Submission to:

Discussion paper:
Ministerial Expert Panel on Voluntary Assisted Dying
Western Australia

AUSTRALIAN CHRISTIAN LOBBY
About Australian Christian Lobby

Australian Christian Lobby’s vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 125,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

acl.org.au | Like us on facebook.com/ACLobby | Follow us on twitter.com/ACLobby
24 May 2019

Dear Sir/Madam,

The Australian Christian Lobby welcomes the opportunity to submit to the Ministerial Expert Panel on Voluntary Assisted Dying.

While the ACL has many reservations about the introduction of VAD, we make the following submissions with particular concerns about whether euthanasia can ever be legislated safely. There is much evidence from overseas that suggest that initial safeguards are later eroded. Further, we are concerned that it is difficulty to ensure that the decision for VAD be entirely ‘voluntary’ and also that the freedom of conscience of medical professionals be protected.

Please feel free to contact me if I can offer any clarifications or further information regarding this matter.

Yours sincerely,

Peter Abetz
Director | Western Australia
Contents

Introduction .................................................................................................................. 2

Language ..................................................................................................................... 4

Key Issues .................................................................................................................. 5
    Palliative Care

The Decision ................................................................................................................. 6
    Informed consent
    Residency
    Medical professionals’ role in decision making
    Decision making capacity

Cultural Vulnerability ................................................................................................ 10
    Cultural and linguistic considerations
    Vulnerability of indigenous communities

Medical Practitioners ................................................................................................. 13
    Freedom of conscience
    Doctors trained in assisted dying
    Medication
    Suffering
    Assessment

Death Certification ...................................................................................................... 16

Conclusion .................................................................................................................. 17
    Summary of Recommendations
Introduction

The Australian Christian Lobby recognises that the task of the Committee is not to debate the pros and cons of physician assisted suicide. However, we would wish to couch our submission in the context that we do not believe it is possible to enact legislation that is ‘safe’ in the sense of being able to ensure that there are no wrongful death.

FAILURE OF MEDICINE – TO COMMIT TO THE SICK

Palliative care specialist, associate professor, Natasha Michael warns that the introduction of the Voluntary Assisted Dying Act 2017 in Victoria identifies three major threats to healthcare:

- Validating suicide as an acceptable choice;
- accepting substandard medical care by supporting the lack of rigour in defining eligibility; and finally,
- introducing into the healthcare curriculum the intentional ending of life as acceptable medical treatment.

“Hereby” she writes, “a new generation of healthcare professionals abdicate their commitment to the sick.”¹

As a palliative care specialist, Dr Michael is concerned that the eagerness with which many embrace physician assisted suicide is due to a lack of understanding of the enormous benefits offered by palliative care which actually answer many of the fears about death which propel the pro-euthanasia arguments. She writes:

> Palliative care is deeply misunderstood. It is viewed simply as the care of the dying, without understanding the totality of what it can offer, when it is done well. Stories of bad deaths arise not simply from the memory of the repugnance of death, but from one of ill preparation and a failure of professionals and society to help families delve deeply into what matters most.²

The Australian Christian Lobby agrees with the poignant description of the benefits of palliative care addressed by Dr Michael. The ACL also agrees that the introduction of euthanasia by any other name is a failure of medicine and an inversion of traditional values embodied in the Hippocratic Oath and in medical practice since.

CAN WE LEGALISE EUTHANASIA ‘SAFELY’?

The Discussion Paper raises many questions that cannot be answered without implicitly accepting the premise that euthanasia can be legalised “safely”. ACL contends that some deaths through nefarious intervention, lack of good options, indirect or direct pressure, will inevitably result from legalised euthanasia and international examples bear this out. The correct question therefore is not whether euthanasia can be made safe, but rather how many deaths of elderly people are considered acceptable in order to offer the “choice” of euthanasia to those among the wealthy, white, worried well, who, having the privilege of genuine choice, typically lobby for the legalisation of euthanasia out of concern regarding loss of agency in old age.

Rather than addressing the specific questions therefore, the remainder of this submission will point to defects in the premise that euthanasia can ever be safely legalised. But we trust our submission will help to make the legislation less unsafe.

It is essential that the dignity of the human person be at the centre of all our deliberations as a civil society. Proposing methods of hastening death, especially when all avenues for nurturing life are not pursued is a

¹ Michael, Natasha "We can’t let voluntary assisted dying negate our commitment to the ill” The Age, 23 May 2019

² ibid

Australian Christian Lobby
failure. Legislating for such hastening of death, when there is a lack of intention to provide excellent palliative care, is not something of which our society can be proud.

It was a former Labor Prime Minister who remembered and articulated our responsibility to each other in a civil society:

[Euthanasia] constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human...  
... What matters is the core intention of the law. What matters is the ethical threshold being crossed. What matters is that under Victorian law there will be people whose lives we honour and those we believe are better off dead.  
In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. Too much of the Victorian debate has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature. ⁸

---

Language

VAD – EUPHEMISM FOR EUTHANASIA

The issue of language is politically loaded. The Discussion Paper prefers the term ‘voluntary assisted dying’ to discuss the concept of euthanasia. At best, it is ‘physician assisted suicide’ as the path to death requires the involvement of medical professionals through the prescription, and possibly the administration, of death causing drugs.

An ancient but evergreen practice with controversial political and ethical issues is to manipulate ideas and language, spinning them to serve one’s ends... The advocates for physician-assisted suicide make use of a favorite method from the spin tool box, that of obfuscation, defined in dictionaries as an effort to render something unclear, evasive, or confusing. I believe that in recent years, many (though hardly all) advocates of euthanasia and physician-assisted suicide have used organized obfuscation as a political tactic...” ⁴

Key Issues

ELIGIBILITY CRITERIA - PALLIATIVE CARE

An additional question that should be added to the comprehensive check list for eligibility to VAD is:

- Has the person participated in a state-of-the-art palliative care program?

If not, the person should be deemed ineligible.

It is acknowledged that the field of palliative care is underfunded and that it is not readily available in regional and rural areas. It is also acknowledged that many people are ignorant of the services provided through palliative care, and that inadequate palliative care results in suffering – physical, psychological and emotional. Patients in distress may wish death, especially in the absence of good palliative care.

Unless palliative care is available to all who would benefit from it, offering euthanasia, voluntary assisted suicide, or dying or other euphemisms will fall short of giving the person true freedom in their decision making.

In the context of a recognised crisis in aged care and where palliative care is known to be inadequately funded, advancing euthanasia as a possible “choice” is a solution that actually diminishes real choice. The vulnerability created for the elderly ought to be self-evident: given sufficiently deplorable conditions, anyone might be persuaded to look on suicide as a blessing. It is therefore reprehensible that, rather than ensuring care for the elderly and dying is properly resourced and implemented, the government opts for assisting the sick to die.

Recommendation:

Unless a person has participated in palliative care, they are deemed ineligible for VAD
The Decision

AN INFORMED DECISION

The considerable space given in the discussion paper surrounding the decision illustrates how complicated this procedure will be, because making a free, autonomous decision is very difficult to ascertain. Whatever measures are put in place, there are always mitigating circumstances.

The availability of euthanasia as a choice produces pressure

A separate objection to euthanasia concerns the impossibility of ever entirely comprehending another person’s motivation. Advocates for euthanasia argue for the importance of giving effect to ‘free choice’. (Presumably, no one who advocates for euthanasia would do so if it meant ending a person’s life against their will, in circumstances where their free choice is compromised by other considerations or where this decision is taken in response to pressure). Free choice can only be said to exist if all other possible motivations to hasten death can be absolutely ruled out. Since no one can fathom the internal processes of another soul – since this choice cannot be clinically isolated from other complicating considerations which may cloud the purity of that choice and thus compromise the freedom with which it is made – the necessary conditions for purely free decision-making are never achievable in practice. Pressure to end one’s life may be direct or indirect.

Direct pressure

Legislated safeguards offer the vulnerable imperfect protection against overt, direct pressure. Governments can legislate narrow circumstances in which euthanasia is allowable, they can stipulate multiple medical opinions, cooling off periods and guidelines for counselling of the patient, etc. However, even with the best safeguards in an ideal world, no system of protections will ever be entirely impregnable to individuals of ill-will who are motivated to circumvent them. Family and doctors are trusted to act entirely in the best interests of their patients and loved ones. On the other hand, it is well-known that most abuse of the elderly occurs at the hands of family members, typically adult children, and that doctors, however well-meaning, may be subjected to pressure. A 2011 survey of 800 family doctors in the Netherlands found that nearly half had “felt pressured by patients or their relatives” to use euthanasia.5

Indirect pressure

Any discussion of the possibility of pressure being applied for the elderly or terminally ill to end their lives prematurely must acknowledge the operation of indirect pressure, which occurs merely because euthanasia is one available end-of-life choice. To imagine that the ability to choose death does not impose pressure on the vulnerable is to believe in a world where every individual operates in complete autonomy and can be trusted to make entirely selfish choices, without any consideration for the effects of these decisions on others. Such a world does not exist.

In the moment that end-of-life choices includes euthanasia, those aspects of care that are perceived as the ‘indignities of aging’ and the inevitable burden that caring for the aged entails are changed from being inevitable and necessary to being avoidable and the product of ‘choice’. The old person who could choose death is now a burden for others through their own selfish choice to stay alive. Such a choice may well be

resented by those required to care for them or pay for their care. Circumstances are not difficult to envisage in which such old people come to regard killing themselves as ‘the right thing to do’. In 2012 in Oregon, 57% of those requesting death reported ‘burden to family and friends’ as an end-of-life concern.

If laws are changed to allow voluntary euthanasia, indirect pressure is the inevitable result. Since death is irreversible, there is no opportunity for injustice to be appealed or victims to be compensated. In such matters of life and death governments must exercise the highest duty of care for all citizens by not enacting legislation that would increase the vulnerability of society’s most vulnerable.

RESIDENCY

We do not think that length of residency should be a criteria for eligibility: If a person has arrived in WA and shortly thereafter is diagnosed with an aggressive terminal illness, it would seem illogical and unjust to deny them a “right” that would have been available had they been living in the state for a little longer. If the parliament considers it morally acceptable for a person to be assisted in prematurely ending their life, then it should accept that it is morally acceptable for anyone, irrespective of length of residency in WA.

However, there need to be restrictions on ‘euthanasia tourism’ where a person may move to WA after having been diagnosed with an aggressive terminal illness. As a general rule we would advocate that a person should only have access to VAD if they are long term residents of WA, or have been diagnosed with a condition shortly after arriving in WA. However we recognise that there may be cases where a long time resident has moved interstate to say retire, and on diagnosis decides to return to WA in order to be closer to family.

Recommendation:

VAD should be available to a person who is diagnosed with an aggressive terminal illness after moving to Western Australia, or who has been a long term resident of WA in the past.

MEDICAL PROFESSIONALS’ ROLE IN DECISION MAKING

The discussion paper asks the following questions about the involvement of medical professionals in the decision-making process. These are very important considerations largely due to the unequal relationship between medical professional and the patient.

One question asked is:

- When should health practitioners be able to discuss voluntary assisted dying with their patients in the same way they raise and discuss other health or medical decisions and care options?

---


For many patients, the mere fact that a medical professional is proposing a course of action carries considerable weight and may constitute indirect pressure suggesting that accelerating death via lethal medication is the recommended option.

Because choosing to end one's life is such a critical, definitive and personal decision, and to avoid indirect pressure on the patient, it should not be the role of the medical professional to introduce the subject.

**Recommendation:**

A request for VAD must be initiated by the patient to ensure that it is 'voluntary'. Doctors should not introduce the discussion of VAD as a treatment option. This could constitute indirect pressure to opt for suicide.

**DECISION MAKING CAPACITY**

Decision making capacity is difficult to determine and, in this instance, the decision cannot be reversed. Issues such as direct and indirect pressure on the person have already been discussed.

Assessing capacity is particularly difficult especially as many sick and elderly people also experience depression for a variety of factors which may or may not be related to the condition for which they seek death.

Many elderly people wish for death as a means to escape from abusive situations. Advocacy groups for the elderly have termed these "the suicides we choose to ignore". An Australian study investigating patterns of suicide among the elderly (the largest study of its type in the world) was published recently in the International Journal of Geriatric Psychiatry. The study found that, of suicides in the 65+ age bracket:

- nearly 70% ... were male, 66% had a diagnosis of depression and nearly 80% were experiencing one or more major life stresses, such as health deterioration. Around 43% were experiencing isolation and loneliness, and nearly 30% had trouble adjusting to life in a nursing home.8

The authors of this study also note that 50% of residents in aged care facilities show signs of depression, compared with just 10%-15% of those living in the community. This figure alone contradicts the view that depression is “a natural part of the aging process”.9 Living alone, rather than mental illness, has been found to be a significant predictor of suicide for the elderly.10

Until all other possible motivations for choosing death are removed, the choice to suicide cannot be assumed to be the expression of autonomy, or unrestricted free choice. A choice is only a free choice when there are at least two good options. Indeed, as outline on page 60 of the JSC Minority Report, in the case of one woman who accessed VAD in the NT under the ROTI Act, she had not been informed of the choices of treatment available to her to address her depression. In addition her condition was not terminal.

**Recommendation:**

Eligibility for VAD, must include an assessment by a psychiatrist to certify that the person does not suffer from any form of depression.

---


Cultural vulnerability

CULTURAL AND LINGUISTIC CONSIDERATIONS

For many societies, discussion about euthanasia and suicide are unacceptable for cultural and/or religious reasons. Addressing this issue is likely to engender mistrust in the medical profession and may result in failure to seek medical assistance for fear of an unwanted outcome such as death. Already in some sectors of society there is a reluctance to go to hospital because ‘that is where people die’. Former US President Nixon is reported as saying “if I go into the hospital, I’ll never come out alive”.11

VULNERABILITY OF INDIGENOUS COMMUNITIES

Modern, western humanism contends that death must ultimately be a matter for individual freedom of choice. Where people are unable, through incapacity, to affect their own suicide, this gives rise to demands that the state facilitate death. The policies now contemplated are a consequence of flawed philosophical foundations that will compel others, including medical professionals who see healing and care as their primary objective, to act against their consciences.

There is another way; a way that entails community and interdependence. It is a way that is understood by our Indigenous communities and which was movingly articulated by Senator Pat Dodson in his opposition to the Restoring Territory Rights Bill on 15 August 2018. To quote from his speech:

> In Yawuru we have three concepts that guide our experience of life. They shape our ways of knowing and understanding and are the collective approach to our existence on this earth and, to that extent, any afterlife that may come. They are: mabu ngarrungu(nil), a strong community—the wellbeing of all is paramount; mabu buru, a strong place and a good country—human behaviour and needs must be balanced in their demands and needs of what creation provides; and mabu liyan, a healthy spirit and good feeling. Individual wellbeing and that of our society not only have to be balanced but be at peace with each other within the context of our existence and experience.

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

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


Australian Christian Lobby
we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected. I cannot support this legislation.  

It is our Indigenous peoples who, when requiring medical treatment, are likely to be far from their people and their community. This exacerbates pre-existing vulnerabilities relating to depression and despondency and is likely to influence them towards different choices to those they would make if palliative care were available in their communities. The opposition to euthanasia expressed by Senator Dodson is cultural.

The United Nations Declaration on the Rights of Indigenous Peoples, article 24.2 states:

"Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right."  

A critical problem is the poor health care options available to Aboriginal and Torres Strait Islander communities with inferior health outcomes throughout their entire lifecycle. A higher percentage of Aboriginal and Torres Strait Islander babies are of extremely low birthweight, there are more maternal deaths, and have a significantly lower life expectation than non-indigenous Australians. They are more likely to develop diabetes and kidney disease than other Australians and much of this can be linked back to lower standards of living and inappropriate diet. These are issues which affect the entire lifecycle.

There are still many lessons to be learned from the death of Gurrumul Yunupingu and the difficulties faced by indigenous people in the health system. For many Indigenous people, treatment requires that they travel large distances and are thereby separated from their communities and support networks.

Recommendation:

Respect must be accorded to those cultures and religions which do not support VAD. This will require medical professionals to be aware of the religious and cultural affiliation of their patients. Offense to patients can be avoided if the onus of initiating discussion of VAD is with the patient as in our earlier recommendation.

VAD is contrary to the cultural practice of indigenous communities. It must be noted that indigenous Australians are vulnerable to many health issues. There needs to be a commitment to better whole of life health care for indigenous Australians.

---

12 Dodson, Senator Pat;  
13 https://healthinfonet.ecu.edu.au/learn/health-facts/overview-aboriginal-torres-strait-islander-health-status/36501/?title=Overview%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20health%20status%2C%202018  
15 Australian Christian Lobby
Medical practitioners

FREEDOM OF CONSCIENCE

The discussion paper asks:

Should a medical practitioner or health service that conscientiously objects have an obligation to refer the patient to a practitioner or service that has no objection? If so, how should the medical practitioner find out which doctors are willing to provide assisted dying?

Doctors should not be required to refer patients to doctors who will assist them in dying.

A significant concern is the fundamental right of freedom of conscience. It is not morally acceptable for a medical professional to exercise ‘conscientious objection’ but then requires them to refer the patient to someone that does not share that objection. This is not conscientious objection. It clearly requires the health practitioner to compromise their conscience.

This issue was addressed in another jurisdiction in relation to referral to another practitioner where the first health practitioner was ethically opposed to euthanasia. In a hearing on Euthanasia in the ACT Legislative Assembly, a question was asked of Ms Gabrielle McKinnon, Human Rights Law and Policy, ACT Human Rights Commission. Ms McKinnon was asked:

“Do you think that any requirement to refer, from someone who refuses to participate, is too onerous or that there is some middle ground referral that under the Human Rights Act may not be considered too onerous?”

Her reply was:

“If I could take that a bit further, the idea is that certainly it would be a limitation on a doctor’s rights to freedom of religion, and their ability to conscientiously object, to require them to participate in the carrying out of voluntary assisted dying. It is certainly arguable that requiring them to directly refer to another doctor, knowing that the outcome of that would be that the person would have access to voluntary assisted dying, is likely to be also seen as a limitation.”

It is a denial of a medical practitioner’s right to freedom of thought, conscience and religion under Article 18 of the International Covenant on Civil and Political Rights (ICCPR) which states:

Everyone shall have the right to freedom of thought, conscience and religion.

Doctors, nurses, and counsellors must be free to exercise their conscience. If they believe assisting someone to die is contrary to their beliefs about the nature and dignity of the human person, they must not be forced to comply by referring the patient to someone else. For many doctors and nurses, participating in the ending of a life is a matter of deeply held conviction. Some will be unable to comply with the assisted dying, even with the risk of heavy penalties, therefore many will be forced out of their chosen profession rather than conform to the law.

---

Australian Christian Lobby
Recommendation:

Doctors may conscientiously object to providing VAD and also object to referring the person to another compliant provider. Such referrals are also in contravention of the medical professional’s freedom of conscience.

DOCTORS TRAINED IN ASSISTED DYING

It is a reversal of medical ethics to ask, as the discussion paper does whether doctors should be trained in voluntary assisted dying.

The practice of medicine has always undertaken to protect the life and health of the patient. It appears counter-intuitive for doctors to receive training in prescribing death. As Dr Michael urges us, there are other values in medicine that do not prescribe death:

*Palliative care continues to encourage medicine and society to be gentler in its acceptance of death. It recognises that, for the ill, disease is a ravaging force that inexorably conquers. For the patient, the convolutions of modern medicine, the uncertainty of therapeutics, the conundrum of multiple doctors across multiple sites bring an uncertain horizon and instil existential anguish. Their journey of illness is ultimately alienating and lonely. For many, it is the desperation for the restoration of dignity and the return of normality that drives the desire for death: “I want to die, let me die.” Not: “Kill me.”*

MEDICATION

The discussion paper raised many concerns about the safeguarding of medication. It is clear that the drugs involved in bringing about death are lethal. Yet, the pre-occupation with making the process appear to be ‘voluntary’ predisposes the promoters of the practice to encourage ‘self-administration’ as though this would provide conclusive proof that the dying was voluntary. In doing so, there is the very real possibility that the drugs may be misused or nor disposed of safely.

It is imperative that such medication not become a hazard to the public.

We understand that the Victorian model will involve staff from the pharmacy of one hospital being required to travel to the patient to dispense the medication. If the patient were to decide that they did not want it after all, there would be real pressure on them to ignore their own change of mind, because they can see that they have caused the pharmacy staff to travel (say) 3 hours to bring the medication. This would put significant pressure on the patient to consume the medication.

But if the lethal medication is simply left in the bedside draw of the person’s bed at home, the potential for the medication to be misused is significant.

Recommendation:

Protocols must be developed to ensure that all lethal medication is kept in a secure place while ensuring that these safeguards do not place indirect pressure on the person to consume the medication without the possibility of delaying the decision or changing their mind.

---

17 Op.cit Michael
SUFFERING

The discussion paper discusses the nature of human suffering. Suffering is, by its nature, subjective. Is this a reference to physical, emotional or spiritual suffering?

ACL views the Committee’s parameter of suffering being anything that can not be alleviated in a manner acceptable to the person as being open to abuse – and effectively creating a suicide on demand model. At very least the terms should be that palliative care has not been able to alleviate the suffering.

ASSESSMENT

Two doctors signing off on a person being eligible for VAD is, in our view, too low a threshold. We propose three doctors, one of whom should be an expert/specialist in the disease/condition that the person is suffering from. A third doctor must be an independent psychiatrist who ascertains that the person does not suffer from depression. It is important to ensure that there is no misdiagnosis which risks the ending of lives without evaluating all treatment options. From the lived experience of the NT ROTI Act, we know that two doctors – neither of whom had any expertise in the condition a woman suffered from – signed off on her request for VAD, including certifying that she had a terminal condition, when she was in fact suffering from , which is not a terminal condition. (see Page 60 of JSC Minority Report for details). In her case Dr Nitschke, went “doctor shopping” till he found another doctor willing to sign off on it.

**Recommendation:**

Three doctors must sign off on any VAD application. One must be a specialist in the disease/condition that the person is suffering. Another must be an independent psychiatrist.
Death certification

Recommendation:

It is essential that all incidents of ‘voluntary assisted dying’ be recognised for what it is. It should be listed as a contributing cause of death on both the Medical Certificate Cause of Death and the publicly available Death Certificate.
Conclusion

As stated in our introduction, the ACL has serious reservations as to whether it is possible to obtain a request for VAD that demonstrates free and informed consent – without any direct or indirect pressure. Further, ACL is concerned that all possible safeguards will not be successful in ensuring that there are no wrongful deaths.

Upon consideration of the issues raised in the discussion paper and with the above reservations we recommend the following as minimal safeguards.

Summary of recommendations:

1. Unless a person has participated in palliative care, they are deemed ineligible for VAD.
2. Eligibility for VAD, must include an assessment by a psychiatrist to certify that the person does not suffer from any form of depression.
3. VAD should be available to a person who is diagnosed with an aggressive terminal illness after moving to Western Australia, or have been a long time resident of WA in the past.
4. A request for VAD must be initiated by the patient to ensure that it is 'voluntary'. Doctors should not introduce the discussion of VAD as a treatment option. This could constitute indirect pressure to opt for suicide.
5. Respect must be accorded to those cultures and religions which do not support VAD. This will require medical professionals to be aware of the religious and cultural affiliation of their patients. Offense to patients can be avoided if the onus of initiating discussion of VAD is with the patient as in our earlier recommendation.
6. VAD is contrary to the cultural practice of indigenous communities. It must be noted that indigenous Australians are vulnerable to many health issues. There needs to be a commitment to better whole of life health care for indigenous Australians.
7. Doctors may conscientiously object to providing VAD and also object to referring the person to another compliant provider. Requiring such referrals would be in contravention of the medical professional’s freedom of conscience.
8. Protocols must be developed to ensure that all lethal medication is kept in a secure place while ensuring that these safeguards do not place indirect pressure on the person to consume the medication without the possibility of delaying the decision or changing their mind.
9. Three doctors must sign off on any VAD application. One must be a specialist in the disease/condition that the person is suffering. Another must be an independent psychiatrist.
10. It is essential that all incidents of ‘voluntary assisted dying’ be recognised for what it is. It should be listed as a contributing cause of death on both the Medical Certificate Cause of Death and the publicly available Death Certificate.