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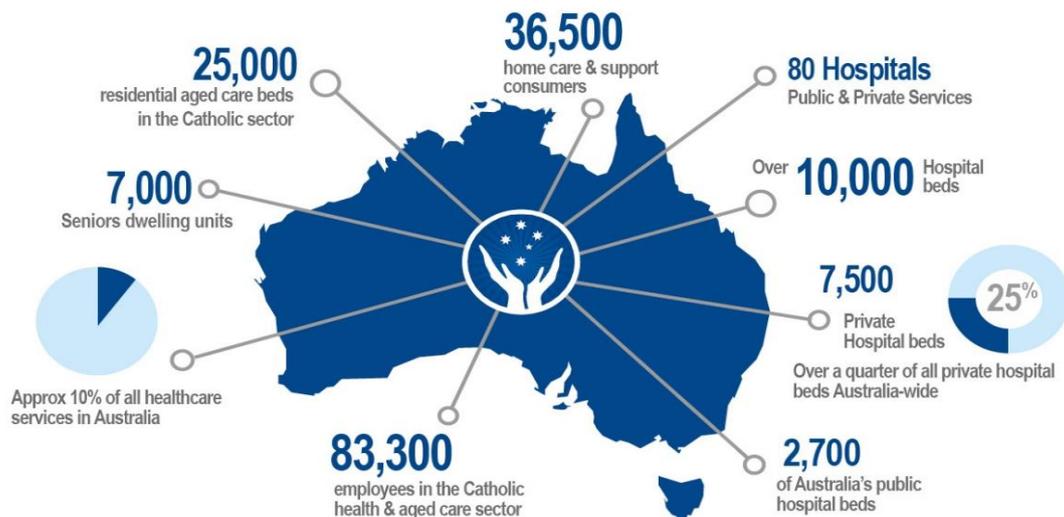
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PARLIAMENT HOUSE  
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Via email: [careinquiry@parliament.qld.gov.au](mailto:careinquiry@parliament.qld.gov.au)

Dear Committee Members,

**CHA Submission to Queensland Inquiry into aged care, end of life and palliative care and voluntary assisted dying**

*Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10 per cent of hospital-based healthcare in Australia. Our members also provide around 25 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly.*



In Queensland (QLD), our member services include Mater group including both public and private facilities, Mater North Queensland, St Vincent's Health Australia, Mercy Health and Aged Care Central Queensland, Ozcare, Southern Cross Care (QLD), Canossa and the Queensland Hibernian Friendly Society Ltd.

CHA welcomes the opportunity to provide feedback on behalf of our QLD members to the inquiry into aged care, end of life and palliative care and voluntary assisted dying. QLD members of CHA requested and guided this submission.

We note that the panel requests feedback on issues of aged care, end of life and palliative care service delivery across the QLD health and ageing service system as well as views of the implementation of Voluntary Assisted Dying legislation. Our members offer a wealth of clinical expertise and experience in this area, particularly with regard to delivering quality end of life care and palliative care - services which Catholic health providers have a long history of providing. CHA has consulted with these experts in tandem with other healthcare professionals integral to providing our hospital and aged care services.

CHA members have always valued the delivery of person-centred care that is founded in a respect for human dignity and life. CHA's view is that it is never permissible to purposefully end an individual's life through euthanasia or assisted suicide because we believe it compromises the inherent value of the person and erodes trust in the medical profession who must care for individuals at all points in their journey.

Please find **attached** our submission for your consideration in which CHA presents a unifying call to action for the QLD government and stakeholders to better support and resource quality end of life care and palliative care.

Should you have any questions or require further information, please do not hesitate to contact me directly: (02) 6203 2777, or email [suzanneg@cha.org.au](mailto:suzanneg@cha.org.au).

Kind regards,



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Chief Executive Officer  
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## Introduction

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10 per cent of hospital-based healthcare in Australia. Our members also provide around 25 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly. Our members operate 80 hospitals, over 25,000 aged care beds, and more than 36,500 care in the home and support services across Australia. In QLD, our member services include public and private facilities of the Mater Group, Mater North Queensland, St Vincent's Health Australia, Mercy Partners Queensland, Ozcare, Southern Cross Care (QLD) and the Queensland Hibernian Friendly Society Ltd.

CHA members have always valued the delivery of person-centred care that is founded in a respect for human dignity and life. We welcome the opportunity to offer a response to the inquiry into aged care, end of life and palliative care and voluntary assisted dying in QLD, and we do so from the position that it is the medical profession's duty of care to preserve and protect life. CHA's view is that it is never permissible to purposefully end an individual's life through euthanasia or assisted suicide because we believe it compromises the inherent value of the person and erodes trust in the medical profession who must care for individuals at all points in their journey. Based on our experience, CHA believes high quality aged care, palliative care (PC) and end of life care are the best options to allow freedom of choice, comfort, dignity and respect as a person nears the end of life, not just for the individual, but also for the family, carers, and community that surrounds them. We support the approach outlined by the Productivity Commission that recommends to address gaps in end of life care, state and territory governments need to increase the availability of PC services across their jurisdictions (Australian Government Productivity Commission, 2017).

## Aged Care

CHA notes that, under law, the provision of aged care services in Australia is the responsibility of the Australian Government. Under the *Aged Care Act 1997* and the *Aged Care Quality and Safety Commission Act 2018*, and related subordinate legislation, the Commonwealth regulates and contributes funding, including to state and territory government entities, for the provision of residential and home-based aged care services.

CHA also notes that the aged care-related issues listed in the issues paper apply Australia-wide and are currently the subject of inquiry by the Australian Government Royal Commission into Aged Care

Quality and Safety. As well as assessing the extent of sub-standard services and the extent to which they may be the result of systemic failures, the Royal Commission is required to investigate:

- how best to deliver dementia care,
- the future challenges and opportunities for delivering accessible, affordable and high quality aged care services,
- what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the aged care system,
- how to ensure person-centred care by allowing people greater choice and control in relation to their care, and
- how best to deliver aged care services in a sustainable way.

CHA's Witness Statement provided to the Royal Commission addresses many of the above issues, including how well the current aged care system meets the needs of people accessing aged care and the community, how well-equipped the aged care system is to meet the future needs of the Australian community, in what way the current system does not meet needs, what the most important issues facing aged care over the next 20 years are, and what changes might be made to improve the system.

A copy of CHA's Witness Statement is available on our website for your consideration: <https://www.cha.org.au/images/agedcare/2019/Statement-NGM-050219.pdf>

A matter of direct relevance to state and territory governments identified in CHA's Witness Statement is the interface between residential aged care services and the wider Medicare health sector. CHA regularly receives feedback that the current interface between residential aged care and the health sector is not working in the interests of people living in residential aged care.

Aged care homes are not self-contained health services. In order for residents to receive timely access to medical services, they are heavily reliant on the wider health care system. As for any Australian living in the community, aged care residents should have timely access to medical services when needed.

Of particular relevance to this inquiry, is timely access to specialist PC services. However, access to specialist PC services provided by PC specialists and specialist nurse practitioners varies across regions and jurisdictions, and is often dependent on health priorities determined at the local level. Notwithstanding this, there are examples where it has been demonstrated that in-reach PC services reduce health system costs and result in better outcomes for people. For example, a program operating in the ACT that provides aged care residents access to specialist care nurse practitioners, education and support for aged care staff and access to equipment has been demonstrated to not

only improve the palliative care experience of residents but also to reduce hospital costs (Forbat et al, 2019).

Accordingly, CHA recommends that a key focus of this QLD inquiry is to explore and recommend options for expanding the availability of in-reach specialist PC services for QLD's aged care homes.

### End of life and Palliative Care (PC)

Compassionate, person-centred palliative care (PC) is an indispensable service within the Australian health care system, particularly in the context of Australia's aging population. PC provides holistic care to patients with debilitating and terminal illness. It is coordinated between the patient, and a multidisciplinary team comprised of clinicians, nurses, necessary allied supports and pastoral care to address the physical, psychological, spiritual, and social needs of the individual.

One of the primary arguments for changes to end of life legislation is that people are suffering at the end of life and current legislation does not facilitate choice and effective treatment to relieve that suffering. However, CHA strongly believes this is not the case. PC currently incorporates many practices that accommodate choice, alleviates suffering, provides comfort, and neither hastens nor postpones death when a terminal illness renders it inevitable. This can include withdrawal of treatment, palliative sedation, or the slow increase and control of pain medications. In the majority of cases, these practices are highly effective and patients experience peaceful deaths. Of the approximately 50,000 palliative care patients admitted to Australian hospitals each year, less than 1 per cent express a sustained desire for additional intervention in the form of physician-assisted suicide (Hudson et al, 2015). High-quality PC is best practice to alleviate suffering and provide comfort allowing a respectful and peaceful end of life.

In February 2019, CHA released a report, Palliative Care in the Catholic Sector, which can be found on our website [www.cha.org.au](http://www.cha.org.au) (Catholic Health Australia (CHA), 2019). This report outlines CHA member services delivered across Australia, barriers and enablers to service as identified by our members, a number of innovative programs CHA members have undertaken to improve PC services in their area and provides recommendations for improvements to services. Priorities for improvement should include those initiatives that enhance:

- Equity in access to care for under-served groups such as Aboriginal and Torres Strait Islander people, those with a non-malignant disease and aged-care residents.
- The ability of people to die in their homes or residential facility by improving access to community-based care.
- The evidence-base for a variety of PC-related aspects of care.

## PC Services in QLD

CHA members provide 13 per cent of all PC-related hospitalisations in Australia. This includes 6 per cent of public PC services and more than 50 per cent of all private PC and private PC inpatient beds.

In QLD, CHA members provide tertiary based PC at the St Vincent's Private Hospital Brisbane (SVPHB) and the Mater Hospital Brisbane, community-based PC services at SVPHB and a number of outreach programs. Of note, SVPHB was among the first organisations to provide private health insurance funded PC in the community setting.

### **St Vincent's Health Australia, St Vincent's Private Hospital Brisbane (SVPHB)**

SVPHB operates the largest PC inpatient facility in QLD, a 40-bed SPC inpatient unit, with shared public and private beds. The service also operates a consultative model of care across the hospital and to other local health services, as well as a specialist community palliative care service across the Brisbane Local Government area. SVPHB is one of the few examples of a private hospital offering private health insurance funded community-based PC.

### **Mater Health Services, Mater Hospital Brisbane**

The Mater Hospital Brisbane has a multidisciplinary PC nursing and medical service with daily outpatient clinics in the Mater Cancer Care Centre, as well as inpatient support and admission to the oncology wards in both the public and private hospital, accounting for approximately 20 inpatient beds.

The Mater Hospital Brisbane also delivers support for the transition between the tertiary and primary sectors for RACF residents, their families, carers and GPs through the Older Person-Centred Care Team (OPCCT). OPCCT forms part of the service that provides PC to older people in their homes and 91 nursing homes in Brisbane Metro South, covering 7,700 residents. Support includes a 24-hour telephone support and education programs for GPs, nurses and staff in RACF.

This initiative has seen reduction in hospital deaths, ward admissions and length of stay of RACF residents. OPCCT support reduced hospital deaths by 88 per cent, with most people able to return to their setting of preference to die. Ward admissions of RACF residents was reduced by 40 per cent and average length of stay for admissions was reduced by 38 per cent. The reported cost benefit of this program is 10:1.

## Are Services Meeting Demand for PC in QLD?

PC services in QLD do not meet the needs of Queenslanders. The demand for services far exceeds the services available, particularly for community-based PC services (Australian Government Productivity Commission, 2017). In 2013, a report found that specialist services in Queensland are "understaffed,

under-resourced, mostly have insufficient beds, and do not have the capacity to provide adequate community care and after-hours cover” (Queensland Parliament Health and Community Services Committee, 2013). It is also estimated that “perhaps tens of thousands of people cannot access desired support to die in their own home and die in hospital instead” (Australian Government Productivity Commission, 2017).

As a result, QLD has the highest rate of PC-related hospitalisations in public hospitals that ended with death (56.7 per cent) and the second highest rate of death in private hospitals (61.8 per cent) (Australian Institute of Health and Welfare (AIHW), 2018). Furthermore, the latest available Palliative Care Outcomes Collaboration (PCOC) data for QLD indicates that services struggle to meet outcome benchmarks, particularly in the community sector (Allingham S et al, 2018).

Aside from the volume of demand exceeding availability of care, concerns remain regarding equity of access to care for those who are in aged care facilities, from Aboriginal or Torres Strait Islander or culturally and linguistically diverse (CALD) communities and those who have non-malignant diseases.

This inquiry presents an opportunity to address barriers that exist in the PC system, particularly those that result in under-resourcing and fragmentation in access to best-care in QLD. The CHA report into Palliative Care in the Catholic Sector describes a number of these barriers, the most significant of which are inadequate funding and restrictive funding models, fragmentation of care, nursing workforce shortages, workforce and community awareness of PC and a lack of research investment.

State and federal funding models create fragmentation and act as a barrier to services. In terms of federal funding for example, there are significant inconsistencies in the ability of practitioners to claim Medicare Benefits Schedule (MBS) PC items and many PC-specific MBS items are considered to be under-remunerated. The Aged Care Funding Instrument (ACFI) is another example of a funding barrier. The ACFI requires the person to be in the terminal phase of care, with a complex and administrative burdensome assessment process to access PC funding which often does not provide any additional funding due to the structure of the funding instrument. Moreover funding under ACFI is not intended to cover the cost of residents accessing specialist palliative care. Similarly, the proposed new funding model for funding care in aged care homes being developed following the Resource Utilisation and Classification Study is not intended to cover the cost of specialist palliative care services, though it is proposing a separately funded classification for residents with a palliative care plan.

In QLD, the state funding models of care also create fragmentation of the system geographically, which significantly impacts equitable access to PC. For example, specialist inpatient PC providers in Brisbane South are unable to provide inpatient services to patients, many of whom are vulnerable

and disadvantaged, in Brisbane Metro or the northside of Brisbane, regardless of where the closest inpatient service is located or the needs of the patient.

In QLD there are also reported time-restricted access policies operating in non-CHA member public community PC services. In these instances, people can only access specialist community PC when they are within 3 months of the end of their life. Such restrictions should immediately be removed.

### Community Expectations of PC

Widespread misperceptions and lack of understanding of PC act as a barrier to access. PC is thought by many to encompass pain relief, pain relief with the meaning to hasten death and to be a place where you go to die (Allingham S et al, 2018). This understanding is not limited to health care consumers, but also an understanding held by many health care professionals and represents a significant barrier to accessing PC services (Weil J et al, 2015). Many health professionals and the community retain a view of PC as terminal care, which is appropriate only after disease-modifying treatment has ceased (Johnson C et al, 2011).

There remains a significant and persistent stigma associated with death and dying amongst health care professionals and in the Australia population in general. Low levels of awareness limits quality and access to care through late referral to PC services, poor symptom control, lack of use of Advance Care Planning (ACP), distress and loss of time to form acceptance (Sellars M et al, 2015). Currently in Australia, 'almost two-thirds of terminally ill people for whom home or hospice palliative care would be appropriate die in hospital, often receiving heroic interventions' that are frequently distressing and unnecessary (Australian Government Productivity Commission, 2017). Initiatives aimed at increasing awareness of PC in QLD have the potential to improve early referrals and engagement with PC services, and ultimately patient outcomes.

Once PC has been engaged, people and their carers expect access to PC services in a timely manner, care in the place of their preference, which for most people is at home, and a holistic approach to care. In QLD and in Australia in general, referral to PC is largely during the terminal phase of someone's life, which often results in suboptimal care and death in hospital rather than at home.

Patients' preferences in PC include living a meaningful life, responsive health care personnel and care environment, responsiveness in the organisation, the ability for their condition to be managed at home, return to home after symptom management if a hospital admission is necessary, personal autonomy, pain relief and family/social support (Sandsdalen T et al, 2015) (Giardini A et al, 2011). While many services are able to provide holistic care, the aforementioned barriers urgently need to be addressed in order to ensure people experience the good death they expect and are entitled to.

### Demand for PC in the Future

PC delivery in QLD is challenging given the high concentration of the population in the southeast of the state and sparse population separated by long distances in the rest of the state. However, more Queenslanders will need end of life services including PC in the coming years than ever before. Demand for PC services is predicted to increase dramatically over the coming decades. By 2056, those aged over 65 will increase from 15 per cent to 22 per cent and the proportion of people aged over 85 will double. As a result of the ageing population and high rates of chronic disease, the number of deaths is increasing rapidly and is predicted to more than double by 2061 (Australian Bureau of Statistics, 2016).

Given the current inquiry into end of life care, it is important to note CHA members' concerns regarding PC, should assisted dying be legislated in QLD. In such a case, it is likely that a significant additional burden will be placed on already stretched PC services to deal with patient and staff education requests and referrals. These concerns have support; internationally, where similar VAD legislation has been approved, services experienced increased workload on PC services generated by referrals, staff training and additional services (Dierickx S et al, 2018).

### Challenges Associated with Delivery of PC in Regional, Rural and Remote QLD

There are long standing concerns with equity of access to quality PC as a result of variability in access for those in non-urban areas (The Productivity Commission, 2016). Both tertiary and community-based services are inadequate and find it difficult to meet the geographical challenges of providing care in regional areas in a timely manner.

Public provision of PC in regional areas often relies on contracting of services from private hospitals in order to meet need; approximately 12 per cent of PC-related hospitalisations in regional and remote Australia occurred in private hospitals in 2014-15 (Australian Institute of Health and Welfare (AIHW), 2018). In CHA member private hospital services in regional areas, 30 per cent of PC services are publicly funded.

However, changes to the private health system in Australia mean that regional private hospitals are increasingly facing challenges to remain financially sustainable. There are a smaller proportion of people in regional areas with private health insurance cover, with 74 per cent of PC hospitalisations in private hospitals in metropolitan areas covered by private health insurance compared to 51.9 per cent in regional areas. Furthermore, the number of patients using private health insurance to fund PC is decreased at a rate of 7.1 per cent in regional areas between 2014-15 and 2016-17.

In our experience in regional areas, patients of tertiary services are also significantly less likely to receive specialist PC services, likely as a result of the necessity of PC to be delivered in other areas of

the hospital due to limited specialist staff and dedicated facilities. While this does not necessarily mean that the quality of care is poor, however, it is reasonable to assume that specialist PC physicians are able to provide better PC than non-specialists. The current model of non-specialist physicians providing PC can be improved by enabling 24hr access to specialist consultancy services for physicians to seek advice.

#### Challenges of Delivering PC for Aboriginal and Torres Strait Islander communities

Indigenous Australians are amongst those who are least likely to access adequate PC, despite the need created by a disproportionate burden of chronic disease and higher mortality rates compared with non-Indigenous Australians (Australian Institute of Health and Welfare (AIHW), 2018). Some cultural and spiritual aspects of death and dying for Aboriginal people are not well supported by conventional western health care. For example, dying on country or in the community can be a core consideration, however, the remoteness of some communities and a lack of culturally appropriate services act as a barrier to achieving this (Waran E et al, 2016).

Adoption of a culturally appropriate palliative approach has been slow, particularly in remote and culturally diverse communities, such as those of Cape York. Specialist services can only be accessed via Cairns, resulting in the need for people to travel over 1000 kilometres to Cairns for treatment. Return to the community following treatment can also be challenging. In 2016, a tripartite agreement was established between St Vincent's Health Australia (SVHA) (CHA member), Northern Peninsula Area (NPA) Family and Community Services and Apunipima Health Council, to undertake a 3-year PC project. The project, funded by SVHA, aims to develop a model of PC for remote Indigenous communities and to understand the PC needs of local communities and what a patient journey could be enables a patient to die on Country. For more information on this project please see page 17 of the submission prepared by St Vincent's Health Australia.

At the project's half-way point, extensive community consultation and action-based research has led to the development of a draft model of care informed by the experiences of 10 clients, a large number for the size of the community. Reported benefits from the project also include improving community PC capacity and building cultural awareness of health care workers who visit the community.

#### Key PC Priorities for the Future

CHA's report on Palliative Care in the Catholic Sector outlines a number of innovative programs CHA members have undertaken to improve PC services in their area which can be replicated in other parts of the country (Catholic Health Australia (CHA), 2019). The report also provides recommendations that are relevant to policy makers when considering changes to improve PC in Australia. These recommendations include:

1. **Establish a National Palliative Care Alliance** to act as an expert independent advisory body to the Australian Government on issues relating to PC. This could be replicated in the QLD jurisdiction in order to address QLD-specific PC issues.
2. **Address systemic funding and access issues.** This includes urgently reviewing explicit or implicit time dependent access requirements, levels of remuneration and barriers to service inbuilt in funding models and public hospital payments.
3. **Strengthen community-based PC to increase at-home death rates and reduce hospitalisations.** This requires increases in resourcing for community services, including intensive in-home support, 24-hour access to telephone support and PC consultancy for all community PC services. Mechanisms to expand the services provided by organisations with existing capabilities should be considered.
4. **Explore and recommend options for expanding the availability of in-reach specialist PC services for QLD's aged care homes.**
5. **Build the capacity of the health and aged care workforce to recognise and respond to PC needs.** The development of capabilities frameworks for aged care and health care staff, ongoing funding for education programs and strategies to address urgent shortage of trained PC nursing staff are needed.
6. **Establish a mandated national minimum data set for PC data collection and continue to work on validated indicators to assess improvement in PC delivery.** In QLD, this should include assisting and encouraging all PC organisations to contribute to PCOC data collection.
7. **Invest in drivers of innovation including increasing PC research funding** using targeted funding opportunities.
8. **Initiate the conversation to improve PC awareness** through funding for PC services and other appropriate organisations to improve end of life literacy and community education about PC, end of life planning, death and dying.

## Voluntary Assisted Dying

CHA's view is that it is never permissible to purposefully end an individual's life through euthanasia or assisted suicide because we believe it compromises the inherent value of the person and erodes trust in the medical profession who must care for individuals at all points in their journey.

Catholic health and aged care services are committed to the ethic of healing, the ethic which is found in both the Hippocratic tradition of medical practice and the long Christian tradition of providing care, especially for poor and vulnerable people. The main features of this ethic as it pertains to people who have a life-limiting illness and/or are nearing the end of their lives are set out in the *Code of Ethics for Catholic Health and Aged Care Services in Australia* (Catholic Health Australia, 2001).

These features include commitments to heal and never to harm; to relieve pain and other physical and psycho-social symptoms of illness and frailty; to withdraw life-prolonging treatments when they are futile or overly burdensome or when a person wants them withdrawn and gives informed refusal of these treatments; and to never abandon patients (Catholic Health Australia, 2001).

We are always committed to improving care at the end of life. In addition, we do whatever we can to ensure that such care is available to all people who need and want it. Though we always strive to ensure that those in our care die in comfort and with dignity, we will not assist them to end their own lives or provide euthanasia (Catholic Health Australia, 2001). We will always continue to promote and provide healthcare that is consistent with our Hippocratic commitment and ethic of care and which avoids harm, especially to those most vulnerable.

## Risks Associated With Voluntary Assisted Dying

CHA believes that there is no form of legislation that would enable VAD to be implemented in a way that guarantees public safety. The risks of VAD are wide-ranging and uncontrollable, threatening the health and safety of vulnerable groups, individuals, and communities, as well as fundamentally undermining the values and ethics that form the fabric of Australian society. It is CHA's belief that there is no way to adequately manage the risks of VAD.

## Safety Concerns of Experts

The World Medical Association (WMA) has publicly stated 'Physician assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.' It called on jurisdictions throughout the world to reject VAD bills warning that 'vulnerable people will be placed at risk of abuse' and 'a precedent will be set that physician assisted suicide and euthanasia are ethically acceptable'. The Australian Medical Association (AMA) shares this view opposing the implementation of VAD legislation

in Victoria. Despite conjecture that VAD can be implemented in a safe way, expert physicians and clinical groups clearly state that legalising VAD is dangerous, inherently risky, and could have many unintended harmful consequences for patients, family members, clinicians and the greater community.

#### Risk of Undermining Community Trust in the Medical Profession.

A large number of clinical experts agree that VAD will erode trust in the medical profession. 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 risks harming both the integrity, and the public's view, of the profession.

Public fear around death and dying has been exacerbated as euthanasia has become associated with PC practices in some Australian communities. People fear the goals and treatment strategies of PC are designed to hasten death, particularly when it comes to the use of some medications such as opioids. These medications are thought by some to be used to administer euthanasia as exemplified by the following example described by Hudson et al (2015):

*"In a busy hospital palliative care consultative service, there are daily discussions with patients, often elderly, who are fearful of opioids precipitating their death. On this day, an 82-year-old Greek man with newly diagnosed pancreatic cancer is concerned that the low dose of morphine prescribed for pain relief will result in his premature death. A great deal of time and reassurance is given, yet still he remains uneasy and reluctant to take effective analgesia."*

Fear of end of life care practices has the potential to be heightened by any attempts to legalise VAD, particularly among vulnerable and at-risk patients. There is a very real risk that patients may begin refusing lifesaving and pain reducing treatments because their trust in the medical profession has been fundamentally eroded and they fear that medical interventions may be used to end their life or that of a loved one.

#### Risk of Undermining Palliative Care

As highlighted above, a great deal of misunderstanding about PC services exists within Australia, both in the community and within the medical profession. Legalising VAD risks compounding the problem with people becoming even more confused about what PC is and what services it provides. It also risks undermining the role of PC within the community with people coming to believe it is an either/or scenario and choosing to forgo vital PC services in the hope of accessing VAD.

CHA PC practitioners believe that their roles as specialist medical providers will be limited and undermined if VAD is implemented. When VAD was enacted in the Northern Territory between 1996 and 1997, the role of the PC practitioner was minimised and became tokenistic. A requirement was implemented that all people wishing to access VAD seek approval from a PC specialist, as they were deemed the only medical specialist specifically qualified to determine a patient's holistic health status as they neared end of life. However, instead of being allowed to fully explore their physical, social, emotional, spiritual and psychosocial health as is the unique and essential role of this medical speciality, they became merely a checked box on the path to euthanasia. This completely undermined the role of PC within the community and led PC specialists to be viewed negatively as they became associated with fear and death (Hudson et al, 2015).

If VAD is legalised, it will require substantial government funding to implement, administer, and ensure essential safety standards and protocols. CHA is concerned that this will result in vital funding and investment being allocated to implement a practice that would be utilised by a small minority of people, when vital PC services that have proven population health impacts are chronically underfunded and under resourced (Hudson et al, 2015).

#### Risk of Inaccurate Prognosis

Clinicians have highlighted the risks associated with providing an accurate clinical prognosis regarding the longevity of a patient at the advanced stages of disease, and the difficulties of defining an individual as being 'at the end of life'. A study exploring the clinical details of the patients who sought euthanasia under the Rights of the Terminally Ill Act 1995 (ROTI), that legalised euthanasia for nine months in the Northern Territory between July 1996 and March 1997, found that of the seven who applied for euthanasia, there were three cases where consensus was not achieved on the terminal nature of the patient's condition (Kissane, Street, & Nitschke, 1998).

As the above examples demonstrate, there is significant difficulty defining and diagnosing terminal illness. 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. CHA is concerned that legalising VAD in any form would lead to the premature ending of lives that could otherwise have been very long and fulfilling with the development of technology and improvements in treatment.

#### Risk of Undermining Mental Health Prevention and Treatment

One of the greatest difficulties for health professionals is determining the mental wellbeing and decision-making capacity of a person nearing the end of life. Terminal illness obviously has a profound

impact on a person's state of mind contributing to significant periods of depression and low mood. In a study of 321 psychiatrists in Oregon, only 6 per cent were very confident that they could adequately determine whether a psychiatric disorder was impairing the judgement of a patient requesting assisted suicide (Ganzini, 1996).

This is also highlighted in the in the ROTI Act in the Northern Territory where of the seven cases who applied for euthanasia four were assessed to have depressive or suicidal thoughts, despite this two of those patients were granted access to voluntary euthanasia (Kissane, Street, & Nitschke, 1998).

The possibility that a person who is suffering from a mental illness would be allowed to access euthanasia is truly frightening. It undermines decades of work within the field of mental health to promote the value and dignity of each and every human being. Governments and experts have spent years trying to prevent suicide and promote mental health treatment, once again highlighted by the recent federal government announcement in the 2019 budget delivered on April 2 of \$461 million to be allocated to a strategy to prevent suicide and promote youth mental wellbeing (Australian Government, Department of Health, 2019). Yet, at the same time state governments are considering the legislation of legal suicide. What message does this send to society?

Australia has spent decades endeavouring to show that suicide is not the solution to a problem yet we are facing a growing movement of advocates working to undermine this narrative, sending a message to society that in some instances suicide is acceptable. This fundamentally undermines years of preventative work by the mental health profession and acts against the fundamental values of dignity and respect for life that have been the pillars of Australian communities. We urge the QLD government to consider the type of community it wants to create, and not act to create a community that does not value and respect the sanctity of human life.

#### Risk to Vulnerable

VAD legislation is particularly dangerous for vulnerable members of the community including; the elderly and frail, marginalised groups such as non-English-speaking Australians, prisoners, homeless, mentally and physically disabled, those living alone without supportive families, and Aboriginal and Torres Strait Islander peoples. These groups face increased susceptibility to abuse, mixed messaging, misinformation, and pressure from others.

Legalising VAD advances the misguided belief that the elderly, sick and vulnerable constitute a burden to society. This type of thinking along with internal and external pressures including; financial concerns, inadequate access to alternative services, physical and psychological abuse, misinformation about treatment options, or a reduced sense of worth and autonomy, may impact on the individual's

choice to make a request. These pressures may push an individual toward accessing VAD when it is a decision that they would not otherwise make. Hudson et al (2015) presents the following scenario:

*“An elderly woman was afraid of being a burden to her adult daughter, knowing that her daughter would need to take leave from work to care for her. This fear led her to express a desire to ‘end it all’.”*

Legalising VAD risks signalling to our most vulnerable members of the population that they lack value and are a burden. CHA maintains its position that person-centred compassionate care is founded on respect for human dignity to improve the living person’s ability to experience a meaningful period of life, leading to death, rather than neglecting the person at a point when they are the most vulnerable and in need of the greatest support.

There is also no way to ensure with complete certainty that vulnerable members of our community will not be coerced into accessing VAD. Evidence from the Netherlands shows that despite legislation that assisted dying must be voluntary and free from coercion, it has been estimated that in 0.7 per cent of cases a life was ended without the explicit and recurrent requests from a patient. This is equivalent to approximately 1000 patients since the Danish legislation was implemented (Van der Mass, 1996: Kowen 1995). This raises the question whether our society is willing to assume the risk if even one life ends prematurely due to coercion or guilt. CHA believes that it is the role of health care providers and governments to protect the vulnerable, not expose them to greater risk.

#### Risk of Legalising Lethal Drugs

The risks associated with the distribution of dangerous and lethal drugs that would be needed to end someone’s life if VAD was to be legalised are vast. 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. There exist very strict regulations for health professionals, yet in order to legalise VAD it is proposed that people with no training or experience be allowed to handle dangerous lethal drugs in their homes, without the checks and balances we mandate for experienced health professionals. How can this be considered safe? Who will ensure the appropriate use of these drugs and that they are not left around endangering the lives others? If the individual dies through natural causes, what requirements will be put in place for recovery of ‘unused’ lethal dose medication? As such, unused medications could command a price on the black market. If an individual takes with them a lethal dose medication, what safeguards will prevent them being induced to take the medication by coercion, psychological or personal pressure, or misinformation?

There are also reported instances of these dangerous drugs not working effectively and recipients experiencing a prolonged, painful death. Differences in personal medical history and body composition can make accurate prescription of lethal drugs very difficult that can result in serious unintended consequences. In Oregon, a longitudinal study found that 3 per cent of assisted suicides have complications including distressing symptoms, with the longest death recorded lasting 104 hours (4 days and 8 hours) (Hedberg et al, 2003: Oregon Public Health Division, 2017). In the Netherlands, it was found that 7 per cent of people experienced unexpected side effects such as regaining consciousness, vomiting, gasping for breath, and seizures (Groenewoud, 2000).

Furthermore, unintended effects of ineffective medication administration can create additional stress and grief for surviving family members which may have long-lasting implications. Research from Switzerland demonstrates evidence of post-traumatic stress disorder and complicated grief for families witnessing suicide (Wagner, Muller and Maercker, 2012). If the primary argument for allowing VAD is to reduce pain and suffering, why would we risk increasing pain and suffering for not only the patient but also the community that surrounds them? This is not a compassionate solution.

CHA would like to call the committee's attention to the lengthy and invasive processes that are required to facilitate medical assistance in dying. Experts in Toronto, Canada, where VAD is legal, are required to undertake distressing and lengthy processes in order to provide medical assisted dying. It is not as simple as taking a pill, nor is it a peaceful passing, as members of the public are being encouraged to believe.

#### [QLD Community Opposition to Voluntary Assisted Dying Being Legislated.](#)

For more details on the CHA member positions in response to VAD please see their individual submissions to the inquiry. CHA member inpatient services have stated that they do not support Voluntary Assisted Dying Legislation and will not provide this service in their facilities.

The above examples highlight that Catholic facilities provide a large proportion of community and health care in QLD and therefore represent a leading community voice on health matters. If Catholic organisations, whose mission and values are based around caring for the community, are unwilling to provide VAD as a service and actively speak out against it, should we not determine that such a practice is not in the best interests of the QLD community?

#### [Indigenous Community Opposition](#)

As outlined in the inquiry issues paper "Queensland is home to a large proportion of Australia's Aboriginal and Torres Strait Islander people. In 2016, some 27.7 per cent of Australia's Aboriginal Torres Strait Islander population (798,365) lived in Queensland." (Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, 2019). There is strong opposition

within indigenous communities to euthanasia and VAD. In consultations with Indigenous communities in the Northern Territory prior to the ROTI legislation implementation in 1995 there was a virtually unanimous consensus from Indigenous communities that they opposed all forms of euthanasia legislation. Of the 900 Indigenous people consulted from over 100 different communities only 2 expressed private views in support of euthanasia (Mackinolty, 1997).

Indigenous opposition to VAD and euthanasia is best exemplified by Senator Patrick Dodson's [speech](#) delivered in senate as part of the 2018 parliamentary debate on the Restoring Territory Rights (Assisted Suicide Legislation) Bill.

*“This concept of interconnectedness is one that transcends across many First Nations groups. It is grounded in our understanding that human resilience is based on our relationships with each other and our connectedness with the world around us. The quality of life for individuals and for our communities are intertwined, not limited to the wellbeing of an individual. We are fundamentally responsible for honouring our fellow human beings. We are called to carry responsibilities, to exercise duties and to honour those who are in need, who are ill, who are elderly, who are dependent and those of the next generation to value life with love, respect and responsibility. This is true of family members and unknown individuals. Moving away from such principles and values begins to reshape the value of human beings and our civil society, in my view.*

*We exist not as solitary individuals; we exist within a family, a community, our cultures and ethos, and in the kinship landscape. I'm a great admirer of those who have cared for loved ones and made personal sacrifices to do so. Not everyone is able to do this, I know, and I do not condemn them for the choices that they make. In the broad sense, we are part of a common humanity. If we give one person the right to make that decision—that is, to assist in committing suicide—we as a whole are affected. If we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected. I cannot support this legislation.”*

If indigenous communities who represent such a large percentage of the QLD community are opposed to the implementation of Euthanasia and VAD, we need to respect these views and look for alternative ways to support those at end of life.

## Protections for Health Organisations

The ability of health professionals to conscientiously object to providing a medical treatment that goes against their ethical beliefs and values is a basic human right that should be respected and protected at all costs. It is CHA's belief that not only should this right be protected for individuals, but the rights and freedoms of health care organisations need also be protected. Not doing so leaves health care facilities and their staff exposed to statutory uncertainty and jeopardises their ability to provide quality care. Protections must be guaranteed otherwise we risk individuals undermining professional practices and the quality standards of health care services.

In Canada, protections for organisation have not formally been legalised, though in practice the right to not provide VAD has been informally respected. However, recently there has been a growing number of calls for all organisations that receive public funding, including those with religious and ethical objections, to be required to provide VAD upon patient request, undermining fundamental ethical and religious freedoms of these services. There has also been some instances of health professionals overstepping professional boundaries to administer VAD in organisations without permission. In one shocking recent case, a medical professional snuck into health care facilities where VAD is not offered, disregarding all protocols and procedures designed to protect patients and staff, and administered lethal drugs to a patient. This caused significant distress and trauma to staff and patients of the facility (Lazaruk, 2018). The right of organisations to object must be protected by law to prevent additional pain and suffering to health professionals and community members.

## Conclusion

CHA members are committed to providing the best possible, evidence based compassionate care to all members of society. We believe that quality end of life and PC is the best and most effective way to provide choice and ease suffering at the end of life. All citizens of QLD should have access to affordable, high-quality and multi-disciplinary palliative and end of life care before any alternatives are considered. As the *United Kingdom End of Life Care Strategy* states:

*'How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services'*  
(National Council for Palliative care, 2013).

QLD has the opportunity to become a world leader in the field of end of life care by modelling and building on successful palliative care examples, a number of which are demonstrated in the CHA report '[Palliative Care in the Catholic Sector](#)', adequately resourcing services, developing policy that is inclusive and community focused, and educating the community on the profound benefits of end of

life and palliative care. CHA strongly believes it is premature to consider introducing VAD when inadequate and inequitable PC services are provided across QLD.

The QLD Government also needs to consider what type of society it wants to create. We urge you to heed the words of experts and peer medical bodies and reject the idea of legislation to legalise VAD. As the above submission shows, there is no safe and ethical way to implement VAD that does not risk the health and safety of individuals and communities.

We thank you for the opportunity to participate in this inquiry and if you require any further information or clarification please contact Suzanne Greenwood, Chief Executive Officer, Catholic Health Australia, on (02) 6203 2777, or email [suzanneg@cha.org.au](mailto:suzanneg@cha.org.au).

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