The Presbyterian Church of Queensland
ABN 43 015 755 489

Our ref:
Date: 15 April 2019

To the Committee Members

We present here a submission by the Presbyterian Church of Queensland in relation to the inquiry into aged care, end-of-life and palliative care and Voluntary Assisted Dying.

We trust that this submission will be helpful to your work.

Yours faithfully

Rev Michael O'Connor
Moderator of Assembly

Rev Peter Barson
Clerk of Assembly

Dr Robyn Bain
Convener – Gospel in Society Today Team

Street Address: Level 4, 19 Lang Parade, MILTON Q 4064
Postal Address: PO Box 1351, MILTON LPO Q 4064
Phone: (07) 3716 2800 **Fax:** (07) 3716 2810 **Website:** www.pcq.org.au

The Presbyterian Church of Queensland

This submission has been prepared by the Gospel in Society Today team (GiST) on behalf of the Presbyterian Church of Queensland (PCQ). Approximately 7500 people attend PCQ churches across Queensland each week. PCQ has sought to faithfully serve the Queensland community in many ways for almost two centuries, and is directly involved in providing health care, aged care, community and chaplaincy care as well as school and tertiary education.

For further information regarding the position of the GiST team and PCQ, please contact the convenor of the committee:

Dr Robyn Bain

Presbyterian Church of Queensland Offices

Level 4, 19 Lang Parade
Milton QLD 4064

Ph: 07 3716 2800

Email: rbain@qtc.edu.au

We welcome and are thankful to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee for this opportunity to make a submission regarding voluntary assisted dying (VAD). We are also very thankful for this inquiry and we pray that God will give you wisdom and courage in this important work.

Summary of Our Position

In this submission, we detail our responses to the following issues for consideration:

Question 21 - **How can the delivery of palliative care and end-of-life care services in Queensland be improved?** We support Aged and Community Services Australia (ACSA) recommendations in their submission to the committee that increased provision of palliative care services be funded, particularly for those dying in residential care services and in their own homes.

Question 25 - Should voluntary assisted dying (VAD) be allowed in Queensland? We urge the Committee to recommend that Voluntary Assisted Dying *not* be allowed in Queensland. We urge this in order to safeguard compassionate care for the suffering and vulnerable in our community. Instead, we ask the committee to recommend increased provision and access to high quality palliative care services.

Question 37 - Should medical practitioners be allowed to hold a conscientious objection against VAD? We argue that medical practitioners should be not only allowed to hold a conscientious objection against VAD but should be supported and protected in their stance.

Question 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? We argue that if practitioners hold a conscientious objection to VAD, they should not 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 offers such a service.

Reasons for Our Position

As Christians, we believe that God speaks to us in our suffering and dying with a message of solid hope and deep compassion. We experience His care for us through relationship with His Son, Jesus Christ. Knowing personally the profound hope and comfort Jesus brings to us in

even the most severe suffering, we long to share this with the people of Queensland as they face suffering and dying too.

We believe that the practice of VAD is not a compassionate response to suffering. God's message of compassion In Jesus Christ provides a very different perspective to suffering and dying compared to the beliefs and assumptions that drive VAD. The Bible shapes our perspective as follows:

- Humans are not autonomous beings but wholly dependent on the life-giving generosity of God. We have been made to enjoy Him and thrive in obedience to His words to us. Every person, every life and every decision we make about our life is significant because we are God-made and God-purposed. We are also made to thrive within interdependent human relationships that seek to honour and care for the other.

- This life now is not all there is. Our life now and after death is in the hands of God. Trying to wrest control from God, including control over our own life and death, is an expression of defiance towards Him. The universal human desire for self-rule leads to self-centred relationships and profound suffering. It deserves His judgement. Death and the subsequent eternal punishment of separation from God is His punishment for self-rule. Thus, death does not lead to nothingness and death itself does not release us from suffering.

- Only God can provide our release from judgement. In love He chose to do so through Jesus Christ. Only through turning from self-rule to trust in Jesus' death and resurrection on our behalf can our suffering be fully relieved after death. Trusting Jesus, therefore, provides hope and perspective through suffering. A 'good death' is only found in Jesus.

- To act with compassion means pointing those who are suffering and dying to true release in Jesus. This involves affirming the value of every person by showing them unconditional, generous, thoughtful and skilful care to the end of their lives. Medical care is God's gift for helping and restoring people according to His design. It is not compassionate to enable others to take life and death into their own hands, and to allow individual choice that may harm the vulnerable. These measures provide no way out of suffering, both now and in the future.

End-of-Life and Palliative Care: Issues for Consideration

21. How can the delivery of palliative care and end-of-life care services in Queensland be improved?

We urge the committee to consider and accept Aged and Community Services Australia (ACSA) recommendations in their submission to the committee. These are:

- increased provision of palliative care services be funded for those dying in residential care services and in their own homes. This includes upskilling of the aged care workforce as well as increased access to palliative care resources and equipment.
- Training of health professionals in palliative care skills including specialists, GPs, nurses, allied health practitioners and carers
- Identification of core palliative care medications and supporting medical practitioners to implement anticipatory prescribing of these medications.
- Resourcing of palliative care facilities
- Research into end-of-life care.

We also urge the committee to pay particular attention to the following factors in palliative care provision: lower socioeconomic status, non-English speaking and indigenous backgrounds, regional areas, nursing homes, very young age and non-cancer diagnoses.

Voluntary Assisted Dying: Issues for Consideration

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

We urge the committee to recommend that Voluntary Assisted Dying *not* be allowed in Queensland.

We urge this in order to safeguard compassionate care for the suffering and vulnerable in our community. Advocates of VAD argue that individual people should be able to choose the way in which they die. While we agree that the state should uphold considerable freedom of individual choice, this should not be upheld to the detriment of supportive and protective social relationships within Queensland communities.

The current prohibition on taking the life of a person or enabling their suicide is a vital boundary for protecting people and relationships within our communities. As a Christian denomination that cares for the elderly, sick and vulnerable in multiple ways, we hold reasonable and grave concerns that the legalisation of VAD, while opening up choice for a few, will have profoundly negative consequences for many in Queensland

Our main reasons for arguing this position are as follows:

a. **While VAD legislation in Victoria and overseas seeks to ensure patients act without coercion, this does not take into account the subtle coercion that the choice of VAD itself creates.** Individual choices are profoundly shaped by social beliefs and structures. The process of VAD assessment supports those patients who adhere to VAD criteria in thinking that euthanasia or suicide is a valid and logical choice. This validation then creates tension within a health care culture that also seeks to honour and support life. Terminally ill patients will find themselves in a situation where hastening death is an option always at hand. They may well feel they need to defend to themselves and perhaps to others why they choose to stay alive, especially when they sense the burden of their care on others. Indeed, the same may eventually be felt by those with long term disabilities and chronic illnesses. It is telling that while an increasingly large percentage of the population are in favour of VAD, a very much smaller percentage of terminally ill patients desire it. In the face of death, patients generally desire more time, not less.[1] No VAD legislation can ensure that the quiet

[1] M. Best, 'Euthanasia' (October 2016) https://freedomforfaith.org.au/library/euthanasia

concerns and doubts of older, vulnerable and disabled people are adequately heard, and their desires and choices protected.[2]

b. **No legal safeguards can fully guard against the abuse and misuse of Assisted Dying practices, including the occurrence of Involuntary Euthanasia.** Transgressions and loosening of legal requirements have been demonstrated in jurisdictions in which VAD is allowed.[3] Moreover, we must acknowledge that, in the real world, those health professionals, family and friends close to a terminally ill person may encourage and enable VAD for reasons of personal gain. No formal safeguards can prevent subtle or masked expressions of selfishness in the use of VAD.

c. A community that supports VAD makes harmful assumptions about the nature of compassion and intolerable suffering.

- Fear, a sense of isolation and existential suffering in the terminally ill are major drivers of requests for VAD.[4] The compassionate response to those experiencing such suffering is not to allow a hastened death but to gather around them, tending to those needs and demonstrating the value of their lives. Indeed, our community would greatly benefit from recovering practices of generously and patiently attending to the dying, learning how to face our own deaths in the process. People are more than independent choice makers — they need loving relationships that provide physical, emotional, psychological and spiritual care in the face of death.

---

[2] J. Bishop, 'The Hard Work of Dying: Refusing the False Logic of Physician Assisted Suicide' (July 2014) https://www.abc.net.au/religion/the-hard-work-of-dying-refusing-the-false-logic-of-physician-ass/10099182

[3] J. Pereira, 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls' in *Current Oncology* 18(2) April 2011, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/
I. Tuffrey-Wijne, L. Curffs, I. Finlay and S. Hollins, 'Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012–2016)' in *BMC Medical Ethics* 19(17), 2018. https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-018-0257-6

[4] Dees MK, Vernooij-Dassen MJ, Dekkers WJ, Vissers KC, van Weel C, 'Unbearable suffering': a qualitative study on the perspectives of patients who request assistance in dying', Journal of Medical Ethics, 37 (12), 2011, pp. 727-34.
N. Richards, 'Assisted Suicide as a Remedy for Suffering? The End-of-Life Preferences of British "Suicide Tourists', *Medical Anthropology: Cross-Cultural Studies in Health and Illness,* 36 (4), 2017.

- A culture that allows VAD makes certain assumptions about what constitutes intolerable suffering and a life no longer worth living. In a society that values autonomy, independence, control and self-sufficiency,[5] those who are disabled, mentally ill, non-productive and dependent are easily judged to have intolerable lives. We argue, however, that vulnerability, interdependency and relationships of exchanging care are a natural part of flourishing human life. In both suffering and taking on the 'burden' of care for others, are opportunities for love, growth and finding meaning.

d. Increased access to high quality palliative care rather than VAD is the compassionate response to suffering in our community. Where good palliative care is available, the vast majority of patients receive the holistic care, including relational support and symptom control, needed to maximise quality of life as they die. Our responsibility as a community is not to attempt to minimise suffering by causing death, a practice that could all too easily substitute for the compassion, skill and relationships human beings need during the hardest moments of their lives. Our responsibility is to minimise suffering through maximising care. Indeed, we strongly commend the committee for undertaking an inquiry into aged care, end-of-life and palliative services.

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

We argue that medical practitioners should be not only allowed to hold a conscientious objection against VAD but should be supported and protected in their stance.

Our previous argument that allowing VAD in Queensland would have profoundly negative consequences for many patients in our health care system as well as for the community more

[5] D. Fleming, 'The compassionate state? Voluntary Assisted Dying, neoliberalism and the problem of virtue without an anchor' (March 2019) https://www.abc.net.au/religion/compassionate-state-voluntary-assisted-dying-neoliberalism-and/10937504

generally logically implies that no doctor, nurse or other health practitioner should be obliged to participate in or support the practice of VAD.

We urge the committee to consider the central role that medical practitioners would play in providing VAD. The shift away from the fundamental values of healing and protecting human life from harm, the weight of assessing patients for VAD, and the administration of lethal medication have been found to have very significant emotional and psychological effects on medical practitioners.[6]

We also urge the committee to consider the pressure that VAD legislation would place upon medical practitioners to provide VAD. Sources of pressure and even intimidation could be individual patients, relatives, health care facility managers, fellow health care practitioners and the community at large.[7]

We encourage the committee to recommend that those medical practitioners with conscientious objections to VAD be supported and protected in their choice.

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?

We argue that if practitioners hold a conscientious objection to VAD, they should not 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 offers such a service.

---

[6] K. Stevens, 'Emotional and psychological effects of physician-assisted suicide and euthanasia on participating physicians' in *Issues in Law and Medicine* 21(3) Spring 2006, https://www.ncbi.nlm.nih.gov/pubmed/16676767
R. Pies, 'How does assisting with suicide affect physicians?' (January 2018), https://theconversation.com/how-does-assisting-with-suicide-affect-physicians-87570

[7] K. Stevens, 'Emotional and psychological effects of physician-assisted suicide and euthanasia on participating physicians' in *Issues in Law and Medicine* 21(3) Spring 2006, https://www.ncbi.nlm.nih.gov/pubmed/16676767

Such a requirement violates the rights of practitioners who both feel such a referral makes them complicit in act of the VAD and is contrary to their duty of care for patients.

Moreover, a genuinely secular society should not privilege the beliefs of one over another by allowing a patient's freedom of conscience and choice to override that of a practitioner. Indeed, it is beneficial for the integrity of health care provision that health care practitioners are able to act as self-consciously moral agents. To override the freedom of conscience of practitioners would likely force some into another profession and deter new entrants. Moreover, it is unreasonable to legally require such practitioners to make a referral for VAD if measures are taken to make VAD widely available in Queensland.

Conclusion

We call upon the committee to recognise:

- The need of every person for physical, emotional, relational and spiritual care as they face death
- That our responsibility as a community is not to attempt to minimise suffering by causing death, a practice that could all too easily substitute for the compassion, skill and relationships human beings need during the most difficult moments of their lives. Our responsibility is to minimise suffering through maximising care.
- That VAD would introduce harmful assumptions about the nature of compassion and intolerable suffering, creating coercive pressure on vulnerable sufferers and medical practitioners to use VAD, and undermining the choice to die a natural death.

Hence, we urge the committee to recommend that:

- Palliative Care service provision be improved, particularly for those dying in residential care services and in their own homes.
- Voluntary Assisted Dying *not* be allowed in Queensland.
- medical practitioners should be not only allowed to hold a conscientious objection against VAD but should be supported and protected in their stance.

- if practitioners hold a conscientious objection to VAD, they should not 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 offers such a service.