6 June 2021

Hon. Stephen Wade, MLC
Minister for Health and Wellbeing

Via email: ministerforhealth@sa.gov.au

Dear Minister,

RE: Calvary Health Care's response – proposed amendments to Voluntary Assisted Dying Bill 2020

On 10 May 2021, I wrote to advise of Calvary's opposition to the adoption of the *Voluntary Assisted Dying (VAD) Bill* currently before the Parliament. On 26 May I wrote to all MHAs a second time in response to the document on Institutional Conscientious Objection provided by Wellbeing SA through your office to every Parliamentarian on 21 May 2021. I am grateful for the responses we received from several MHAs.

We have reviewed with care your letter (MHW-H21-2947) dated 31 May 2021 requesting any feedback or comments as input to your involvement in Parliament's consideration of the above Bill in relation to two (2) amendments as follows:

- a draft amendment for the South Australian Bill reflecting the Queensland approach (the *Queensland amendment*) and
- an alternative approach is being put forward in amendments to the Bill tabled by Mr Steve Murray MP, Member for Davenport (the *Murray amendment*).

Calvary's overarching position

As you know, Calvary is a significant provider of health care and community care services and has served the South Australian community for more than 120 years.

Calvary's position on euthanasia and *VAD* is unchanged. As stated in our letters to every MHA dated 10 May and 26 May 2021, if the Bill is passed, Calvary cannot participate in Voluntary Assisted Dying and will conscientiously object to the scheme.

For the sake of clarity, certainty and business continuity, if the South Australian Parliament is determined to proceed with a VAD scheme, a right to organisational non-participation needs to be on the table.

Calvary's position on the proposed amendments

I am grateful for the opportunity to address the possibility of an institutional conscientious objection (ICO) clause in the Bill and the possible form it may take. As I understand, the options currently being considered are:

- That the Bill remains silent on ICO, much like the Victorian VAD legislation which has addressed ICO in policy.
- Adoption of the *Murray amendment*, which proposes, *inter alia*, offering a service provider the right to refuse to authorise or permit the carrying out of any part of the voluntary assisted dying process in relation

to any resident or patient on the premises and requiring the service provider to undertake reasonable steps to transfer the patient or resident to another facility that offers VAD should they request it. Calvary could work within the constraints set out in this amendment.

- Adoption of *Queensland amendment* (included as an attachment to your letter) sets up a distinction between permanent and non-permanent residences of facilitates. Particularly in the case of permanent residents the amendment requires cooperation of the facility and the facility's staff to such a degree as to amount to coercing such services into the provision of VAD. That there will be difficult cases, potential instances of conflict and recourse to the courts (if this amendment is agreed) is both unnecessary and objectionable. In particular, clauses 12E (3)(b), 12F (3)(b), 12G (2)(a) and (3)(b) and 12H (2)(a) and (3)(b) not only negate ICO, they effectively restrict individual conscientious objection.

Calvary preferences the *Murray amendment* and would prefer that the legislation is silent on ICO rather than incorporate the *Queensland amendment*.

Accordingly, the focus of this letter is to provide an analysis of the effects of the *Queensland Amendment*.

Why the *Queensland Amendment* is highly problematic for Calvary

Clauses 12E (3)(b), 12F (3)(b), 12G (2)(a) and (3)(b) and 12H (2)(a) and (3)(b) would create conditions in which an external medical practitioner who has no knowledge of a Calvary service, no decision-making authority within that Calvary service, and no responsibility to that Calvary service, its staff, or the people under its care *to authorise themselves to enter and provide a VAD related service*.

This is simply incongruous. No service and no hospital would pass accreditation standards if they allowed such behaviour in normal circumstances. What possible reason is there for creating and attempting to permit such a scenario simply because VAD has been legislated for?

If government cannot guarantee our governing bodies, our employees, or those we care for that we can act according to requisite standards and our commitments, then there is a serious question about our enduring viability.

Calvary makes this point because if the government and the community are to continue to benefit from the provision of services organisations provide *according to their ethical commitments*, then there is a corresponding duty to protect these organisations from being coerced to act in a way that is fundamentally *inconsistent with these commitments*.

For that reason, the state has a broader duty to the community it serves to ensure that such organisations are able to object to involvement with VAD. These organisations should of course be required to have clear processes in place to ensure that they do not impede a person who is seeking after a service which they do not provide, within which a commitment to facilitate transfer is reasonable, and that they will not withdraw their care from someone in their care merely because that person is considering VAD. This is Calvary's approach in Victoria. This is the advantage of the *Murray amendment*.

A much more detailed analysis of and submission in relation to the *Queensland amendment* accompanies this letter.

Concluding remarks

Calvary invests significantly to provide health and aged care services in South Australia.

Calvary wishes to continue to contribute to the long term comprehensive, quality and timely health care of South Australians by investing in present services and future developments.

However, **Calvary needs certainty that our services will not be forced by legislation to permit actions that are**

inconsistent with our fundamental ethic of care.

Please direct any questions you may have to Calvary's National Director of Mission, Mark Green:

E: Mark.Green@calvarycare.org.au
P: (02) 9258 1733 M: 0439 828 523

Yours faithfully,

Jim Birch AM
Chair
Little Company of Mary Health Care Ltd.
(Calvary Care)

Calvary Health Care's response – A detailed analysis of the *Queensland amendment*

Introductory Remarks

Until now private facilities have been permitted to offer services to the State which are within their competence and align with their purpose to provide. It would be risky to try to make each and every private facility provide *every* health and aged care service the South Australian community needs or desires.

The COVID-19 pandemic has highlighted the value of diversity and plurality in service types and the particular genius of a health and aged care system which addresses the multiple of complex needs of the community in a variety of ways. This has been a strength of our health care system.

Many who advocate for the introduction of euthanasia are singularly passionate and determined to ensure this option is legally available to the community. They are less focused, Calvary submits, on considering how their goals can be achieved without creating risks to other services that the community needs from the health care system.

Such risks can be mitigated if the State actively funds, offers and employs people to provide a VAD service. Those facilities which offer VAD would identify themselves and people who desire this service would seek the service there.

The University of Tasmania's (UTAS) *Independent Review of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020* (on page 81) observes that 'the issue of organisational non-participation was one of the most complex considered by the Review Panel'. The report continues,

> **No organisation or entity should be compelled to participate in or provide VAD even though non-participation limits access, may compromise therapeutic relationships and, where transfers are required, may exacerbate suffering.**

Key principles set out in Clause 8 (1) of the Bill are

> (e) a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained;
>
> . . .
>
> (g) individuals should be supported in conversations with the individual's health practitioners, family and carers and community about treatment and care preferences;
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> (h) individuals are entitled to genuine choices regarding their treatment and care;
>
> (i) there is a need to protect individuals who may be subject to abuse;
>
> (j) all persons, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

These principles are as valid for individuals and institutions who do not want or desire euthanasia as they are for those who advocate for VAD.

***Queensland Amendment* negates ICO**

If enacted, the *Queensland amendment* would not grant organisations a positive right of non-participation in voluntary assisted dying but rather, in its effect, **remove any right** that an organisation may already have, whether explicitly or implicitly.

Calvary does not offer and will not offer the service of Voluntary Assisted Dying. We are not capable, equipped nor constituted to do so.

Two major risks

The *Queensland amendment* creates two risks which we will need carefully to consider.

1. The risk of breaching the law of the land (which Calvary cannot do); and
2. the risk that we will need to cease to provide particular services, including residential aged care, which we submit will be a tragedy and the loss of a significant good in South Australian society.

Effect on Calvary's private hospitals

The *Queensland amendment* will require Calvary's three hospitals that do not provide VAD services to allow medical practitioners onto the premises to make decisions **which override** any decisions by the admitting doctor (the hospital doctor in charge of that person's care during the hospital admission). This privilege is to be extended to the administration of the VAD substance itself.

To be clear, the amendment is creating a circumstance in which an external medical practitioner – who has no knowledge of a service, no decision-making authority within that service, and no responsibility to that service, its staff, or the people under its care – will be authorised under the VAD Act to enter and provide a VAD related service, and to override decisions of (or make decisions in lieu of) the medical practitioner who is *directly responsible for a patient's care and wellbeing*.

This is a breach of duty of the care protocols that are essential to the high quality and safe care we provide in Australia. This would be unprecedented and should not be contemplated in any circumstance.

Notwithstanding this breach of ordinary medical practice in hospital settings, the amendment could require hospitals to accredit particular medical practitioners for the specific and explicit purpose of providing VAD services on their premises.

In the case of Calvary services, our accreditation process requires medical practitioners to agree to abide by our *Code of Ethical Standards* whilst providing care on behalf of, or within, our services. Authorising medical practitioners in this way constitutes an unacceptable level of involvement in VAD in our services. Furthermore, the provision of such a service in a hospital setting – and a residential setting – necessarily involves all staff involved in the provision of that person's care in the hospital and directly compromises their right to individual conscientious objection. Calvary cannot be part of this.

Effect on Calvary's aged care services

The *Queensland amendment* raises similar prospects of requiring the complicity of the entity where VAD services are to be provided in an aged care facility. Examples include:

- circumstances where the coordinating and consulting medical practitioners need to make enquiry as to the person's decision making capacity and whether they are acting freely and without coercion – such enquiry, should it be carried out purposefully, would require the involvement of the facility's care team, which would draw them into the VAD process in a problematic way; and
- circumstances where drug storage protocols require the central storage of medicines and other substances (including VAD substances) for reasons of safety would require the involvement of facility staff in a problematic way.

Conflict of laws

We have read Chapter 20 of the report of the Queensland Law Reform Commission (*QLRC Report)*. We note the recommendations 20-1, 20-2 and 20-3 on page 647. We remind the Government of South Australia that residential aged care is regulated under a Commonwealth Act and that providers are required to adhere to standards proscribed by Commonwealth authorities. The combined effect of the proposed Bill before the House of Assembly and the *Queensland amendmen*t may be to require our staff to abet suicide under Commonwealth

legislation. If this amendment is enacted, in an abundance of caution, Calvary may need to refer all VAD related deaths law compelled us to facilitate in a Calvary residential aged care service to the Coroner and self-report a potential issue of non-compliance to the Commission for Safety and Quality. In addition, the level of risk involved may necessitate recourse to the courts, particularly if there has been any history in a resident's life of elder abuse, coercion or clinical indications that a person is not able to act with full freedom or capacity.

A residential aged care facility cannot be equated to a private home in a suburban street

The other viewpoint put forward strongly in the *QLRC report* is that a person should be able to access a lawful end of life option in the privacy of their own home unless they have agreed otherwise, for example in the terms of any lease or similar binding contract (15.268). Calvary makes two observations.

The concept of 'home' needs to take account of the context and setting. And so does the provision of care.

A residential aged care facility simply cannot be equated with an individual's private home. There are multiple common areas, activities and services which bring different people together from the privacy of their own rooms into an experience of common life. The needs, desires, cultural background, religious preferences and age of each resident needs to be and is accommodated by the provider of care.

Once VAD is legislated, Calvary must continue to accommodate the differing sensibilities of its own mission, residents, staff, volunteers and visitors in its care.

The administration of the VAD substance in such a setting cannot be a private matter bounded by the bricks and mortar of a typical Australian residence.

The concept of 'home' needs to take account of the context and setting. And so does the provision of care. For this reason, to legislate a requirement that the administration of the VAD substance of a resident must take place in the residential aged care facility if this is what is requested by that individual is short-sighted. The legislative imperative (as proposed in clause 12H (2) for example) undermines all the other obligations which a provider like Calvary must balance and to which, in other cases, must adhere. The *Murray amendment* is far more cognisant of the actual situation with which a provider like Calvary must balance.

The *Murray amendment* reflects the approach of the New Zealand High Court

We refer to the decision of the High Court of New Zealand (*Hospice New Zealand v Attorney General* [2020] NZHC) cited in the report of the Queensland Law Reform Commission (*QLRC Report)* at 15.33 to 15.37. We reproduce two paragraphs in full:

> 15.36 In considering these issues, it was accepted 'that an organisation may well have an entrenched moral ethos through which it operates' and that 'so far as is practicable, an organisation should have the benefit of the right to freedom of conscience and to hold its opinions free of interference'. The Court held that the [NZ] Act does not require organisations to provide assisted dying services. It does not prevent an organisation from excluding assisted dying from its services or from the work of health practitioners employed by the service, as long as practitioners can also comply with their obligations under the Act. It was observed that it may be possible to put into place guidelines about this matter.
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> 15.37 The Court added:
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> > Hospices or other organisations that choose not to offer assisted dying services may employ or engage health practitioners on the basis that these services are not provided by the hospices or organisations, but it will also be necessary to have arrangements for how health practitioners can comply with their objections (sic) under the End of Life Choice Act if a request is made of them by a person in the hospice or organisation's are.

Calvary submits that this is the best approach. The *Murray amendment* better facilitates such an approach to

managing the obligations of a service provider like ourselves if the VAD Bill is enacted by the Parliament of South Australia.

QLRC Report objections to the *Murray Amendment* refuted

Calvary observes the QLRC discusses the approach proposed in the *Murray amendment* in paragraphs 15.48 to 15.60. We quote paragraphs 15.59 and 15.60 in full.

> 15.59 Where the criteria mean that access to voluntary assisted dying will occur inside the objecting institution, the authors submit that the legislation should provide that access must be permitted by the institution. This is based on the view that a person's claim to access voluntary assisted dying outweighs an institution's objection when both outcomes cannot be achieved. Unless this approach is taken, the authors argue that it would effectively mean that 'a person who is unable to be reasonably transferred or leave the institution for periods to access [voluntary assisted dying] would be prevented from accessing [voluntary assisted dying] by an institution that is objecting'.
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> 15.60 Therefore, they propose that legislation should state that, where transfer is not possible or unduly harms the person's interests, an objecting institution will be required to permit a person to access voluntary assisted dying within the institution and will take reasonable steps to allow this. ***This may include permitting existing staff who are willing to be involved in conducting assessments or administering the medication to the person or allowing other doctors to visit the person and provide the assistance required.*** In addition, the institution would not be allowed to impede a person self-administering the medication when its administration is authorised by the legislation. (Emphasis added.)

Calvary makes the following submissions.

1. Plurality and access to diversity in choice are the hallmarks of a just and fair society.

The notion that a person's claim to access voluntary assisted dying outweighs an institution's objection when both outcomes cannot be achieved is absurd. The institution itself comprises human beings – staff members, volunteers and residents/patients all of whom have legal and human rights. How does one person's preference for a particular good (euthanasia) *outweigh* another person's preference for a different good (palliative care and no euthanasia)? What definition of the peace, order and good government of a State requires any institution to offer every conceivable good that may be desired? Plurality and access to diversity in choice are the hallmarks of a just and fair society.

2. Unprecedented changes in the practice of health care

The *Queensland amendment* is predicated on the basis that Calvary will permit existing staff who are willing to be involved in conducting assessments or administering the medication to the person or allowing other doctors to visit the person and provide the assistance required. As stated above our *Code of Ethical Standards*, our by-laws and our policy framework do not allow our staff to be involved in euthanasia. No doctor who is not credentialed can practice in a Calvary hospital. No doctor can be credentialed who does not abide by our *Code of Ethical Standards*. The effect of the *Queensland amendment* is to require us to change our constitution, our mission and our values or to risk being perceived to be in breach of the *Voluntary Assisted Dying Act* and subject to its penalties.

As we stated earlier, this is an unprecedented outcome in the practice of health care in this country and, Calvary, submits an egregious outcome. We concur with an academic quoted in the *QLRC report* as follows:

> 15.73 In summarising this issue, an academic submitted that:
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> > In a multi-faith, plural society respect for difference and diversity ought be demonstrated by recognizing that individuals and entities are different and not all can or ought be obliged to participate in every practice which the State has determined to make lawful.

When care cannot be provided Calvary already transfers care for the time required to meet the resident's or patient's needs

To be clear, Calvary is fully supportive of, and aged care accreditation surveyors have confirmed that Calvary does, facilitate consumer choice to a very high degree. The Charter of Aged Care Rights is effectively replicated in the Spirit of Calvary which informs all Calvary Models of Care. Calvary would refer a person seeking access to voluntary assisted dying to an alternative provider and to take steps to facilitate that person's transfer of care (*per* QLRC 15.166). Resident agreements between our care recipients and Calvary specify the care and services that Calvary has the capacity to provide. When this care cannot be provided we transfer care for the time required to meet the resident's needs.

The public funding argument

Those who advocate for the *Queensland amendment* observe that many entities receive public funding, that a provision to allow organisational non-participation and or institutional conscientious objection could be discriminatory and restrict choices and access to voluntary assisted dying for some people, and that the result of such a provision may be to give an entity to the capacity to object to voluntary assisted dying and then to transfer a person from a place that they consider to be their home.

Calvary observes that in the case of its residential aged care facilities, most 'public' funding is provided by the Commonwealth which does not require or allow VAD. Our normal practice is to transfer residents to service providers who can meet the many needs we cannot provide because of the nature of the residential aged care model (for example, acute health needs, mental health services, specialist medical services).

VAD is not within our competence

It can be very reasonably argued that if VAD is not a service within the competence of a residential aged care facility it will be better for a person who is insistent on access to VAD to be in the care of an organisation and surrounded by staff who have the capability and desire to assist the legally authorised practitioners to facilitate the consumption of the VAD substance. The combined effects of Clauses 15 and Clause 11 will in effect limit our capacity to provide effective care for a person considering a VAD request. Calvary could not credential or retain the services of a registered health practitioner authorised under Clause 15 of the Bill because the VAD service contravenes our *Code of Ethical Standards*. A good navigator service will assist all parties find the appropriate place.

Who has the responsibility to provide VAD?

As to the pertinent question of access to VAD, where the provision of a particular service is contested, it is the responsibility of *those who believe the service is a good idea* to assure access to it. This responsibility should not be placed on the shoulders of those who object to it. Therefore, government and participating providers should take responsibility for making VAD easily accessible if they believe it should be.

Concluding Remarks

The question of institutional conscientious objection is grounded in a long history of ethical practice as an expression of the living mission of an organisation. The question arises from a particular understanding by a particular community of leaders and practitioners of what is right and what is wrong in the practice of medicine. It is for this ethic that protection is sought. This ethic is that practitioners will not intentionally inflict death on patients, nor intentionally assist patients, residents or clients to take their own lives.

The decision of an individual, who resides in a particular community with a group of other individuals (such as a residential aged care service) to take a substance for the purpose of causing their own death affects these other people. Their decision impacts on the personal belief systems and values of others around them, including the

values of their carers who must necessarily be involved. All these people, who operate and live together in community can and do suffer moral injury and can experience moral distress. They can and may conscientiously object to being involved.

Making an action or a service legal does not necessarily create a right which binds every member of society to meet. Indeed, if Parliament wants the whole community to benefit from a service, the Parliament should ensure that the Government of the day provides that service or contracts the provision of that service by willing and competent persons or organisations. It would be unwise to force those not orientated or equipped to offer the requisite public service to provide that service. This has not been the practice of governments in this country to date.