10 May 2021

Calvary Health Care’s concerns regarding the *Voluntary Assisted Dying Bill 2020* (SA)

Implications of legislation legalising euthanasia

Calvary acknowledges the very difficult task before Honourable Members to make good decisions on behalf of all South Australians. Accordingly, we wish to register the very serious concerns we have with the *Voluntary Assisted Dying Bill 2020* currently before the House of Assembly.

Importantly, and given the Bill has been amended in the Legislative Council, we strongly recommend the need for—at the very least—a renewed and independent process of community and expert consultation.

Present Context

The *Voluntary Assisted Dying Bill 2020* is being debated at a time of COVID-19 pandemic and two Royal Commissions, each dealing with many examples of neglect and abuse of vulnerable people reliant on aged care and disability services in Australia.

These kinds of concerns are front and centre in the reports of the Royal Commission into Aged Care Quality and Safety and the ongoing work of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Vulnerability of the Elderly

The Royal Commission into Aged Care Quality and Safety found that the prevalence of elder abuse in Australian residential care is at least 39% not including financial abuse, social abuse and sexual abuse. The incidence of elder abuse puts pressure on frail aged people to see their lives as redundant and worthless. It is reported that this abuse mainly comes from family members. The Australian Institute of Family Studies (AIFS) reports that it is likely that between 2 per cent and 10 per cent of older Australians experience elder abuse in any given year and this increases with age. The prevalence of neglect is possibly higher.

It is one thing to respect personal autonomy; it is quite another to pass legislation where vulnerable members of the community may be led into a VAD death not by a genuine exercise of personal autonomy, but rather because they feel pressured to agree whether directly or indirectly through subtle social pressure—or, worse, are actually unaware of the nature of the process being undertaken by interested third parties “for” them.

Their incurable “disease, illness, medical or neurodegenerative condition” (Clause 13 (1) (d) and (4)) may serve to add to the sense of the burden they feel themselves to be. In ending their lives they relieve the suffering of those around them.

The clauses on decision making criteria (Clause 4), access to VAD (Clause 13) and Divisions 3 and 4 of the Bill do not require any assessment of a person's familial or social condition. In fact there is a presumption of decision making capacity. The fact that a person feels inward pressure or external coercion may never emerge. Outside a therapeutic relationship predicated on a continuity of care, the existence of subtle social pressure would not be detected.

Two recent Royal Commissions suggest that legislated safeguards designed to protect vulnerable people from abuse and neglect have been simply ignored.

We must ask ourselves: Have we done enough to mitigate against the real and present risk of elder abuse in our community; minimise the suffering associated with advanced disease; and ensured quality services to support ageing and dying with dignity before we allow people to give up on themselves and before we effectively give up on them, rather than fighting incisively and pointedly for the precious gift of life, and life with quality and meaning?

Surely there are other things, other areas formed on the principles of compassionate and genuine care that require immediate and dedicated work in South Australia.

In our work across six states and territories in Australia, we have developed considerable expertise in providing effective palliative treatments to care for those who are terminally ill and provide a positive end of life experience for them, their families and significant others in the community.

Our First Peoples

Aboriginal and Torres Strait Islander peoples have strong views about the importance of Elders, the importance of a person's journey at the end of life and the interconnection of this personal journey at life's end with the ongoing relationships with the community and the land. Our First Peoples find it difficult already to accept aged care services and palliative care. The distrust of Aboriginal people in health services will be further eroded by this legislation and this will hinder any improvement in Aboriginal health outcomes. Aboriginal communities have not been consulted about this legislation. It is understandable that they might find in this legislation another reason to stay away from the South Australian health care system.

Calvary's role in the Community

Calvary is a significant provider of health care and community care services in South Australia. We are a Catholic health and aged care organisation whose services have served the South Australian community for over 120 years. Our national LCMHC Board has always had a Director who resides in South Australia.

Our dedicated role in the South Australian community is to care for and alleviate the suffering of those in need. Our clinical reach is complete, with services from birth through to end of life care and everything in between. We operate three private hospitals, Calvary Adelaide (SA's largest private hospital), Calvary North Adelaide (a heritage site for South Australia) and Calvary Central Districts (caring for the Northern community); two retirement homes, Calvary Flora MacDonald and Calvary St Catherine's, Berri, together with a network of community care services. Our dedicated role in the South Australian community is to care for and alleviate the suffering of those in need.

Calvary has recently partnered with Medibank and SA Health in Wellbeing South Australia's (WBSA) My Home Hospital, an innovative home service for patients who may otherwise be hospitalised.

Consultation

The Government has not yet consulted stakeholders in relation to the proposed legislation to assess its impacts on their services. Certainly Calvary has not been consulted. And we are a major health care provider in this State.

Calvary invests approximately $400 million per annum to provide health and aged care services in South Australia. We operate 40% of the private hospital bed licenses. To date this year we have cared for more than 45,000 patients. We presently care for 219 palliative care inpatients and 242 patients in their homes. We are assisting over 5,800 community care clients in their homes. To date in 2020-21, we provided more than 305,000 occasions of service to these clients. We have 203 aged care beds and since January 2021 have cared for more than 300 patients in WBSA's My Home Hospital program.

On average, in last year of life patients access hospitals 4-5 times and Calvary provides a high quality alternative to the public system which is often overwhelmed.

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 including assurance, that our services are not forced by legislation to permit actions which are inconsistent with our fundamental ethic of care.

Calvary is a well-regarded community of healthcare practice

Calvary undertakes a significant experience survey process that tracks the patient experience of our service provision. This process culminates in a Net Promoter Score (NPS). At the time of writing our service in Calvary North Adelaide Hospital (where we operate the Mary Potter hospice and a community palliative care service) has a NPS of **88.7%**. In Calvary Adelaide Hospital we enjoy a NPS of **89.6%** and at Calvary Central Districts the NPS is **87.4%**. There is a reason why these NPS are so high.

Our hospitals are communities of practice. The mission, vision, clinical by-laws, policies and procedures both attract and bind all practicing in this community. Many people choose Calvary and other faith-based services precisely because there is a clear identifiable focus of purpose, an articulated code of practice, a strong and clear ethical and values-based proposition, a sense of continuity of care which is grounded in mission and is not dependent simply on the good offices of an individual practitioner. Our hospitals are valued by our patients, as the high NPS suggests.

Medical decision making is extraordinarily complex, involving multiple members of the health care team, the patient, the family, the social worker, and the administrators, among others. That is to say, health practitioners work in communities of practice. To simply allow only individual conscientious objection denies the existence of the need for a common purpose, which through a health facility's by-laws, codes, policies and procedures, bind all practicing in this community. Accordingly, the Bill needs to recognise not only the individual consciences of clinicians but also the discerning community of practice, embodied in the institution that determines both virtuous action and harm to be avoided.

Institutional Conscientious Objection

The imposition of VAD or any other practice or procedure on our services will violate the consciences of most of the individuals involved together with the decade's old institutional commitment to promoting and upholding critical ethical and other values. In fact, such an imposition would communicate that autonomy is valued only to the extent that one's autonomy aligns with that of the State. We are all strengthened when we nurture communities (including faith-based communities) where people can maintain a sense of personal coherence and integrity while making their contributions to the common good of all.

Calvary health and aged care services are not merely random assemblies of doctors, nurses, allied health professionals and administrators. Rather, they are collections of individuals drawn together by common purpose and values – a purpose that ultimately generates a distinct singular institutional identity, character, culture and purpose.

The conscience of Calvary institutions is rooted in the fact that our Trustees and our Board profess a set of fundamental moral commitments and compels coordinated acts in accordance with them. Calvary exercises its conscience by using these fundamental moral commitments when deciding on courses of action – for example, in the way it delivers health care. By extension, to fail in the conscientious application of this moral commitment would be to lose our integrity, character and purpose.

An institution's right to freedom of religion must naturally extend to expressions of that religion belief. Catholic health and aged care services operate under a *Code of Ethical Standards*, which includes a commitment to heal and never to harm. The Bill must recognise that to err from this moral commitment is to undermine the integrity and purpose of these services.

Clause 7(1)(j) of the Bill states

> all persons, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

The additional principle which flows from this is missing:

> all communities, including health facilities, have the right to be shown respect for their cultures, beliefs, values and communal characteristics.

Clarity of public policy

Out of respect for those who have a different view and for the sake of clarity, certainty and business continuity, a right to organizational non-participation needs to be legislated.

As a matter of public policy, it is desirable, if not essential, that patients accessing Calvary health care services have a clear understanding of what clinical practices will and will not be provided or permitted within these services. In our view this ought not merely be left at the level of contractual arrangements between the patient entering a service and the service itself. Rather, there ought be statutory recognition of the right of a health service to refuse to offer or to facilitate VAD processes within its premises. For this reason, a clause should be included in the bill enabling Calvary facilities - and indeed any other institutions, faith based or otherwise - to opt out of a voluntary assisted dying (VAD) processes on the grounds of conscientious objection. This would give greater certainty not just to clinicians and staff but to the wider community.

Respecting choice

The University of Tasmania (UTAS) *Independent Review of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020* (Tasmania) (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.

Our own experience in South Australia is that prior to choosing an aged care home, a prospective resident is often reassured by the knowledge that the environment in which they will be cared for until the end of their life is one that does *not* offer VAD. They make a choice based on that institution's declared values and purpose.

There may be instances where a patient has chosen to reside in a Catholic health care service knowing that VAD is not offered but then changes his or her mind. The question arises as to how the patient's own choice and autonomy may be reasonably accommodated.

Notwithstanding our fundamental philosophical objection to the introduction of any VAD bill, Calvary recognises that where a VAD scheme has obtained parliamentary approval, a statutory right of immunity from facilitating, assisting or enabling VAD on their premises should not prevent a patient from having access to VAD at another place in which VAD is enabled.

For that reason, we propose formalising - either in the law or in regulation – a protocol facilitating the transfer of patients or residents in our members' care to a facility that offers VAD should they so wish. Our ethic of care dictates that we will never abandon a patient, therefore we must and will respect the rights and needs of a patient or resident who is in our care and who chooses to avail themselves of VAD.

Concluding Remarks

If the Bill is passed, Calvary will not participate in Voluntary Assisted Dying.

Calvary's mission calls us to accompany people and relieve suffering and never to harm nor intentionally bring about the death of a person who is not dying.

We can continue to offer high quality palliative care and partner with other stakeholders who have similar objectives.

Calvary acknowledges the difficult task before Honourable Members. However, in an issue of such importance, and in the context of many differing values, we must be clear about our position on Voluntary Assisted Dying.

Calvary will continue to assist the Parliament in any way we can.

We look forward to discussing these matters with you in person.

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

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