."[xv]

Risk of Acting Prematurely

Dr Frank Brennan, a palliative care specialist at Calvary, St George and Sutherland hospitals, recalls an 82 year old woman, who was dying of metastatic cervical cancer. Her son told health care staff that "we would not treat a dog like this." The woman said to the doctors, "My son said I should ask for a needle to end my life." But the doctors told her that this was not possible. About sixteen days later, the woman was unexpectedly reunited with her daughter, with whom she had been estranged for many years. After their tearful reunion, the woman was much more settled. When the daughter heard the full story, she said, "My God, if VAD was legal I may have missed seeing Mum altogether."

Care of the dying is an art

Palliative care is essential to Calvary's mission. Our models of care seek to make people feel welcome, heard and cared for whatever their experience and situation. 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. Dr Frank Brennan cites the following case.

> A 62 year old man with mesothelioma is dying. His physical symptoms are reasonably well controlled but he is emotionally and spiritually anguished. He is referred to Palliative Care. The family say later "We didn't think this would help at all. You can't mend a broken spirit."
>
> The Palliative Care team met him and through careful communication and support allowed the patient to express his upset, fears and distress. He began to feel much better.

One of the myths about palliative care is that it is powerless to assist patients who are intractably burdened by symptoms or anguish. **At precisely the moment medicine may say 'I'm sorry there is nothing more I can do' palliative care engages intensely with the person who is suffering and aims to support them throughout their illness until their death.** 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.[xvi] This is critical.

Value of life becomes dependent on a person's will to live

Many people fear the possibility of unbearable suffering as a consequence of illness or accident. Five States have already legalised VAD in the hope that this will both reduce fear of an intolerable future for the many and provide an early death as an alternative to suffering for the few.[xvii] And yet, even the most carefully-thought-through changes can have perverse and unintended consequences. The following example is illustrative of the cultural risk - a risk of failing to see a non-VAD alternative.

> "They didn't mean to frighten me. I think they thought it was a comfort. But it was every day, every ward round, they told me that if I want to, I could choose to die…" Ujjal was explaining why he recently ran away from a hospital in his adopted home town in the Netherlands and returned to live with his mother in England, bringing his toddler and his Dutch wife with him.
>
> The GP found a large tumour in Ujjal's rectum, and referred him for treatment. They diagnosed a sarcoma of the rectum, a very rare cancer that can be cured by complete surgical removal, provided it has not already spread. Ujjal's rectum, lower bowel and bladder were removed. A false bladder was made using a portion of his intestines. He had a bag on his belly to collect his urine and another to collect his faeces. He felt lucky to be alive.
>
> The wound never fully recovered. Ujjal developed an oozing sore at one end of it that wept smelly pus. Antibiotics made no difference. Somehow, the pus was leaking through a minute crack in the skin behind his scrotum. A wine-cork-sized tumour in the pelvis was removed and radiotherapy followed. The ooze continued.
>
> The lower part of Ujjal's bowel had shriveled up in reaction to the radiotherapy and burst. His pelvis was filled with excrement, germs swarmed into his bloodstream, he had unbearable abdominal pain. More surgery. Now Ujjal had a third bag on his belly to collect discharge from the damaged bowels. But the ooze continued.
>
> The kind Professor of Surgery explained Ujjal still had some tumour in his pelvis and this would continue to grow. "The cancer is hollow, like a tennis ball, and germs are growing inside, making a filling of pus. Every now and then the pressure builds up and the pus leaks out. There is no further surgery that could help. Many people would not wish to live in that state. Here in the Netherlands, there is an extra choice for you. If you would not like to live like this, then we have the euthanasia."
>
> Ujjal understood how that thought might be a comfort to someone else. But he also knew that his heart lay at home. Once the possibility of euthanasia was raised for him, Ujjal found that he was afraid to admit to new symptoms, in case euthanasia rather than symptom management was recommended. Ujjal demanded his bag and his belongings… Within a week he was a resident in his mother's house in the UK.
>
> Ujjal was admitted to a single room at the hospice the day after his assessment. A day-bed in the room was made up for his wife, and we borrowed a travel cot for his daughter. In effect, they took up residence while we considered how best to support Ujjal's decision to live with his most beloved women for the rest of his foreshortened life. He was enthusiastic to try any experiment that might improve his wellbeing. Thus, we devised ways to use tampons to collect the pus from the open wound, we used drugs to alter the consistency of his faeces to reduce leakages, we used special wound dressing to contain and reduce the smelly ooze and we used a spinal line to numb the pain. Ujjal adapted to wheelchair mobility, taking his daughter for rides around the hospice and grounds.
>
> Ujjal lived with us for two months. His cancer eventually obstructed his kidneys, and he became comatose after a few days before dying very quietly while his daughter was running and laughing in the garden outside his room.[xviii]

This case demonstrates one of the challenges of a culture which allows doctors and health care staff to initiate discussions about VAD with their patients. While 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.

Medically hopeless is not the same as being without hope or without the capacity for hope and good palliative care recognises and address this. As the distinguished bioethicist, the late Nicholas Tonti-Filippini once said,

> "…I would argue that legislation that permits euthanasia could never be made safe for those of us who have serious chronic illnesses, because the essence of such legislation is to make respect for our lives contingent upon the strength of our will to survive."

Clauses with safeguards can be amended

We have laid out below our recommendations for amendments to this Bill, but our strong objections to the fundamental tenets and practices of this Bill should be noted.

We also have concerns that the clauses enshrining safeguards can be subsequently amended. When Victoria legalised VAD in 2017, it was frequently argued that the legislation was "the safest and most conservative in the world". The legislation came into effect in 2019 and less than two years later, there are already calls being made for the removal of safeguards.

In 2020, an article in the *Journal of Law and Medicine* addressed "severe limitations" to the legislation.[xix] This included the "arbitrary" minimum age of 18 and the "severe difficulties" of assessing capacity in patients with mental illness and cognitive impairment. Another 2020 journal article entitled "Too much safety?" cites the much touted safeguards as "significant barriers" which "create a stigma" around VAD. A 2021 article in the *Journal of Bioethical Inquiry* argued that the eligibility criteria of being "already dying" makes doctors the gatekeepers of VAD and effectively limits the "realization of autonomy at the end of life."[xx]

Our Recommendations

Calvary does not support this legislation. If the Law and Justice Committee is minded to recommend the Bill to the Legislative Council, we submit the following recommendations *may* make the legislation safer for vulnerable people. We note, however, that evidence from overseas and in Victoria demonstrates that safeguards can soon be regarded as obstacles and impediments to be removed.

- **Fund better palliative care to enable universal access across rural and remote areas.** 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.
- **Uphold doctors' rights to conscientious objection:**
    - Clause 21 (5) (b) states that a medical practitioner who has refused to act as the coordinating practitioner due to a conscientious objection needs to provide the patient with VAD information approved by the Health Secretary. This is at variance with clause 9 (1) (a), which states that a medical practitioner with a conscientious objection is not required to participate in the request and assessment process.
    - If the person is referred to a psychiatrist or other registered healthcare professional to assess decision making capacity or coercion, the referring practitioner needs to notify the psychiatrist or other registered healthcare professional that the purpose of the assessment is in regard to a request to access VAD.
- **Uphold the rights to institutional conscientious objection.** Residential aged care providers must not be forced to provide VAD, even if they have to allow it. Moreover, institutions with a conscientious objection often attract staff because of their ethos. If forced to provide or facilitate VAD, they may lose staff (confronted and deeply affected by the experience) at a time when workforce is difficult to obtain.
- **Require a person in a residential aged care facility, or their practitioner, to notify the residential aged**

care provider of their intention to seek VAD. Currently the Bill only states that residential aged care providers should be informed, but there is no obligation to do so (clauses 90-96). Staff and other residents need to be informed, particularly in the case of a self-administration decision, as this may cause distress and the opportunity for pastoral care and support should be available to staff and other residents. This is particularly important when one considers that residents often share rooms; and other residents' sensibilities, emotional well-being, values and beliefs ought to be protected. They may be frightened by the death prematurely orchestrated in the adjacent bed and fear that this may have a flow on effect. Residential aged care providers can be informed without compromising their conscientious objection if they are not forced to participate in the process.

- **Restrict the ability of healthcare workers and providers of professional services to initiate conversations about VAD.**
- **Remove any requirement for community care providers to assist or provide access to a VAD practitioner.**
- **Strengthen safeguards for persons with a disability or mental health impairment** to address the concerns eloquently put by R. Eames in an opinion piece as follows:

> "In my opinion – as a disabled person whose disability will at some point kill me, as someone who has watched family members die slow and painful deaths, as an atheist who used to support VAD laws until I saw the realities of our healthcare system – there are too many fatal and widespread problems in our current healthcare system to safely legislate VAD.
>
> First address the widespread abuse and neglect in aged care and disability care.
>
> First legislate fully funded medical care, so people don't have to make GoFundMes (sic) for cancer treatment.
>
> First address the embedded racism in medicine, especially for Aboriginal & Torres Strait Islander patients.
>
> If this is about individual choice – first consider who is given power to choose.
>
> First ensure people are supported to live, adapt, and have their pain treated.
>
> Then we can talk about assisted suicide."[xxi]

- **Require a mandatory referral to assess decision making capacity and freedom.** According to clause 27(3), the practitioner 'may adopt the decision made by the psychiatrist or other registered healthcare professional.' Despite the mandatory referral to a psychiatrist or other registered healthcare professional if there is any question regarding the patient's decision making capacity, the practitioner is not required to abide by their decision.

Concluding Remarks

Calvary does not support VAD nor do we recognise these interventions as medical treatments. Accordingly, Calvary is not, and will not, be involved in the implementation of any Voluntary Assisted Dying legislation and Calvary will not provide services permitted under this or any similar legislation.

We will not change the way in which we currently deliver compassionate palliative and end of life care; we will continue to optimise quality of life and support people and their families.

Calvary supports the submission from Catholic Health Australia.

Calvary will seek to assist the Committee in any way it can, and would welcome the opportunity to provide further evidence, if required.

> *"I have seen many wonderful things that patients and families have experienced in the end stage of illness. These may not have occurred if there was on opportunity to end a life prematurely."*
>
> Kevin Hardy, Calvary Nurse Practitioner

Jim Birch AM
Chair
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For more information

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[i] See Calvary's Annual Review accessed at https://www.calvarycare.org.au/wp-content/uploads/2021/09/fy1920-annual-review-v2.pdf#page=2 on 16 November 2021 at 3 of 64.

[ii] See S Wenham, M Cumming, E Saurman. *Improving palliative and end-of-life care for rural and remote Australians. Public Health Res Pract.* 2020; 30(1):e3012001 accessed at https://www.phrp.com.au/issues/march-2020-volume-30-issue-1/improving-palliative-and-end-of-life-care-for-rural-and-remote-australians/ on 16 November 2021.

[iii] Gemma Tognini, *Assisted dying? Give me assisted living every time, The Australian,* 19 November 2021 accessed at https://www.theaustralian.com.au/commentary/assisted-dying-give-me-assisted-living-every-time/news-story/4179d3255147d92c9cacb193ab63b8de?btr=9fe840625d2db01fcdb36a069e4febb2 on 22 November 2021.

[iv] Dr Natasha Moore, *Assisted dying laws will not end suffering, WA Today, 16 November 2021 accessed at https://www.watoday.com.au/national/nsw/assisted-dying-laws-will-not-end-suffering-20211112-p598e3.html on 16 November 2021.*

[v] Patrick Dodson, *Voluntary Assisted Dying: A First Nations Perspective, The Australian*, 05 October 2019 accessed at https://www.patrickdodson.com.au/voluntary_assisted_dying_a_first_nations_perspective on 20 November 2021.

[vi] See the Royal Commission into Aged Care Quality and Safety Interim Report: Neglect at 193 of 336 accessed at https://www.palliaged.com.au/Portals/5/Documents/Australian_Context/Royal-Commission-interim-report-volume-2.pdf on 16 November 2021

[vii] See the Royal Commission into Aged Care Quality and Safety Interim Report: Neglect at 193 of 336 accessed at https://www.palliaged.com.au/Portals/5/Documents/Australian_Context/Royal-Commission-interim-report-volume-2.pdf on 16 November 2021

[viii] Voluntary Assisted Dying Review Board, "Report of Operations: January - June 2021" Safer Care Victoria, p 9. https://www.bettersafercare.vic.gov.au/sites/default/files/2021-08/VADRB%20August%202021%20report%20FINAL.pdf

[ix] Dr Natasha Moore, *Assisted dying laws will not end suffering, WA Today, 16 November 2021 accessed at https://www.watoday.com.au/national/nsw/assisted-dying-laws-will-not-end-suffering-20211112-p598e3.html on 16 November 2021.*

[x] See the *Final Report Executive Summary, Royal Commission into Aged Care Quality and Safety* accessed at https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf on 19 November 2021.

[xi] Bridget Campion, *Bioethics Matters: Medical Assistance in Dying: A Review of the Legislation*, Canadian Catholic Bioethics Institute, accessed at http://www.ccbi-utoronto.ca/2020/02/14/bioethics-matters-medical-assistance-in-dying-a-review-of-the-legislation/ on 22 November 2021.

[xii] Hal Swerissen and Stephen Duckett, *Dying Well Report 2014, Grattan Institute*, available at https://grattan.edu.au/report/dying-well/ accessed 16 November 2021.

[xiii] Hal Swerissen and Stephen Duckett, *Dying Well Report 2014, Grattan Institute*, available at https://grattan.edu.au/report/dying-well/ accessed 16 November 2021.

[xiv] CD Ruijs, G van der Wal, AJ Kerkhof and BD Onwuteaka-Philipsen, *"Unbearable suffering and requests for euthanasia prospectively studied in end-of-life cancer patients in primary care". BMC Palliative Care.* 2014 Dec 23; 13(1):62. doi: 10.1186/1472-684X-13-62

[xv] Gemma Tognini, *Assisted dying? Give me assisted living every time, The Australian,* 19 November 2021 accessed at https://www.theaustralian.com.au/commentary/assisted-dying-give-me-assisted-living-every-time/news-story/4179d3255147d92c9cacb193ab63b8de?btr=9fe840625d2db01fcdb36a069e4febb2 on 22 November 2021.

[xvi] Dr Frank Brennan, Departments of Palliative Medicine and Nephrology, St George and Calvary Hospitals, Sydney, New South Wales, Australia, Royal Australasian College of Physicians, "To die with dignity"- an update on Palliative Care. *Internal Medicine Journal* **47** (2017) 865-871.

[xvii] The fifth Report of the VAD Review Board, Victoria (to 30 June 2021) shows that since June 2019 (when the Act commenced) until 30 June 2021:

- 836 people have been assessed for eligibility to access voluntary assisted dying
- 674 permit applications have been made
- 597 permits have been issued
- 331 people have died from taking the prescribed medications.

[xviii] From *With the End in Mind How to Live and Die Well*, Dr Kathryn Mannix (2017).

[xix] Savulescu J. (April 2020). The Voluntary Assisted Dying Law in Victoria - A Good First Step but Many Problems Remain. J Law Med. 27(3):535-550. PMID: 32406618.

[xx] Hempton, C., & Mills, C. (2021). Constitution of "The Already Dying": The Emergence of Voluntary Assisted Dying in Victoria. *Journal of Bioethical Inquiry*, *18*(2), 265–276. https://doi.org/10.1007/s11673-021-10107-1

[xxi] R Eames, *Dignity: Exploring the Reality of Assisted Dying, Honi Soit,* 29 October 2021 accessed at https://honisoit.com/2021/10/dignity/ on 22 November 2021.