

I attended on 5 November last to give evidence to the Health, Social Care and Sport Committee concerning voluntary assisted dying.

I noted a recent publication from a Scottish academic.

Palliative care-based arguments against assisted dying.

Bioethics. 39(2):187-194, 2025 Feb.

Colburn, Ben. Department of Philosophy, University of Glasgow, Glasgow, Scotland.

In the abstract it states “that growth in palliative care services has stalled in countries where assisted dying has been legalised; and that legalised assisted dying impedes the growth of palliative care or causes it to decline”.

I thought that it may be of interest to the Committee to know that a decline in palliative care services has not been observed in Australia since the introduction of voluntary assisted dying. Consistent data shows that just above 80% of persons accessing voluntary assisted dying had or still were receiving palliative care. Attached is a presentation from Palliative Care Australia regarding a survey of 1,000 palliative care workers. On slide 4 it reports that the introduction of voluntary assist dying is perceived to have been followed by an increased demand for palliative care, not a decline.

I note that the various State legislation in Australia imposes a legal obligation upon health practitioners when receiving a request for voluntary assisted dying to inform the person of all of the options for care and specifically to include palliative care. This is in contrast to the normal situation in which there is no legal obligation for a health practitioner to talk about palliative care. Given that there are misunderstandings about and a lack of knowledge of palliative care in the public generally, this obligation has a positive impact upon the use of palliative care services.

I trust that this may be of interest to the Committee.

Yours sincerely

Julian

Julian Gardner AM  
Chairperson  
Voluntary Assisted Dying Review Board



**Palliative Care**  
Australia  
*Matters of life and death*

# **Healthcare worker perceptions of VAD across service settings**

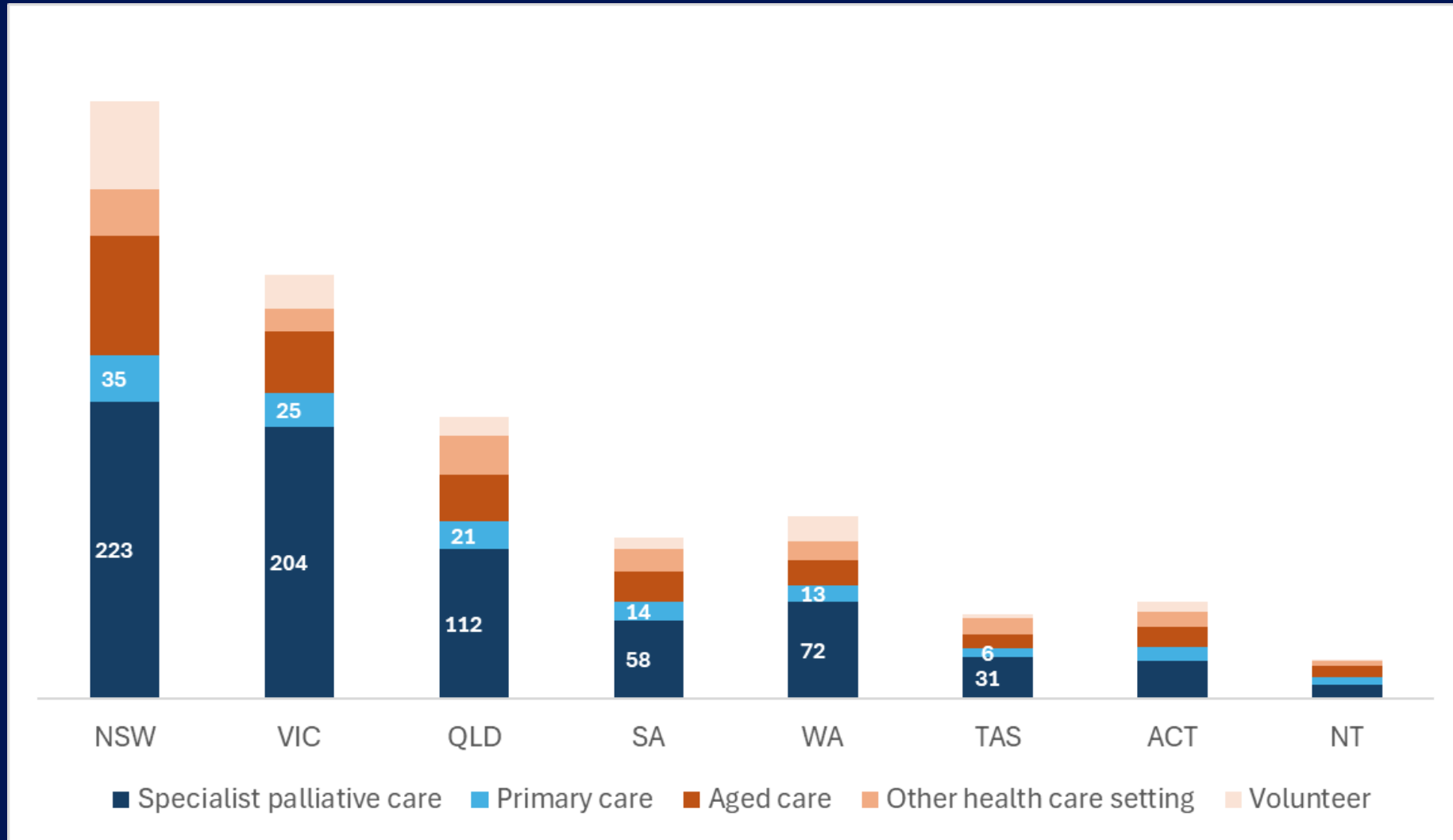
Josh Fear  
National Policy Director, Palliative Care Australia

# PCA's survey

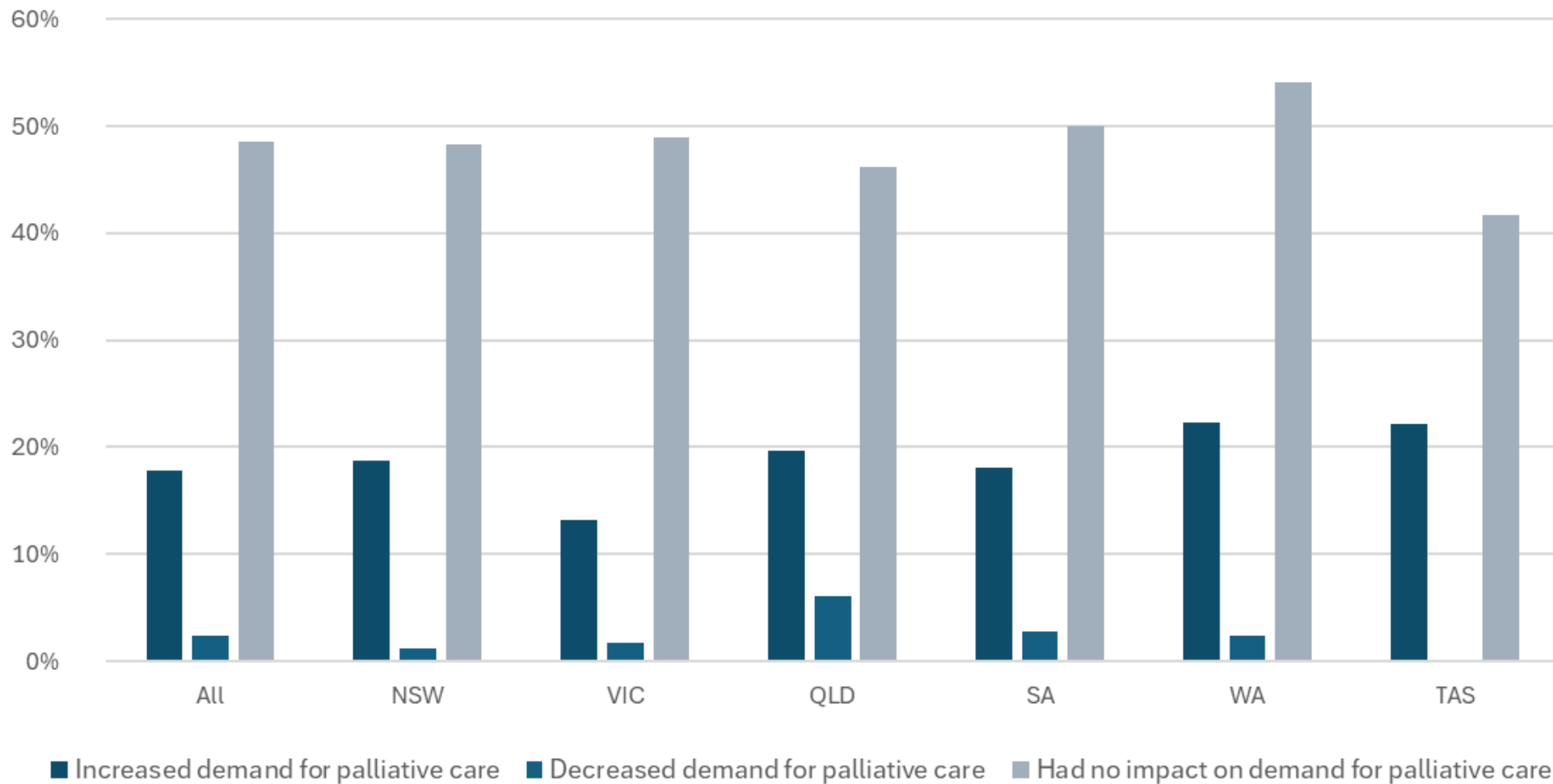
- Online survey of the palliative care workforce
- Open from 17 May - 11 August 2024
- n=1,400
  - 738 specialist palliative care workers
  - 129 primary care workers
  - 248 aged care workers
  - 142 other healthcare workers
  - 148 palliative care volunteers
- ACT and NT respondents not asked questions about VAD

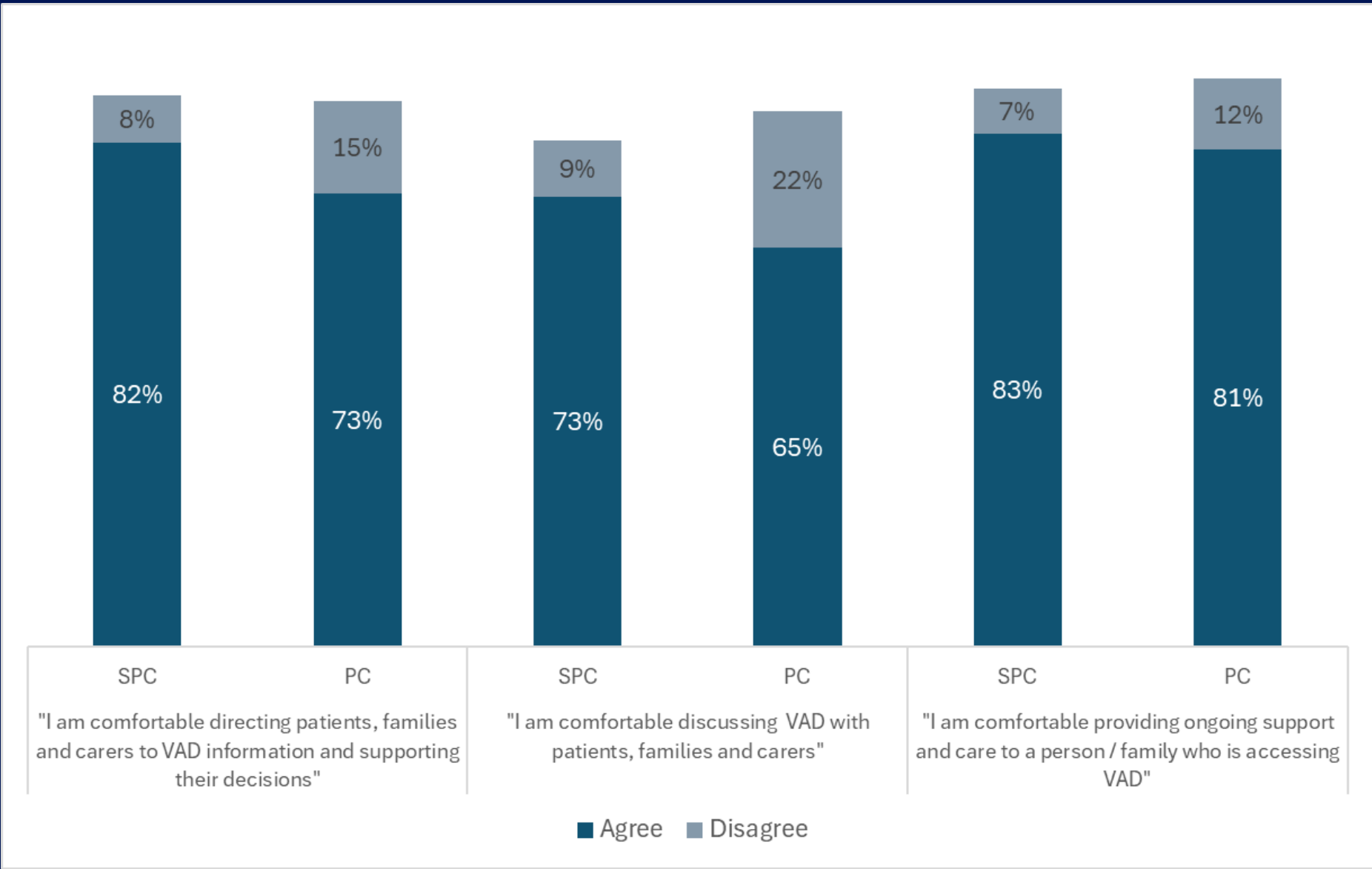
# Survey sample

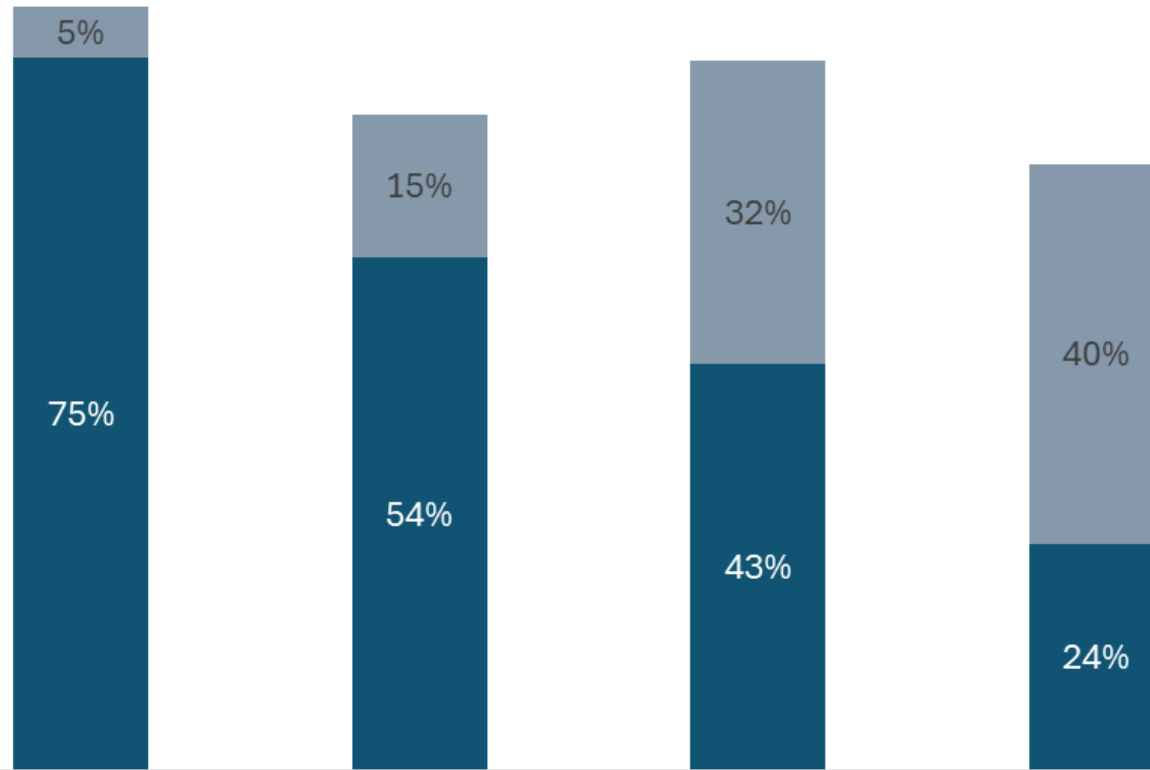
Specialist palliative care and primary care, excluding NT and ACT, n=809



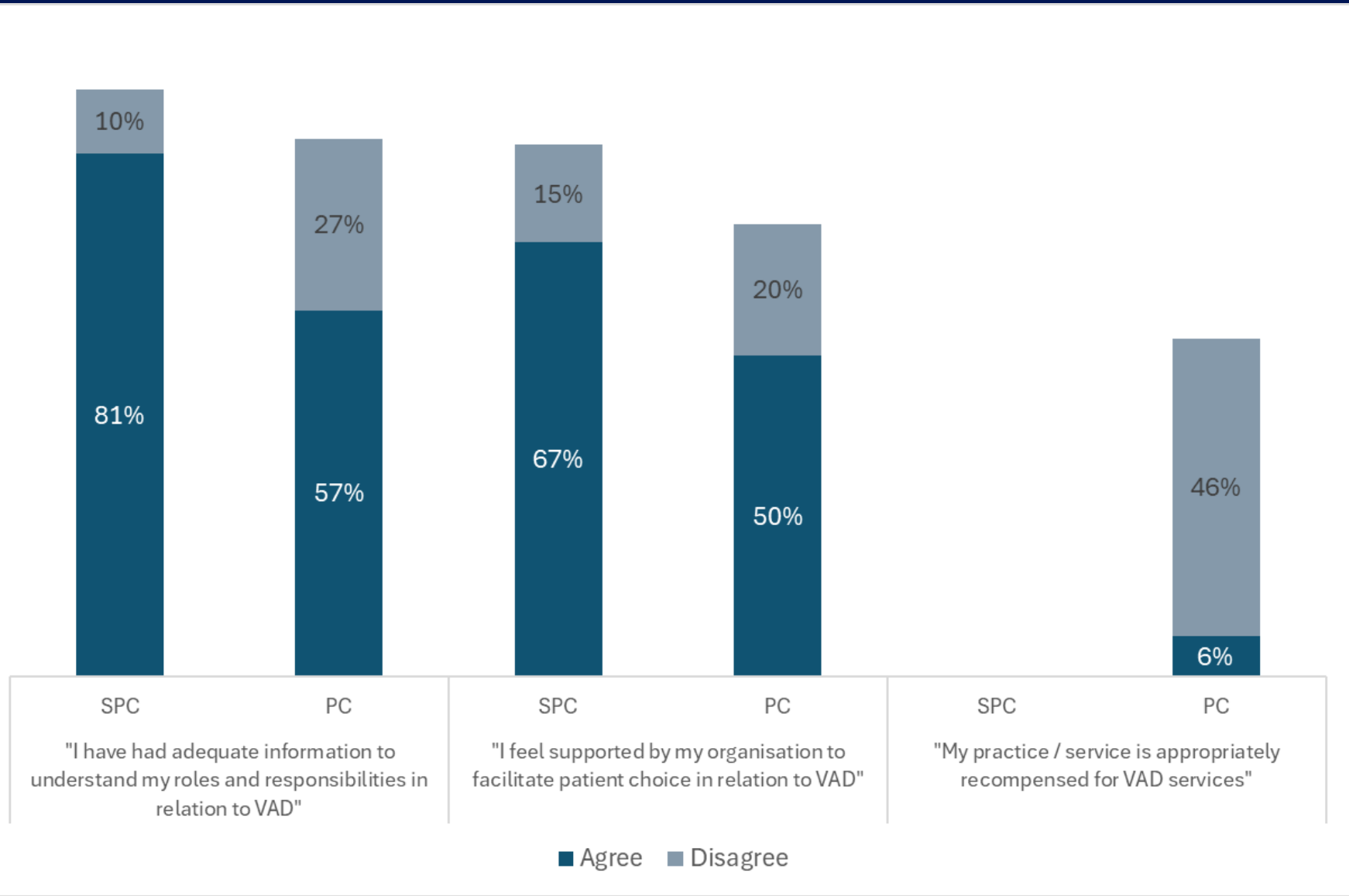
## In your view, has the introduction of VAD...?





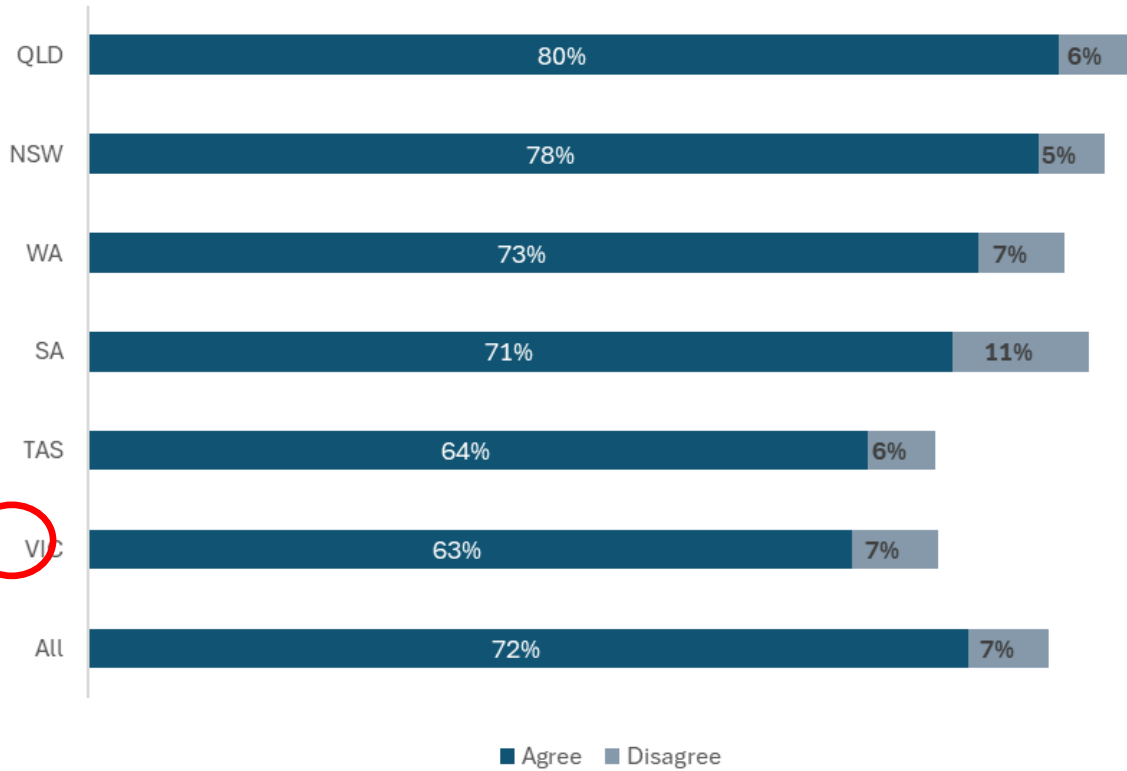


SPC                      PC                      SPC                      PC  
 "In the last year, more patients, families and carers want to talk to our practice/service about VAD"    "Patients, families and carers can easily navigate the system and access VAD"  
 ■ Agree    ■ Disagree

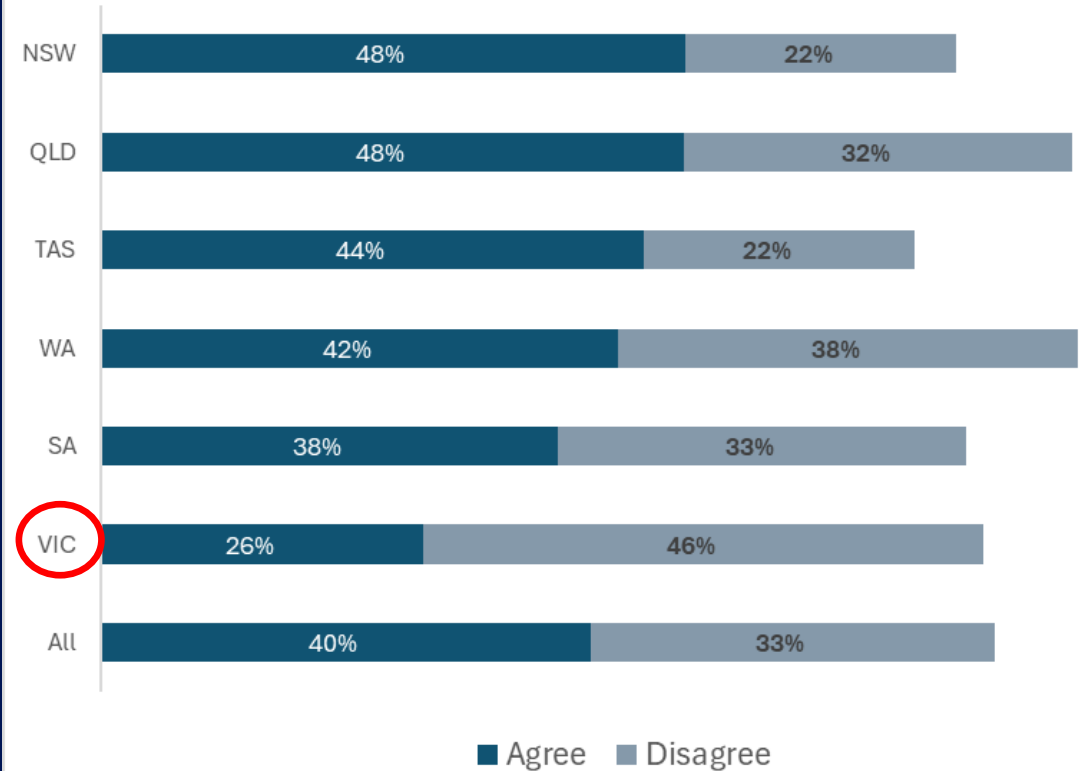


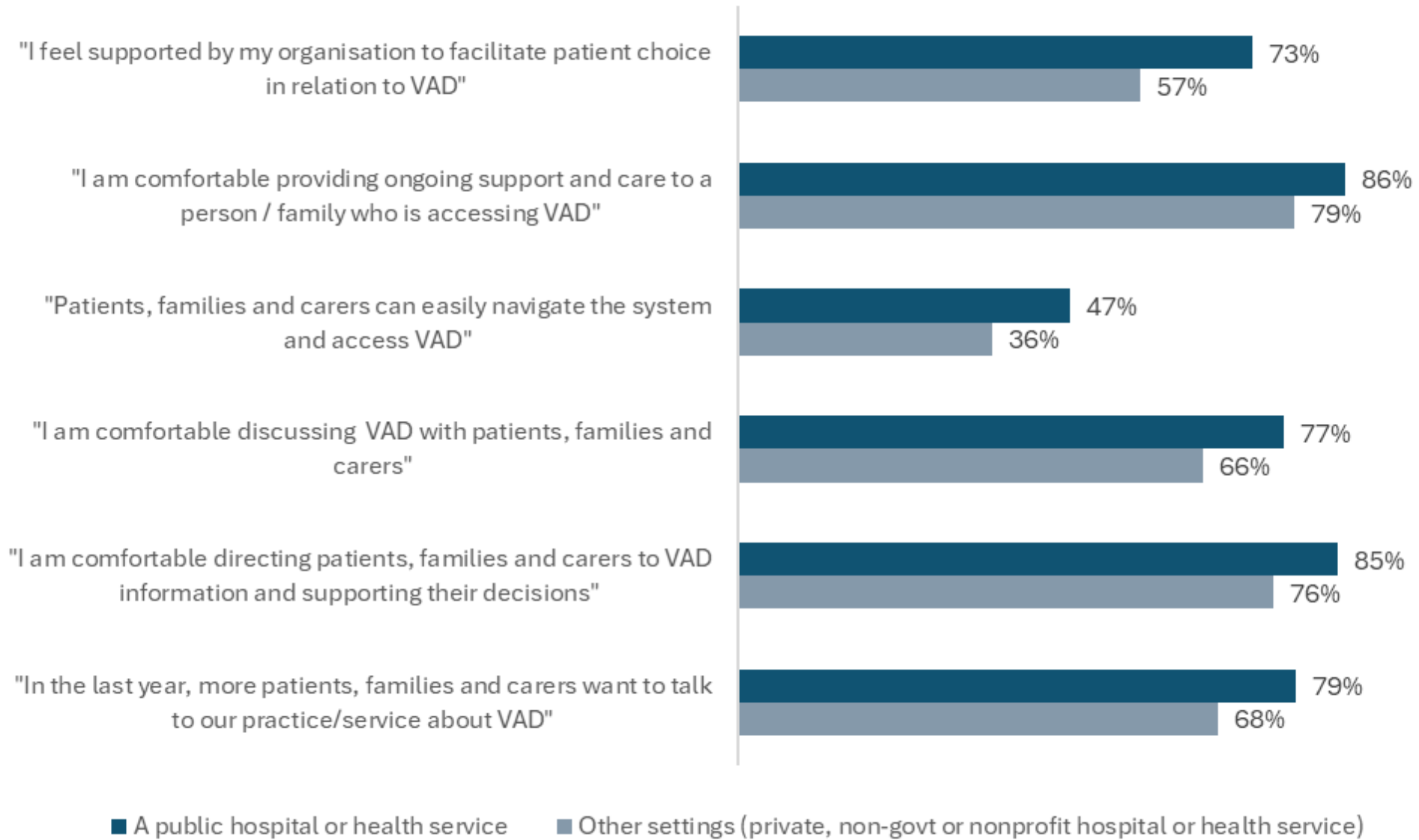


"In the last year, more patients, families and carers want to talk to our practice/service about VAD"



"Patients, families and carers can easily navigate the system and access VAD"





**“Has the introduction of VAD had other impacts that you would like to provide information about?”**

# VAD can increase access to palliative care

*“It has made patients in general more interested in discussing end-of-life options as well as the role of Palliative care.” (PC)*

*“VAD has helped more people understand and discuss care options at the end of life.” (PC)*

*“Encourages discussion around end-of-life options if the patient knows about it.” (PC)*

## Patient autonomy, control and choice

*“I am proud to be able to support my patients and their family through a dignified passing that my patient has independently chosen.” (PC)*

*“If choice is central to palliative care, so too should access to VAD in EOL care (PC)*

# VAD as an insurance policy

*“I think this element of 'a back-up plan' has been beneficial for patients. (PC)*

*“Fewer patients seem afraid of dying now that safe painless alternatives are available.” (PC)*

*“Knowing VAD is an option gives patients peace of mind, even if they don’t use it.” (SPC)*

*“Patients often choose VAD because it gives them a sense of control over their illness.” (SPC)*



# Patients want to maintain decision making capacity

*“Patients refuse symptom control to maintain capacity for VAD.” (SPC)*

*“Some patients refuse opioids out of fear of losing their ability to access VAD.” (SPC)*

*“Patients fear losing capacity for VAD if they take symptom management medications.” (SPC)*

*“Patients sometimes decline palliative care interventions to maintain VAD eligibility.” (SPC)*

*“Patients sometimes decline palliative care because they assume it will interfere with VAD.” (SPC)*

*“Patients reject symptom control because they don’t want to lose capacity for VAD.” (SPC)*



# Consumer misperceptions

*“Many people confuse palliative care with euthanasia.” (SPC)*

*“Patients and families sometimes think palliative care offers VAD.” (SPC)*

*“Families sometimes assume palliative care provides VAD services.” (SPC)*

*“There are misunderstandings around palliative care and VAD.” (SPC)*



# Challenging Conversations

*“Discussions about VAD add complexity to conversations around symptom management.” (SPC)*

*“Conversations with patients wanting VAD and being turned down are difficult to navigate.” (SPC)*

*“The presence of VAD complicates conversations about other end-of-life care options.” (SPC)*





# Workload and paperwork

*“It is significantly easier to access VAD than it is to access comprehensive high-level palliative care.” (SPC)*

*“VAD adds an additional workload for palliative care staff.” (SPC)*

*“VAD adds another layer of care but with no additional FTE. It adds to the palliative care workload.” (SPC)*

*“The paperwork involved in processing VAD applications and coordinating consultations has increased our workload tremendously.” (SPC)*

*“The VAD administrative tasks add a lot of extra work for an already stretched palliative care team.” (SPC)*

*“Handling VAD-related consultations means we spend less time providing direct patient care.” (SPC)*

*“It has made care of the terminally ill more difficult and more complex as there is another level of complexity and referral process.” (PC)*

# Funding barriers in primary care

*“Again this is all unfunded work and pressure is placed on GPs to provide services at no cost to their patient.” (PC)*

*“Long complex discussions are needed with family, which of course is not well-funded under Medicare.” (PC)*

# Ethical conflicts both ways

*“Hospital policy forbids discussion of VAD unless the patient identifies it as a topic they want to explore.” (PC)*

*“The residential aged care facilities that I consult in have taken a ‘we don’t want to know what’s happening’ approach.” (PC)*

*“I have noticed some colleagues are reluctant to discuss this because it is not in line with their personal values.” (PC)*

*“Experienced team members are leaving due to being objectors of VAD.” (SPC)*

*“Staff are made to feel like they are doing things wrong when a patient asks for VAD.” (SPC)*

*“There is often a feeling of moral distress when staff disagree with a patient’s choice of VAD.” (SPC)*

*“Some staff find it difficult to reconcile their values with the provision of VAD.” (SPC)*



# Faith-based service settings (1/2)

*“I’m all for VAD for those who need it and can think it through logically but there is only limited support down here and the local church is against it so it’s a battle.” (PC)*

*“VAD raises ethical dilemmas for clinicians, especially in faith-based organizations.” (SPC)*

*“Staff in Catholic organizations are told not to discuss VAD with patients.” (SPC)*

*“I work in a Catholic hospital that does not permit staff to discuss VAD.” (SPC)*

*“Staff conscientious objection has led to patients missing the opportunity to access VAD.” (SPC)*

*“Staff who object to VAD can struggle with supporting patients who choose it.” (SPC)*



# Faith-based service settings (2/2)

*“VAD is not supported in Catholic organizations, leading to ethical dilemmas.” (SPC)*

*“In Catholic facilities, patients are not allowed to discuss or access VAD.” (SPC)*

*“In Catholic-based facilities, VAD is strictly off-limits due to religious policies.” (SPC)*

*“The local hospital down here is run by the Catholics, and won’t let non-Catholic palliative care workers in because of VAD.” (SPC)*

*“Those clients who are linked with a Catholic health service find it unfortunate that they are not able to be supported by their specialist clinician within that service due to the Catholic beliefs.” (PC)*

# Impact on staff

*“The introduction of VAD has increased staff distress.” (SPC)*

*“VAD has caused moral injury to palliative care staff.” (SPC)*

*“Staff struggle emotionally when patients choose VAD.” (SPC)*

*“VAD has divided opinions within workplaces, leading to emotional challenges for staff.” (SPC)*

*“Staff report feeling unprepared for the emotional complexities of VAD.” (SPC)*

*“There is minimal education available for staff on VAD processes.” (SPC)*

*“Staff are asking for more information about VAD, as the process is secretive.” (SPC)*

*“Healthcare professionals need more education on the legalities and practicalities of VAD.” (SPC)*

# Impact on families

*“Families are left with complex grief following VAD.” (SPC)*

*“The bereavement process after a VAD death is more nuanced.” (SPC)*

*“Families are often unprepared for the grief following VAD.” (SPC)*

*“Families sometimes find VAD deaths more emotionally complex.” (SPC)*

*“The emotional complexity of VAD impacts families greatly.” (SPC)*



# Access barriers, especially in rural and regional areas and for the less mobile

*“I feel that there is increased frustration experienced with clients attempting to access VAD especially when they are unable to physically attend the vital appointments.” (SPC)*

*“Lack of Regional availability has resulted in anger and great disappointment from families unable to access due to lack of clinicians and distance.” (SPC)*

*“The process living rurally can take too long , patients sometimes die before substance available.” (SPC)*

*“Unfortunately I feel that access to VAD is a first option for rural and remote patients rather than a second option after a patient has received an equitable access to good palliative care In this particular rural or remote area..” (SPC)*

*“It is extremely difficult for patients to access in rural areas. Telehealth would be great, but it is not available for VAD out here.” (SPC)*







**Palliative Care**  
Australia  
*Matters of life and death*

**Thank you**

[josh.fear@palliativecare.org.au](mailto:josh.fear@palliativecare.org.au)