LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE VOLUNTARY ASSISTED DYING BILL 2023

(Reference: Inquiry into the Voluntary Assisted Dying Bill 2023)

Members:

MS S ORR (Chair)
MS L CASTLEY (Deputy Chair)
MR E COCKS
DR M PATERSON
MR A BRADDOCK

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 31 JANUARY 2024

Secretary to the committee:
Ms K de Kleuver (Ph: 620 70524)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

WITNESSES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

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Amended 20 May 2013

The committee met at 1.29 pm.

KENNEDY, MR JOHN, President, ACT Right to Life
HOMAN, MS MOYA, Council member, ACT Right to Life

THE CHAIR: Good afternoon, everyone, and welcome to the public hearing of the Select Committee on the Voluntary Assisted Dying Bill 2023 for its inquiry into the bill. The committee will today hear from a wide variety of witnesses who made submissions to the inquiry.

Before beginning, the committee wishes to acknowledge the traditional custodians of the land that we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect the continuing culture of the traditional owners and the contribution they make to the life of this city and this region. We would also like to acknowledge all families who have a connection to this country, and we would like to acknowledge and welcome all Aboriginal and Torres Strait Islander people who may be attending today's event.

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be very helpful, witnesses, if you used the words: "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

Voluntary assisted dying is a sensitive topic. The secretariat have information on supportive organisations available for witnesses or other people attending this public hearing who are affected by issues raised in this hearing.

In our first session today we welcome witnesses from ACT Right to Life. Can I please remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement, which is the pink card on the table. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Once you have had a chance to look at the card and you are comfortable, can you please confirm that you understand the implications of the statement and that you agree to comply with it.

Ms Homan: Yes. Thank you.

Mr Kennedy: Yes.

THE CHAIR: I note with thanks that you have provided the committee with a written statement. We will not be reading that out, but the committee will take that and incorporate it into its consideration. We will now go straight to questions. I will start with my colleague Mr Braddock, who is online.

MR BRADDOCK: Thank you. I totally respect Right to Life's position in opposing the bill and the reasons for doing so. My question is: should the bill pass, are there any changes that you would like to see made to the bill, even despite your opposition to the fundamental purpose of the bill?

Mr Kennedy: I am having trouble understanding that; sorry.

MS CASTLEY: Are there any changes? I believe Mr Braddock is asking: are there any changes you would like to see, understanding your complete—

Ms Homan: Opposition.

MS CASTLEY: You are opposed.

Mr Kennedy: What I have submitted?

MS CASTLEY: Yes. That is right. So—

Mr Kennedy: Yes. That is fine. No changes.

MS CASTLEY: So you have no recommendations on any changes to the bill—

Mr Kennedy: To the bill?

MS CASTLEY: Yes.

Mr Kennedy: I definitely have no expectation, please, that we would recommend changes to the bill.

MS CASTLEY: Okay.

MR BRADDOCK: Okay. Thank you.

MR COCKS: I was interested that, in your submission, you raised concerns about elder abuse. I am wondering if you could talk a bit about how you would see a situation of elder abuse occurring in respect to assisted dying.

Mr Kennedy: I think that is in the context that the Royal Commission into Aged Care Quality and Safety found that abuse was rampant in the aged-care sector. Unless there have been significant changes to it already, it is conducive to abuse. I see one of the potential dangers of this bill being that there could be a range of circumstances where aged, frail people are vulnerable to coercion. I do not think I need to list the reasons for that. I think it would be self-evident that people can take advantage of aged-care people, who may themselves feel that their life span has served its purpose. They become fragile. They become concerned about their viability, the care for them, and any level of coercion can help them on a pathway that is not productive for their lives. I think it is a real danger point.

MR COCKS: In that respect, it seems like one of your concerns is that—if I can put it this way—lives are not being valued equally once they reach that part of their life?

Mr Kennedy: I think generally there is a question over whether lives are valued. It is important to recognise that the fundamental point of difference here, between us and this bill, is that the bill itself is written from the perspective of a secular world view. We come from a Christian world view. We see life as established in God, understood in God. It finds its purpose and its meaning in God, and our role here on Earth is to care for and protect life. We have a fundamental view about life and its vulnerability, and the rights around life. I see nothing in this bill that meets us in this democratic society in which we live, that reflects any view from those who are pro-life. I think it is completely opposite to our desires and intentions around life.

MR COCKS: It sounds like, from your submission, you are concerned about the potential for the review to specifically include children—those under 18. Can you explain further why you are concerned about that group?

Mr Kennedy: I think, firstly, because it has happened elsewhere. We have got some very prominent people in this society—the ACT Human Rights Commissioner, the Children and Young People Commissioner, the Discrimination, Health Services, Disability and Community Services Commissioner, together with the minister responsible for this legislation—already speaking loudly and clearly about their desire to see, on the basis of some misunderstanding of justice, that children or young people should be included in this. I find that absolutely abhorrent.

DR PATERSON: You reference the medical profession and the challenges that they may face in implementing this bill. We heard from the national body—the nursing federation, I think it was—in evidence yesterday. They were saying that they have surveyed hundreds of thousands of nurses around Australia and they were yet to hear any opposition to voluntary assisted dying from the nursing profession. There appears to be a lot of support to see this bill implemented and passed. I am interested in your views on that.

Mr Kennedy: I must move in different circles. That is not my perspective on it. I have not researched it, but I was very taken with the views of Associate Professor Marion Harris, who is a medical oncologist in Melbourne who spoke on behalf of many in the medical profession. She said, "I don't feel that doctors should be involved in intentionally causing the deaths of their patients." This bill would create a need for some to ask for care, instead of having an expectation of care as a default in their illness. If there are doctors that support it, I do not understand it, because it is not the nature of the medical profession. The medical profession has always been geared around the protection and care of people. Why they would move the paradigm now to see death as an outcome for people is beyond our comprehension.

I have family in the medical profession. My mother was. My daughter is. Another daughter works at the hospital. The people that I speak to speak very much against this notion that death is the answer for patient care. It is a misnomer to even call it patient care.

DR PATERSON: What if it is what the patient wants?

Mr Kennedy: If it is what the patient wants? That is the fascination, because that is a sort of cultural question that defines it as an exclusive right of a person to have an influence to change a bill for society.

DR PATERSON: The legislation may be there, but only individuals get to choose.

Mr Kennedy: Yes. People have been taking their lives since Adam was a boy, and they make that decision based not on their autonomy but on their free will. I have not found too many people who have suicidal ideation who want to change society's rules around death. It seems to me to be quite extraordinary when you have got a group of people who are going to affect the culture of our city and our society.

I live with thoughts that are expressed through scripture and elsewhere that have always been historically true. I know that the prophet Isaiah, to risk boring people who do not read the scriptures, talked about people living in the shadow of death. Jesus himself, when he came to this earth, was motivated by that very thought. We definitely live in the shadow of death in this city. We definitely live in it and we are going to add another layer to it. I know that it is totally unproductive to raise the issue of abortion, but it brings to our world a shadow of death.

DR PATERSON: Can I just interrupt you there. We obviously have very different views; I have very different views to you. If we have legislation that allows for individuals to go on their own course of life and their own path—given that in this case they might be facing terminal illness with incredible pain and suffering, and it is not suicidal ideation; it is a completely different issue—do you not think that you can have your thoughts and choose your pathway through life and they can choose theirs?

Mr Kennedy: Why change culture to do that? Why would you change culture to do that? That is the idea of changing the culture of our city in the interests of people who suffer. You say to me that we have different perspectives; we definitely do. One of the great challenges when you have a Christian perspective is that the secular mindset and the argument that is foundational in this bill is built on a premise that some people suffer extraordinarily.

We can meet this bill at a couple of very significant levels. We can see that the right to life that is part of the United Nations convention is a place where we meet: the dignity of people. Their right to life is something that we agree with, and the bill opens with those things. But the bill then loses its sense of focus, for us, because it goes on to traverse the idea of suffering as being the reason for changing culture.

The idea of suffering from a Christian point of view is totally different. It has an inherent potential for redemption in suffering. It is an extraordinary thing. It is a mystery and it is not to be written off as a reason for people to die. The greatest example of suffering in a redemptive sense was the Lord Jesus. He died for our salvation. He died to bring life to everybody. There is an inherent quality of life in suffering. I watched my mother die—

DR PATERSON: But there is an inherent quality of life in allowing people to choose their last days and—

Mr Kennedy: People have always had a capacity to choose to suicide.

THE CHAIR: I am sorry; I am going to interrupt here. I am just going to remind all members and witnesses that we are dealing with a very sensitive topic. We clearly have some different views, but I hope that we can all approach each other with respect and give each other a chance to be heard. I am going to be a little bit more tough on that;

just giving you a heads-up.

MR COCKS: I want to go back to the issue around opposition versus endorsement by different groups. Yesterday what we heard from the college of nurses—and they were very explicit—was that it was in their consultation process that no-one had come forward to them to oppose it. They certainly were very clear that that did not mean universal assent. You mentioned that you speak with people as well. Would you say that there are people within the Christian networks that you have got and within the Right to Life movement who are within that medical or healthcare arena who share similar views to you?

THE CHAIR: Mr Kennedy, noting that you have already touched on this, please answer the question, but can you be brief.

Mr Kennedy: Moya is a 30-year palliative care nurse. She has travelled this journey of suffering and care with many people, including her own husband, who died of cancer last year. It is interesting, isn't it, the way you have phrased the question that not many people have come forward. I think that is indicative of a cultural change. When there is a regulation or a law being promoted in a small city like Canberra, where they are government employees, people are very vulnerable to silence in the face of bills like this because it means their jobs, it means their career and it means their place in the workplace when they take a stand.

Who takes a stand against a movement of this nature in such a vulnerable occupation as nursing? For nurses or doctors, their whole modus operandi towards life—their training, their beliefs—is geared around care, protection, and nursing in a way that is supportive of people in whatever journey they are faced with in the latter stages of their life. When they come across the idea of that paradigm change in an instantaneous way because there has been a bill drafted, advocating on the basis of the small minority of people who suffer extreme suffering, they are faced with a dilemma.

THE CHAIR: Mr Kennedy, on that note, I think we will let Ms Castley have a question.

MS CASTLEY: You talked about elder abuse, and in the submission you talk about concerns about regulatory powers being extended to possibly coerce people. Could we hear from Moya, with your experience as a palliative care nurse, about where you see this might happen? Could you give us a bit of your experience?

Ms Homan: In my experience, you hear people say that people die in pain and agony. If people are given good palliative care, there are very few times when the pain control cannot be sufficient for them. Our whole aim was to keep the patient comfortable. There are different kinds of suffering: mental, physical, spiritual. If all those areas are being addressed, I cannot see—

MS CASTLEY: My question then is: what about this bill do you feel does not protect people? Please would you talk about that.

Ms Homan: I think that people should be offered proper palliative care. I do not think anyone's life should be terminated before the natural end of their life.

THE CHAIR: I have a question on the topic of elder abuse. Mr Kennedy, I think you gave reference to the royal commission, talking about elder abuse being rife throughout the aged-care sector. Is there any other evidence that you have based your views on—that elder abuse could arise because of this bill—or was that the only part that you could point to?

Mr Kennedy: No. I think it is more a question of seeing the levels of coercion that exist in our broken state, really. You see stories and you read reports about people who are seeking an outcome to their parent's life because of financial issues. It is the vulnerability of people. If you go around nursing homes, as I have, people are left lonely; they are isolated. We see it through St Vincent de Paul, which I am part of, in our conference. We go to homes and hear stories firsthand about families being difficult with their ageing parents. That is not an uncommon thing for us as we visit people around the suburbs. People are suffering obviously from neglect from their families. With a bill like this, it opens up the door to other prospects.

We can sit here and speculate. I would imagine that if you present a bill like this the research has been conducted to see what sorts of outcomes it achieves in other countries, to see what sorts of dangers lie in front of the legislators who make these rules for our society. I do not know what has been explored. I do not know whether you have looked into the impact on young people in other countries—Canada particularly—and the aged people there. I am confident that it has got that potential, from the research and the day-to-day realities that I have dealt with. I could reflect on a number of cases where I have seen people just left—

THE CHAIR: Mr Kennedy, I appreciate your view. The part I am having trouble reconciling, though, is that the things that you have spoken about, while very serious, would not meet the criteria to access the scheme. Loneliness would not be considered an acceptable reason to access the scheme. I am having a little bit of trouble—just in the interests of transparency—connecting your argument to the actual operation of the scheme, not taking away from the fact that obviously there are a lot of people who do have loneliness and that there are a lot of other reasons, bigger social issues, that we need to deal with.

MS CASTLEY: People can object. There is that part in the bill that says if you do not agree with voluntary assisted dying you can say no. Does that provide you with any comfort at all, that there are safeguards in the bill?

Mr Kennedy: If you go back to my premise, I do not fundamentally agree with life ending in this way. Trying to improve the ways that life ends in this way is a rather contradictory thing for me to comment on. Really, I cannot. In the mind of a Christian—and all Christians should hold this view—life is a matter for God. It begins at conception and it ends at natural death, and we have no right to interfere with it at any other stage.

MS CASTLEY: I understand. We had Anglican representation yesterday, and Catholic, and the Christian Lobby as well. They obviously shared the same views but were also able to offer us, as a committee, some robust recommendations that if this must go ahead then "we would recommend these things". I am just wondering, back to Mr Braddock's question: is there anything at all that you would like to recommend to us, because we have to write a report on what you are presenting?

Mr Kennedy: I would like to say something. Whether you would like to hear it or not I do not know. I think there is a credibility issue around the government and the issues of life. When the statements they make around the dignity of life and protection of life are measured against full-term babies being aborted in Canberra without any protection or care—the ones that are born are left alive to die without care—how is there credibility around the issues of life?

THE CHAIR: Mr Kennedy, I appreciate that you wish to share your views, but I do tend to agree with my colleague Dr Paterson that that is not the topic we are here to discuss. I appreciate that we are talking about life, but we are talking about the bill.

Mr Kennedy: I said I would like to say something.

THE CHAIR: And we let you say what you wanted to say. Following on from what Ms Castley said, here is the part I am having a bit of trouble reconciling. I want to make sure I have understood correctly what you are saying. You just cannot agree to the bill because of the premise of it; therefore, any questions we would have about ways to improve the bill, certain aspects of the bill that might be approached differently through legislation, all of those things you are just not going to comment on because you just oppose the bill. That is what I have taken away from today's hearing.

Mr Kennedy: I think you would be pretty aware that I do not have much time for the bill as it is presented. With a title like ACT Right to Life, I do not think you would expect us to have a position of supporting a bill of this nature.

THE CHAIR: I think it is semantics, but I will just put it on the record. I am not asking you to support the bill. I was saying: is there any feedback specific to the bill? I think you have made it quite clear that you do not support it and the reasons why you do not. I do not have a lot more questions, if we have covered off what you want to say.

Mr Kennedy: My comment about the bill is based on an experience I had when I was working in Samaritan House with the men's refuge. My boss asked me to write a case manager report. I gave it to him, after labouring on it, and he said, "I like the first sentence." I like the first sentence in the bill, about the dignity of people and human life—nothing else.

THE CHAIR: We might wrap it up there. I think we have covered everything we are going to cover in this session.

Mr Kennedy: We are very grateful; thank you.

THE CHAIR: On behalf of the committee, we thank you for coming along today. We are committed to making sure that we have a balanced inquiry and that we hear from all sides of the debate. Thank you for your time. There will be an uncorrected proof sent to you for you to review. Please liaise with the committee secretariat around that.

Mr Kennedy: On behalf of ACT Right to Life, thank you all for listening to us.

Short suspension.

HOOPER, MR JOSEPH, Chief Executive Officer, Australia New Zealand Society of Palliative Medicine
GOLD, DR MICHELLE, President, Australia New Zealand Society of Palliative Medicine
CHAPMAN, DR MICHAEL, Palliative care specialist and member, Australia New Zealand Society of Palliative Medicine

THE CHAIR: We welcome witnesses from the Australia New Zealand Society of Palliative Medicine. Witnesses, I would like to remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement, which should have been provided to you by the committee secretariat. Can I please remind you that witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Can I please get you all to confirm, one at a time, that you understand the implications of the privilege statement and that you agree to comply with it.

Mr Hooper: I understand and agree to comply. Thank you.

Dr Gold: Yes, I understand that and agree to comply with it.

Dr Chapman: Yes, I understand and agree to comply.

THE CHAIR: Thank you all very much. We are not having opening statements; however, if you do have an opening statement you are welcome to provide that in writing to the committee secretariat and a copy will be made available to members. We will proceed to questions.

MR BRADDOCK: Your submission talks about separating the assisted dying process from palliative care. We have had quite a few community groups who see those as one—that is, they would like to be able to access palliative care and also access VAD. Can I ask: what does that separation look like to you? What would that mean for the *[audio dropout]* or the service delivery to the client?

THE CHAIR: Andrew, your sound was dropping in and out a little bit. If I heard correctly—and you can give me a thumbs up or a thumbs down—the question you were asking was about the number of other witnesses or contributors to the inquiry who have suggested that palliative care should be seen as not an either/or to voluntary assisted dying; that there is a role for both. Your question, Andrew, if I am correct, is: how do our witnesses today see that role and the interaction between the two working? Is that correct? Yes. Good.

Dr Gold: I might briefly start, then perhaps Michael would like to say a few words on that. I think it is quite clear that this is the same group of consumers or individuals that we are talking about: the people who would like to benefit from accessing palliative care and the people who may like to consider voluntary assisted dying as an option.

I work in Victoria. From my own experience in this sphere, it is very clear that the best outcomes overall are achieved when those two components of providing end of life care for individuals actually work together, have good liaison and can work collaboratively to provide the individual with all the appropriate elements that they might require to have a dignified and comfortable end of life. They may not be the same people that are providing the voluntary assisted dying and providing the palliative care, but a collaborative approach is really important and can work extremely well. Michael, would you add something?

Dr Chapman: Thanks, Michelle. I would echo all of Michelle's comments there. My personal view is that VAD is best understood as an end of life choice. In the context of people with advanced illness who are in the process of making end of life choices, all people should have access to palliative care and that should be a routine part of the specific care that is provided within that space.

Generally speaking, palliative care providers—and I think ANZSPM would feel the same way—would agree that palliative care is not isolated and specific to specialist palliative care provision but is a focus on comfort, quality and dignity for people with advanced illness, provided by a broad range of clinicians and providers. Specialist palliative care is the thing that is required when there is additional complexity or additional needs that cannot be met by that generalist care provision.

I think that in the future, in the ACT, people who are in the context of wishing for or wanting VAD should have access to palliative care, absolutely. That should include specialist palliative care, where that is required due to the complexity or because their needs cannot be met otherwise.

MR BRADDOCK: Thank you.

DR PATERSON: I am quite ignorant in this space. Would a patient who meets the criteria for voluntary assisted dying likely be undergoing palliative care to that point and then make the decision to access voluntary assisted dying, or not necessarily?

Dr Gold: The short answer is not necessarily. The way I am reading the legislation, there is quite a spectrum of people that may start to engage in questions about their end of life choices, including voluntary assisted dying. Some of them may not have had need for or been introduced to palliative care services at that point. Others will be well engaged with palliative care and then be seeing this as something additional that they would like to explore.

If I might go back to what Michael said previously, palliative care encompasses a whole range of providers and a whole range of skills and techniques. Sometimes that is provided by the specialist that has been caring for them; sometimes it is provided by a GP. That specialist palliative care is, if you like, a subset, so when we think about how we are saying someone is having palliative care, they could be doing that in a whole range of ways.

Dr Chapman: Yes. I completely agree, again, with Michelle's comments there. I have an anecdote which I think is relevant. I was speaking to someone the other day about this topic. They were a VAD proponent, telling me that if they had an advanced illness in the future they would definitely want VAD and definitely not want palliative care, with this sort of sense that in fact these were binary choices.

My sense is that, as I said before, in the future assumption that the ACT has legislation encompassing VAD, for a person to be able to make a valid choice, they need the best care available to them in the manner that they see fit. That should include a focus on and a component of palliative care for all people with advanced illness. My personal belief is that that creates a requirement for us to make sure that clinicians who are involved in VAD provision have knowledge not only of how to get access to palliative care but also of how to provide palliative care, because maybe that is the only person that that community member is talking to when they are considering what their end of life choices should be and what care requirements they have.

I would agree again with Michelle's comment. Not everyone who validly may request access to VAD in the future will have palliative care access, and certainly not all specialist palliative care access. My interest is to make sure that all of those people have access to the care they need when they need it.

THE CHAIR: This is to whoever would like to answer, but probably Michael and Michelle, because you have been saying the most on this. In the bill—I think it is section 152 and around that area—it does say that a health professional, when having a conversation about voluntary assisted dying, must also take reasonable steps to ensure that the individual knows of the palliative care options available to the individual. Given that it is a requirement to make sure that those options are known, and given the discussion we have just had that not necessarily everyone accessing VAD would be already accessing palliative care, my question to you is: how adequate is that provision, and if there were additional provisions required, what would you see those as being?

Dr Chapman: Thank you for your question. I think it is a really important point. The way it is framed there, it does create the sense that palliative care is something alternative and different. I think the assumption here is that the most recognisable part of palliative care is specialist palliative care provision, and you only get that if someone refers you to those kinds of services.

Probably a better way of thinking about this legislatively would be to recognise that palliative care should be a seamless care provision provided to people with advanced illness, which may or may not include specialist palliative care provision and referral on to those services if there are needs and if there is a wish from the care recipient that they want that kind of care, that additional specialist input. I have not really wordsmithed that, but I think that something focusing on this being the actual care requirement, with additional referral if wished for, perhaps would be a better way of the legislation framing that particular point.

THE CHAIR: Okay. Can I test something with you, then? What you are saying is something along the lines that acknowledges that, if the patient is not already receiving palliative care, palliative care is explained to the patient as an option? Is that the kind of nuancing you think would improve that sort of approach?

Dr Chapman: Yes. Again, it is so tricky because these are definitions and things we deal with all the time and it seems a bit artificial to everyone else, but to me—

THE CHAIR: Yes. But then the lawyers come along and it takes on a whole new dimension. Yes.

Dr Chapman: Exactly right. The way I tend to define palliative care to my patients is that, when you have got an illness that cannot be taken away altogether, palliative care is all the things we do to make sure each day is as good as it could be. In the context of a person with advanced illness, that has to be provided to everyone. Everyone needs that. That is what good care looks like.

THE CHAIR: In the context of this bill, though, your definition is far broader than what the bill would be legislating to agree to. I can completely see how your definition would apply to your work and how it is actually quite a good definition, from what I know of this subject matter. However, if you apply it to that specific context, it takes on a very different meaning from the application of a legal perspective. I understand your wanting to take the approach that you practise, for good reason, within your own practice. The part I am wondering about is how we reconcile that with something that is easily understandable under the law for people who have to implement a scheme which we need to be clear for people to be able to appropriately administer.

Dr Chapman: Thank you. If this is already in the legislation and I am just not as au fait with it as you, my apologies. I think it is about defining, perhaps, the key characteristics of what palliative care should encompass. A focus on comfort, quality and dignity, for instance, as an element of ongoing care provision, as something that is mandatorily required as part of care in the context of VAD discussion, might be a way of doing that, because then you are moving away from the nuance of whether or not this is palliative care or that is palliative care. Actually, what we are talking about is making sure that those things are being done.

THE CHAIR: I have a feeling that where these might be butting up against each other is that not everyone you would treat with palliative care would necessarily be eligible to access VAD. So the palliative care definition in the bill would be more specific to the people looking to access VAD, and their circumstances. I think I am going to tease that out a bit more with other people. I will leave it there.

MR COCKS: One of the big concerns that I have heard of personally, and that has been raised in discussions today, is around assisted dying for older people specifically. We have heard both about the potential for elder abuse and—I think it is in your submission—mention of the potential for people to choose assisted dying instead of substandard aged care. It is something that also came through in some material from National Seniors. Are they valid risks, from your experience, and is there any evidence base that links through to those?

Dr Gold: I do not have evidence at my fingertips that would be able to suggest that that has been something that has happened with any frequency in Victoria. We work all the time with people who tell us they would rather be dead than go to an aged-care facility, and that is before they have even set foot in one. I think it is a reasonable concern. It is something that is reasonable to consider. Those people who tell me that, by and large, would have the capacity to make a decision about voluntary assisted dying. Whether they then would fit the other criteria, obviously, is a very individual situation.

With all the steps that are in place in the legislation that you are proposing, a lot of that mirrors what we have in Victoria, combined with the fact that it has been a challenge here to have enough practitioners providing this “service” or “therapy”, or however we define that. People have had to be pretty feisty and really wanted to have voluntary assisted dying.

Coercion, I think, has always been a concern—that someone would be coerced into wanting voluntarily assisted dying by other people who have different vested interests. But I think in practice that has proved not to be such a concern. There are a couple of different ideas there. I do not think I have solved any of your concerns or actually addressed your question with a meaningful solution. I think there would be people who may consider that that is a better option: to access voluntary assisted dying rather than give up their independence. How often it would happen, I could not say.

MR COCKS: There were some concerns, I think, specifically in regard to aged-care facilities in the submission. I am curious about where you see the line for initiating conversations about assisted dying and whether those provisions that are in section 152 are adequate to fully protect against coercion.

THE CHAIR: I might just ask our witnesses if they have got easy access to section 152. I think there is some scrambling on computers going on, by the looks of it. Mr Cocks, do you have it? I have got it here. I am happy to read it to people.

MR COCKS: That might be helpful.

THE CHAIR: Yes. Section 152 is the requirements for health professionals when initiating conversations about voluntary assisted dying. It says:

> (1) A doctor or nurse practitioner may initiate a conversation about voluntary assisted dying with an individual only if—
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> (a) the individual has a condition or conditions mentioned in section 11 (1) (b); and
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> (b) the doctor or nurse practitioner is satisfied that they have the expertise to appropriately discuss treatment and palliative care options with the individual; and
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> (c) the doctor or nurse practitioner takes reasonable steps to ensure the individual knows of—
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> (i) the treatment options available for the condition or conditions; and
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> (ii) the likely outcome of the treatment options; and
>
> (iii) the palliative care options available to the individual; and
>
> (iv) the likely outcome of the palliative care options.

Then it essentially repeats that a health professional may also do this under similar circumstances, and then we have a lot of definitions, which, in the interests of time, I will not read through, if that is all right.

Dr Gold: As it is written, it sounds quite reasonable. My concern with that is the individual, be that the doctor or the nurse practitioner—and certainly when we come down to other health practitioners. It is their own assessment that they are satisfied that they have the expertise to appropriately discuss treatment and palliative care options with the individual. I do have some concerns with that. As we put in our submission, the general level of education in medical schools around end of life care and options for the various things is certainly, in many cases, not what I would consider up to an adequate level.

People are starting off with an inadequate level of knowledge to adequately explain that or appropriately discuss that. Certainly, having the right practitioner to discuss what your treatment options are for a rare, uncommon or complex condition would be a question in some cases. How you would word that in legislation obviously is not my area of expertise. Palliative care options are, again, not well understood by a lot of non-palliative care specialists. I think there are some concerns that I would raise in that regard. Thank you.

Mr Hooper: I think, Michelle, the way that section 152 reads is basically a subjective test for the individual to be satisfied. For the individual practitioner to be satisfied that they have the expertise is subjective. And then for the doctor and nurse practitioner to take reasonable steps to ensure that the individual knows all the options or the potential outcomes et cetera is also a subjective test, based on the first premise that the individual practitioner assumes they have the appropriate knowledge and skills.

Take that test and place it into the context of limited education in this very specialised area, certainly through medical school. I also understand that, for this purpose, people going through medical school would not be the ones doing this. It is someone with post-specialist registration, so it could be someone 12 or 15 years into medicine. Nonetheless, it is a subjective test. Within the legislation there is no objective measure of having undergone that special education.

Part of our submission was very focused on the importance of education and contextual knowledge. People working in palliative care would have very good knowledge of VAD and the legislation because it would become part of their trajectory of care. People not working in palliative care but getting involved in VAD will not have the equal knowledge of palliative care and all the options and the current treatments et cetera. So there is a tension there which we wish to highlight for the committee.

MS CASTLEY: Based on something you said, Michelle, with regard to VAD training, I note in your submission that you said the six hours is inadequate, and that other training is for a week. What would your recommendation be there?

Dr Gold: Good question. A lot of that six hours was very focused on the mechanics of getting the processes right and the legalities of who was eligible and ineligible. I would like to see at least an equal amount of time—which is then very onerous; I acknowledge that—spent on some general principles of communication skills and on at least a basic understanding of what palliative care can provide in terms of support to live independently, support to live comfortably, symptom management, and various other aspects that palliative care intuitively does. If you have done your specialist training in gastroenterology, that will not cover any of this. Yet you are definitely quite clearly eligible to become the coordinating practitioner.

There is not a lot of room for specialist palliative care or additional palliative care in the average general practice training program. A number of excellent GPs have learned it as they go, or they have done six months additional training in palliative care. That is certainly not the majority. Maybe they are the ones that would be interested to do this. That would be great. But I would really like to see that, if someone had not already done that additional qualification, there was at least a decent component in the voluntary assisted dying training.

MS CASTLEY: Thank you.

Dr Chapman: I agree with all the previous comments. As Joe said, the capacity assessment would be another element to that, and management of grief and bereavement. Longitudinal and ongoing intuitive education would also be of value, perhaps not as a requirement for the engagement of VAD but as a recommendation for ongoing training, given that, I presume, some VAD providers may do the training and then not actually be involved in the practice for a very long time in the future, or very sporadically.

DR PATTERSON: Following on from that, I want to mention conflict in bereavement support. We heard from Carers ACT about the challenging role that carers may have, particularly if they have different viewpoints on voluntary assisted dying—going through that process with someone who they care for and the consequences afterwards. I am wondering if you can speak to what you think would be a good recommendation on post-bereavement support for family members who are going through this.

Dr Gold: This is a little bit controversial perhaps. I will try to be brief as well. I think that, yes, where people are accessing voluntary assisted dying, the families need support. Perhaps because this is a new thing as well, we want to make sure that they are getting that. But really anyone who has lost a relative, a partner, a loved one, should have access to bereavement support. There should be baseline availability within the community. I guess I am thinking that maybe voluntary assisted dying, in five or 10 years, will become a less special category and that it really should be something that is available to all people. I will just say that I think some ongoing support and self-care for the practitioners involved in it is looking to be a really important component. There is a burden and there is a toll that it seems to be taking on some of the practitioners.

MS CASTLEY: I note that you are concerned about the two days for conscientious objectors, that two-day turnaround. Can you explain why, and what you would recommend?

Dr Gold: I think if someone is a conscientious objector they will get in there and put in their objection. That is probably the easiest one to do. But with some of the assessments I am just concerned that it would take people a longer time to find the information that they need and collect it from different sources. They have to see the patient in their clinic, write a report and submit it by whatever means is devised, within that time frame. The fine is quite significant if you do not comply with the time frame, leaving me to be concerned that it may put people off wanting to be a provider.

MS CASTLEY: Thank you.

THE CHAIR: I think we put this question to the nurses too: if that is too short, what is an adequate time frame? How long is a piece of string?

Dr Gold: I would say a week.

THE CHAIR: I think we will wrap it up there. Thank you very much for appearing today. We do appreciate witnesses making themselves available and answering our questions. I do not believe you have taken any questions on notice. An uncorrected proof *Hansard* will be sent to you by the committee secretary for you to check for any factual errors. Keep an eye out for that. Thank you again for your submission and for appearing today.

Short suspension.

BRENNAN, DR FRANK, Palliative care physician, Calvary Health Care
GREEN, MR MARK, National Director, Mission and People, Calvary Health Care
HAWKINS, MR ROSS, Regional Chief Executive Officer, Southern NSW and ACT, Calvary Health Care

THE CHAIR: We now welcome witnesses from Calvary Health Care. I would like to take a moment to remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. For witnesses here in the room, it is the pink card on your table. For our witness appearing online, the secretariat will have sent one to you for your reference. I would like to remind you that witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Can I please get you to confirm that you understand the implications of the statement and that you agree to comply with it.

Dr Brennan: Yes.

Mr Green: Yes.

Mr Hawkins: Yes.

THE CHAIR: Thank you. We are not inviting opening statements. If you do wish to provide an opening statement, you are welcome to give it to the secretariat or to table it, and the committee will take that into its consideration. We will start the questions.

MR BRADDOCK: Thank you for your submission, particularly about the stronger safeguards, because it definitely concentrated my mind on that. I have also got other community groups talking to me about how overly onerous the current safeguards are within the existing bill. I am curious: how much of a risk is there with the bill, as currently phrased, in terms of potentially vulnerable people obtaining VAD?

Mr Green: Thank you for the question. It is a difficult topic to speak about, but perhaps we can make some points. I note that the last group of people made some points which we would support. One of the things about these journeys is the extent to which you know the person who is receiving care. I think that being able to understand who they are, what their goals of care are and what their needs are is a critical thing.

People who are experiencing very complex, life-threatening scenarios are vulnerable. They are vulnerable because they are going through a whole lot of experiences and it may be their first encounter with these things, and there are a lot of things going through their minds which they have to process. There might be grief. There might be the prospect of having to leave your home and go into care. There might be the unknown around what the disease trajectory is going to be and how the physical symptoms will manifest.

They may never have seen someone die. This is the first thing that makes this whole area complex. One of the things that we have learned in palliative care is how important it is to get to know the person and enable them to speak about whatever is on their mind. The second thing is that there may be a whole lot of things that can be done which the person has not even considered or become aware of, and it is very important that the person has the opportunity to receive that information and the time to process it. The third thing is, I guess, this notion of accompaniment. Any journey towards the end of our lives is a journey. It may be long or it may be short, but walking side by side with someone and assisting them to navigate this journey is also important.

When we are looking at this bill and the question of safeguarding, the question I would ask is: has the bill set up the appropriate framework and has the bill defined the eligibility criteria such that it allows all of those things to happen? Otherwise, people may be moving towards decisions which could be premature. The people who are advising them may not have the requisite knowledge and be able to explain all of the options. We could end up possibly prematurely losing someone in our community who has a valuable contribution to make, simply because they have acted without full cognisance, full understanding of what might be possible for them. I do not know, Frank, whether you want to add anything to that?

Dr Brennan: Yes. Thanks, Mark. And thank you to the committee for inviting us. I appreciate the question, because the story of vulnerability is something that is so inherent in this whole process. We see this over and over again. There are multiple things on people's minds: "What is going to happen in the future? Is this treatment going to work? What if it doesn't work? I am now starting to feel exhausted and in pain. How are my spouse and my family coping?"

In that tumult—sometimes it can be a tumult—people can be quite vulnerable to the sense of: "Okay. What's next? How am I going to work out what is the right thing for me?" It can be compounded, particularly if there has been no exposure, or limited exposure, to palliative care—the very discipline that has grown over many decades in response to this story. There can be a sense of palliative care and, indeed, misconceptions about palliative care. So that can compound it, and people think, "Ah, yes. Well, the VAD is the thing that I'll go to," and decisions are made without full information, really.

THE CHAIR: I will just remind everyone, including witnesses, that we do not have a huge amount of time, so in the interests of getting through, maybe short answers are good answers.

Dr Brennan: Sure.

THE CHAIR: Where possible.

MR BRADDOCK: I suppose the inverse of that is ensuring that the strengthening of the safeguards that you are talking about is not too onerous. Will your recommended strengthening of safeguards do that—add extra time when someone is intolerably suffering, as they sort of tick the boxes and get the appropriate sign-offs?

Mr Green: I suppose the question for the committee is: what ultimately is in the public interest and the common good? We would submit that you start with the most vulnerable people in the community and you ask yourself whether those people, through the safeguards there, are protected from making decisions which could be impacted by their particular social circumstances, their life experience et cetera. Our views on this are well known. If we are going to have this legislation and if people who have lived with a lot of vulnerability through their life are not protected, to the extent that they make decisions which are irreversible, that is not a good outcome.

MR COCKS: I want to acknowledge the work that has gone into your submission and, in particular, that you have gone to other jurisdictions' legislation and you have pointed out a number of places where the ACT legislation goes further—and, it sounds like, at times considerably further than others. In terms of palliative care specifically, I was wondering if you could outline what the concern is around funding for palliative care and the risk. It sounds like there is a risk that palliative care will not be adequately funded in the context of assisted dying.

Dr Brennan: This is a really important question, because we have these two domains sitting next to each other: the VAD story and the palliative care. I think that, ideally, having equity of access to palliative care is extremely important. Rather than an idea or a concept, where the VAD doctors may themselves be struggling to articulate the nature of palliative care, let alone the experience, having palliative care well funded and adequate and well supported is very, very important.

The worst possible story is where palliative care is sort of sidelined and everyone is focusing on the VAD and already many of their symptoms and their distress are not being addressed adequately. I think that adequate and good support to palliative care is really important. I would go further and say there should be public education on palliative care. We talk a lot about training medical students and nurses, but I think in the general population there are a lot of misconceptions, and I think that is an extremely important part of this whole story that unfolds.

MR COCKS: Thank you. I thought one of the interesting things from the palliative medicine submission was that palliative care is more than just the physical relieving of suffering; it goes to both the psychological and spiritual. I think they even reference that. How do you think, here in the ACT, we are performing on palliative care as a baseline, before we even introduce this legislation?

Mr Green: Ross, I do not know if you want to comment on this. To answer, we are probably drawing on our own experiences as a provider when we were running Clare Holland House. We were certainly able to work with the team there to stand up some innovative programs, and we were certainly able to have a good homecare service. Could we have reached everyone that might have desired palliative care? Could we have done more with the number of beds in the specialist palliative care unit itself? You will remember that we received funding from both the government and a foundation to increase all of that. There were submissions made to the Legislative Assembly for specific increases in palliative care. I think the simple answer to your question is that there is more to be done. Ross, is there anything we should add?

Mr Hawkins: No. I think you are quite right, Mark. Obviously, up until July last year we were running specialist palliative care services in the ACT and did the best that we could for the community. I think the key for us, though, is to make sure that—and I think it is in our submission—there are appropriate levels of reporting and visibility so that we continue to see what is being spent on palliative care in the ACT and there is a continuing level of investment, and that that money is not diverted off to fund VAD.

As we pointed out in our submission, we think it is incredibly important that the VAD board have visibility of that so that palliative care services are not diminished as you look to move to introduce VAD.

DR PATERSON: In your submission you raise concerns about the review and directing in the legislation some aspects that should be undertaken in the review. Would you like to speak to what your concerns are about that?

Dr Brennan: Yes. I stand to be corrected here. The bill seems to be a little bit unclear as to the exact role of the board. It talks about monitoring and following things through and collecting data, but whether the aim of this bill is that the board will have oversight and potentially, as, say, in New South Wales, have the final sign-off in terms of allowing the VAD to go ahead—versus a more retrospective overview of it—is unclear in the bill. I suppose the concern is that if it is mainly retrospective then all the steps in the VAD process may not be getting adequate oversight and things may be not done well or not done adequately. There may not be enough vigilance about that process. But I stand to be corrected in terms of the actual sense of the wording of that.

DR PATERSON: Regarding the review after three years, is there anything that you—

Dr Brennan: Excuse me. Yes. Sorry; I misunderstood your question. You go ahead, Mark.

Mr Green: I think the point being made in the submission is that the clauses as they are drafted are not "required". In other words, it is open to the government of the day, or indeed any member of the Legislative Assembly, to initiate such an inquiry at any point in time. It is a question for the Assembly, but is it good practice to try to bind a future parliament to do something or other? Because no-one can predict the circumstances and the situations that are going to be encountered by that parliament.

I guess the question for the committee, and therefore the Assembly, is: is this something that is strictly necessary? What value, at this point of the territory's journey, does this clause add? Secondly, if it is there—and given some of the strong feelings about this matter—is it actually helpful at this stage to introduce something new into the territory and have this question mark, even as it begins, about how it might evolve? I think we could be creating a series of expectations by having these clauses which, at a later point, a parliament cannot fulfil. So my question back to the Assembly is: why are these clauses there? What value do they add and, in fact, are they even necessary?

DR PATERSON: Is there anything that you think should be built into a review in three years—a particular aspect? People have already talked about access issues for children and young people. Is there anything that you think should be built into a review in a few years time that is not there already?

Mr Green: I can start. My colleagues might add to this. I think any review is an opportunity to look at how a service, a procedure, a policy, is working. How effective has it been? That is an obvious thing. Has it been safe? Have we learnt from things that have gone wrong? Are we learning from things that have gone wrong? Have the people that the bill seeks to protect been protected? What adverse outcomes have there been? That is a starting point. Ross, what else am I missing?

Mr Hawkins: I would say, Mark, that when it comes to review, it should be done in a broad sense, and I think what you argued in our case is how prescriptive the current legislation is, as opposed to that broad sense of: "How is the legislation working?" Rather than being hemmed into specific topics and areas, there should be the opportunity to consider its implementation in the broad.

Mr Green: The other thing, too, is that the bill sets out a number of principles in the early part which I think probably everyone would support, whether you are supporter of the bill or not. Back to the points that Dr Frank was making earlier about palliative care, one of the critical things would be: what impact on the provision of palliative care has this legislation ultimately had? If it has been enhanced and improved and more people are accessing it, that would suggest that the bill has not achieved one of the aims that we fear it could achieve, which is to open up a means for people to end their lives prematurely and to reduce the costs of providing a service to them.

MS CASTLEY: I am going to be cheeky and try to throw two elements into one question, if I can. You talked in your submission about the disparity between New South Wales and the ACT. I would love to hear your views on the two days if someone conscientiously objects. Is that time frame—noting that there were concerns with that turnaround—one of the disparities?

Dr Brennan: Yes. The conscientious objection story is there. Thank goodness there is a conscientious objection clause. The two-day story, I think, is realistically too tight, too short. I can understand the sense that, because of the sense of urgency of what people are going through, once a patient has made a clear and unambiguous request there should not be any unnecessary delay. But I think that, in terms of the logistics of this, it would be appropriate to have it as a longer period. As to how long, I think perhaps a week or more, to give those doctors a chance to do what they need to do on a daily basis. The first part of your question was—

MS CASTLEY: New South Wales and the ACT; how the bill is different. We are an island within New South Wales—

Dr Brennan: You are. That is right. There are quite a few differences, and I am sure you are aware of those differences. In the eligibility criteria, how inconsolable suffering is defined is different, and the inclusion of the anticipation of future suffering is a new concept—the prognosis being open-ended, not as specific dates or times. So that is a difference there. The other story is the legislative protection, within New South Wales, of institutions that declare that they will not participate, that they can make a rule that VAD doctors do not come on site. That is quite a difference. I am coming back to the ACT VAD board story because that is very important, as to whether that is a major difference in oversight or not. And then there are the criteria for VAD practitioner certification. I gather they are going to be in the regulation, rather than in the bill itself. That is important as well. So there are quite a few points of difference.

MS CASTLEY: What do you think the impact will be on Canberra?

Dr Brennan: It is a really interesting question, and part of that will come from the experience of seeing how things unfold not only in New South Wales but around the country. In New South Wales we are the baby state. We are the very last of the states. It has only been since 28 November, as you know, that we have come on board. It may be that over time there is a sense that the eligibility criteria are too liberal, potentially. That is going to be a whole story as it unfolds.

Then, of course, there are the qualifications and the background of the VAD doctors—if it is just too wide, and whether they have the capacity and the skill set to be able to do what they need to do in the assessment process. Another interesting thing—and it might be my reading of the bill—is the VAD doctor's responsibility to speak about palliative care, I know the initiating conversation needs to include palliative care, but I could not see it occurring with the VAD doctors. It is really important that they articulate what their sense of palliative care is.

MS CASTLEY: Thank you.

THE CHAIR: Just picking up on New South Wales and the ACT, you reference the New South Wales bill a lot and say that the ACT should essentially adopt some of the measures that are in the New South Wales bill. I could not quite wrap my head around that, in the sense that we do have a different health system; we have a different population. There are a lot of differences there. This bill, in the development, has been put quite extensively to the ACT healthcare system and has responded to a lot of the feedback that has come from a lot of people within that system. Dr Brennan, picking up on your comments that the New South Wales legislation is still very much in its early days, I guess I am having a little bit of trouble reconciling how it is that the New South Wales one is the one we should look to when we have a lot of other paths, plus our own ACT healthcare system particularities, to take into account.

Mr Green: There are probably some pragmatic considerations to think about here too, and Ross may speak a little bit more eloquently to this than I. Our experience of care is that we are a cross-border community and there are people coming from New South Wales into the ACT for care. There are clinicians who live in New South Wales who work in the ACT and deliver care here. We are not two separate pods, if you like, of people.

Let us look at a couple of pragmatic things. For a clinician, to know that there is some consistency of practice, whether they are working on the New South Wales side or the ACT side, is a very helpful thing. You are trying to reduce psychosocial hazards. You are trying to reduce moral distress. You are trying to reduce unwarranted variation in care. At a time when our workforce is under pressure, you do not want to add further pressures by complicating their world, which is unnecessary. There are some very pragmatic things to be thinking about. There is also the risk of confusion: "Goodness. I am in the ACT. It's this policy I've got to follow. Now I am in New South Wales; it's this."

The other thing, as I understand it from reading the bill, is that the director-general is able to authorise for people who may not be eligible to apply for VAD in New South Wales to have it in the ACT because of the close connection they have with the ACT community. How is all of that going to work, and what are some of the risks? The standards in the two jurisdictions are different, so these are important pragmatic considerations that affect not only individuals who might be considering exploring it but also the clinicians and the treating teams and the services that have to operate in both environments. Ross, have I missed anything?

Mr Hawkins: No. In terms of that practical application, Ms Orr, I think one of the key issues for us is when you look at the obligations that sit on Calvary as a facility operator, as defined in the act, and what we have to do—and this is set out in our submission. Look at how that would set out what we have to do about providing access to a service, and how that runs counter to the legislation that we have already got to apply in applying for a licence under the Health Act 1993.

So we have this issue where we are potentially to be asked to provide a service through VAD, but actually, through our licensing that we get through the ACT government, we are not credentialled to provide that service. There is no way for us, under the current act, to object and say, “We can’t provide this service,” and be really clear to the population about that. Instead, the act forces us into a position that potentially runs counter to our accreditation that we have through the safety regulator. I think there are some really serious considerations that we need to have in this space about what we are going to be asked to do under this act, and how it could potentially require us to fall foul of the licensing that ACT Health has for us under the Health Act 1993.

THE CHAIR: Okay. It sounds like a question for us to put to government. In listening to your answer, Mr Green, I appreciate that there was a level of pragmatism in the answer, and I picked up on that. If I can a little bit cheeky, why should it be that we adopt New South Wales, and New South Wales does not adopt the ACT?

Mr Green: I do not know whether I can really give a very helpful answer to that question. I think there are a few reasons that your colleagues in New South Wales might give. The New South Wales legislation was probably built around the models that were operating in some of the other jurisdictions. There would have been political constraints, I would imagine, which guided the Legislative Assembly and the Legislative Council in New South Wales. There is that dimension to it.

What I would say of the ACT bill—and our submission makes this clear—is that it opens up things in a way which takes the application of this well beyond what is going on in other states. To your earlier question about what a future parliament might do, the direction is quite clear. That is a very important development that needs particular consideration. As I said right at the beginning, the standard I would submit that we need to be looking at is: “What is going to happen to the most vulnerable people in the population?” What is going to happen if people are led to a decision to take their own life, through this bill, when in fact they might have had more time and more opportunities, and they have missed them. That is not a good outcome.

THE CHAIR: Thank you. As it is three o’clock, we might wrap it up, on that note. I do not believe there were any questions taken on notice. I would like to thank you for taking the time to put in your submission and to appear today. There will be an uncorrected proof of the *Hansard* sent to you to check for factual errors, so the committee secretary will be in touch. Again, thank you very much. We will move to our next witnesses now.

Dr Brennan: Thank you, committee members.

Mr Green: Thank you very much.

THE CHAIR: Sorry; I have got the time wrong. We had until 3.15. Did you want to keep going? I have messed that up. That is a me thing.

Dr Brennan: That is okay.

Mr Green: While we are still here.

THE CHAIR: I cannot tell the time. Ross can dial back in if he wants to. Sorry.

Dr Brennan: That is all right.

THE CHAIR: That is my bad.

Mr Green: I will just have to let him know that we are still here, if that is all right?

THE CHAIR: We might as well. We have got the 15 minutes. My apologies. That is just a little bit of an error on my behalf.

DR PATERSON: You are very efficient.

THE CHAIR: Yes. I think we might just keep going. And if Mr Hawkins comes back then we will just—

Mr Green: I have been able to send him a text.

THE CHAIR: Okay.

MR COCKS: Mr Green, I was very happy that you could be here today, given your role, because I think one of the things that we have lost a little bit in some of the discussions has been the impact on healthcare professionals and providers, beyond the immediate impacts on the patient. One of the concerns I have heard raised by medical practitioners is about both the psychological risks and the moral hazards around participating, and the challenges in conscientious objection. I wonder whether you have any views or experiences from your people.

Mr Green: Yes. The short answer is yes, and certainly we have views. I will provide an illustration, and I will do it without identifying anyone. At a particular point in our journey last year, a resident in one of our aged-care homes went through the VAD process and was granted an administration certificate. This person proceeded to administration and died in the home.

Our staff—we have clear procedures about this—stood down and were not involved in the administration of the substance. Nevertheless, that person's experience and that person's death affected every one of those people who were caring for them—the mode and the manner of it. Even the medical practitioner who administered the substance was affected by that. So there is a level of distress and grief and loss and confusion, and each individual is different, so each one experiences it differently. That affects people.

One of the questions, naturally, that people ask is, “Did we do enough? What did we not provide? What was wrong with our care that this person went down this path?”

This is a philosophical point, I guess. If we have an attitude in our society that individualism and autonomy are the most important things that we value, then we do not look at the fact that human beings live in communities and have obligations and responsibilities towards one another. A decision by one affects the other. If that is not a factor in our thinking and we operate on a very narrow, rights-based model, we find that what we do in our actions is that we impinge upon the experience, and sometimes the rights and duties and responsibilities, of other people. That is when moral distress takes place.

Healthcare professionals, as Frank will testify, are pretty resilient and strong people, but coming out of COVID, coming into a situation where workforce is harder and harder to attract and retain, where attrition rates in public and private services alike are high, it is in our interest, it is in the public interest, that we limit and reduce the instances of psychosocial hazards and moral distress to the point we can.

Therefore, it is about acknowledging that a human community of practice, an organisation, may have a different view about something. Allowing them to provide the service that they can provide to their best of ability—and allowing other services to provide what they do not provide—is good practice. It enables everyone to make the contribution they can to the fullest extent they can, and it reduces the instances of moral distress, let alone ethical distress and those psychosocial hazards that I just referred to. Plurality is a good thing. We do not expect every service to deliver the whole suite of options available to anyone. It would be humanly impossible. Sorry; I am not being brief enough for you.

MS CASTLEY: We really appreciate your very well considered responses. You talk about Calvary policy, mandates, and adherence to the code of conduct and the accompanying code of ethical standards.

Mr Green: Yes.

MS CASTLEY: Calvary does not credential external health practitioners to enter Calvary facilities. Can you talk to the committee about what this bill means for you in this regard?

Mr Green: All right. Let’s focus on our two private hospitals, because they are the critical services in Canberra. We can manage the residential aged-care space. It is really important to talk about that, but, in the interests of time, let’s focus on the hospitals. Ross, I think this is a question for you, to talk about how we manage credentialling and how we manage the choices of the services that we provide.

Mr Hawkins: Sure. Thanks, Ms Castley. Mark is right that our primary concern with the legislation sits within our two private hospitals and that it effectively covers us as a facility operator. We are not considered a service provider under the legislation. Where the conscientious objection provisions fit, the support, we are seen as a facility operator and there is no ability to conscientiously object.

Therefore, when it comes down to the wording of the act and the provision of a service within that—and it covers residential aged care and hospitals—we are deeply concerned that what that means within a hospital causes an issue with how hospitals currently work, in terms of our standard credentialling process. For me to have my licence to run that hospital, as given to me by ACT Health, I have to comply with the regulator's considerations of the services that we provide. It is set out within the safety and quality standards that we have to comply with. Effectively, how can I comply with that and the way our credentialling works, and deliver a whole lot of services and models of care within that, and then allow another service to be delivered in my facility?

That, to me, causes great concern about what it would look like for someone to be able to come into my facility and provide a service when I have not credentialled them. I have not gone through all of the safety models of care points that sit within my licensing arrangements. It causes me deep concern that that has not been necessarily considered—those kinds of broader implications—because ultimately it does sit differently. There is a different level of support for a facility operator that runs residential aged care than for a facility operator that would run a hospital.

MS CASTLEY: Thank you. I note that you have some recommendations on what changes are in your—

THE CHAIR: Mr Hawkins, I just want to check that I have understood this correctly, because it is quite complex when we start getting into the accreditation of things. The scenario you are applying this to is the assumption that Calvary Health Care would not be providing this service at one of the hospitals and therefore an external provider would have to come in. How would it work for your accreditation if the service was provided by Calvary but there were individual conscientious objections within the organisation?

Mr Hawkins: Okay. I think I have got it. Individual conscientious objection is fine. An individual health provider can do that, or a health service provider can do that. What we are worried about is someone who comes into our hospital. They are there for a range of reasons. They want to engage with voluntary assisted dying, but that is not a service that Calvary provides. That is not something that we credential any of our VMOs to do, so that service has to be provided by a third party. What would that look like, with a third party coming in to a facility that I run and operate to a very stringent standard and with credentialling for that standard? What would it look like to enable a third party to do it? I think that would put me in direct contradiction to my obligations under the licence that I hold with ACT Health.

THE CHAIR: I think I can understand. I am just trying to get to the subtlety and the nuance of this, because it is nuanced. There is a lot going on.

Mr Green: Yes, so think about things like insurance.

THE CHAIR: Yes.

Mr Green: Like medical liability.

THE CHAIR: Yes. Mr Green, in the interests of time, I am just going to keep my train of thought, if that is all right. What we are talking about, if I have picked up correctly what you are saying, Mr Hawkins, is that Calvary will not be implementing voluntary assisted dying under the bill, institutionally or individually for their staff. I think you said you have got a protocol that says staff—

Mr Hawkins: No, Ms Orr, that is not what I said. This becomes an issue because I credential a whole range of VMOs and services within my hospitals, whether it be maternity services, orthopaedics or ophthalmology. We do a whole range of services and we credential doctors to provide those services.

This is about when someone comes into the hospital and requests a service that we do not currently provide and we have no-one credentialled to do that—how that service is provided, and my obligations that sit with me, as a facility operator, within the legislation, under which there are strict liability offences. What I am saying is: if someone comes into a hospital and requests a service that I do not typically deliver and I do not have anyone credentialled to do that service, what would that mean for Calvary?

THE CHAIR: I guess the bit in my head, if you can talk me through your understanding of it, is that, under the bill, the circumstance where someone would be coming into a facility is when the facility is not providing that service. You would not be providing the service; someone else would be coming in. So the only scenario where I see another party coming in is if it is not offered as a service by Calvary. Have I at least got that part correct?

Mr Hawkins: I think so, yes. Calvary would not want to offer a voluntary assisted dying service.

THE CHAIR: The part in my mind is: "If Calvary is offering the service, there is not actually a need for a third party to come," so it gets around the point that you are making, but then I also appreciate that you are saying that, because of your ethos, that is not a service you wish to offer.

Mr Hawkins: Correct, and it would appear, from my read, that the legislation is geared very much to residential aged care, which has a very different set of quality standards that govern it, as opposed to hospitals, which have a different set of standards.

THE CHAIR: Yes. That is fine. Thank you. I think I have caught on enough to satisfy myself with that one.

Mr Green: Would you be assisted by a supplementary submission on this? Is there something more that would help you?

THE CHAIR: If you would like to provide further information, anyone is always welcome to provide further information to the committee. I do think what Mr Hawkins has said has clarified it enough for me, though. I appreciate that you are very busy people, with health facilities to run.

Mr Green: You have to look at the particular clause to actually understand the implications, and we do not have time to do that.

THE CHAIR: Yes. That is fine. Are we fine with what we have heard in the testimony or do we require further information?

MS CASTLEY: Can I just clarify: is there more information about the aged-care homes that you have referred to, Mr Hawkins, in the submission? You said that it is different to the hospital facility. Is there different information?

Mr Hawkins: No, but, Ms Castley, we would happily provide some details of the different levels of regulation that sit amongst both. That is not a problem.

MS CASTLEY: Thank you. That would be great.

THE CHAIR: I think I know the point you are going to. Mr Hawkins, just to clarify there: what you were saying was that the accreditation for the hospital is quite different to the accreditation for the aged-care facilities, and a third-party provider is much more problematic for a healthcare facility than an aged-care facility. Have I got that correct?

Mr Hawkins: Correct, but it would not be a problem for us to set out very clearly what our obligations are as a facility provider, and under what legislation, and therefore how this act would potentially intersect with it.

MS CASTLEY: Thank you.

THE CHAIR: You are taking that on notice to provide the committee with some more information. I think we have reached the actual finish time of the session now! We have now got one question taken on notice. We request that the answers come back within five days of the uncorrected proof being sent to you. The committee secretariat will send the proof to you. Once you have received that, if we could have the question on notice back within five days of that, that would be great. On behalf of the committee, thank you very much for your time today.

Hearing suspended from 3.14 pm to 3.31 pm.

TOBIN, DR BERNADETTE, Acting Director, Plunkett Centre for Ethics, Australian Catholic University

THE CHAIR: Welcome back to the public hearings for the committee's inquiry into the Voluntary Assisted Dying Bill 2023. The proceedings today are being recorded and transcribed by Hansard, and will be published. The proceedings are also being broadcast and webstreamed live.

Voluntary assisted dying is a sensitive topic, and the secretariat has information on support organisations available for witnesses or other people attending this public hearing who are impacted by issues raised in this hearing.

We are now welcoming Bernadette Tobin. Bernadette, can I get you to confirm that you are appearing as an individual, and state your full name for the record.

Ms Tobin: Yes. My full name is Bernadette Tobin, and I am the Director of the Plunkett Centre for Ethics, Australian Catholic University, located at St Vincent's Hospital in Sydney.

THE CHAIR: Bernadette, can I just confirm: are you appearing in your individual capacity or are you appearing on behalf of the Plunkett Centre for Ethics?

Ms Tobin: No, I am appearing on behalf of the Plunkett Centre. I think I ticked that box, but if I did not, I apologise.

THE CHAIR: No, that is fine. This is just so that we get it correct for the *Hansard*. I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement, which would have been sent to you by the secretariat. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Can I please get you to confirm that you understand the implications of the statement and that you agree to comply with it.

Ms Tobin: I do on both parts; yes.

THE CHAIR: We are not inviting opening statements; however, if you wish to table one you are welcome to provide it to the secretariat, and the committee will be able to read it at a later date. We will just jump straight into questions.

MR BRADDOCK: Thank you. Ms Tobin, regarding your point about the object of protecting individuals from coercion and exploitation, where you are saying there is nothing substantial in the bill to achieve that object, what would you expect to see in order for that objective to be demonstrated?

Ms Tobin: Mr Braddock, you ask me a very hard question. It is your bill, not mine, and you would know that I am not in favour of this practice. I have only one suggestion to make to you, and that is that some kind of involvement of the person's GP—someone who has known the person—might provide the ingredients for you to ensure that the proper protections are in place.

MR BRADDOCK: Thank you.

MR COCKS: I want to go to point 6 of your submission. You make the statement in there around other jurisdictions recognising “the community value of there being a variety of hospitals, of hospices, of aged care facilities, some of which have intuitional codes of ethics according to which doctors should never, and will never, in these institutions bring about the death of a patient or resident”. Why do you think it is important to have that variety of options out in the community?

Ms Tobin: Look, the reason why I think that is important is that in a pluralist society a variety of universities can keep each other up to the mark. A variety of hospitals—a variety of aged care institutions—can keep each other up to the mark. So it is not just that in a liberal, pluralist society there ought to be such a variety, but there is actually a value to the community in there being such a variety.

I understand that this practice is to be legalised, but I am recommending to you that you see the value of that variety of institutional arrangements so that someone can go into a hospital knowing that the practice will be facilitated, or knowing that they can go into another hospital or aged facility knowing that it will not be facilitated. Now, I understand your arguments against that; I am really urging that mark of a genuine normally pluralist society on you.

MR COCKS: It is interesting to me. You make the statement that people should know when they enter that facility whether assisted dying is provided or not. How would you make sure people were making an informed choice in that sort of context?

Ms Tobin: Is your question about someone going into an aged care facility—how would they know?

MR COCKS: How would someone know going in? Are there particular requirements that you would see being appropriate for those organisations which conscientiously object? Are there requirements you can see for them that would make it reasonable and make sure consumers are aware of where they stand?

Ms Tobin: Yes. I certainly think that people should know in advance where they stand, so a hospital, an aged care institution, should make it perfectly plain that this is a certain kind of institution and that it has no truck with this kind of service. So there will be a variety of ways of doing that—on the website, in the entrance, et cetera—and I would expect that gradually an understanding of these institutional differences will grow in the community.

DR PATERSON: I am just wondering. In the paper that you sent through as part of your submission there was discussion around “the choice will not be necessary” pressure. I was struggling to grasp that. Could you describe what you mean about that?

Ms Tobin: Yes. I think that the bill as drafted at the moment illustrates two ways in which legislation of this kind inevitably widens in scope. One way in which the bill, as currently drafted, allows for bracket creep is that it allows that virtually anyone over a certain age will be eligible, so the contrast would be with those jurisdictions where a doctor has to say that the person is likely to die within a finite time. The bill, as drafted, will allow virtually anyone over a certain age who so chooses to access the service. That is one way, in fact, choice will be the only thing that matters.

I predict that in another way your bill will rule out choice itself—and that is that in the end, you say that the bill is to be reviewed in three years, and the reviewers are to look at a couple of things. One of those is whether it should be possible that people can choose access to this service in advance—in a so-called "advance directive". Now, once that becomes the case the practice will no longer be voluntary. Choice will no longer be needed, because if I say in advance, "If I get to a certain condition, I want this service," when I get to that condition, however I am, I am likely to have the service administered to me. So choice will then be out.

I accept that it is a complicated thought, but what I am saying is there are two ways in which I think your bill, as currently drafted, allows great scope for bracket creep. I am really hoping that you will rein it in, in two ways—one, by requiring eligibility to involve a doctor saying that you are likely to die within a finite period, and the other being that you absolutely insist that the practice is voluntary, so you rule out any consideration of people being able to note in advance that they would accept it. I hope that makes sense.

DR PATERSON: Yes. We actually received a lot of submissions that were arguing for a consideration of conditions like dementia and for a discussion around that, even at this point in the bill.

Ms Tobin: Yes.

DR PATERSON: As seen through the submissions we received, there is a pretty active advocacy out there to see us at least discuss those issues. So in terms of just disagreeing with it, do you have anything further to add in terms of a circumstance like dementia where, as you said, someone initially will make a choice when they have the mental capability, and then when they do not anymore, that is no longer their present choice, necessarily? Do you have anything further to add to that discussion?

Ms Tobin: I understand that within organisations that support the legalisation of assisting someone to undertake suicide, there is a real split between those who are absolutely insistent that it be voluntary, and some who think that the law should rule out any scope for ordering it in advance. There are those who think that you legalise it first of all, and then the next step is that you enable people to have access to it when they have dementia.

I know this argument, and I know you have received submissions to this effect. but I really urge you to recognise that it will no longer be voluntary if you encourage that kind of access. Now, you and I both understand the suffering dementia can cause, not just to the person but to others, but the scope for abusing what you are about to legalise in those circumstances is so wide that I really urge you to take a step against that. And my reason, as I said, is very simple: it will no longer be voluntary.

MR COCKS: On the discussion you just had, it sounds as if you have a concern about the nature of consent, and I would like to try and have this conversation outside, as much as possible, just the frame of assisted dying and individual positions on it. It sounds as if the position you are presenting is that to be fully voluntary and fully consensual, consent needs to be, as it is in other spheres, active and ongoing, and that it can be withdrawn at any time. Would that be a fair assessment?

Ms Tobin: Thank you for that question. You get something that I think is very important. I can take up your point of responding to you outside the context of the VAD question. When people are dying they need good end-of-life care, and one of the parts of good end-of-life care is that therapeutically futile treatment is not imposed on people, and nor is treatment the burdens of which outweigh the benefits. So there certainly is a place for advance-care planning, but there are basically two ways of doing it. One is to ensure that someone who knows the person can help the decision-makers—the doctors and nurses at the time—provide the treatment and care that is faithful to what the person wanted. And another way is to write all of that down on a bit of paper and then the doctor has no choice but to follow what is written on a bit of paper. I think the former way—of involving someone who knew the person and could help the doctors understand what the person did not want, in particular—is the better and safer way.

MR COCKS: Okay. The other half of the question is around the idea of consent being withdrawn, and the idea that someone can change their mind about something that they have previously consented to.

Ms Tobin: Yes. I am not sure what you are asking me about that, but that is—

MR COCKS: That is okay.

THE CHAIR: I am going to cut Mr Cocks off so I can have a question which is still along this line of inquiry. Ms Tobin, can I just check? This line of inquiry is around advance care directives. From what I picked up, what you are saying is about having the ability to reverse the decision made—which might not be possible if you are not of legal cognitive functioning—if you have left an advance care direction. But my read of the bill is that while it is in the clause saying it should be considered in future reviews, it is not actually applicable to bill right now as this bill functions. So my question to you is: would the things that you have put forward in this discussion apply outside of that clause which is looking at the review and the future review, or is there something we should be considering in the current bill, now?

Ms Tobin: What I am suggesting to you is that you drop the reference to what the reviewers should look at. All three—(a) (b) and (c). I am talking about one, but I cannot remember which one.

THE CHAIR: Yes. There was quite a deep conversation, I would say, on consent and what consent means. I just wanted to check if it is applying to that section on the review, and your concerns around the review, and not necessarily applicable to the rest of the bill.

Ms Tobin: My concerns are about the review; yes.

THE CHAIR: Okay. I think that answers my question, and I think that also puts us pretty much to time, provided I am reading my schedule correctly now. Ms Tobin, we thank you very much, especially considering you have called in from a faraway place, and persevered with the IT. Thank you very much for appearing today. I do not believe you have taken any questions on notice, but you will be sent an uncorrected proof *Hansard* for you to check. You will see that come through from the committee secretariat. With that, I think we will finish up and get ready for our next witness. So thank you again, Ms Tobin.

Ms Tobin: Thank you for the opportunity. Thank you.

DONNELLAN, MR ANDREW

THE CHAIR: We are now welcoming Andrew Donnellan, who is appearing today as an individual. Can I please get you to confirm your name and the capacity in which you are appearing, just for the *Hansard* record?

Mr Donnellan: Andrew Donnellan, and I am appearing in my capacity as an individual.

THE CHAIR: I would like to remind you of the protections and obligations afforded by parliamentary privilege, and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Can you please confirm that you understand the implications of the statement and that you agree to comply with it.

Mr Donnellan: I have read and understood and agree to comply with the privilege statement.

THE CHAIR: Great. Thank you very much. We are not inviting opening statements, but if there is anything you wish to provide as an opening statement you are welcome to leave it with the committee secretariat, and the committee can take it into consideration. We will proceed straight to questions.

MR BRADDOCK: Mr Donnellan, your first recommendation is that health practitioners must not be allowed to initiate discussions about euthanasia. What I am concerned about is that if we adopted that recommendation how would patients even know that voluntary assisted dying was available as an option?

Mr Donnellan: Firstly, it has been a topic of significant discussion and debate within the community. It is not exactly a secret that the government is considering introducing voluntary assisted dying legislation. It is not exactly a secret that similar legislation exists in other parts of Australia and the world. And, obviously, it has been a topic of substantial public debate and discussion, but also the government is proposing to establish a care navigator service. There will be organisations and structures, I am sure, that will be providing information to the public about the availability of voluntary assisted dying.

My comment in relation to health practitioners initiating discussions is really about the specific risk in a health practitioner relationship. You know, in a doctor-patient relationship, there is obviously a bit of an imbalance in power. You have someone who is vulnerable and someone who is a qualified practitioner who is the person who a patient has to deal with in order to get access to all of their other treatments and all of their other supports. And certainly I think some patients would find it quite unwelcome to have their doctor be the one who initiates that discussion about accessing the assisted dying scheme.

MR BRADDOCK: Thank you. I appreciate the clarification.

MR COCKS: I have a supplementary question. It sounds as if what you are concerned about is a risk that people in a vulnerable state may take a comment, or the initiation of that discussion, as a suggestion that it would be an appropriate way forward.

Mr Donnellan: Yes. Obviously, if it is your doctor who starts that discussion, I think it goes without saying—you know, they are the ones initiating that discussion—that they are going to consider that it is an option that is appropriate. You might not think that merely bringing up one option among others is suggesting that someone should take it—it is merely bringing it up as a possible option—but I certainly know that in cases, not just of assisted dying, but all sorts of other medical procedures, when I have been to the doctor and they have brought up the possibility of doing a particular diagnostic procedure, I have had to ask them back and forth quite a bit to elicit whether that is something that I really need to be doing as a matter of urgency, or it is something that I could do any time in the next six months if I felt like it. That kind of discussion can be quite difficult and, obviously, if you are in a situation where you qualify for the assisted dying regime—you are eligible for that process—you are in a more vulnerable situation than most patients.

MR COCKS: Okay. Thank you. I have a substantive question. You make a point in your second page that facility operators should be permitted to completely opt out of the VAD scheme and provide no support, and you have suggested that making it clear to a prospective patient that that is the stance of a facility, would have benefits because patients would be able to choose a facility that aligns with their position and their beliefs. Can you talk a bit more about what you see as the value in that.

Mr Donnellan: I can just talk about me, personally. As I have mentioned in my submission, I disagree with euthanasia as an option—acknowledging, of course, that that is very much a minority view in the ACT and in Australia more broadly—but if I were choosing a facility for myself, if I were to find myself in a position where I needed disability group care or admission to an aged care facility at some point in my future, I would probably be reassured if I had the option to go to a facility which clearly states that they are in line with my values on that.

MR COCKS: Thank you. And it sounds like you would see the place for some requirements for facilities that were taking that option?

Mr Donnellan: Sorry, can you—

MR COCKS: Some obligation to be very clear about that.

Mr Donnellan: Yes. I think that is not unreasonable. I do believe that facility providers and, in particular, religious organisations that are involved in the provision of care—I do not want to come across as saying, “Corporations are people too”!—are really engaged in that activity as an emanation of, you know, the fundamental right to freedom of religion and freedom of belief. I would think it is reasonable, though, for people to be aware of what an organisation’s position is.

MR COCKS: Thank you.

THE CHAIR: Dr Paterson?

DR PATERSON: I refer to your strong stance against the option of extending voluntary assisted dying to people under 18, and the fact that that is even mentioned as part of the review. We have had some interesting discussions in the Assembly. One was in terms of raising the age of criminal responsibility, but we have also had discussions around lowering the voting age. So there have been lots of discussions around this 14- to 18-year-old age group and their capacity to make decisions about their own future. So I am interested in your perspective on this. Is it just that 18 is your line, and that is where it should end? Why not explore? For example, we heard from someone yesterday who I think was saying that their child was diagnosed with a terminal illness and they died only a couple of months past the age of 18, so they would not have had access—and they most likely would have wanted access—to voluntary assisted dying. So where do you sit on the fact that there could be a 16- or 17-year-old that is fully across their illness and what they are facing and would really like access to voluntary assisted dying?

Mr Donnellan: As you mentioned, there have been a lot of discussions around the age of responsibility for various things. You know, you mentioned criminal responsibility and voting. Fundamentally, I think 18 is the age which is broadly accepted in Australian law for most purposes as the age at which you are a competent adult. Obviously there has been a lot of talk about existing tests such as Gillick competence when it comes to minors being able to make decisions about their healthcare.

Ultimately, we are talking about a very, very profound decision. The impact of that decision goes beyond someone voting, someone being tried for a minor crime, or someone making other healthcare decisions that are less consequential. I think that it is pretty dangerous. I appreciate that there are people who are in a situation where they are under the age of 18 and they are not considered legally competent and they have a decision that they would like to make that they cannot make. This impacts young people across all spheres of life.

I actually moved to Canberra away from home—away from my parents—when I was 16. So I went through my first two years at uni not having legal competence to do a lot of the things—or some of the things—that I would like to do. But I think in this case, it would be very unwise to be looking at expanding access to under-18s at this point. And I am also concerned that the placing of the age eligibility requirements in the mandatory statutory review provision of the bill is signalling well ahead of time that it is the intention of the Assembly to eventually go down that path.

I realise that is not what the bill states. It is calling for that to be included as part of a review process, and I am sure that when that review process happens it will be an issue that is thoroughly canvassed, but whether or not the issue of age eligibility is mentioned in the bill, that is something that future Assemblies and future independent reviewers would presumably want to look at anyway, given the interest, it appears, from advocates and community members. I think that putting it in the bill in the way that it is now is signalling ahead of time that it is the Assembly’s intention to go down that path at some point.

MS CASTLEY: I have questions around your comments about palliative care. You said that the government must ensure that introduction of this legislation does not lead us down a path of funding cuts to healthcare. Where are your concerns based on around this? Have you seen this happen in other jurisdictions? What are your concerns?

Mr Donnellan: I guess I should start by saying I am a random member of the public. I am not an expert in palliative care or healthcare funding but obviously there have been media reports quite recently about decisions by the New South Wales government in relation to palliative care funding. I would say that I have not read deeply into the details of the New South Wales health budget. I cannot say for sure whether I think those particular reports are a real story or a media beat-up but I do note, I think, the submission that Calvary Health Care made to this committee. They mentioned that other jurisdictions—I believe they mentioned New South Wales and South Australia—included a specific statutory provision to require the government to make a report on the funding that goes to palliative care services and to monitor whether that increases or decreases following the introduction of the VAD legislation.

I guess I would say more broadly that some of the other submissions to the committee from the various palliative care associations and institutes have mentioned the need for the palliative care strategies to be fully funded and to be actively monitored to make sure that we achieve the outcomes. I should say that there are organisations within the healthcare system in Australia that are trying to do a lot of good work.

I have a little bit of familiarity with this. One of my close relatives works for a hospital in Sydney where they provide treatment to profoundly disabled children. I note, obviously, that that is a slightly different situation to what we are talking about with palliative care, but they provide a unique model of care that is not provided by any other institution, public or private, anywhere in Australia, and they do not get a single dollar of block grant funding from the state or federal governments. They get a bit from NDIS; they get a bit of funding for patients that are wards of the state. They are reliant on holding dinners with businesspeople to fund their operations and keep their doors open. So I think that there are definitely organisations in the healthcare system who are crying out for more funding and not finding it.

THE CHAIR: My question was actually on palliative care, so it has somewhat been covered. Is there anything you wanted to add around palliative care? We have had quite a bit of a discussion today—I do not know if you watched any of the other witnesses—certainly around ensuring that the option to access palliative care is still known and it is not seen as an either/or. I guess I am just asking whether you have any views or suggestions on how we could best ensure that the bill achieves that—that it is not seen as an either/or option; that palliative care has prominence as well.

Mr Donnellan: Yes. I guess I would note the comments that were made in other submissions about the provisions for making sure that practitioners inform patients of their rights to access palliative care. One other point I make in my own submission is that I do think that it should be a mandatory consideration for practitioners to look at socioeconomic supports and to ensure that people are not just aware of the healthcare services side of what supports are available to them but ensuring that they can access financial supports and housing support and those other things which can provide relief from difficult situations.

Fundamentally, I guess, I am not an expert in the area; I just think the government should be really making a strong commitment to make sure that the services are properly funded, that awareness is broad within the community and that palliative care is seen as a very respectable option for people to be taking for their end-of-life options.

THE CHAIR: Thank you. That brings us to the end. Mr Donnellan, you added that last bit you wanted to add, and I think we have hit the end of time, so I thank you on behalf of the committee for appearing today. I do not believe you have taken any questions on notice so we will not need to follow up with those, but you will be sent an uncorrected proof *Hansard* for you to have a look at. If there are any factual errors, please just let us know. Once again, thank you for coming in today. We do appreciate your taking the time to provide the committee with your submission and your testimony.

Mr Donnellan: Thank you.

The committee adjourned at 4.09 pm.