ST VINCENT'S HEALTH AUSTRALIA

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Voluntary Assisted Dying Bill

St Vincent's Health Australia Submission

10 April 2017

St Vincent's Health Australia Ltd
ABN 75 073 503 536

Level 22, 100 William Street
Woolloomooloo NSW 2011

Telephone 02 9367 1100
Facsimile 02 9367 1199

www.svha.org.au

Table of Contents

1. St Vincent's Health Australia Response 1
1.1 About St Vincent's Health Australia 1
1.2 St Vincent's Health Australia's care for people at the end of their lives 1
1.3 Principles of St Vincent's Health Australia's Response to this Bill 2
2 Specific Responses 3
2.1 The Person/ Making a request 3
2.2 Conscientious Objection 3
2.3 Monitoring the Use of a 'Lethal Dose of Medication' and Attendance 4
2.4 After a Person has Died 4
2.5 Oversight 4
2.6 Support for Doctors 5
2.7 Availability of Palliative Care 5
2.8 Protection of the Vulnerable 5
2.9 Definitional issues: 'Euthanasia', 'Medication', and 'Voluntary Assisted Dying' 6

1. St Vincent's Health Australia Response

1.1 About St Vincent's Health Australia

St Vincent's has been providing health care in Australia for more than 155 years since the first hospital was established in Sydney in 1857 by the Sisters of Charity. When the first five Sisters arrived in Australia in 1838 they carried with them the vision of their Founder, Mary Aikenhead to reach out to all in need of care, especially in the service of the poor. In a newly established colony, the challenges were many and varied. There was a great need among the community for the particular gifts of Mary Aikenhead's Sisters – education, outreach and health care. This need was most keenly felt by those on the margins of the fledgling colony.

It is the legacy entrusted to us by the Sisters of Charity that continues to inspire St Vincent's Health Australia (SVHA) to strengthen and grow our mission. Today, we conduct services in Queensland, New South Wales and Victoria in public hospitals, private hospitals, and aged care facilities. We work with many of Australia's premier research institutes and universities, and we work in partnership with other Congregations and health care providers. Our 18,400 staff provide more than 1 million episodes of care for patients and residents each year. We stand with and serve those who are living on the margins of our society.

1.2 St Vincent's Health Australia's care for people at the end of their lives

The Bill under discussion has to do with responding to persons as they near the end of their lives. End-of-life care has been a core part of St Vincent's Health Australia's work since our early years. The Sacred Heart Health Service at St Vincent's Hospital Sydney, is Australia's oldest palliative care service, having been established by the Sisters of Charity in 1890 as a dedicated hospice for the terminally ill. Our Caritas Christi Hospice at Kew (Melbourne) was the first inpatient palliative care facility in Victoria, founded by the Sisters in 1938.

St Vincent's Hospital Melbourne's clinical services are multi-faceted and include 34 palliative care in-patient beds, a palliative care consultancy service, day hospice, out-patient clinics, and telephone advice services. St Vincent's Hospital Melbourne also jointly operates the Centre for Palliative Care with the University of Melbourne. The Centre has a state-wide role in palliative care education and research in Victoria, with networks and collaborative projects extending nationally and internationally.

St Vincent's Hospital Sydney offers a 39 bed inpatient unit and a 24 hour community and outpatient consultative service in Eastern Sydney which annually cares for around 700 inpatients, and a similar number of outpatients.

In Queensland, St Vincent's Private Hospital Brisbane operates the state's largest palliative care inpatient unit (30 beds) as well as a Specialist Palliative Care Community service for public patients with over 200 patients currently under their care. In a Queensland-first, St Vincent's Private Brisbane recently launched a two-year pilot program in partnership with the private health fund, Bupa, offering its Brisbane policyholders with access to specialist palliative care services and greater choice on their preferred care pathway and location to improve their quality of life.

In view of this, SVHA brings significant experience and a proven track record of excellence and innovation in end-of-life care to this current discussion.

1.3 Principles of St Vincent's Health Australia's Response to this Bill

As a Catholic healthcare organisation, SVHA holds the sanctity of human life at the heart of its approach to healthcare, and this informs all of its responses to those who are sick and vulnerable.

The proposed legislation fundamentally contradicts this principle, and so as an organisation we do not support it. We believe that the best way to respond to the vulnerability of those who are nearing the end of their life is to put more resources into palliative care and its aligned disciplines. Nonetheless, we appreciate that the Panel "will not consider feedback that expresses an opinion for or against assisted dying".[1] Hence, our response here focuses on issues that arise within the Discussion Paper. For the avoidance of doubt, no feedback that SVHA provides in this document should be interpreted as indicating support for any legislative changes to permit Voluntary Assisted Dying.

We also note our support for Catholic Health Australia's (CHA) and the Caroline Chisholm Centre for Health Ethics' (CCCHE) responses to the Discussion Paper submitted on behalf of the Catholic health sector.

[1] Voluntary Assisted Dying Bill Discussion Paper, v.

2 Specific Responses

2.1 The Person/ Making a request

The discussion paper notes that a "medical practitioner's assessment of capacity may, in some cases, involve referral to other disciplines when necessary in order to ensure potential influencing factors like co-existing physical symptoms, untreated mental conditions such as depression or anxiety, and family pressures or socioeconomic issues are appropriately assessed and managed". [2]

This is a particularly fraught area of the proposed legislation. The Parliamentary Committee also recommends that "The request must be voluntary and free of coercion" but does not specify what measures can be put in place to ensure this.

Ascertaining freedom in personal decision making requires assessment of personal impediments (such as individual psychological issues), relational pressure (such as implicit or explicit family preferences) or social pressure (such as current social conceptions of aging or the value of a sick person's life). Where such pressures exist, one cannot argue that a person is making a request in a way that is "voluntary and free of coercion". Leaving this assessment to individual doctors without more detailed criteria or processes places undue pressure on these professionals and is also open to exploitation. Furthermore, we note that 'capacity' as used in the document is a legal definition. Two problems emerge here. First, the use of this implies that medical professionals need to provide a legal opinion, as against a normal medical decision which would be made by a patient and would not reflect a judgment on 'capacity'. Second, clinical care experience demonstrates that different people in relationship with a patient will have different understandings of what 'capacity' means – there are no efforts in the document to address any such issues.

SVHA is also concerned that the proposed legislation does not make provision for an unbiased psychologist or psychiatrist always being involved in determining decision-making capability and intent. However, we note more rigorous assessment will likely be necessary given the complexity of the issues raised above. The Panel should consider this as part of its deliberations.

2.2 Conscientious Objection

SVHA supports the Parliamentary Committee's recommendation that "No doctor, health practitioner or health service can be forced to participate in assisted dying" and notes that SVHA as an organisation will be a conscientious objector to any such legislation.

However, nothing within the Discussion Paper is articulated as to how an organisation might conscientiously object and require that the objection hold for all those employed in its service, nor how any such objection would be able to be taken without pressure being placed on those who hold it (such as political pressure, funding pressure for organisations, and so on). Nor are there any indications of what supports would be available to individual clinicians who conscientiously object within organisations that support the legislation, or for situations wherein patient and family bring undue pressure on a doctor to comply with requestions for physician assisted suicide. Our feedback to the Panel is that this question needs to be considered carefully, as there will be a significant

[2] Voluntary Assisted Dying Bill Discussion Paper, 4.

number of providers and individuals for whom this part of the proposed legislation will have a large impact.

2.3 Monitoring the Use of a 'Lethal Dose of Medication' and Attendance

There are no details in the Discussion Paper regarding follow up care for a person who has been prescribed the lethal drug and has taken it home to administer. If healthcare providers are willing to provide a lethal drug to their patients, they have an obligation to know when a person has taken the drug to be able to care for them if it does not work or for any further physical or emotional suffering which may occur. There is also an obligation to ensure that such drugs are monitored and adequately disposed of if not used, to prevent any accidental ingestion.[3]

A specific moral issue also arises on this point in relation to *euthanasia*. Specifically, if a physician prescribes an oral dose of a lethal drug to a patient who is unable to administer it, is the physician then *obliged* to administer the medication through other means? If physicians are ethically comfortable with physician assisted suicide but not with euthanasia this will cause significant problems – it is an issue that the proposed legislation needs to be more clear about.[4]

2.4 After a Person has Died

The recorded cause of death should be ingestion of a lethal drug, not a person's underlying disease as this was not the actual cause of death. Were a person to ingest a lethal drug, and that drug of itself and by intention causes death, then it is an act of suicide.[5] In other words, they died because of the lethal drug. While SVHA appreciates that there may be sensitivities around this, if we as a society are not willing to formally recognise an actual cause of death then this of itself makes an important point about the legislation so proposed.

2.5 Oversight

SVHA notes the importance of a review Board, as recommended by the Parliamentary Committee. However, we are concerned that the proposed legislation does not suggest that an ethicist also be appointed to the Board to monitor any ethical issues that arise if the legislation is approved and enacted. Furthermore, SVHA is concerned that there are no safeguards to ensure that members of such a Board are free from conflicts of interest which would bias their capacity to review cases of assisted dying and euthanasia effectively.

---

[3] A further problem arises here in relation to the distinction between Physician Assisted Suicide and Euthanasia, which is discussed under the definitional issues raised below.

[4] See also further discussion below in the section on definitional issues.

[5] Pope John Paul II, *Evangelium Vitae* (1995), no. 66. Available at http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html

2.6 Support for Doctors

Evidence from countries that have legalised euthanasia or physician assisted suicide has demonstrated the significant negative personal effect that it has on doctors and other healthcare professionals who are involved in it.[6] The proposal includes no information about support services that are to be available to such professionals either before they choose to be involved with physician assisted dying or euthanasia, or after they are involved.

2.7 Availability of Palliative Care

Australia is a world leader in providing effective palliative care, and we note that requests for physician assisted suicide or euthanasia dramatically decrease where such care is accessible to those who are dying.[7]There is also strong evidence on the benefits of palliative care in relieving symptoms and pain, and improving quality of life, mood, satisfaction with care for patients (and their carers) and, in some cases, even survival for patients.[8]

Hence, it is of concern to SVHA that part of the review process does not explicitly involve discussing palliative care options with those requesting physician assisted suicide or euthanasia. Furthermore, the majority of medical practitioners, especially GPs who it is assumed will play a key role in the enactment of this legislation should it be passed, care for comparatively few dying patients as against those who specialise in palliative care. Hence, the absence of meaningful palliative care expertise undermines the capacity of expert judgment in responding to those who are requesting physician assisted suicide. SVHA is gravely concerned that there is no requirement that part of any such assessment be meaningful and substantive contact with a palliative care provider in order to ensure that a fuller knowledge (and thus freer decision) can be provided to those requesting physician assisted suicide or euthanasia. Furthermore, we reiterate our concerns that this legislation will take much needed funding away from palliative care services.

2.8 Protection of the Vulnerable

SVHA supports the concerns raised by the CHA and CCCHE submissions regarding protection of vulnerable persons and the significant risk that would exist for these persons were the legislation to be passed. In addition to this, SVHA wishes to raise concerns related to its recent submission to the Australian Law Reform Commission Elder Abuse Inquiry (3 March 2017).[9] As noted in that document, SVHA has led research in this area and is currently working to provide safeguards against elder abuse. SVHA's concern about the legislation so proposed is that it would add another level of risk in relation to the elderly, a group who are already vulnerable to abuse and who may become more so

---

[6] Sharon Kirkey. "Take my name off the list, I can't do any more': Some doctors backing out of assisted death." *National Post*, February 26, 2017. Accessed April 7, 2017. http://news.nationalpost.com/news/0227-na-euthanasia.

[7] Peter Hudson, Mark Boughey, et al (2015) Legalizing physician-assisted suicide and/or euthanasia: Pragmatic Implications for palliative care, *Palliative and Supportive Care*, Oct; 13(5):1399-409.

[8] J Temel, et al (2010), Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, *New England Journal of Medicine*; 363:733-742.

[9] St Vincent's Health Australia, *Australian Law Reform Commission Elder Abuse Inquiry: St Vincent's Health Australia submission*, available at https://www.alrc.gov.au/sites/default/files/subs/345._st_vincents_health_australia.pdf

should this legislation be passed. Our submission to the Inquiry recommends that "All service providers who may come into contact with older victims should be able to identify when family violence is occurring and know what to do in response."[10] We are concerned that no awareness of this issue is shown in the legislation, and no specific safeguards are in place to protect this vulnerable group.

2.9 Definitional issues: 'Euthanasia', 'Medication', and 'Voluntary Assisted Dying'

The proposed legislation explicitly states that it is for physician assisted suicide, meaning that "a person should self-administer the lethal drug".[11] However, where it makes provision for those who are unable to administer the medicine themselves it notes that "a doctor should be able to assist the person to die by administering the drug".[12] This confuses physician assisted suicide, in which the person who wishes to end their life is the acting agent for their own death and the physicians who prescribe the lethal drug cooperate with this act, and euthanasia, in which the physician is the acting agent.[13] There is an important moral difference between these two acts which implicates a physician in different ways, both on a personal level and on an ethical level, and will have different personal consequences for physicians. Any legislation needs to be clear in identifying this difference. Further, if legislation provides for the possibility for euthanasia on top of physician assisted suicide, then this should be explicit in its communication so as to ensure those who are voting on such legislation are properly informed.

Furthermore, the document consistently uses the terminology of "a lethal dose of medication" throughout, which clouds the object of any drug prescribed which has death as its object. This is not a 'medication' as such, which is defined as "a drug or other form of medicine that is used to treat or prevent disease".[14] This gives the impression of the drug being intended to treat a patient as against killing them, which is dishonest. A more accurate definition would be "lethal drug". Again, the proposed legislation needs to be more explicit in its communication so as to ensure those who are voting on it are properly informed.

Finally, the document is named in a way that clouds its true object. Entitling it 'voluntary' assisted dying removes the necessity of the physician's role in the process. Using the word 'dying' instead of 'suicide' is a misnomer as the act that would be made possible and legal through the legislation is properly defined as suicide. Again, the proposed legislation needs to be more explicit in its communication so as to ensure those who are voting on it are properly informed. SVHA has grave concerns that legislation which is intended to legalise physician assisted suicide is not clearly titled as such.

---

[10] Ibid, p. 3.
[11] Discussion Paper, p. 16
[12] Discussion Paper, p. 16.
[13] Bernard M. Dickens, Joseph M. Boyle Jr., Linda Ganzini, 'Euthanasia and Assisted Suicide' in *The Cambridge Textbook of Bioethics*. Cambridge: Cambridge University Press, 2008, p. 72.
[14] Oxford English Dictionary, 'medication'. Available at https://en.oxforddictionaries.com/definition/medication.