

Submission of Victorian Faith Leaders

Feedback on proposed amendments to the Voluntary Assisted Dying Act 2017

Most Reverend Peter A Comensoli
Archbishop, Catholic Archdiocese of Melbourne



Sheikh Muhammad Nawas Saleem
Public Officer/Secretary, Board of Imams Victoria



Shri Makarand Bhagwat
President, Hindu Council of Australia (VIC)



His Grace Bishop Kyriakos of Melbourne
His Grace Bishop Evmenios of Chora



Jasbir Singh Suropada
Chairperson, Sikh Interfaith Council of Victoria



Ramandeep Singh Arneja
Secretary, Victorian Sikh Gurdwaras Council



His Eminence Mykola Cardinal Bychok CSsR
Eparch, Eparchy of Saints Peter and Paul of Melbourne for Ukrainian Catholics in Australia, New Zealand and Oceania



Most Reverend John Panamthottathil CMI
Eparch, Syro-Malabar Eparchy of St Thomas the Apostle, Melbourne



Reverend Monsignor Paul Mingana
Episcopal Vicar of Melbourne,
St Thomas the Apostle Chaldean
Catholic Diocese of Australia & New Zealand



Very Reverend Daniel Ghabrial
Vicar General,
Coptic Orthodox Diocese of Melbourne



Reverend Monsignor Joseph Takchi EV OAM
Episcopal Vicar for Interstate Parishes,
Maronite Eparchy of Australia,
New Zealand and Oceania



Submission date: 31 March 2025

Background

As religious leaders who minister to and care for more than 2 million Victorians in our communities, we appreciate the opportunity to provide feedback on proposed amendments to the *Voluntary Assisted Dying Act 2017* (the *VAD Act*) in Victoria.

Through our many communities, schools, homes for the aged, chronically unwell and those with disabilities, hospitals and numerous pastoral and social welfare services, we support and care for others, with a particular focus on those most in need. This work is achieved through the hard work and dedication of thousands of staff and countless volunteers.

Our communities' focus on health care, aged care, education and social services is by no means accidental, but rather, is a response to the faiths that we each hold. This is a core focus of the mission and identity of each of our communities.

We are deeply committed to accompanying those sick and at the end of life, shaped by an enduring commitment to best practice and excellence in care. This includes holistic medicine that takes into account the totality of the human person – body, mind and soul.

Introduction

Through the Department of Health, the Victorian Government has sought feedback on a list of proposed changes to the *VAD Act*. These proposed changes followed the *Five-Year Review of the Operation of Victoria's Voluntary Assisted Dying Act 2017* (the Review). However, these changes were not recommended by the Review and were outside its terms of reference. Furthermore, the Department's consultation process provides insufficient detail of the proposed changes and inadequate time for the proper consideration required by such weighty matters. While recognising these limitations, this submission offers a response to each proposed legislative change.

The terms of reference for the Five-Year Review of the *VAD Act* did not include consideration of changes to the legislation. In fact, the Victorian Government made clear that, "As this legislated five-year review is operational, it is not considering changes to the legislation itself". This means that many respondents to the Review will not have had the opportunity to offer views on potential legislative changes.

The Review itself makes no recommendations for legislative change. Possible amendments are raised only in an addendum to the Review based solely on the feedback of a proportion of respondents who made submissions outside the Review's terms of reference. The Government's proposed legislative changes are, therefore, neither supported by their own Review nor based on the submissions of all participants to that Review.

Furthermore, the Department of Health has undertaken this consultation in great haste, offering respondents two weeks to respond to what amounts to very vague descriptions of proposed changes that could have far reaching consequences for Victorians – and literally on matters of life and death.

Given the magnitude and seriousness of what is being proposed, it is appropriate that any changes be carefully and thoroughly examined. Any proposed amendments should first be published as an exposure draft to allow thorough public consideration, particularly given the many participants in the Review who were not invited to comment on the legislation and potential changes to it.

Below is set out a response to each of the proposed changes. Most of the proposed changes would weaken protection for vulnerable Victorians and should not proceed. Two proposals – relating to potential conflicts of interest for health practitioners and a further review of the *VAD Act* – are supported in principle, but it is not yet apparent that there is a clear need for legislative change to achieve these ends.

While commenting on the various proposed changes, we must state that from the outset, we do not believe euthanasia or assisted suicide can ever be made safe – since they involve acts that are unsafe in their very essence.

Response to proposed changes

1. Allow registered health practitioners to initiate discussions about VAD, within broader end of life discussions.

Strongly opposed.

This is not a recommendation made by the Review. When VAD was first introduced in Victoria, the prohibition on health practitioners initiating a discussion about VAD was regarded as a central safeguard. This proposal seems to redefine that central safeguard as an access barrier. Allowing health practitioners to raise the possibility of accessing VAD with patients who have not raised it themselves elevates VAD from a “legal end-of-life option” to some kind of equivalence with health care. Providing patients with lethal substances to end their life is not health care and no legislation in any Australian jurisdiction defines it as health care. This change raises a substantial risk of patients being pressured or coerced into using VAD – either by health practitioners or by others placing pressure on those health practitioners. This pressure does not need to be overt or explicit to have an impact on a patient, especially one that is vulnerable and unwell. The power imbalance between a health practitioner and a patient is clear.

Forms filled out by those accessing euthanasia or assisted suicide in overseas jurisdictions indicate that being a burden on others is a key reason why people seek to end their lives through such measures. For example, in the United States, the State of Oregon’s published data shows that, to date, 47.1 per cent of people seeking to end their own life through such means report being a burden as an end-of-life concern.ⁱ

In a time of limited resources – especially in health care – allowing health practitioners to raise VAD with their patients opens up the risk of patients being made to feel that they are a burden on an already strained health care system. This change should not proceed.

2. Require registered health practitioners who conscientiously object to provide minimum information.

Strongly opposed.

This is not a recommendation made by the Review. VAD is not health care and no legislation in any Australian jurisdiction defines it as health care. Health practitioners who conscientiously object to VAD should not be obliged by law to violate their consciences, particularly to provide information about something that is not health care. The Review noted the strong support for retaining the conscientious objection provisions and offers only non-specific, anecdotal assertions that “some requests” for VAD were “obstructed” as justification for such a dramatic change. Many hard-working health practitioners want no part in causing death and such changes risk driving good people from the health sector. Their beliefs are supported by the World Medical Associationⁱⁱ and Australian Medical Associationⁱⁱⁱ who hold that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life. This change should not proceed.

3. Amend Australian citizenship and permanent residency requirements to permit VAD access to people who can demonstrate 3+ years' Australian residency.

Opposed.

This is not a recommendation made by the Review. This change should not proceed.

4. Introduce an exemption process to the Victorian residency requirement on compassionate grounds.

Opposed.

This is not a recommendation made by the Review. Protections for vulnerable people should not be weakened by reducing the eligibility criteria for accessing VAD. This change raises significant risks of forum shopping by patients seeking to circumvent their own state or territory laws. This change should not proceed.

5. Update the prognosis requirement to 12 months for all VAD applicants.

Strongly opposed.

This is not a recommendation made by the Review. Protections for vulnerable people should not be weakened by reducing the eligibility criteria for accessing VAD. The further into the future a prognosis is made by a health practitioner, the less reliable that prognosis becomes, raising very serious risks that patients could choose to end their life based on an inaccurate prognosis. As the Review indicates, this proposal would be at odds with the majority of jurisdictions in Australia. Combined with the proposed removal of residency requirements, it raises significant risks of forum shopping by patients seeking to circumvent their own state or territory laws. This change should not proceed.

6. Remove the requirement for third prognosis assessments for people with neurodegenerative conditions where prognosis is assessed as between 6-12 months.

Strongly opposed.

This is not a recommendation made by the Review. Protections for vulnerable people should not be weakened by reducing the eligibility criteria for accessing VAD. This proposal raises very real and significant risks for vulnerable patients if they are not properly assessed by the appropriate health practitioner given the "increased difficulty in determining a patient's prognosis when it may be beyond six months", as clearly articulated in the Victorian Government's own *Voluntary assisted dying: Guidance for health practitioners*.^{iv} This change should not proceed.

7. Shorten the time period between the first and final request from 9 days to 5.

Strongly opposed.

This is not a recommendation made by the Review. Protections for vulnerable people should not be weakened. Reducing the required time interval between the first and final requests substantially increases the risk of vulnerable people being pressured into choosing VAD, particularly where they are still coming to terms with changes in their condition or prognosis. This proposal would leave patients able to access VAD faster than they can access proper palliative care in many settings, especially in regional areas. This change should not proceed.

8. Allow greater applicant choice of administration method and simplify permits to prevent delays.

Strongly opposed.

This is not a recommendation made by the Review. Protections for vulnerable people should not be weakened. Allowing a single permit to be issued for both self-administration and practitioner administration of the lethal substances authorised under the *VAD Act* raises significant risks for vulnerable patients. The proposal is also likely to create conflicts for health practitioners, particularly where the practitioner may choose to be involved in an assessment but not wish to be involved in administering a lethal substance to their patient. This proposal would further erode conscientious objection protections for health practitioners. This change should not proceed.

9. Introduce an exemption process to interpreter requirements.

Strongly opposed.

This is not a recommendation made by the Review. Protections for vulnerable people should not be weakened. Providing a process to exempt patients from using an accredited interpreter raises significant risks for vulnerable patients who do not have strong English language skills and particularly for those from smaller language groups. Without the quality assurance provided by proper accreditation, a significant risk arises that misunderstanding will occur when interpreters are not familiar with the nuances of a given language or dialect. Relying on unaccredited interpreters raises significant risks of a lack of independence that could result in a vulnerable patient being pressured into accessing VAD or deliberate mistranslation by those who wish to make the choice on the patient's behalf. Precise and accurate communication should be central to a decision of such gravity. This change should not proceed.

10. Prohibit medical practitioners from being a beneficiary or family member of the applicant.

Supported in principle, but no need has been demonstrated.

This is not a recommendation made by the Review. If the Department of Health is aware of instances of health practitioners assisting patients to access VAD where the practitioner stands to benefit from a patient's death, this information would be gravely concerning and should be made public. No person who has a conflict of interest should be assisting a patient to access VAD. However, no evidence has been presented to indicate that there is a need for legislative change given existing ethical obligations on medical practitioners. The review did not address this issue or identify any specific concerns. This change should only be pursued if existing protections from unethical behaviour by medical practitioners are actually insufficient and should not be used as a vehicle for other changes.

11. Remove forms from the Act and provide in VAD regulations.

Strongly opposed.

This is not a recommendation made by the Review. Decisions about matters like VAD are far too serious to be delegated to public servants who are not directly accountable to the people in the way that elected Members of Parliament are. The structure of the forms and the information collected make up a central part of the administration of VAD. Any changes to these forms risks altering the eligibility criteria and assessment processes and must be carefully and explicitly considered by Parliament. This change should not proceed.

12. Require additional review of the operation of the Act at 5-year intervals.

Supported in principle, but opposed in practice.

This is not a recommendation made by the Review. We do not believe euthanasia or assisted suicide can ever be made safe – since they involve acts that are unsafe in their very essence. While further reviews of the legislation would be appropriate, these can be undertaken at any time and without the need for legislative change. This change is unnecessary and should not be used as a vehicle to enact other changes.

Conclusion

While we appreciate the opportunity to provide feedback on these proposed changes to the *VAD Act*, an issue of such importance – literally on matters of life and death – requires far more detailed consideration. We call on the Government to publish an exposure draft of any legislative changes it intends to pursue and provide sufficient time for thorough public consideration and consultation.

ⁱ Public Health Division, *Oregon Death with Dignity Act: 2023 Data Summary*, Oregon Health Authority, <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year26.pdf>

ⁱⁱ World Medical Association (2019), *WMA Declaration on Euthanasia and Physician-Assisted Suicide*, <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>
World Medical Association (2022), *WMA Declaration of Venice on End of Life Medical Care*, <https://www.wma.net/policies-post/wma-declaration-of-venice/>

ⁱⁱⁱ Australian Medical Association, *AMA Position Statement: Euthanasia and Physician Assisted Suicide*, <https://www.ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016>

^{iv} *Victorian Government, Department of Health, Voluntary assisted dying: Guidance for health practitioners*, <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/v/voluntary-assisted-dying-guidance-for-health-practitioners.pdf>