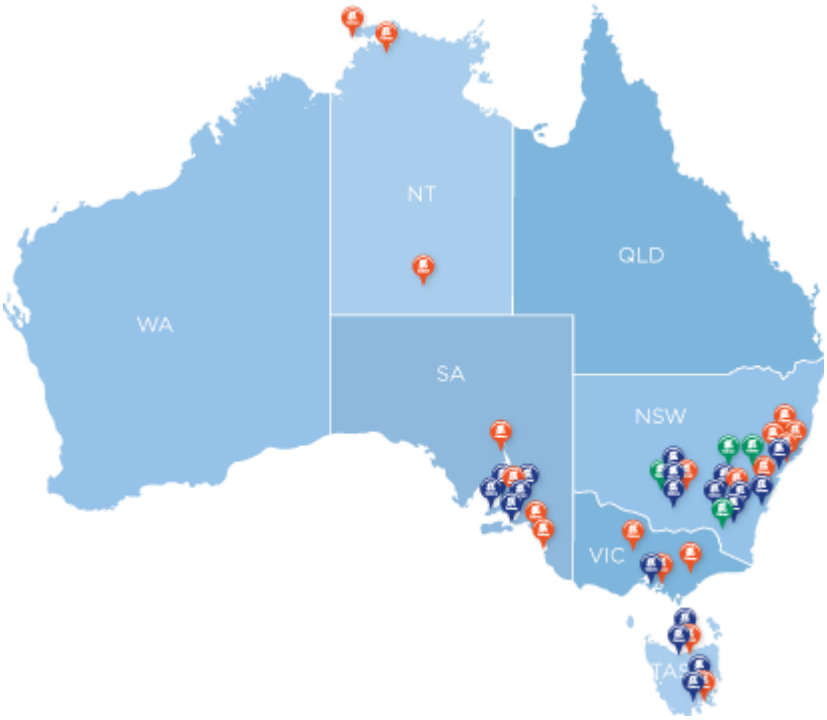
5 October 2017

Voluntary Assisted Dying Bill 2017 (NSW)
Calvary's Position

Calvary's role in the NSW Community

Since the establishment of Calvary in 1885, with the arrival of the Sisters of the Little Company of Mary in Australia, Calvary has become well known for the provision of health care to the most vulnerable, including those reaching the end of their life. With more than 12,000 staff and volunteers, 15 public and private hospitals, 17 retirement and aged care facilities, and a national network of Community Care centres. We operate across six states and territories within Australia.



Calvary Health Care Kogarah public hospital in Kogarah, NSW is recognised as a leader in Specialist Palliative Care. We provide Specialist Palliative Care Services and Rehabilitation Services to the local St George and Sutherland Shire regions and extensive Community Health Services to the St George region.

We are one of the largest sub-acute hospitals in NSW serving approximately 12,500 patients per year.

We provide palliative care as an inpatient service, at home or in residential care facilities. A person can be admitted for pain and symptom management, respite care or end of life care.

We use a team approach to address the needs of patients and their families. Our care is coordinated with other services and is focused on the whole person. We help patients to achieve their goals and improve their quality of life.

Calvary Mater Newcastle public hospital in Waratah, NSW, is the major cancer care centre for the Hunter New England Local Health District, delivering more than 320,000 occasions of outpatient services and in excess of

16,000 inpatient treatments per year. Calvary Mater Newcastle is also home to a world renowned research facility. Staffed by leading researchers in oncology, toxicology, psychiatry and palliative care, we are affiliated with major universities and colleges and international research partners.

We provide Palliative Care as an inpatient service, at home or in residential facilities. Patients can be admitted for pain and symptom management, respite care or end of life care.

Calvary Riverina Hospital in Wagga Wagga, NSW, provides a range of services to the Riverina community including Calvary Riverina Surgicentre, our award winning Drug and Alcohol Centre, and Maternity and Women's Health Services.

The Mary Potter Palliative Care Unit provides inpatient palliative care services and support to public and private patients. This service is supported by a multidisciplinary team of nursing, medical and allied health practitioners who provide much needed specialist care to patients who are nearing end of life. We provide specialist palliative care for acute patients and, as a member of the Palliative Care Alliance, have established links with hospice and home-based community palliative services for both public and private patients.

Calvary Retirement Communities operates 873 aged care beds and 272 independent living units across 14 sites in NSW, including at Ryde in Sydney, in the Hunter Region and in Newcastle.

Calvary Community Care has been supporting people in their own homes and communities throughout NSW for over twenty years. We deliver a range of aged care, disability and other support services that enable independence, improve social connections and promote positive health and well-being.

Calvary's position – fundamental questions outstanding

Calvary does not support the passage of this legislation. Calvary accepts that there are a plurality of views on the subject of voluntary assisted dying. Calvary will not, however, participate if the legislation is passed.[1]

Calvary cannot support the notion that assisting a person to commit suicide, or to end their life directly and intentionally, is an expression of care. We strive to eliminate suffering but not the people who are experiencing the pain or physical incapability.

Clause 9 of the Bill establishes the conditions for eligibility "to request assistance from medically qualified persons to voluntarily end their own lives".

[1] Calvary has reviewed the Royal Australasian College of Physicians' (RACP) feedback in response to the NSW Parliamentary Working Group on Assisted Dying's (PWGAD) Draft *Voluntary Assisted Dying Bill 2017*. Calvary agrees with the comments made on pages 4-10 of the RACP submission. Some of these comments have now been addressed by those are sponsoring the private member's Bill.

9 Request for assistance to voluntarily end life

(1) An eligible person may request a registered medical practitioner for assistance to end the person's life in accordance with this Act.

(2) A person is ***eligible*** to make a request under this section if:

(a) the person is at least 25 years of age, and

(b) the person is an Australian citizen, or a permanent resident of Australia, and is ordinarily resident in New South Wales, and

(c) the person is suffering from a terminal illness, and

(d) the registered medical practitioner to whom the request is made (referred to in this Act as the ***primary medical practitioner***) has informed the person that, in the practitioner's opinion, the person is suffering from a terminal illness, and

(e) as a consequence of the terminal illness, the person has been experiencing severe pain, suffering or physical incapacity to an extent unacceptable to the person.

(3) The primary medical practitioner must not be a close relative of the person who makes the request.

(4) A request under this section is referred to in this Act as a ***request for assistance***.

(5) A person who makes a request for assistance is referred to in this Act as the ***patient***.

Clause 18 (c) further requires that the medical practitioners involved have formed the opinion

(c) there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure.

And Clause 19 requires the primary medical practitioner to provide certain information to the patient

19 Information to be provided by primary medical practitioner

(1) The primary medical practitioner must, after conducting an examination under this Part, provide the following information to the patient in writing:

(a) information relating to the nature of the illness and its likely course,

(b) information relating to the medical treatment, including palliative care, counselling and psychiatric support and measures for keeping the patient alive, that might be available to the patient,

(c) information relating to the consequences of the administration to the patient of an authorised substance, including the risk and possible adverse consequences of the administration not resulting in the death of the patient,

(d) information relating to the right of the patient to rescind a request for assistance,

(e) any other information required by the regulations.

(2) If the patient is unable to read the written information, the primary medical practitioner must also provide the information to the patient orally.

(3) In addition, the primary medical practitioner must offer to refer the patient to a palliative care specialist. The patient is not required to accept the offer of referral.

(4) The patient must, after receiving information and offer of referral under this section, indicate to the primary medical practitioner that the decision to request the assistance still stands.

Considering the effect of these clauses in their totality, Calvary submits that the following scenario is permitted under the proposed Bill.

A person aged 25, suffering from an illness which in reasonable medical judgment could result in their death within the next 12 months, who says to a medical practitioner, "I am experiencing severe pain, suffering or a physical incapacity to an extent unacceptable to me," can lawfully be assisted to die.

Determining how long a person has to live is not an exact science and is a challenge even for the most qualified doctors. At one year, the margin for error in prognostication significantly increases and many clinicians would find it this a difficult assessment to make. Patients are at risk of ending their life when they could potentially have several

more years to live.

Under this legislation we could fail as a community to offer a person with a terminal illness the chance to live the life remaining to them as fully and as richly as possible. Such an outcome, Calvary submits, is not in the interests of the common good. The passage of this Bill may implicitly suggest to the community that the State of NSW places greater value on facilitating the death of a person whose suffering is great than on investing in treatments, care and social support mechanisms which could help them live a longer life with less pain and suffering.

Without easy access to quality pain management (palliative care), a social safety net and good community support systems, some people may request physician assisted dying as they feel they have no other choice. This is especially so for people who live in rural, regional and remote areas and for people from culturally and linguistically diverse communities who have less access to palliative care services. People with little support from family, who are socially isolated and with access to limited economic resources may also come to believe it is better that they die rather than seek help to live with less suffering.

We do not believe that this legislation contains adequate safeguards to protect vulnerable populations, especially those with incurable cancer, progressive neurological illness, the aged, the infirm, and people who live with disability. These groups of people can experience high rates of depression and isolation. The risks that this legislation poses for the majority of these human beings are great.

The Bill does not specify the regimen or drugs that would be used.

Calvary has deep concerns with respect to the **lack of information** about the proposed clinical regimen for voluntary assisted dying in the draft legislation; including any reference to the known complications, safety and effectiveness, let alone how risks would be managed.[2] Clause 6 defines an "authorised substance" as "a substance that is declared by the regulations to be an authorised substance for the purposes of this Act or that belongs to a class of substances so declared." This is not a matter that should be left to regulation.

Calvary has identified significant issues of implementation, unaddressed in the Bill which should be discussed, clarified, debated and ultimately provided for in legislation. This factual information, if provided, would enable legislators better to access whether the clinical regimen is safe, respects human dignity and is consistent with the value of compassion. Both the rationale for and efficacy of the proposed legislation depend on the means, the mode and the manner by which a person obtains their own death. **If the clinical regimen is unsafe, gives rise to complications or is ineffective, the legislation will fail to achieve its stated intention and will put people in NSW at risk.**

These are threshold issues which cannot be left to be resolved in the six months between the passing and

[2] The the Australian and New Zealand College of Anaesthetists made a similar point in their submission to the Ministerial Advisory Panel in Victoria. On page 16 of the College's submission, they state:

> "There must be disclosure in the legislation of the type, dose and formulation of the lethal dose of medication to be administered and of the alternative methods that may be used if the patient is unable to self-administer or ingest or absorb the lethal dose of medication."

See http://www.anzca.edu.au/documents/anzca_voluntary-assisted-dying-submission-report_2.pdf accessed on 10 August 2017.

commencement of the legislation (*per* Clause 2 of the Bill). These are issues to be resolved before the law is introduced.

Threshold issues which need to be addressed before legislating

Calvary agrees with three observations made by the Royal Australasian College of Physicians (RACP) and submits that the revised Bill has not addressed these concerns, namely that

- the Bill conveys a legal process, with little understanding of the clinical care context. This is apparent in the sections covering assisting persons, prognosis, suffering and physician opinion,
- the Bill is heavily based on individual autonomy and does not adequately address the context in which end of life decisions are made, and the significant role of family and carers,
- the process for preparation of a Bill of this nature has not been undertaken in a sufficiently robust manner.[3]

In addition to the ethical questions which have been ably raised with Members of Parliament and the NSW community by our sister Catholic health and aged care services and religious leaders, Calvary has concerns about two (2) key or threshold questions.

1. What lethal substance will people use to end their own lives (bring about their own deaths)?

2. Who will assist them (to die) and how will this be done?

The answers to these questions are threshold concerns which we believe should be thoroughly explored and addressed before legislation is enacted and not left to be sorted out later.

1. What lethal substance will people use to end their own lives?

The draft Bill does not specify the regimen or drugs that would be used. Clause 6 states

> **6 Authorised substances**
>
> An ***authorised substance*** is a substance that is declared by the regulations to be an authorised substance for the purposes of this Act or that belongs to a class of substances so declared.

Assisted suicide is not a simple procedure with 100% effectiveness. Accordingly, we raise the following issues:

- What drug is proposed for oral ingestion in NSW?
- Is the drug pharmaceutically available? Who will dispense it?
- Will the Commonwealth Government (through the TGA) allow the drug to be imported and dispensed?
- Will the drug be on the PBS?
- If not on the PBS, what will be the fee to access it?
- Who will credential this scope of practice?
- What are the known risks and complications?

[3] *RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017* page 2 accessed at https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf on 20 September 2017.

Before legislation is enacted, it is important that the community has information about the proposed lethal substance, how it will be sourced, its efficacy, the risks and benefits.

International reports have identified that complications of medically assisted dying are under-reported, however in those countries where assisted dying or euthanasia have been legalised there are reports of patients vomiting under sedation, having seizures, of people who wake up having taken medications they expected would end their life and patients who take up to four days to die after the administration of lethal drugs.[4]

In some cases oral drugs fail to be effective and have to be followed by intravenous drugs directly administered by clinicians. Until the protocols that will be used to undertake medically assisted dying have been shown incontrovertibly to be 'safe' and effective the legislation is premature. Safeguards in the legislation are not the same as having safeguards in place to ensure the safe introduction of clinical practices in accordance with existing standards. The latter should be our first priority.

If the substance is not effective in bringing about the death of the person through self-administration or administration by their nominee, what are the obligations of clinicians in this situation?

The Bill is not clear. Clause 29 (3) purports to protect a medical practitioner and a health care facility operators if s/he

> (a) provides the assistance, or
> (b) is a designated health practitioner and administers an authorised substance to the patient, or
> (c) prepares, sells, possesses or supplies an authorised substance to be administered to the patient in accordance with a request for assistance under this Act, or

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[4] See for example, Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA.* 2016;316(1):79–90. doi:10.1001/jama.2016.8499; accessed at http://jamanetwork.com/journals/jama/article-abstract/2532018 on 10 August 2017. Problems and complications are discussed on page 86 as follows:

> There are no flawless medical procedures; all procedures and interventions can have complications. Determining the rate of problems and complications related to euthanasia and PAS has been challenging because of definitions and the lack of witnesses. For several years, Oregon reported no complications. Between 1998 and 2015 (average number of deaths per year, 55), Oregon reported absence of data on complications for 43.9% of cases, no complications for 53.4%of cases, and regurgitation of medication in 2.4%of cases as the sole complication. The state reported that between 2005 and 2012, 6 patients (0.7%) regained consciousness after ingesting the lethal medications but paradoxically does not classify this as a complication. The median time between ingestion of barbiturate and death was 25 minutes, but the range extends to 104 hours—more than 4 days. The number of prolonged deaths—those taking longer than a day—is not reported in Oregon. In Washington state, for 2014 and 2015 combined, the data are less complete. For the 292 reported cases, 1.4% of patients regurgitated the medications, and 1 patient experienced a seizure. It is unclear if any patients in Washington state regained consciousness. Only 66.8% of patients died in less than 90 minutes, while the range extends to 30 hours.
> A comprehensive 2000 study of problems and complications in 649 Dutch cases (prior to the actual legalization) revealed a higher frequency of problems with PAS than with euthanasia. Technical problems with PAS, such as difficulty swallowing, occurred in 9.6% of cases, and complications such as vomiting or seizures occurred in 8.8% of cases. In 1.8%of PAS cases, patients awoke from coma and in 12.3%of cases time to death was longer than anticipated or the patient never became comatose. For euthanasia, 4.5%of cases had technical problems, such as inability to find a vein for injection, and in 3.7% of cases patients had complications such as vomiting, or myoclonus. In 0.9% cases patients awoke from coma, and in 4.3% of cases time to death was longer than expected or the patient did not become comatose. These data are 16 years old, and 13 years of legalization may have reduced the complication rate. There are no data from other countries, including Belgium, on problems or complications with euthanasia or PAS.

(d) refuses or fails to provide life-saving measures to the patient at any time while a request for assistance is in force in relation to the patient under this Act, or
(e) is present when the assistance is provided by the primary medical practitioner, or when an authorised substance is self-administered by the patient or administered to the patient by a designated health practitioner, or
(f) destroys an unused authorised substance (under the supervision of the primary medical practitioner if the person is not the primary medical practitioner) or possesses the substance for that purpose, or
(g) does any thing required or permitted under Part 4.

Calvary submits that the Bill is not clear enough. If the substance is not effective in bringing about the death of the person through self-administration or administration by the designated practitioner, the obligations of clinicians in this situation are uncertain and open to multiple interpretations.

Calvary agrees with the Royal Australasian College of Physicians (RACP).

> *There are serious risks that outcomes may not always be certain and may be the opposite to what was intended. Possible scenarios include:*
>
> *- A medical practitioner in attendance when the patient ingests and the lethal dose of medication has not been effective*
>
> *- A medical practitioner in the Emergency Department receiving a patient who has ingested the medication but it has not resulted in the death of the patient – moreover, if there is uncertainty as to whether the patient intended to die, health professionals would be obliged to provide life saving interventions*
>
> *- A medical practitioner in the Emergency Department receiving a patient who has ingested the medication and the family request treatment because they do not agree with their decision to end their life*
>
> *- A paramedic called to a patient who has ingested the medication but it has not been effective*
>
> *- A paramedic called by the family to a patient who has ingested the medication because the family do not agree with their decision to end their life.*
>
> *Clear guidelines would have to be developed to assist and protect all individuals involved in the above scenarios before, during and afterwards.*[5]

Whether the outcome of the legislation under consideration is effective and safe will depend heavily on a thorough analysis and understanding of the efficacy and risks of the proposed lethal substance(s). What are they?

In addition, people will need answers to other questions they have.

- Will the assisted dying procedure (pre and post care) have an item number? If not, who will then pay for

[5] *RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017* page 11 accessed at https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf on 18 September 2017.

the assessments required? The individual or the state? Who will pay for access to a psychiatrist, which is compulsory?

- Who pays for the administering of substance when it is taken?
- If the state of commonwealth government is paying, how many medical, psychiatric or psychological assessments can you have? If you have one assessment, then withdraw your request only to make a new request at another time, can you have other assessments? Or will access be capped?

The most recent version of the Bill attempts to ensure that the patient who is seeking to access the lethal substance understands some of the risks and complications.

For instance, clause 5 (2) of the Bill states

> (2) A ***designated health practitioner*** is a registered medical practitioner, or a nurse, whose registration under the Health Practitioner Regulation National Law in the relevant health profession is endorsed under that Law as being qualified to administer, obtain, possess, prescribe, sell, supply or use a substance included in Schedule 8 to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* of the Commonwealth.

Clause 13 of the Bill states

> **13 Standards for provision of assistance**
>
> In providing assistance to a patient under this Act, a primary medical practitioner is to be guided by appropriate medical standards and such guidelines, if any, as are prescribed by the regulations, and must consider the appropriate pharmaceutical information about any authorised substance to be given or administered to the patient.

And finally, Clause 19 (1) (c) requires the primary medical practitioner to provide the patient with information in writing "relating to the consequences of the administration to the patient of an authorized substance, including the risk and possible adverse consequences of the administration not resulting in the death of the patient."

While this is a step in the right direction, Calvary submits that these clauses are no substitute for informing the community as a whole, **before legislation is enacted**, about the proposed lethal substance, how it will be sourced, its efficacy and all the risks associated with this substance.

2. Who will assist patients (to die) and how will this be done?

The legislation is structured on the basis that self-administration of the lethal dose is the norm. If a person cannot self-administer, a medical practitioner can administer the substance. Clause 5 of the Bill states:

> **5 Provision of assistance**
> (1) A primary medical practitioner ***assists*** or ***provides assistance*** to end a patient's life if the medical practitioner does any of the following for the purpose of, or in connection with, ending the patient's life:
> (a) prescribes and prepares an authorised substance for the patient,
> (b) gives an authorised substance to the patient for self-administration,
> (c) if the patient is physically incapable of self-administering a lethal dose of an authorised substance—administers the substance to the patient or gives the substance to a designated health practitioner for administration to the patient.
> (2) A ***designated health practitioner*** is a registered medical practitioner, or a nurse, whose registration under the Health Practitioner Regulation National Law in the relevant health profession is endorsed under that Law as being qualified to administer, obtain, possess, prescribe, sell, supply or use a substance included in Schedule 8 to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* of the Commonwealth.
> (3) A ***designated health practitioner*** does not include any person who is a close relative of the patient.

The Royal Australasian College of Physicians (RACP) has identified two scenarios, "*relating to administration of a lethal drug by the patient, which have not been considered fully considered"* which include:

- *The patient ingests the medication by self-administering it into a feeding tube;*
- *The patient is physically unable to take the medication but is able to independently direct a machine to administer the medicine.*[6]

Clause 5(c) of the legislation is unclear about what is to happen if a person cannot ingest the substance orally or through a feeding tube. What regimen and what substances are to be used in these circumstances?

Does "prepares" in Clause 5 (1) (a) include preparing medications to be administered intravenously?

If so, there is no discussion either of the regimen to be used nor the drugs required. A patient will likely be required to take a chain of increasingly strong medicines including: a drug to prevent vomiting; a drug to reduce anxiety; and then a lethal drug to stop their breathing. Evidence from overseas shows complications can include: seizures, failure to induce coma, and a longer than anticipated death, requiring a physician to euthanize the patient.

The Canadian regimen uses an intravenous system with five separate drugs administered. See Appendix.

a. Midazolam – for sedation (also used in colonoscopy, etc.)
b. Lidocaine – to anaesthetize the vein because the third injection can cause pain.
c. Propofol – an anesthetic agent to induce deep sedation (myocardial and respiratory depression)
d. Rocuronium – to paralyse muscles so breathing ceases
e. Bupivicaine – to stop the heart.[7]

This is a complex regimen. As noted above, many things can go wrong. It is essential to make clear who will do the administration and what training they will have.

If drugs are not administered appropriately, the person seeking VAD may end up being conscious, paralysed and unable to breathe; surely the opposite of a compassionate end.

Once doctors understand what is actually required of them to administer a lethal dose of medication, they may be less willing to participate.

Other concerns

The VAD legalisation involves a **social issue, not a health issue**. Its introduction will, however, have **significant impacts on our health system** which haven't been considered.

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[6] *RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017* page 5 accessed at https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf on 18 September 2017.

[7] See University Health Network (UHN) *Medical Assistance in Dying Framework* accessed at http://www.psychiatry.utoronto.ca/wp-content/uploads/2016/06/MAID-Framework-Aug-6.pdf on 10 August 2017. The protocol is available at http://www.uhn.ca/healthcareprofessionals/MAID/Pages/MAID_intervention_process.aspx

The premise behind the proposed legislation is that it is an individual's right, and is being proposed for a small minority of the population. It is expected that the majority of people who request VAD will do so in terms of concerns relating to independence, dignity, fear of being a burden rather than issues related to symptom management.

There has not been a *targeted* consultation with the health sector, who will be responsible for overseeing and administering this system change; nor the Commonwealth who have responsibilities for aged care services, primary care, policy leadership for palliative care and workforce training.

Calvary believes that the VAD legislation amounts to a sweeping societal reform that is being introduced without understanding all the consequences.

Some of the consequences which need further thought may be summarised as follows:

- A 48 hour cooling-off period (proposed in Clause 12) is far too short given the nature of the decision being made.
- Clause 18 (1) (a) of the legislation requires that 'in the medical practitioner's opinion, the patient is suffering from a terminal illness'. Clause 4 of the Bill states: "A terminal illness is an illness that will, in reasonable medical judgment, result in the death of the person suffering from the illness within the next 12 months." As the *RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017* points out, determining how long a person has to live is not an exact science and is a challenge even for the most qualified doctors. At one year, the margin for error in prognostication significantly increases and many clinicians would find it this a difficult assessment to make. Patients are at risk of ending their life when they could potentially have several more years to live.[8]
- There is very poor death literacy within the community. Most people don't know what palliative care is, even fewer people have completed advance care plans, yet with this legislation the people of NSW will be expected to make informed choices about accessing VAD.
- The proposed legislation is silent on families being involved in the decision making process. As a specialist palliative care provider, Calvary deals with conflict within families and the decision making process at the end of life on a frequent basis. How is this to be managed?

[8] "Being confident of a 12 month lifespan on an individual basis is very difficult. As expressed in a recent systematic review, accurate forecasting is (nearly) impossible for a number of reasons explained below.
Prognostication is generally a variable skill not only affected by patient factors but also level of clinician experience, duration of relationship with the patient and whether it is done by an individual or a multidisciplinary team. It is based on statistical data which will only apply on average. Therefore if a certain group of patients have a 12 month expectation of life, a significant proportion will die before this time and a significant proportion afterwards. Studies are also heterogeneous. Most studies have been in the cancer population and there are studies in the non-cancer population where forecasting is even more inaccurate. As described in the review, there are also varying types of estimates (continuous, categorical, and probabilistic) and of the three estimates, probabilistic "may be slightly more accurate than categorical or continuous". The Bill is using the least accurate method to draw judgments which are uncertain in nature.
Studies show that clinicians are more likely to overestimate than underestimate survival."
RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (NSW) July 2017 page 4 accessed at https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf on 18 September 2017.

- As a society we are making every effort to counteract suicide, yet we are now proposing legislation that would recognise that some suicides are acceptable and that health professionals will assist in that process. We already know the impact that suicides have on families and those close to the individual.
- Rigorous care needs to be taken in determining how the vulnerable will be protected; legislation needs to takes **into account signs of risk factors for the coercion or abuse of persons who are dependent on the care of others** – such as family violence, substance abuse, gambling addiction and mental health issues.
- The legislation needs to be make clear who will be responsible for providing family support, counselling and conflict mediation, bereavement counselling for people choosing VAD.

Doctor-Patient and Patient-Hospital and Clinician-Clinician Relationships

- The VAD legislation potentially changes the role of the doctor in our society. By asking our doctors to participate in this process we are potentially **undermining the patient/family trust**; **not just in doctors but our health care system**.
- **What is the potential impact on the access of vulnerable populations to health services**? Will they be further marginalised through fear of a system that is perceived to support gravely ill people to end their lives?
- Nearly 50% of deaths occur in a hospital. Will patients be able to access assisted dying in a hospital setting? What are the implications for both public and private hospitals? How will health services deal with other patients who object? What safeguards are needed for staff? Similar concerns will arise in aged care settings.
- How will health workers work side by side with each other if there is difference in opinion? One colleague is willing to participate in assisted dying work, the other is not. How does this affect the team? Will this be detrimental to patients? What skills will be needed to manage this?

Issues related to good end of life care

Access to palliative care is not universal nor equitable across the state. Under the proposed legislation patients are to be made aware of what palliative care is available to them and offered a referral. What happens if someone lives where palliative care is not available? What is the approach that will be taken? How will people meaningfully engage with any palliative care options? What if the primary and secondary medical practitioners have little knowledge about or experience of the practice of palliative care?

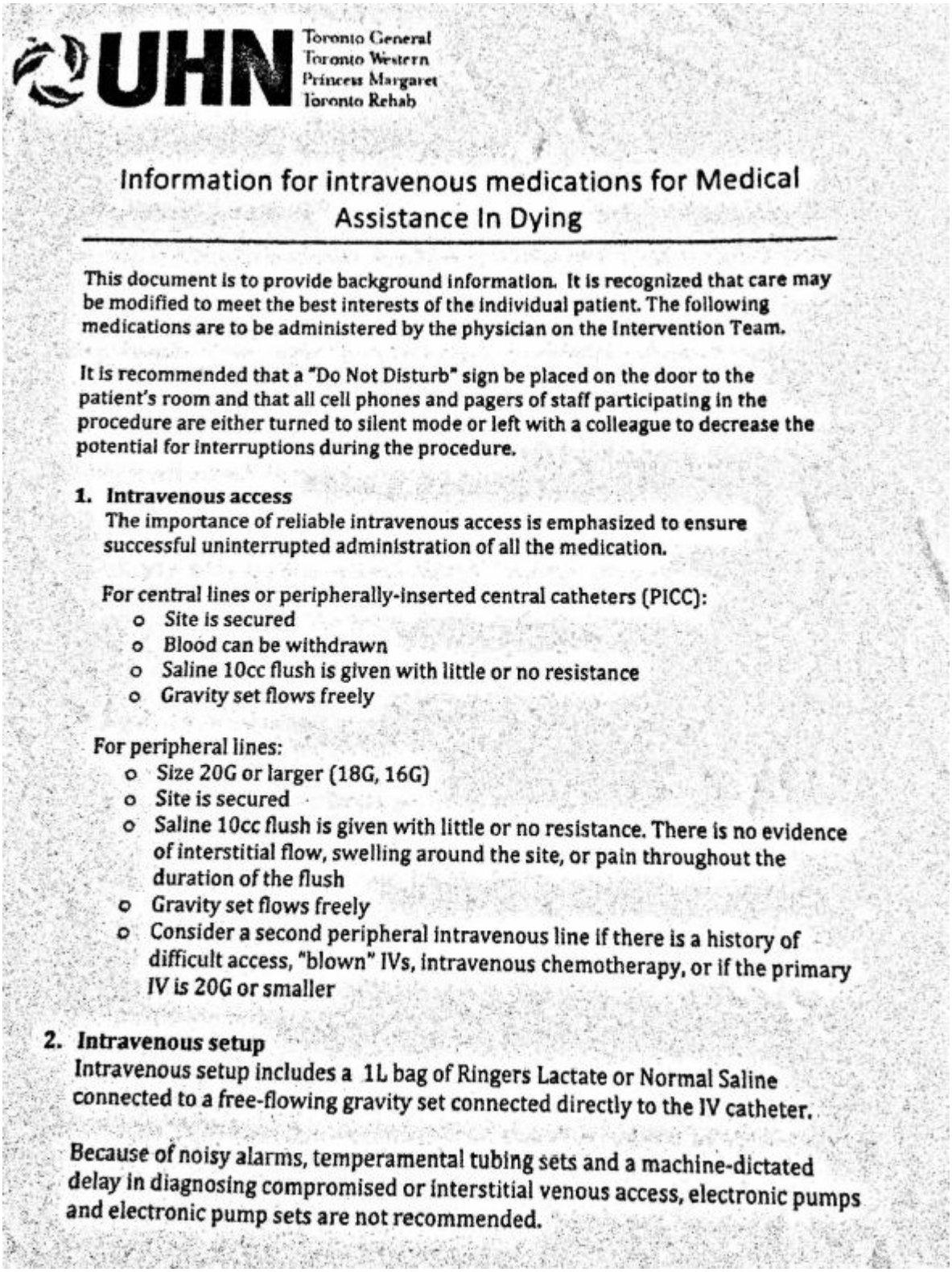
Concluding remarks

As a significant provider of health care in NSW, we raise these concerns with you because of the ramifications of proceeding with legislation before all the major questions have been answered. In particular, it is important to know and to have evaluated the efficacy and risks of the lethal substance which will be used. It is important to know exactly what will be involved if a doctor is to assist another person to end their own life.

Calvary submits that it is not in the public interest to proceed with the legislation. Given the social significance of the proposed law, good public policy development suggests that all the major questions are addressed before enacting legislation.

The Hon. John Watkins, AM
Board Chair
5 October 2017

Appendix



UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab

Information for intravenous medications for Medical Assistance In Dying

This document is to provide background information. It is recognized that care may be modified to meet the best interests of the individual patient. The following medications are to be administered by the physician on the Intervention Team.

It is recommended that a "Do Not Disturb" sign be placed on the door to the patient's room and that all cell phones and pagers of staff participating in the procedure are either turned to silent mode or left with a colleague to decrease the potential for interruptions during the procedure.

1. **Intravenous access**
   The importance of reliable intravenous access is emphasized to ensure successful uninterrupted administration of all the medication.

   For central lines or peripherally-inserted central catheters (PICC):
   - Site is secured
   - Blood can be withdrawn
   - Saline 10cc flush is given with little or no resistance
   - Gravity set flows freely

   For peripheral lines:
   - Size 20G or larger (18G, 16G)
   - Site is secured
   - Saline 10cc flush is given with little or no resistance. There is no evidence of interstitial flow, swelling around the site, or pain throughout the duration of the flush
   - Gravity set flows freely
   - Consider a second peripheral intravenous line if there is a history of difficult access, "blown" IVs, intravenous chemotherapy, or if the primary IV is 20G or smaller

2. **Intravenous setup**
   Intravenous setup includes a 1L bag of Ringers Lactate or Normal Saline connected to a free-flowing gravity set connected directly to the IV catheter.

   Because of noisy alarms, temperamental tubing sets and a machine-dictated delay in diagnosing compromised or interstitial venous access, electronic pumps and electronic pump sets are not recommended.

All other intravenous infusions should be discontinued to avoid backflow of medications.

Run IV at 50-100mL/hr until time of injection, and then run "wide-open."

3. **Medications**
   - The pharmacy department will prepare two complete kits including all pre-filled syringes labeled as described below. The kits will be dispensed from the pharmacy department by a pharmacist to a member of the MAID team on a patient-specific basis pursuant to a prescription from the intervention physician that has been verified by a pharmacist.
   - Physician to administer all medications completely , sequentially and rapidly as detailed below with minimal or no delay between syringes .
   - If a gravity set is not used consider flushing with 10mL of saline after every syringe.
   - Midazolam 10mg (1mg/mL = 10mL). Use 10mL syringe. Label as
     Syringe A: midazolam
     For deep sedation/coma
     Consider Aadvising those who are present that the patient may gasp following administration of this medication.
     Inject over 10 seconds
   - Lidocaine 2% 100mg (20mg/mL = 5 mL). Use 5mL syringe. Label as
     Syringe B: lidocaine
     Necessary for peripheral venous access only
     For reduction of discomfort on injection of propofol
     Inject over 5 seconds
   - Propofol 1000mg (10mg/mL = 100mL). Use two 50mL syringes. Label as
     Syringe C: propofol and **Syringe D: propofol**
     For induction of coma, myocardial depression, respiratory depression, and vasoplegia
     Warn the patient that there may be some discomfort on injection, and that the goal of lidocaine is to relieve this but some patients may still experience pain.
     Consider advising those who are present that after the injection is completed an assessment of awareness will be completed.
     Inject each syringe continuously and promptly over 30 seconds
     After completing the injectios, check eyelash reflex and whether there is any response to verbal stimulus. If there is no response to stimuli then proceed to injection of rocuronium.
   - Rocuronium 200mg (10mg/mL = 20mL). Use 20mL syringe. Label as
     Syringe E: rocuronium
     For muscle paralysis

Consider advising those who are present that cardiac arrest can occur up to 20 minutes after respiratory arrest has occurred. In other words, the patient's heart may continue to beat for some time after the procedure is complete.
Inject promptly over 5 seconds

Rocuronium should always be administered after propofol, even if respiratory and/or cardiac arrest has already occurred with propofol alone.

A minimum of time should elapse between the administration of midazolam, lidocaine and propofol, i.e. these should be administered in a short sequence.

Painful stimuli (e.g. sternal rub, trapezius squeeze, pressure on orbital bone or nailbed) should be avoided as these may cause distress to those who are present, and are likely unnecessary.

Should there be a response to stimuli, do not administer rocuronium. Instead, administer a further:

- Midazolam 10mg (Syringe 1)
- Propofol 1000mg (Syringes 3 and 4)

Then check for response to stimuli. If there is none, then administer rocuronium 200mg (Syringe 5)

- Bupivicaine 0.5% plain (5mg/mL = 80 mL). Use 2x 50mL syringes. Label as **Syringe F and G: bupivicaine**
  For inducing asystole
  Inject continuously and promptly over30 seconds per syringe

It is anticipated that all of the prefilled syringes will be used for each patient . For whatever reason should this not be the case (e.g. patient changed their mind to proceed) ensure all unused pre-filled syringes are returned to the pharmacy department for proper tracking and disposal.

Step	Syringe Label	Drug	Rate of administration
1	Syringe A	Midazolam	Over 10 seconds
2	Syringe B	Lidocaine	Over 5 seconds
3	Syringe C	Propofol (1 of 2)	Over 30 seconds
4	Syringe D	Propofol (2 of 2)	Over 30 seconds
5	*confirm coma achieved*		
5b	If still responding to stimuli, administer second set of midazolam and propofol from second kit		
6	Syringe E	*Rocuronium	Over 5 seconds
7	Syringe F	Bupivicaine (1 of 2)	Over 30seconds
8	Syringe G	Bupivicaine (2 of 2)	Over 30 seconds

* **Rocuronium should only be administered once coma is ascertained**