

Queensland Baptists  
Submission to the Queensland Parliament's  
"Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying"

### **Who we are**

Queensland Baptists is the trading name of The Baptist Union of Queensland. The Baptist Union of Queensland is a voluntary association of Baptist churches in Queensland and was incorporated by letters patent in 1927.

Queensland Baptists are a multi-cultural and multi-generational movement of people serving communities in metropolitan, regional, coastal, rural and remote Queensland through a network of approximately 200 churches with a combined regular attendance of around 30,000 people. At the 2016 census over 87,000 people in Queensland listed their religious affiliation as Baptist.

While the Baptist ethos values the autonomy of the local congregation, there are times, places and occasions where a statewide voice or opinion is sought from Christian denominations and community groups, and other times and occasions where, in our view, a statement on behalf of the Baptist movement in Queensland can make a significant contribution to the market place of ideas.

### **Introduction**

Thank you for the opportunity to make a submission to the current "Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying". Pastors and churches regularly deal with the practicalities of end of life care, visiting those who are dying and spending time with loved ones after the death to arrange funerals which celebrate the life of the deceased. The care arm of Queensland Baptists, Carinity, makes a significant contribution to aged care in this state.

However, resource constraints mean we will focus on voluntary assisted dying in this submission, as this is of greatest concern to us. This does not mean the other issues are unimportant, or unrelated to voluntary assisted dying.

### **What we believe about voluntary assisted dying**

1. Queensland Baptists believe that all people are made in the image of God, so human lives are precious and of intrinsic worth. The value of life is not diminished by age, lack of productivity or illness.
2. This does not mean that prolonging life with futile or burdensome treatment is an ethical necessity.
3. It does however mean that intentionally ending life to avoid suffering of any kind is morally unacceptable.
4. Treatment which intends to reduce suffering is acceptable, even if it may hasten death.<sup>i</sup> This differs only in degree from some other medical treatments which also have side-effects, and although intended to preserve life or reduce pain, do sometimes cause or hasten death.
5. We believe the state has an obligation to protect people from harm, especially those people who are elderly, disabled or otherwise vulnerable to abuse. Deliberately taking a person's life is the ultimate harm.

6. We believe that legalising voluntary assisted dying will increasingly promote mistrust between patients and their health practitioners, and patients and their families. The community's view of medical practitioners and other involved health practitioners, especially among the vulnerable, will change so that they are seen as potential agents of death as well as health.
7. We are concerned that legalising voluntary assisted dying will have unintended consequences, in particular the devaluing of those who see themselves (or are seen by society) as being of low value.
8. Similarly we are concerned that governments, in response to voluntary assisted dying, and we trust unconsciously, may reduce spending on end of life care with their budgets benefiting from the consequent reduction in health care costs.
9. We believe that it is impossible to ensure that "assisted dying" is always truly voluntary. Abuse of the elderly occurs, and older people will be bullied into "voluntary" assisted dying. To believe otherwise is to ignore the accumulating evidence of elder abuse.
10. Further, with legalisation of voluntary assisted dying, people's view of the state and community morality will change. Whereas at present the state overrides people's autonomy when necessary to prevent people from harming themselves, the state will be come to be seen as prioritising autonomy over preventing harm. This is a highly significant change, and one which will have unintended consequences, some of which are unpredictable.
11. We therefore call on the Queensland Parliament to reject any legislation which legalises voluntary assisted dying.

### **Provision of palliative care**

We acknowledge and grieve for the distress and pain that is sometimes experienced by people at the end of life, and those who care for them. Our resolve is to work alongside others to support them with love, compassion and effective practical and palliative care. Further, we believe that greater provision of palliative care services is a far better option for those needing end-of-life care. Mental health factors such as depression often underlie the decision to request voluntary assisted death, and where present, these should be treated with effective and compassionate medical care. Society readily funds programs to prevent suicide in those with mental health problems. It should do the same for all those experiencing pain or despair which lead to a desire to end their lives.

### **Unintended Consequences**

We believe that the legalisation of voluntary assisted dying will have unintended consequences. As the "Multifaith Statement on the Voluntary Assisted Dying Bill 2017" stated, "We are concerned that deliberate interventions to end life tear at the fabric of our society." Attitudes to those who are vulnerable will change. Some are beginning to advocate euthanising those who are disabled or no longer of use to society. In 2013 the Japanese finance minister was quoted as saying that the elderly should be allowed to "hurry up and die" to relieve pressure on the state to pay for their medical care (The Guardian 22 Jan 2013). Listing this under the heading "unintended consequences" acknowledges this is not the motivation for most who advocate for voluntary assisted dying. But voluntary assisted dying makes it easier for those with this motivation to realise their aims. Data from the Netherlands and Belgium is increasingly sounding the alarm in relation to this 'slippery slope' argument, where voluntary assisted dying has been extended to groups not originally envisaged<sup>ii</sup>. We must not repeat their mistakes.

Even more concerning is evidence that some doctors may pressure patients into voluntary assisted dying. In evidence presented to the House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill in 2005, a Dutch doctor reported that a colleague phoned him, saying, “The problem is the patient is refusing euthanasia”. Previously when faced with the same clinical issue the colleague had “solved” the problem by convincing the person to accept euthanasia<sup>iii</sup>.

There is a cognitive dissonance in promoting suicide prevention programs on one hand, and the promotion of voluntary assisted dying on the other. As bishops from eight different denominations said in their open letter<sup>iv</sup> in 2017, “Endorsing suicide as a solution to pain and suffering sends a confusing message to our society, particularly to the young and the vulnerable.”

The notion that some lives are not worth living underpins voluntary assisted dying. This puts the most vulnerable in our community at risk. It reinforces a notion that some lives are more valuable than others.

The free choice and autonomy of a small number of individuals must always be weighed against the common good. In this case, we strongly believe that voluntary assisted dying introduces ethical shifts into our society that are contrary to the common good.

### **Response to some of the committee’s questions**

#### *25. Should voluntary assisted dying (VAD) be allowed in Queensland? Why/why not?*

Queensland Baptists strongly oppose “voluntary assisted dying” (VAD) for the reasons given above. For this reason we are reluctant to offer suggestions to reduce the harm that will result, as their mitigating effect will be limited. However, recognising that variants of VAD have become legal in a number of jurisdictions, we provide answers to some questions as follows.

#### *34. What safeguards would be required to protect vulnerable people from being coerced into accessing such a scheme, and why?*

We believe that it is impossible to protect vulnerable people from being coerced into “voluntary” assisted dying. Stricter safeguards could however result in fewer cases of involuntary assisted dying, but they will still occur. An analogy has been drawn between the death penalty and VAD<sup>iv</sup>. Just as with the best intentions, the legal system was incapable of preventing innocent people from suffering the death penalty, so with the best intentions legal systems will be unable to prevent some people being put to death who do not wish to die.

Safeguards which may lessen the number of people coerced into VAD include: certification of a terminal illness with death likely within three months, compulsory counselling, a waiting period of at least two weeks after the initial written request and a review of medical and counselling opinions by an independent person not involved in the care of the person for whom VAD is proposed. To insure that conflicts of interest are minimised, the reviewer should be appointed and paid by the state.

To argue that these measures are too onerous or resource intensive is to devalue life. Where a life is at stake, resources should be provided by the state. And as the state will benefit by reduction in the use of other resources, it would be unreasonable to argue that the state does not have the resources necessary to provide counselling and an unbiased review of the facts.

A period of at least two weeks, with a minimum of two counselling sessions would be necessary to minimise the number of vulnerable people who are coerced into assisted dying. Practitioners who are closely involved with the person and their family are the best placed to describe what they see and hear, but because of that involvement will find it hard to be objective, and may themselves be subject to coercion by other interested parties, often without realising it.

Health practitioners are also vulnerable to seeing VAD as a solution to ending their own distress when they are faced with a suffering person, and a small minority are also unethical. If it were otherwise the Australian Health Practitioners Registration Authority would not initiate any disciplinary proceedings. The Harold Shipman case is perhaps the most notorious instance of professional misconduct, where a general practitioner in England murdered vulnerable patients under his care.

The counselling sessions should explore whether undiagnosed or untreated mental health conditions such as depression are present. Where these are present and effectively treated, there is good evidence that people change their mind and no longer request VAD. In fact psychological and social issues more often underlie requests to die than physical symptoms<sup>ii</sup>.

Mutual “suicide pacts” should be banned. Almost always in these situations there is an imbalance of power, and one ‘partner’ in the relationship has the ability to coerce the other into decisions they may not otherwise make.

*35. Should people be provided access to counselling services if they are considering VAD? If so, should such counselling be compulsory? Why? AND*

*36. How could a VAD scheme be designed to minimise the suffering and distress of a person and their loved ones?*

We welcome the recognition that legalising VAD will cause suffering and distress to the person contemplating VAD and their loved ones. Please also see the answer to the previous question with regard to the place of counselling.

A person facing death may feel guilty for not requesting VAD if they believe their loved ones are distressed by their suffering. The loved ones may feel guilty, either at the time or years later, because they fear that they have in some measure coerced the patient into something they did not want, or because the patient would not have felt the need for VAD if they had been more caring. It is difficult to live with a conflicted conscience, especially when there is no possibility of undoing the damage, as in the case of VAD. One study found that 20% of relatives of patients who died following assisted suicide had post traumatic stress disorders<sup>v</sup>.

This may perhaps be mitigated by counselling sessions where the person considering VAD and their loved ones are encouraged to interact in a safe environment and explore the question of guilt.

However, there will be times, circumstances, and complex relationships where this is impossible to do safely. Some people will not want their loved one to undergo VAD, and this will be a source of conflict which strains relationships at the very time when people wish to draw close. This may compound the grief reaction in the bereaved person. In these circumstances follow up and the offer of ongoing counselling must occur for those who are at risk of further suffering and distress. As the state has allowed the VAD, they should fund the alleviation of consequential distress.

*37. Should medical practitioners be allowed to hold a conscientious objection against VAD? If so, why? If not, why not?*

We are concerned with the phrasing of this question, as we do not believe those writing it intend the state to be involved in regulating people’s beliefs or dictating matters of conscience. The state cannot in fact allow or disallow people to hold opinions. They can prohibit them expressing these opinions or acting on them, and we will take the question to mean this; that is, “Should medical practitioners be allowed to refuse to participate in VAD?”

Nevertheless we are surprised at the question. Since the Hippocratic oath was written in approximately 400 BC, medical ethics has prohibited doctors from killing people. To expect this long standing ethical principle to be overturned by an act of parliament is unusual to say the least.

As late as 2016 this has been the Australian Medical Association's position. That is, "The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life."<sup>vi</sup>

We also note and support the Australian Medical Association Code of Ethics (revised 2016) which advises medical practitioners as follows: "4.2.3 Recognise your right to refuse to carry out services which you consider to be professionally unethical, against your moral convictions, imposed on you ..."

Many health practitioners will find state sanctioned killing abhorrent and unethical. To attempt to coerce these people to assist in the killing of another human being will violate their consciences, damage their relationships with other staff (not to mention their patients and their families), and build resentment towards the system in which they are working. Coercion would also almost certainly result in workplace discrimination against people who for religious or other reasons conscientiously object to VAD. If taken to the extreme, such people will be excluded from some health professions.

State coercion seems quite contrary to the focus on individual autonomy or promotion of a "pro-choice" ethic which we presume underlies the endorsement of VAD. If the process being advocated is autonomous and voluntary for the one seeking this course of action, why should the same rights not be extended to health practitioners? Dying, is not, after all, a treatment, and places medical practitioners at odds with the "first do no harm" principle of the Hippocratic Oath. One would expect that those who promote VAD because of commitment to the principle of autonomy might also support the freedom of health practitioners to choose not to be involved in the ending of life.

There is also a practical aspect to this question. If an obligation for medical practitioners to be involved in VAD is written too broadly, then those who are incompetent in this area will be legally obliged to carry it out. Medicine has many specialities and sub-specialities, and no one practitioner is competent in all areas.

Many medical practitioners work in areas that are removed from situations where VAD might be discussed with a patient, for example in radiology and pathology. It would be foolish and even dangerous to pass VAD legislation that applied to all medical practitioners. Compelling any professional to operate outside their area of competence is potentially dangerous.

To coerce practitioners into this practice is also to ignore the mental health implications for those who participate. VAD causes significant emotional and psychological distress to those involved<sup>iii</sup>. To coerce a person into a practice which may cause them mental health problems is unethical.

*38. If practitioners hold a conscientious objection to VAD, should they be legally required to refer a patient to a practitioner that they know does not hold a conscientious objection or to a service provider that offer such a service? If so, why? If not, why not?*

This question is related to the previous one. Referral is a service, and where a practitioner refers a person for VAD they are still ethically responsible for the consequences of that service. Insisting that practitioners who hold a conscientious objection to VAD refer to a provider they know will offer VAD is to inevitably implicate them in the process. Clearly referral too is a matter of conscience. So it is illogical to adopt a position whereby medical practitioners are allowed to refuse involvement in VAD but must however be involved through referral.

Ultimately the question becomes: How far should the state be allowed to go in coercing health practitioners into practices they find unethical and against their conscience? And the related question logically follows: Does the state want to bar from practice those who find euthanising people unethical?

In fact, there is no need for medical practitioners to be involved in carrying out VAD. This is shown by the execution of criminals in the United States of America which occur without medical practitioner involvement.

As suggested above, medical practitioners may need to certify that death is likely within a given period (however unreliable this estimate) but others can provide counselling and assess the voluntary nature of the request (again, however unreliable this assessment is). Legislation could allow others to provide the required drugs without the need for medical practitioners' involvement. So coercion of medical practitioners is unnecessary.

An open letter signed by over 800 New Zealand doctors states, "Doctors are not necessary in the regulation or practice of assisted suicide. They are included only to provide a cloak of medical legitimacy."<sup>vii</sup> To compel doctor involvement for what can be perceived as a "cloak of medical legitimacy" is unethical.

It is of interest that a survey of selected physicians in Canada found that though the majority supported physician assisted suicide, most would not provide a prescription for drugs to end life to an eligible patient. They preferred another party to do this<sup>viii</sup>.

The question of competence is also relevant for referral. Some medical practitioners have no need to refer to other medical practitioners. For example, those involved solely in Travel Medicine do not see sick people so do not have any established patterns of referral.

Queensland Baptists acknowledge the dependence of parts of this paper on the one prepared by Australian Baptist Ministries, of which we are a constituent part. This paper was entitled "Submission on the Medical Services (Dying with Dignity) Bill 2014". We also acknowledge some sentences have been taken from a letter written by our sister organisation, Baptist Churches of NSW and ACT, entitled "Letter sent to all members of the Legislative Assembly & all Members of the Legislative Council in New South Wales, Re: NSW Voluntary Assisted Dying Bill 2017", dated 3<sup>rd</sup> October 2017.

In response to question 27, *If you are a health practitioner, what are your views on having a scheme in Queensland to allow VAD?*, we note that the initial draft of this submission was written by a medical practitioner, Dr Neil Parker (MED0001380985) and reviewed by another registered medical practitioner (non-practising), Rev Murray Lean (MED0001341382).

*References are included as end notes on the following page.*

- i We support the AMA Code of Ethics (2016) section 2.1.15 which states:  
“Respect the right of a terminally ill patient to receive relief from pain and suffering, even where that may shorten their life.”
- ii Physician-Assisted Suicide and Euthanasia: Emerging Issues From a Global Perspective, *Journal of Palliative Care*, In Press, <https://doi.org/10.1177/0825859718777325>
- iii Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia on Participating Physicians, *Issues in Law & Medicine*, 2006;21(3): [http://www.pccf.org/articles/issues\\_law\\_medicine\\_stevens\\_article.pdf](http://www.pccf.org/articles/issues_law_medicine_stevens_article.pdf)
- iv An Open Letter from Christian Leaders to the Premier of Victoria regarding the Proposed Victorian Assisted Suicide and Euthanasia Bill, 31 July 2017.
- v Death by request in Switzerland: post traumatic stress disorder and complicated grief after witnessing assisted suicide. *European Psychiatry*, 2012;27(7): 542-546. doi:10.1016/j.eurpsy.2010.12.003. Quoted in ii above.
- vi Euthanasia and Physician Assisted Suicide, AMA Position Statement 2016, section 3.1.  
<https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402>
- vii Doctors want no part in assisted suicide: <http://www.doctorssayno.nz/>
- viii Physician Assisted Death: A Canada-wide survey of ALS health care providers. *Neurology*, 2016;87(11)