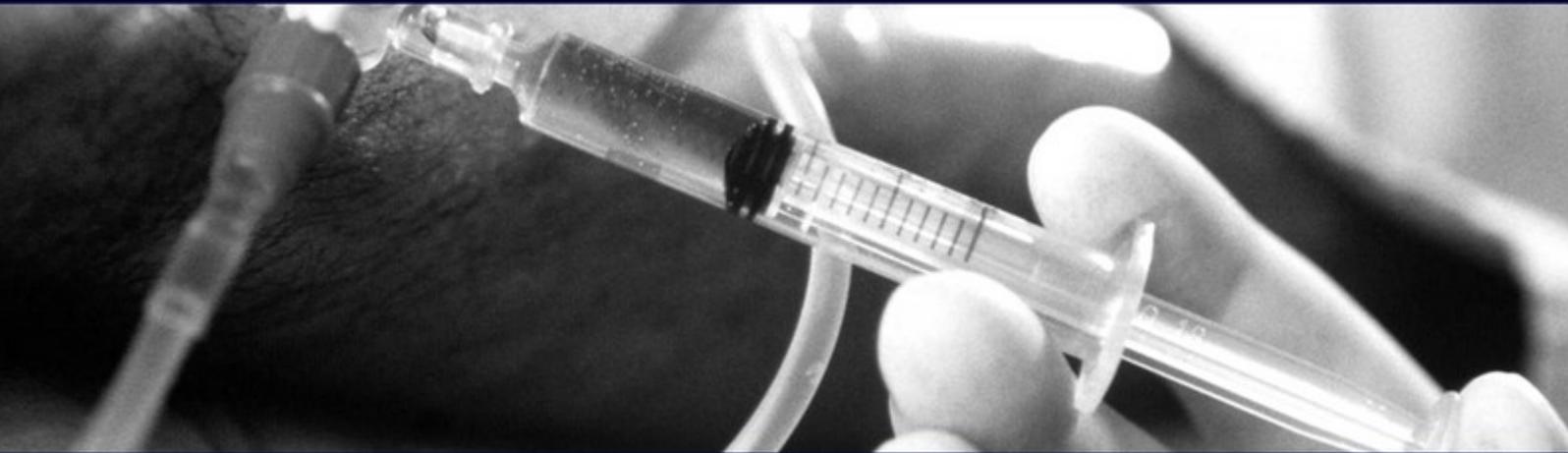




CATHOLIC HEALTH
Australia

VOLUNTARY ASSISTED DYING BILL
DISCUSSION PAPER



MINISTERIAL ADVISORY PANEL
APRIL 2017

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10 April 2017

To: Professor Brian Owler, Chair, Ministerial Advisory Panel

Catholic Health Australia (CHA) represents Australia's largest non-government grouping of hospitals, aged and community care services, providing approximately 10 per cent of hospital and aged care services in Australia, including around 30 per cent of private hospital care as well as approximately 5 per cent of public hospital care.

CHA welcomes the opportunity to provide feedback on behalf of its Victorian members to the Voluntary Assisted Dying (VAD) Bill Discussion Paper, feedback due 10 April 2017. Victorian members of CHA requested and guided this submission with meetings conducted on a number of occasions to facilitate the delivery of a cohesive collective response.

We note that the panel requests feedback based on our members' clinical expertise and experience particularly with regard to delivering quality palliative care (a service which Catholic health providers have long been associated). CHA has consulted with these experts in tandem with other healthcare professionals integral to providing our hospital and aged care services.

Please find attached our submission for your consideration.

Should you wish to seek clarification of any aspect of our submission, please do not hesitate to contact me directly: (02) 6203 2777. Or email suzanneg@cha.org.au

Regards,

A handwritten signature in black ink, appearing to read 'Suzanne Greenwood', is written in a cursive style.

Suzanne Greenwood LLM LLB FAIM MAIDC
Chief Executive Officer
Catholic Health Australia

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INTRODUCTION

Catholic Health Australia (CHA) represents Australia's largest non-government grouping of hospitals, aged and community care services, providing approximately 10 per cent of hospital and aged care services in Australia, including around 30 per cent of private hospital care as well as approximately 5 per cent of public hospital care. Our members operate 77 hospitals, over 800 aged care facilities and numerous community care and care in the home services across Australia. Our members in Victoria include Cabrini, Calvary Health Care, Mercy Health, St John of God Health Care, St Vincent's Health Australia, Southern Cross Care (Vic), and Villa Maria Catholic Homes.

CHA members have always valued the delivery of person-centred care that is founded in a respect for human dignity and life. While we welcome the opportunity to offer a response to the Voluntary Assisted Dying Bill Discussion Paper from the clinical perspective, we do so from the position that it is the medical profession's duty of care to preserve and protect life rather than act as an agent to hasten its end. We recognise the Ministerial Advisory Panel overseeing responses to the discussion paper has stated that opinions either supporting or opposing voluntary-assisted dying (VAD) legislation will not be considered; however, CHA's view is it is never permissible to purposefully end an individual's life through euthanasia or assisted suicide. CHA is writing on behalf of members and their clinicians to outline concerns with the content of the discussion paper that does not adequately support patients or clinicians and has the potential consequence of redirecting patients away from humane end-of-life alternatives offered through palliative care.

Palliative care provides holistic care to patients with debilitating and terminal illness. It is coordinated between the patient, the clinician, and necessary allied supports to address the physical, psychological, spiritual, and social needs of the individual. Clinicians assist patients and their family in the progression of their condition to improve quality of life, relieve suffering, and provide support for their comfort and wellbeing until their natural death. While this field has seen welcome growth and better resourcing over the last 20 years, these services are not accessible to all regions in Victoria or to many vulnerable groups. A public awareness of what services are available for end-of-life care is not always effectively communicated, resulting in public support for legislation that is not fully informed.

CHA members are concerned that the community voice has not been adequately considered in the discussions surrounding VAD. There is a small but vocal percentage of the community strongly

supporting this legislation that has received a great deal of media attention, however the experience of our members has been quite different, having encountered notable confusion and indecision within society surrounding this issue. It is essential to ensure that the community has been adequately informed and all voices heard before the implementation of legislation which has long-lasting and potentially injurious consequences.

Legislating VAD has far reaching implications for individuals, institutions, and greater society that cannot be addressed in isolation, ignored, or struck from the discussion. Greater concern for the change in social attitudes in end-of-life care; impacts to vulnerable groups; support for clinicians who do and do not provide assisted dying services; and the implications for institutions who conscientiously object to the delivery of these services should be further examined. CHA's response will further elucidate these concerns and call on the Ministerial Advisory Panel to consider the implications of legislating complex life-and-death policies on the public, institutional, and sociological well-being for Victorian residents.

We also note that the title of this bill 'Voluntary Assisted Dying Bill' uses language that infers a moderate intervention; CHA members are of the opinion that we could equally replace 'Voluntary' with 'Physician' as this is what the implications are for the medical practitioner; and indeed substitute 'Dying' with 'Suicide' as for all intents and purposes the individual will be taking their own life. For the purposes of clarity throughout this submission and comparison to others we will refer to the Bill as currently named, however ask that you note our objection to the proposed title.

THE PERSON, THEIR FAMILY AND THE COMMUNITY

The decision-making capacity test outlined in the *Medical Treatment Planning and Decisions Act* (2016) fails to address circumstances outside these wide parameters outlined in the discussion paper.

The case for VAD assumes that respect for the patient's wishes, rather than respect for the patient as a whole, is the foundational value of medical ethics. Respect for the patient's wishes is unquestionably part of respecting the patient, but valuing these wishes above the patient would prevent doctors from ever refusing any patient request, even if it would clearly harm their health. The long-accepted firm foundation for medical ethics (including the duty to respect the patient's wishes) is the incalculable intrinsic objective worth of the patient. Intentionally causing death would require us to render valueless that which is of essential value: the patient.

The use of the language of 'capacity' in the proposal has the potential to create confusion around the rights and responsibilities of clinicians when providing assessment. Our clinicians understand the term capacity to specify legality. As such the use of such language mixes the legal and clinical paradigms and creates added pressure around an already complex, and burdensome decision. Clinical assessments are the preferred terminology as it allows an expert to comment on a person's ability to make an informed decision without making a legal judgement.

ACCESS AND ELIGIBILITY

It is difficult to provide an accurate clinical prognosis regarding the longevity of a patient at the advanced stages of disease and therefore equally difficult to define an individual as being 'at the end of life'. Defining advanced terminal disease as a 'serious and incurable condition' is also problematic, as there are many serious and incurable diseases that are not considered terminal, but manageable with the right evidence-based treatments and access to appropriate models of care. The protection of vulnerable persons, some of whom would

be at risk of being categorised as having a 'serious and incurable condition', and identified eligible for VAD, must be of the highest priority. Proposed definitions do not adequately exclude some of these vulnerable persons such as the mentally and physically disabled and people with severe mental illness.

It is the view of Catholic Health Australia and its member organisations that questions regarding access and eligibility around VAD should not be limited to the specific phrasing as outlined in the Discussion Paper. There are questions around access and eligibility that have not been adequately answered.

In the Netherlands, between 2011-2014, there were 110 reported cases of euthanasia or assisted suicide (EAS) for individuals with serious and incurable psychiatric disorders (Kim et al, 2016). If legislated, will persons with a serious and incurable psychiatric condition be eligible for VAD in Victoria? Will all Victorians have access to VAD, regardless of where they reside, including in geographical locations that do not provide an alternative to VAD, such as an adequately funded high-quality multi-disciplinary palliative care service? Will there be adequate access to the professionals that have been proposed to make the assessments of eligibility, i.e. psychiatrists and psychologists with end-of-life experience, or physicians with formal training in palliative care? As there would in the majority of cases be implications social and psychological for the family, the physicians and the community, it is critical that the government's proposed support services incorporate the provision of accessible and evidence-based guidance for all members of the community.

It is CHA's view that no Victorian should be considered eligible for VAD when the policies and resources necessary to ensure all Victorians have access to alternatives such as affordable, high-quality and multi-disciplinary palliative care are currently inadequate. This could result in those with less access to high-quality palliative care being offered VAD instead. It is also CHA's concern that VAD would be made readily available and accessible to individuals with advanced disease who would have no feasible alternative when in need of end-of-life care.

Whilst we are aware that safeguards are proposed, CHA still believes that there are large vulnerable proportions of society who could be adversely treated if VAD were to be legalised by the State of Victoria.

The disabled community: Many disabled people insist that they need the right to live well before they are given the right to die with assistance. This is particularly relevant (highlighted in a recent *Four Corners* episode [“Fighting the System”, 2017]) as we know that as a society we often fail to give disabled people the help and support that they need. We therefore strongly encourage the Victorian Government to invest in supporting people living with disabilities and ensuring the transition to the NDIS as a priority. Otherwise, an already vulnerable segment of the population without sufficient access to the services they need could be rendered especially susceptible to the suggestion of VAD.

Regional access and equity for all Australians: CHA is concerned that where requests are made for VAD in rural and regional areas where access to adequate health services is already limited, those individuals will not be treated equally to those that live in a metropolitan area. Recent data analysis by the Department has already illustrated a lack of access to mental health and especially psychiatrists in rural/regional Australia when 9 out of 10 psychiatrists live in major cities (AIHW, 2014).

MAKING A REQUEST

Any individual living with advanced terminal disease should be considered particularly vulnerable and those who request VAD especially so. CHA is of the view that the highest levels of safeguards must be in place to protect the individual interests of individuals living with life-limiting disease, however it is problematic to determine appropriate safeguards to ensure a request for VAD is a true request or indeed voluntary, because there may exist a great many external variables that could impact on the individual's true agency and capacity for choice.

For example, a psychiatrist trained in the psychiatric assessment of patients with advanced terminal disease may be capable of appropriately assessing the cognitive status of the

individual, however there may be societal, community, and personal pressures unidentified or otherwise not judiciously considered. Such pressures could include financial concerns, inadequate access to alternative services, physical and psychological abuse, misinformation about treatment options, or a reduced sense of life value that may impact significantly on the individual's choice to make a request. Additionally, it is problematic to act on a request for VAD when the cognitive status of an individual at end-of-life may change significantly from week-to-week or day-to-day.

Palliative care practitioners are equipped to ease the fears and anxieties associated with death and dying for the individual and the family carers whilst playing a key role to provide opportunities for individuals with advanced disease to make informed choices about treatments that are acceptable to them with a focus on enhancing personal agency and the individual's quality of life. Of the approximately 50,000 palliative care patients admitted to Australian hospitals each year, less than 1% express a sustained desire for physician-assisted suicide and so the evidence is overwhelming that for high-quality palliative care is highly effective as a life-preserving intervention (Hudson et al, 2015).

Palliative care specialists together with psychiatrists working in palliative care possess the expertise and skillsets required to assess the basis of an individual's request for VAD, however it is CHA's concern that in 2012 there were a total of 31 palliative specialists practicing in Victoria, amounting to 0.5 full-time equivalent palliative medical physicians per 100,000 of the population (AIHW, 2014). The expertise to make such important assessments is not adequately available in the healthcare system to ensure equitable access for all Victorians in need. CHA is concerned that in the current model for legislation proposes assessment for VAD by a psychiatrist and two physicians who must agree who on eligibility, yet there is no requirement for physicians or psychiatrists to possess expertise in treating patients at the advanced stages of disease and, therefore an accurate assessment would be problematic.

PROPERLY INFORMED

There is currently a high level of misunderstanding and misrepresentation around the positive health outcomes achieved by palliative medicine.

While CHA acknowledges that palliative care cannot guarantee an individual a pain-free death, less than 1% of palliative care patients request VAD. As palliative medicine currently provides end-of-life care to approximately 50,000 Australians with advanced terminal disease each year, CHA is adamant that any government-driven campaign to educate patients, the wider community as well as the state's healthcare practitioners about VAD must first seek to equally inform all stakeholders about alternatives to VAD, including palliative care. However, it is CHA's view that a traditional information campaign alone would not be adequate to ensure all parties, and in particular the physicians involved, would be properly equipped with the specialised knowledge and skillset required to respond adequately to a request for VAD.

The specialist skills attributed to palliative medicine are currently neither commonplace nor incorporated into existing healthcare professional curricula. The response to a request for VAD would require a professional, highly-experienced, compassionate and individualised response. Such a response requires exceptional skills, judicious timing, and the capacity and commitment to engage in shared decision-making with the individual and the family, particularly when confronting the less tangible existential aspects of suffering. Such an expert response, informed by specialist knowledge, expertise in advanced disease and end-of-life care, and a tradition in compassionate patient centred care, in-turn informs the individual about the realities of death and dying and their options for treatment and works to relieve fears and anxieties.

Marginalised groups such as non-English-speaking Australians, the elderly and frail, prisoners, homeless, mentally and physically disabled, those living alone without supportive families, Aboriginal and Torres Strait Islander peoples, and individuals susceptible to elder and other forms of abuse are particularly vulnerable subsets of a group already rendered vulnerable by advanced terminal disease. For these individuals, susceptibility to mixed

messaging and misinformation around treatment options and the value of such interventions is already problematic. Special care needs to be taken by palliative practitioners and other health professionals to ensure a compassionate, individualised response is provided to inform individuals from these demographics.

While CHA acknowledges that an information campaign addressing end-of-life choices is intended to accompany any legislation for voluntary assisted dying, it would prove unacceptably inadequate in addressing the individualised needs of those with advanced terminal disease, their families, members of the wider community and all healthcare professionals. These needs can only be properly addressed by better resourcing Victoria's significantly under-resourced palliative medicine service sector.

The proposed model to legalise VAD does not first require engagement with a high-quality palliative care specialist or multi-disciplinary palliative care service for consultancy and treatment and thus will fail to properly address the fears and anxieties of an individual with advanced disease. Additionally, it is CHA's view that the Victorian healthcare system is not currently equipped or otherwise adequately resourced to provide equitable access to the necessary professionals with the appropriate skillsets capable of facilitating a properly informed decision by an individual to pursue VAD.

CONFIRMING A REQUEST

An individual's engagement with a suitably proficient palliative care service is of critical importance and should be a mandated component of any VAD legislation. However equitable access to quality palliative care in Victoria does not currently exist. Furthermore, while the speciality of palliative care equips practitioners with the unique skillset to respond to an individual's request for VAD with compassion and an in-depth knowledge about the treatments available to them, it does not equip practitioners with the expertise or the inclination to advise an intervention in the form of VAD.

The current model for legislation does not outline competency requirements for physicians or psychiatric professionals proposed to provide assessment with specific regards to

palliative and end-of-life care. There is no requirement for specialised palliative training for physicians – whether specialists or generalists – or for the psychiatrists and psychologists who the current model proposes would provide assessment.

Will the assessment of two general practitioners (GPs) be legislated sufficient, or two GPs and a psychologist? Physician experience with patients with advanced disease or at end-of-life, knowledge of treatment options, and competency to assess cognitive ability is significantly variable. How will the government ensure that the complex assessments required are conducted accurately, on a case-by-case individualised basis with all parties wholly informed, and guarantee the necessary proficiencies across the whole spectrum of assessing physicians are consistent across the State of Victoria? Will GPs and psychiatric professionals with no end-of-life or palliative care competencies be eligible to confirm requests for VAD? Has the Victorian Government conducted sufficient financial modelling around the viability of ensuring every Victorian has localised access to the assessment and support services proposed? What safeguards will be put in place to ensure both the referring clinician and assessors make the individual aware of alternatives to VAD, and the positive outcomes achieved by palliative care? Will the engagement of these services be practicable for every Victorian with access to VAD?

It is CHA's view that in contrast to a multi-disciplinary palliative care service, well-meaning general clinicians will often be ill-equipped or poorly supported to address the complexity of suffering attributed to advanced terminal disease, resulting in the risk VAD would be utilised as the least demanding and most apposite intervention in lieu of accessible end-of-life service alternatives. It is of particular concern to CHA and its members that clinicians in smaller regional, rural, and remote communities will not be provided the necessary support networks available to their peers practicing within metropolitan Melbourne. Without specialised end-of-life training and access to palliative care specialists, confirming an individual's request for VAD may be influenced by community or family pressures and/or burden of workload.

CONSCIENTIOUS OBJECTIONS

Where a practitioner objects to participating in VAD as is permitted in the proposed legislation what should the organisational response be? How will an organisation treat those many practitioners who have conscientious objections? From an HR perspective and in terms of team care, this could be very difficult to manage at the bedside. How to ensure continuity of care when a member of a medical team conscientiously objects to VAD will be difficult in mitigating disruptions in the delivery of services and supports. CHA believes more consideration needs to be taken in:

Professional integrity: Historical ethical traditions in medicine are strongly opposed to taking life. For instance, the Hippocratic Oath states, "I will not administer poison to anyone where asked," and I will "be of benefit, or at least do no harm." Linking VAD to the practice of medicine could harm both the integrity and the public's image of the profession.

Fallibility of the profession: Physicians do and will make mistakes. For instance, there may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Before establishing any new legislative regime, the State has an obligation to protect lives from these inevitable mistakes and to improve the quality of pain and symptom management at the end of life.

Even given the assumption that VAD is ethical, robust respect for conscientious objection is still ultimately good for patients. Patients entrust themselves to their doctors, and doctors must be worthy of this trust. The doctor's moral integrity - a commitment to acting in accordance with moral norms - is foundational to his/her trustworthiness. Suppressing conscientious objection prizes moral conformity over moral integrity and systematically teaches physicians to suppress their basic moral intuitions in favour of social pressures. It also teaches the profession to be less sympathetic of and tolerant toward patients' diverse moral beliefs. Thus, robust respect for conscientious objection should be viewed as an important public good that upholds the quality of medical care.

Health practitioners who conscientiously object must not be required to refer patients to other health practitioners, as to require them to do so is simply requiring them to facilitate

the death, even if not administered directly. Health practitioners who conscientiously object should not be required to declare their objection, as their objection is the usual and historical position of a health practitioner.

ADMINISTERING A LETHAL DOSE OF MEDICATION

If a patient insists on VAD and is in a Catholic hospital or aged care facility, processes will need to be established around how that person, who may be frail and perhaps elderly, will be moved. There are clinical and practical considerations to take into account here. When a medical practitioner is involved in a patient being moved they need to be assured that clinically the patient won't suffer as a result. Practically, places in aged care are limited. What will happen if a person who insists on VAD does not intend to suicide immediately, but a new place of care cannot be found?

MONITORING THE USE OF A LETHAL DOSE OF MEDICATION

Strict legal requirements currently exist around the storage, handling and dispensing of medicines defined as Schedule 8 (S8) under the Standard for the Uniform Scheduling of Medicines and Poisons because of the high risk of misuse. They have to be prescribed, dispensed, documented and destroyed in specific ways that are in compliance with each state and territory's different drug regulations. Such safeguards should not be seen as 'placing undue burdens or pressure' but as being necessary safeguards and controls.

Somehow, the Victorian government will need to implement a regime that registers and tracks the dispensing and use of the lethal dose medication, including its storage and handling. Concerns include:

- If no autopsy is performed on a person who has been prescribed a lethal dose of medication, then no control exists to determine if the medication has been used or remains in an uncontrolled environment in the deceased's home.
- If lethal dose medication is held by the individual, how can safe storage and handling

be assured? Will others residing with the individual be put on notice of the presence of the lethal dose medication? What safeguards will be required to protect children or vulnerable persons who may be residing with the individual who possesses the lethal dose drug?

- If the individual dies through natural causes what requirements will be put in place for recovery of 'unused' lethal dose medication? Such medication would command a price on the black market.
- If an individual who has been prescribed and dispensed with a lethal dose medication asks a family member or carer to give them the medication without explaining what the intent or the outcome will be, results in that person unknowingly assisting the killing of the individual. The rights and emotional responses of the innocent persons who may be implicated in the death must be considered and protected.
- Conversely, if an individual is dispensed and takes with them a lethal dose medication, what safeguards are there to prevent them being induced to take the medication by coercion, psychological or personal pressure, or misinformation?

ATTENDANCE

Requiring a health practitioner to be present at the point of voluntary terminating life could place patients in a precarious position. As shown in evidence from other jurisdictions, patients who are prescribed lethal medications do not always terminate their lives. In the case of Oregon, discrepancies in the prescriptions written for VAD versus those who are recorded as dying from VAD are consistent year-on-year. For some patients, the sense of control they gain from having the option available is enough comfort to not have to carry out the act of self-administering the medication. Requiring a health practitioner to be present would require the patient to make an appointment in advance. This, in-turn, may put additional pressure on the patient to follow through with terminating their life when they otherwise may have privately refrained from VAD.

As the Discussion Paper reads now, there is the possibility that a person could be alone when deciding to use the lethal dose medication. Consideration must be given to what appropriate support should be available to the person and their family and carers. Furthermore, only making the lethal dose medication available through an attending doctor would be an important safeguard against the risks previously described.

Is it reasonable to expect that others must be in attendance? Is it reasonable to expect that an individual must die alone? These opposing challenges create an unresolvable paradox.

People are social beings and the decision by one to voluntarily end their life has a direct impact on others. The ability of one person to voluntarily end their life but with an expectation that others are in attendance, such as family, physicians, carers or pastoral care support places a burden on those others, the possibility of which is only created by VAD legislation being introduced.

LETHAL DOSE OF MEDICATION NOT EFFECTIVE

Some families have reported cases where VAD resulted in a laboured and prolonged death. The extent to which these patients may have suffered cannot be known, but the potential for these incidents is possible with patients who have often been heavily medicated in later stages of their terminal illness. These unintended effects of ineffective medication administration create additional stress and grief for surviving family members.

Currently, in certain jurisdictions in the USA where VAD is legal, doctors are working on developing medicinal alternatives for a euthanasia drug due to rapid price hikes in a commonly used medication for VAD. Doctors in these jurisdictions decide what medication to prescribe in these circumstances, which can vary in cost, accessibility, and effect. One alternative that was developed by clinicians was too harsh, causing burning in patients who became distressed with the pain they experienced (Aleccia, 2017). What medications are used, how they are sourced, how they are financed, and how they are administered have been shown to contribute to the complexity of this process.

OVERSIGHT

In the Discussion Paper, there was no mention of how these services would be covered or whose responsibility it will be to finance the implementation of this legislation. Has there been robust financial modelling conducted by the Victorian Government to determine the viability of providing equitable access to support services, including but not limited to appropriate educational resources and expert counselling for the individual, the family and the community before and after the instance of VAD? How does the government propose to support this new legislation? Will there be modifications to the MBS and PBS which will only apply in Victoria? CHA draws attention to recent legalisation of medical cannabis passed by the Commonwealth with no accompanying information or funding mechanisms. How can patients access medical cannabis? How do medical practitioners prescribe? CHA feels this is an example of legislation being passed without adequate thought given to process and implementation considerations.

Education for the community and health workforce will also be essential, and if implemented properly, will be equally costly. For a properly informed Parliamentary decision on the legislation, it will be important that the government release its modelling and funding requirements of the potential costs of implementing a holistic VAD package.

Further consideration might be given by the Victorian government to how funding allocated to implementing VAD could equally be used to support thousands of disabled people who, on 1 July, will be excluded from access to services whilst the troubled transition to the NDIS takes place? Funding for mental health services have always been less than adequate, not just in Victoria but Australia-wide. Homelessness is also a major issue. Looking after the vulnerable and poorest people in our society has never been more important, and CHA asks that adequate support be given to those suffering with disability, mental health conditions; those living in rural and regional areas who cannot access the same health services as their counterparts in the city.

LIABILITY AND INSURANCE

CHA opposes the legislation of assisted suicide or euthanasia. Any regulatory framework for VAD would need to set out strict requirements for duty of care and reporting for which a physician who helps a patient to suicide will be exempted from punishment.

CHA recommends consultation with medico-legal and insurance specialists as there are complexities inherent in the proposal for legislating physician-assisted suicide.

Presently, life insurance policies are voided by suicide. As the taking of the lethal dose medication is voluntary, this would void any life insurance policy held by the individual. The Discussion Paper suggests that the underlying condition could be used on the death certificate. Transparency is important to protect against abuse. In addition to recording VAD on the death certificate, the exact numbers of prescriptions given to patients, whether the prescription is filled, and whether the patient ingests the lethal medicine must be recorded and monitored in some way.

The right and ability for hospitals, health care providers and physicians to choose not to participate in the implementation of VAD, without consequence, must be paramount. No requirement to refer should be imposed.

Numerous studies (Amarasekara, 2001) have shown that the power to accelerate the termination of life will inevitably lead to significant abuses, and that any legislative attempt to legalise the termination of life will be incapable of providing adequate safeguards due to the inherent nature of the circumstances in which the decision to die is made. The MULR article concludes: "An enhancement of a doctor's power over a patient's life and death and a heightened perception that it is right for a doctor to terminate lives that are not worth living, resulting in large scale abuses of patients at the lowest ebb of their lives is the inevitable consequence of the Dutch legislation."

The importance of effective safeguards is critical to any mooted regulatory framework being introduced, but drafting such safeguards appears impossible.

CONCLUSION

This submission has demonstrated the lack of safeguards in place to address the needs of vulnerable people including the disabled community, those affected by mental illness, and people who live in rural and remote communities. They are not only particularly vulnerable to the abuses and exploitation that this legislation could introduce, but they also face the prospect of losing prospective funding diverted to implement the proposed legislation instead of funding and supporting existing programs such as the NDIS and palliative care programs.

It is clear that palliative care will face unfair burden if this proposed legislation is implemented. There is a profound lack of training and understanding in the medical community of the intricacies and skills required when providing compassionate care to those people experiencing terminal illness. Yet palliative care is so chronically underfunded and under resourced it is unrealistic to expect clinicians to be able to provide comprehensive and equitable care to all Victorians. There is also no requirement for physicians or psychiatrists to possess expertise in treating patients at the advanced stages of disease and, therefore, accurate assessment would be problematic.

The financial implications of this legislation are also of great concern. How the government proposes to support the implementation of this legislation through a detailed financial model has not been produced. The cost of educating not only the health care sector but also the community will be substantial and significant planning and modelling needs to be considered. There is a fear that rapid unplanned implementation will place extra pressure on the already overstretched health sector and community.

CHA members are committed to providing the best possible, evidence based compassionate care to all members of society. CHA and its members strongly consider that the proposed Victorian Voluntary Assisted Dying Legislation will inhibit the capacity of clinicians to do this, and denigrates the overarching principle that has underpinned the medical community for centuries of "do no harm". The legislation in its current form raises too many questions to be considered safe and equitable; therefore, the Ministerial Advisory Panel must consider whether their legacy will be to compassionately protect and dignify a patient's life or hasten their death.

REFERENCES

Hudson P, Hudson R, Philip J, Boughey M, Kelly B, Hertogh C. *Legalizing physician-assisted suicide and/or euthanasia: pragmatic implications Palliative and Supportive Care*. 2015; 13 (5) p. 1399-1409

Kim S, De Vries R, Peteeet J. *Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014*. JAMA Psychiatry 2016;73(4) p.362-368

Medical Training Review Panel – Eighteenth Report: May 2015 p.81

Medical Treatment Planning and Decisions Act 2016 (Vic). Can be accessed at: [http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B4D3EBB66E52E98CCA25807A0014F70D/\\$FILE/16-069aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B4D3EBB66E52E98CCA25807A0014F70D/$FILE/16-069aa%20authorised.pdf)

“Fighting the System”. Prod. Linton Besser, Klaus Toft, Jeanavive McGregor. *Four Corners Report*. ABC. 28 March 2017.

Australia Institute for Health and Welfare, *Palliative care services in Australia, 2014*. Mental Health Services in Australia 2014, Canberra. Accessed at < <https://mhsa.aihw.gov.au/resources/workforce/psychiatric-workforce/>>

Aleccia, JoNel. *“Docs In Northwest Tweak Aid-In-Dying Drugs To Prevent Prolonged Deaths”*. Kaiser Health News 2017. Web. 10 Apr. 2017.

Amarasekara, K, and M Bagaric. *“The Legalisation Of Euthanasia In The Netherlands: Lessons To Be Learnt.”*. Monash University Law Review 27(2): (2001): 179-96. Print.