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Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George Street
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Dear Member of Parliamentary Committee (Health, Communities, Disability Services and Family Violence Protection)

I wanted to make contact with you just at the time that the report(s) from "Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying" are due to be finalised. I represent over 800 health professionals, with over 80 members from Queensland, who are deeply concerned about the misinformation and inaccurate accounts involved in current attempts to introduce euthanasia and physician assisted suicide legislation to Queensland, as well as the negative implications of introducing such legislation for our Queensland citizens.

I would like to make the following contributions to your deliberations:

1. Highlight the petition tabled to parliament "Euthanasia – we can live without it"
2. Attach / provide a copy of the booklet: "Euthanasia and Physician Assisted Suicide – Are they clinically necessary or desirable?". This is written by one of the pioneers of palliative care in Australia – Dr Roger Woodruff. In particular I highlight Dr Woodruff's eloquent summary of the Arguments for and against Assisted Dying on pages 66 – 86 of this booklet.
3. Provide a response to the report "Intentional self-harm deaths of persons with terminal or debilitating physical conditions in Queensland, 2016 – 2017", and including recent ground breaking research from Victoria published in psycho-oncology.
4. Highlight that legislation will undermine safety, healthcare and social agendas for vulnerable populations.
5. Provide a critique of the argument that "Voluntary Assisted dying will enhance palliative care provision"
6. Explain that euthanasia and physician assisted suicide are not part of palliative care healthcare provision.
7. Emphasize the point and research that most people aren't in severe pain when they die.

Highlight the petition tabled to parliament "Euthanasia – we can live without it".

The Hon Dr Steven Miles MP responded to this petition on Nov 18 2019. I note that there were 7473 signatures to this petition. There were also 1877 signatories to the tabled Paper Petitions for this same petition. This giving a total of 9350 petitioners. This compares to the petition supporting Euthanasia entitled "Voluntary Assisted Dying" which had just 6665 petitions. There is a perception that the community is overwhelmingly in support of Euthanasia or Voluntary Assisted Dying. The number of petitioners in these respective petitions does not support this notion.

> Queensland residents draws to the attention of the house the critical lack of palliative care currently in Queensland. Whether in outback communities, rural towns, or in the South-East corner, every Queenslander deserves equal access to expert health care. Instead we are failing our society's most vulnerable by drastically underfunding palliative care especially in rural and remote areas. Consideration of legalising euthanasia whilst palliative care is not available lacks integrity.
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> Other concerns in consideration of euthanasia include:
> - the increase of elder abuse and inheritance impatience;
> - the fundamental change that euthanasia brings to the doctor-patient relationship, causing vulnerable people to fear seeking medical assistance;
> - the normalisation of suicide at a time when we are desperate to reduce Queensland's alarmingly high suicide rate;
> - and the fact that the ones who need our care the most - the elderly, the disabled, the clinically depressed - are particularly vulnerable to the suggestion of euthanasia.
>
> Your petitioners therefore request the House to:
>
> - ensure equal access to world class palliative care for every Queenslander, including the most vulnerable in our communities, by directing resources to fix our health system, not by starting a death system. The opposite of pain is not death - it is relief from pain, the result of expert palliative care; and
> - address the underlying causes of those desiring help to commit suicide, by properly resourcing palliative care for every Queenslander without delay.

A response to the report "Intentional self-harm deaths of persons with terminal or debilitating physical conditions in Queensland, 2016 – 2017"

In relation to the discussion on Physician Assisted Suicide (PAS) or Voluntary Assisted Dying (VAD) there is interest in whether suicide rates increase, stay the same or reduce when VAD is introduced. How do we as a profession and also as a society manage the situation where it is okay for some individuals to be supported in committing suicide, when in other situations we are trying to prevent suicide.

There are the coronial reports that say that patients are committing suicide because of their terminal illness, often alone and without telling their families. And this is one of the arguments used for VAD. It is argued that a legal process with clinical support would prevent these suicides.

There is the report from the National Coronial Information System on the website of the Health Committee of Queensland Parliament. "Intentional self-harm deaths of persons with terminal or debilitating physical conditions in Queensland, 2016-2017 (1). Over a 2 year period (Jan 1 2016 to Dec 31 2017) there were 168 deaths of relevance identified that were reported to a Queensland

coroner where the deceased died as a result of intentional self-harm and suffered from a terminal or debilitating physical condition. Firstly, these situations are very tragic. Andrew Denton on his recent visit to Brisbane highlighted such deaths. On reflecting on this problem, I note the report does not provide the total number of suicides in Queensland (from what I can see). This would seem a helpful denominator. Another report tells us that sadly in 2018 there were 767 suspected suicides by Queensland residents (2). So the number of deaths that the coronial report refers to is approximately 84 / 767 or 10 % of suicides.

Research out of the United States, revealed that legalizing PAS has been associated with an increase in rate of total suicides relative to other states and no decrease in non-assisted suicides. By non-assisted suicides, this would include the suicides that are documented in the Coronial report as outlined above. This suggests that either PAS does not inhibit (nor act as an alternative to) non assisted suicide, or it acts in this way in some individuals but is associated with an increase inclination to suicide in other individuals (3).

Also of note, in 2018 there were 30, 860 registered deaths in Queensland. In terms of the deaths highlighted by the coroner, we are looking at 0.27 % of all deaths. There is clearly significant suffering for this group of patients, however the percentage does put it in context in terms of the general population. The paper from the USA suggests that legislation does not prevent such deaths.

A recent publication in Psycho-Oncology delves into a similar case series from Victoria of 118 patients (4). This data was available from the Victorian Suicide Register. Half (50 %) of the patients were categorised as "probable" suicides due to their cancer diagnosis, 45 (38%) were possibly related and 14 (12 %) were unrelated. Of the first 2 groups combined, they were less likely to have a history of mental illness prior to their cancer diagnosis. Only 42 % of "probable group" had metastatic cancer, meaning that 58 % had early or locally advanced stage cancer (which may be curable). Fourteen (24 %) of the probable group had engaged with a right to die organisation and 10 patients (17 %) of from this group had contact with palliative care. Top reported concerns of the "probable" group included pain 66 %, loss of independence 34 %, loss of mobility 24 % and heavy burden of cancer treatment (48 %). Suicidal intentions were known to clinicians in 66 % of cases and to family and friends in 19% of cases.

My interpretation of this study: There is no evidence to support that most, or many of these suicides in those with cancer would meet Victorian or Western Australian eligibility for VAD or ever wanted VAD - although some in individual cases this may have been the case. There is little evidence that any similar cases would be prevented in the future by legal VAD. Lack of access to high quality specialist palliative care and other supports may have resulted in many of these patients with cancer being driven to suicide. But there is no evidence to suggest lack of access to VAD drove this group as a whole to suicide.

VAD will also not address the issue of burdensome treatments or over-treatment in modern medicine, which often delays appropriate goal setting and protects the autonomy of patients toward referral for appropriate end of life care. This is where appropriate timing of referral to palliative care for complex cases, provision of palliative care by general practice and advance care planning is so important.

It is not well appreciated that a stressor or sometimes stressors accumulating as multi-factorial stressors may cause an individual without any previous history of mental health issues to

decompensate with acute onset of anxiety and depressive illness and these patients can take impulsive actions to end their distress. I argue that this is likely what process is reflected in the coronial data - not a desire for assisted suicide. Legalised VAD won't help to prevent these deaths; prompt recognition and treatment of anxiety and depression in the physically ill and the widespread availability of high-quality support services and palliative care services might.

In relation to overseas evidence around suicide practices, it is often seen that suicide rates have actually risen in line with the introduction of legislation, with the figures from Oregon (suggested by Mr Denton to be an example for Australian processes) demonstrating rising suicide rates in line with application of legislation. Oregon now demonstrates a 41% higher rate of suicide compared to other US states and boasts one of the highest rates of suicide in the 35-65 years aged group, the great majority of whom were not receiving medical or mental health treatment at the time of their suicide (5). Once a society accepts the logic that suffering allows suicide, it becomes difficult to restrict it philosophically to only those with a terminal illness.

Regional and remote areas of Queensland already have higher rates of poor health and suicide, including amongst the young and indigenous. Will euthanasia and assisted suicide legislation really give our people a choice, or will it just give the wrong messages and undermine true health care and social agendas for our young and vulnerable by legitimising suicide, rather than emphasising the need to seek help?

Implications from the possible introduction of VAD practices to Queensland are also extended to how societies perceive infirmity, disability and aged conditions. It is the role of governments to plan and provide for systems that protect and care for all its citizens. There is still much to be done in Queensland toward this as demonstrated by recent Royal Commissions and reports on regional health in both service provision and health care for vulnerable groups, and for whom undetectable abuse and coercion is commonplace.

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Critique of the Argument that VAD enhances palliative care

I / we would argue we need to focus on implementing best practice state wide palliative care, before focusing misdirected efforts on Voluntary Assisted Dying (VAD). There is no real choice if basic palliative care provision is not present - especially in regional Queensland.
In terms of the argument that VAD enhances palliative care, I would like to look at the case study of

Canada, and suggest this is not the case.

The Canadian Hospice Palliative Care Association (CHPCA) and Canadian Society of Palliative Care Physicians (CSPCP) recently launched a joint statement on November 17, 2019 (1). I paraphrase and shorten much of their argument, and some of my wording is very similar to the statement.

They note that there is public confusion between palliative care and what is called in Canada Medical Assistance in Dying (MAiD).

They state that national and international hospice palliative care organizations are unified in the position that MAiD is not part of the practice of hospice palliative care.

Palliative care and Euthanasia-Physician Assisted Suicide (EPAS/ Voluntary Assistance in Dying / MaiD) differ in multiple areas including philosophy, intention and approach.

Palliative care focuses on improving quality of life and symptom management through holistic person-centered care for those living with life threatening conditions. Palliative care sees dying a normal part of life and helps people both live and also die as well as possible. Palliative care does not seek to hasten death or intentionally end life.

In VAD, the intention is to address suffering by ending life through the administration of a legal dose of medications at an arbitrary “eligible” person's request.

Less than 30 % of Canadians have access to high quality palliative care, yet more than 90 % would benefit from it. Despite this starting point, access to palliative care is not considered a fundamental health care right for Canadians. In contrast, MAiD has been deemed a right through the Canada Health Act after a single court judgement, even though deaths from MAiD now account for less than 1.5 % of all deaths in Canada (4). In fact, since MAiD was introduced into Canada, there has been a reduction of funding to palliative care services, with a recent cuts resulting in the closure of major hospice facilities in British Columbia, following the Ministry of Health’s mandate that all hospice facilities receiving funding must provide MAiD.

You can read more about the Canadian context in The World Medical Journal (5)

An important consideration here is that the palliative care approach to death and dying is considered best holistic medical and nursing practice by worldwide organisations, including the World Health Organisation and World Medical Association. The safety of application and practice of VAD, on the other hand, is questionable. Safety and scope-creep are also issues here, once a law is changed.

Overseas data remains incomplete and under-representative of complication rates, with minimal description of the impact of those complications for those with failed administered of these drugs, and with misleading claims around safety. A survey of American oncologists reported that physician assisted suicide attempts failed in 15% of cases (6). In the Netherlands, 18% of attempts were completed as euthanasia by injection because of longer-than-expected time to death, failure to induce coma or awakening of the person (7). How can governments introduce controversial practices into legislation that are not a part of ethical medical and nursing practice, and which discount significant safety considerations in terms of application and administration, with

implications for what is then perceived to constitute medical practice?

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Most people aren't in severe pain when they die

I acknowledge that there is much grief when a loved one dies. Although, at the same time, death is an inevitable consequence of living, and a natural process that all humans go through at some stage. We also acknowledge the reports that the Committee has heard during the enquiry where descriptions of immense suffering were made. However, we believe it important to balance this with the research evidence looking at things from a population perspective – particularly when palliative care is available. In this context, we would argue the concern should be around lack of access to palliative care rather than to VAD.

We are fortunate in Australia that palliative care has developed to a point of being a world leader in this field – although there is variation according to post code of the services available. We are also fortunate in that we have an excellent system of outcome measurement in palliative care, through

the Palliative Care Outcome Collaborative (PCOC). Palliative care is effective at managing the holistic needs of patients and their families at the end of their life (1-3).

"The majority of patients receiving palliative care have no or mild symptoms and problems in the last stage of their life. A small number of people do have high symptom needs and burdensome problems. Fatigue is the most common symptom. It causes severe distress for around 13 % of patients and this reduces to approximately 8 % just before death. Pain is the next most common symptom, with 7 % of people experiencing severe distress, and this reduces to approximately 2.5 % just before death" (1). Other problems with appetite, breathing, bowels, insomnia and nausea are experienced by less people and all of these symptoms are improved by the end of life, when palliative care supports are in place.

"For people receiving palliative care, severe pain or other distressing symptoms are rare in the final stages of life. Despite what most people thing, pain and other symptoms actually improve as people receiving palliative care move closer to death, as also does the desire to die. People in their final days and hours experience less pain and other problems than earlier in their journey" (1).

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Thank you for considering these arguments raising concerns about Voluntary Assisted Dying based on research and evidence-based literature. Thank you also for your hard and dedicated work of consultation and review as a member of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee.

Kind regards,

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Mr Bob Nelson, B Social Science MA, Psychologist, NSW
Dr Karen Lopez Karen, MBBS BSc Med FAFRM, Rehabilitation Physician, NSW
Dr Rachel Chalmers, MBBS FRACP, Nephrologist, NSW

Dr Melissa Lee, B Dental Surgery, Dental Practitioner, NSW
Ms Joan Lane, RN, Nurse, NSW
Dr Andrie Tanuwidjaja, B Dental Surgery, Dental Practitioner, NSW
Dr Kristy Choi, B Dental Surgery, Dentist, NSW
Ms Sarah Fogarty, B App Sc Occupational Therapy, Occupational Therapist, NSW
Dr Patricia Suarez Novoa, MD MICGP MPHTM, General Practitioner, NSW
Dr Colin Summerhays, FRACS FRCS (England), General Surgeon, NSW
Ms Margaret Summerhays, B Nursing, Registered Nurse, NSW
Dr Louise Holliday, MBBS FRACGP, General Practitioner, NSW
Ms Maureen Mulheron, Registered Nurse, Nurse, NSW
Dr Catherine Faehrmann, MBBS FRANZCP, Medical Practitioner, NSW
Ms Stephanie Herrenberg, Registered Nurse, Nurse, NSW
Ms Evelyn Bernado, Hospital Scientist, Scientist, NSW
Dr Ann Tokura, MBBS, General Practitioner, NSW
Dr Catherine Lennon, MBBS FRACGP IBCLC, General Practitioner, NSW
Ms Elizabeth McCarthy, Registered Nurse, Nurse, NSW
Dr Catherine Wong, MBBS FRACP, Paediatrician, NSW
Dr Gavin Wong, MBBS FRCS Edinburgh FRACGP Dip Children's Health, Medical Practitioner, NSW
Dr Madeline Wong, Bmed Dip Children's Health, Medical Practitioner, NSW
Dr Sebastianus Kwon, MBBS FRACS, Surgeon, NSW
Dr Maighdlin Galea, MBBS FRACGP, General Practitioner, TAS
Ms Marguerite Bell, B Pharmacy, Pharmacist, NSW
Ms Katherine Higgins, Registered Nurse, Clinical Nurse Educator, NSW
Mr Paul Donkin, Chemist, Chemist, NSW
Dr Cheryl Woodcroft, BSc MBBS, Medical Practitioner, NSW
Ms Deirdre Hulton, Registered Nurse, Nurse, NSW
Dr Roberta Leary, MBBS Hons, Medical Practitioner, NSW
Ms Lillian Augoustinos, Bachelor of Social Work, Social Worker, NSW
Ms Judith Sultana, Registered Nurse, Nurse, NSW
Ms Ruth Stoodley,Exercise Physiologist, Physiologist, NSW
Ms Bev Littlefair, Registered Nurse, Nurse, NSW
Ms Julie Dulay, Registered Nurse, Nurse, NSW
Ms Mary Manan, Registered Nurse, Nurse, NSW
Ms Jehan Manan, Assistant in Nursing, Nurse, NSW
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Dr Myra Tan, MD, Medical Practitioner, NSW
Ms Teresa Thompson,, Physiotherapist, NSW
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Ms Grace Nakhil, B Pharmacy, Pharmacist, NSW
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Dr Marguerite Harb, MBBS, Medical Practitioner, NSW
Dr Anthony Zandes, MBBS, Intern Doctor, NSW
Dr Anne Cunningham, MBBS FRACP, General Practitioner, NSW
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Ms Tania Sequeira, RN, Nurse, NSW
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Dr Michael Thompson, MBBS FRACP, Medical Practitioner, WA
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Mrs Cecilia Hawkins, RN, Nurse, NSW
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Mr Greg Peters, RN, Clinical Nurse Specialist, NSW
Ms Chiara Porcu, RN, RN in Aged Care and Community, NSW
Ms Ann-Marie Power, RN, Nurse, VIC
Ms Dona Sakr, Diversional Therapist, Health Practitioner, NSW
Mrs Biji Mathew, RN, Nurse, NSW

Mrs Monica Bones, Enrolled Nurse, Nurse, NSW
Mrs Aruna Ellis, RN, Nurse, NSW
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