

A legal framework for voluntary assisted dying

Report Summary

Report No 79
May 2021

**Published by:
Queensland Law Reform Commission**

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(Queensland Law Reform Commission) 2021

ISBN: 978-0-6481164-9-3

**Previous Queensland Law Reform
Commission publication in this reference:**

Queensland Law Reform Commission, *A legal framework for voluntary assisted dying*, Consultation Paper, WP No 79 (2020)

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A LEGAL FRAMEWORK FOR VOLUNTARY ASSISTED DYING IN QUEENSLAND

A voluntary assisted dying law gives individuals who are suffering and dying an additional end of life choice.

It allows eligible people who are dying to choose the timing and circumstances of their death.

It gives an option that can limit suffering at the end of life. It is not a way to end life for those who are not dying.

The Commission's task is to recommend 'the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland' should voluntary assisted dying become law in this State. Our task is not to consider the desirability of introducing voluntary assisted dying legislation. It is to recommend the contents of an appropriate voluntary assisted dying scheme and draft a Bill based on those recommendations.

'Voluntary assisted dying' refers to the self-administration of a prescribed substance or its administration by a health practitioner with the purpose of bringing about the person's death. It is based on the person's voluntary request. The process of request, assessment and administration must comply with the legislation's requirements.

The terms of reference make it clear that the proposed legislative scheme is for individuals who are 'suffering and dying'. It is not intended to apply to individuals who wish to die because they are tired of life or in decline, but who are not dying.

This fact may disappoint those individuals and supporters of a broad-based scheme for voluntary euthanasia or medically assisted suicide. It also may allay the fears of others that a voluntary assisted dying scheme would be generally accessible for those who do not wish to go on living.

The report's essence

VOLUNTARY: the decisions to request access and to continue with the process must be made **voluntarily and without coercion** (including improper influence).

ASSISTED by doctors and nurses. If a person is eligible and chooses to go to the final stage, they either **self-administer** a substance **prescribed by a doctor** or have an **experienced doctor or nurse** administer the substance so as to hasten, at the person's request, their death.

DYING: to be eligible the person must be **suffering and dying**.

The person must be **separately and independently assessed by two doctors** (who meet the law's qualification and training rules) to be **eligible**.

To be eligible under the draft Queensland law, the person must:

1. have an **eligible condition**
2. have **decision-making capacity**
3. be acting **voluntarily and without coercion**
4. **be aged at least 18 years**
5. fulfil a **residency** requirement.

To satisfy 1, the person must have been diagnosed with a **disease, illness or medical condition** that is:

- **advanced, progressive and will cause death,**
- expected to cause death **within 12 months,** and
- causing **suffering** that the person considers to be **intolerable.**

The timeframe of 12 months makes clear that voluntary assisted dying is an option only for those who are at the end of life. The voluntary assisted dying scheme is not a choice between life and death but a choice for those who are in the process of dying and wish to choose the time and circumstances of their death.

The scheme has many **safeguards**. The process of request and assessment involves **three separate requests** that are clear and documented.

The process has a **waiting period of at least 9 days** between the first and final request.

The person must also be told, more than once, that they may decide at any time not to continue the voluntary assisted dying process.

After the request and assessment process, the substance is prescribed and supplied only if the person chooses to proceed to the substance administration stage.

Most people want to live for as long as possible without experiencing intolerable suffering. This includes individuals with a terminal illness who are eligible to access voluntary assisted dying.

Allowing eligible people who are dying to **begin** the process during what is expected to be the last 12 months of their lives does not mean that they will proceed to obtain the substance and administer it as soon as they become eligible. Experience shows they are likely to wait until they are closer to death.

Also, some people may leave the process of assessment until it is too late. They may lose capacity or die before the process can be completed.

Doctors, nurses and other health practitioners who have a **conscientious objection** to voluntary assisted dying will have the right to choose not to participate.

An **Oversight Board** and existing authorities will ensure the law is being complied with.

A **Statewide Care Navigator Service** will give information and assistance to people and help patients, their families and friends, and health practitioners navigate the process.

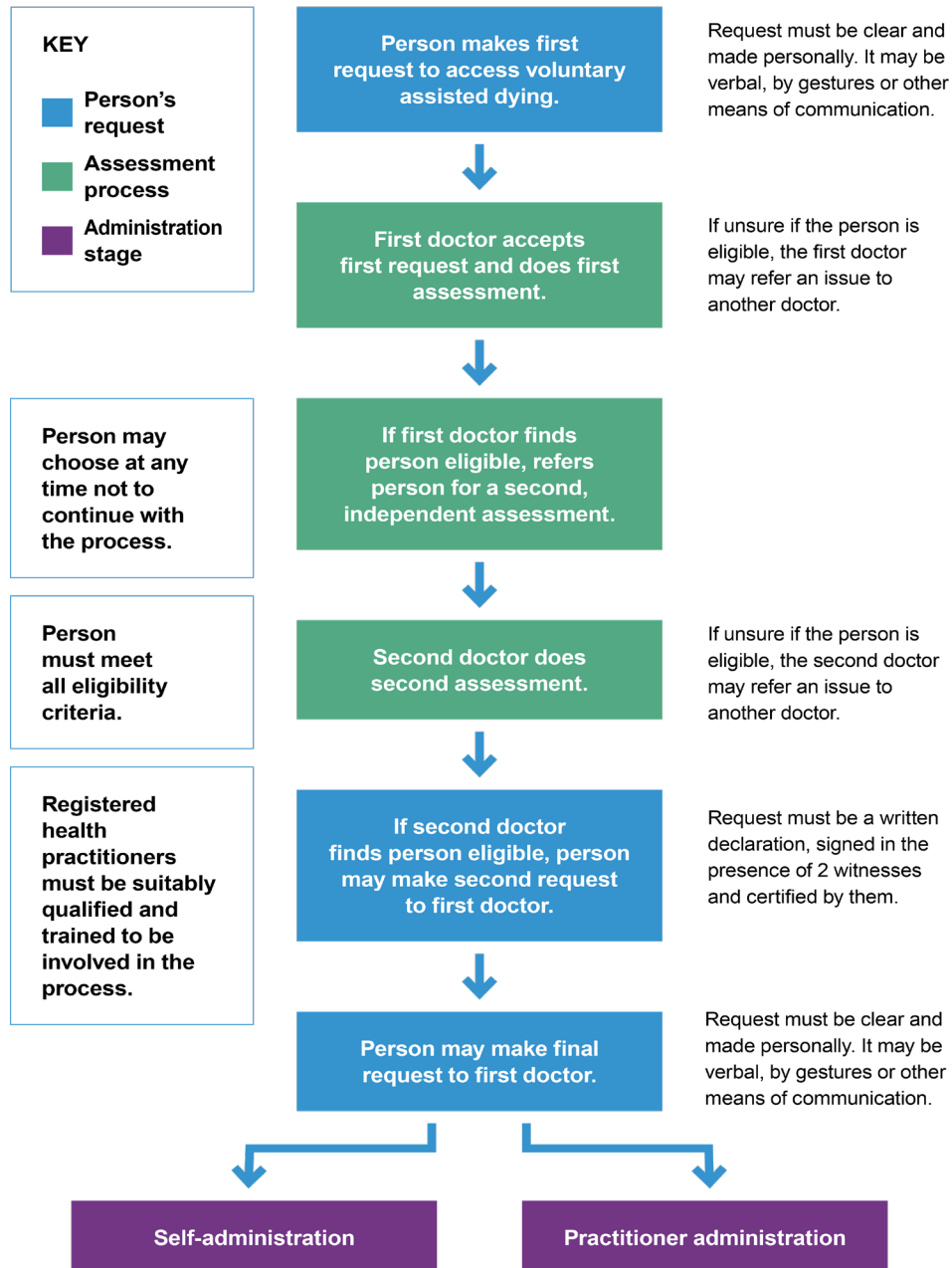
The Commission was asked to recommend '**the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland**' should voluntary assisted dying become law in this State.

The report details the principles on which the Bill is based, voluntary assisted dying laws in other places, and how they work in practice in Victoria. It identifies strengths and weaknesses in those laws so as to inform the democratic process in Queensland.

The Commission has aimed to develop a draft law **for Queensland** that is **compassionate, safe and practical.**

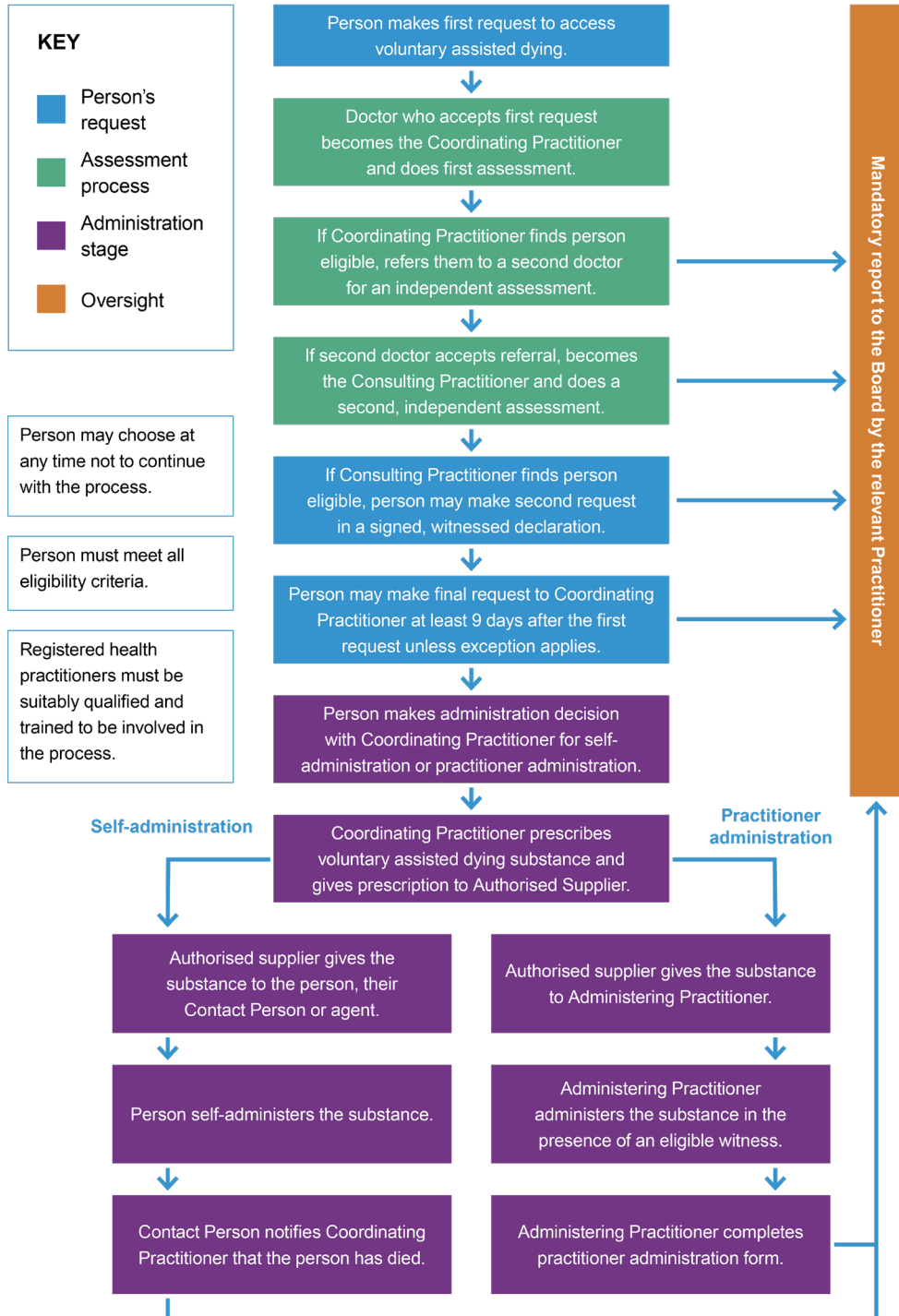
Diagrams of the proposed process

The proposed process



Administration follows choice of process, prescription and supply of substance.

The proposed process in detail



Values and principles

The proposed scheme for people who are ‘suffering and dying’ is based on values and principles discussed in the report. There are many and they conflict to some extent. They must therefore be reconciled and balanced. This includes reconciling:

- respect for personal autonomy; and
- safeguarding the vulnerable from coercion or exploitation.

A person’s autonomy includes autonomy in determining end of life choices.

Protection of the vulnerable requires safeguards and eligibility criteria to ensure that, if the person has a disease, illness or medical condition making them eligible to access the scheme, they:

- have decision-making capacity;
- make decisions that are voluntary and made without coercion;
- make choices that are informed about other end of life options, such as further treatment and palliative care; and
- demonstrate that the choice to request voluntary assisted dying is enduring.

This last point means that access to voluntary assisted dying should not be available simply after one request. The request should be a settled one and endure over a reasonable period.

Palliative care

Our terms of reference state that the provision of ‘compassionate, high quality and accessible palliative care for persons at their end of life is a fundamental right of the Queensland community’.

The importance of palliative care for people experiencing unrelenting pain or suffering from terminal illness or a degenerative condition was also noted by respondents and witnesses to the Parliamentary Committee’s inquiry. Many referred to the benefit of palliative treatment as a part of end of life care for patients.¹

The Parliamentary Committee recognised that palliative care ‘needs to be adequately resourced and supported irrespective of whether voluntary assisted dying legislation is introduced’ and, ‘if it is introduced, it is imperative that people have the full range of options available to them so that they can make an informed choice’.²

We agree. Therefore, any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care.

1 See especially Qld Parliamentary Committee Report No 34 (2020) [7], 106–8.

2 Ibid 109. See further, the Parliamentary Committee’s recommendations on palliative care and end of life care in Qld Parliamentary Committee Report No 33 (2020).

What is voluntary assisted dying?

Voluntary assisted dying is an end of life choice. As noted, it refers to the administration of a prescribed substance, either by self-administration or by a registered and suitably-qualified health practitioner, with the purpose of bringing about the person's death. It is based on the person's voluntary request, and follows a process of requests and assessments.

Other end of life choices include continuing with treatment to try to remedy the condition, or receiving palliative care.

Palliative care aims to improve the quality of life of patients and their families in dealing with a life-threatening illness, through the prevention and relief of suffering. It does this by the treatment of pain and other problems, physical, psychosocial and spiritual.³

Administering medication to relieve intolerable pain and suffering may have the effect of hastening death. The health practitioner does not *intend* to hasten death. Voluntary assisted dying, on the other hand, involves administering a substance to *intentionally* hasten death, and thereby stop suffering that is intolerable.

As the law currently stands, the self-administration of a substance to kill oneself, and which results in death, is suicide. Persons, including health practitioners, who assist that process of self-administration commit the offence of aiding suicide.⁴ Depending on the circumstances, a person who administers the substance at the person's request may commit the offence of murder or manslaughter.⁵

Voluntary assisted dying legislation alters that law in defined circumstances. Laws of the kind enacted in Victoria, Western Australia, Tasmania, and New Zealand create a process by which persons who are suffering and dying, and who meet eligibility criteria, may be prescribed a substance for the purpose of self-administration or, in some circumstances, health practitioner administration. Their eligibility to access voluntary assisted dying is assessed by two independent medical practitioners who are qualified and trained to make those assessments. The person seeking to access voluntary assisted dying must:

- have decision-making capacity; and
- make decisions that are voluntary and made without coercion.

The staged process also demonstrates that the choice to request voluntary assisted dying is enduring.

Voluntary assisted dying laws provide that someone who ends their life in accordance with the process does not commit suicide, and that the health practitioners who assisted them to die are not liable for homicide or the crime of assisting suicide.

A note on language

Other terms are used in this context. We do not intend to dictate what language people use. We use the term 'voluntary assisted dying' because it is the term used by the Parliamentary Committee whose report was the precursor to this review. It also is the term used in our terms of reference and in legislation in Victoria and Western Australia. It is a fitting description.

3 Qld Parliamentary Committee Report No 33 (2020), xii.

4 *Criminal Code 1899* (Qld), s 311.

5 See *Carter v Attorney-General* [2014] 1 Qd R 111 for a discussion of the elements of, and the relationship between, the offence of murder and the offence of assisting suicide. The Queensland Court of Appeal (White JA, Atkinson and Martin JJ agreeing) explained at 127 [50]:

'to kill someone by a positive act, with the requisite intention, even though that person expressed a desire to die, is murder. ... Where person desirous of death brings about their own death by their own act, any person who assists in that act of autonomy by the suicide, but does not do the deed, has aided the suicide.'

Voluntary assisted dying laws in other places have different titles.⁶ For example, the New Zealand law is titled *End of Life Choice Act*, but uses the term **assisted dying** which is defined to mean:⁷

- the administration by an attending medical practitioner or an attending nurse practitioner of medication to the person to relieve the person's suffering by hastening death; or
- the self-administration by the person of medication to relieve their suffering by hastening death.

Canadian legislation, which adopts a similar model, uses the term **Medical Aid in Dying ('MAiD')**. In the United States, voluntary assisted dying is often referred to as **physician-assisted suicide** or **aid-in-dying**.

Other terms that are sometimes used in this context include 'euthanasia' and 'assisted suicide'.

Euthanasia refers to the intentional taking of a person's life by another person in order to end intolerable suffering.⁸ Euthanasia covers various practices including:

- passive euthanasia where medical treatment is withheld or withdrawn; and
- active euthanasia where medical intervention takes place.

Within each of these categories, euthanasia may be voluntary (at the person's request) or involuntary. Therefore, the term 'euthanasia' covers different ways of deliberately ending a person's life to stop their suffering: passive voluntary euthanasia, active voluntary euthanasia, passive involuntary euthanasia and active involuntary euthanasia. Because of its generality and historic connections to involuntary euthanasia, the term 'euthanasia' is not commonly used to describe voluntary assisted dying.

Assisted suicide refers to circumstances in which a person causes their own death after being given the means or knowledge to do so by another person. For example, the person providing the assistance may provide the substance or information to assist a person to take their own life. As noted, assisting suicide is a crime. It does not require medical assistance: it may be assistance given by a family member, a friend or a stranger, including by supplying information over the internet. Another important distinction between assisted suicide and voluntary assisted dying, is that the person whose suicide is assisted by someone may not be dying and suffering intolerably.

The model of voluntary assisted dying legislation considered in this report therefore differs from assisted suicide in general. It is confined to a person who suffers from a condition that will cause death and who experiences suffering that cannot be relieved in a way that the person considers tolerable. The assistance is given by health practitioners. If the assistance is authorised by legislation, then, in law, the death is not treated as a suicide and the health practitioner is not treated as having assisted a suicide.

Voluntary and assisted

Voluntary assisted dying is an active and voluntary practice. This distinguishes it from passive practices not intentionally directed towards causing death, such as withholding or withdrawing life-sustaining medical treatment.⁹ It is a voluntary practice in that it is undertaken at the person's request. More than one request is required. The decision to access the process must be made freely and without coercion. The assistance is provided by health practitioners, hence the alternative expression 'medical aid in dying'. Medical practitioners assess eligibility and may prescribe the medication. Usually, the person

6 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas).

7 *End of Life Choice Act 2019* (NZ) s 4.

8 AMA, Position Statement: Euthanasia and Physician Assisted Suicide (2016) 1; Australian Human Rights Commission, Euthanasia, human rights and the law (Issues Paper, May 2016) 3.

9 See, eg, AMA, Position Statement: Euthanasia and Physician Assisted Suicide (2016), [2.2].

self-administers the substance, but in some circumstances the law allows, at the person's request, practitioner administration.

A dying person who chooses this option does not die by suicide

Some will call voluntary assisted dying a form of suicide. The draft Bill does not. This is because the legal option for a dying person to hasten their death by having medical assistance to decide its precise timing should be treated for what it is. Health practitioners who follow an exacting process to assist a dying person to choose the timing of their death should not be characterised as assisting suicide.

If experience from other jurisdictions is a guide, persons who are eligible to access voluntary assisted dying will choose to have a substance administered only when they are very close to death from the condition that made them eligible. Administration allows a person who is close to death to determine the timing of their death – hastening it so as to end intolerable suffering.

Therefore, the draft Bill states that the person is taken to have died from the disease, illness or medical condition from which they were dying, and which made them eligible at the end of their life to access voluntary assisted dying. It also states that a person who dies as a result of the self-administration or administration of a substance in accordance with the law does not die by suicide.¹⁰

The proposed scheme's design

As required, we have had regard to the Parliamentary Committee's report about voluntary assisted dying¹¹ and to legislative and regulatory arrangements in other Australian and overseas jurisdictions.

The legislative schemes in Australian and some overseas jurisdictions, such as New Zealand and Canada, have a similar basic architecture. In simple terms they provide:

- **eligibility criteria** for access to voluntary assisted dying, such as age, residency, and a condition that will cause death and causes suffering that cannot be relieved in a way that the person considers tolerable. There usually are criteria about decision-making capacity and acting voluntarily.
- **a process for independent assessment** of eligibility by two suitably qualified and experienced health practitioners.
- **administration of a substance**, prescribed by a doctor, either by self-administration (possibly but not necessarily in the presence of a health practitioner) or administration by a health practitioner at the person's request.
- **conscientious objection** by health practitioners who do not wish to participate in the scheme.
- **accountability** by oversight provisions that include reporting obligations, monitoring by an oversight body and provisions to enforce compliance.

The legislative models also differ in some respects. For example, the Victorian Act requires that the relevant condition be 'incurable', whereas the Western Australian Act does not. This is because the view was taken in Western Australia that the words 'advanced, progressive and will cause death' clearly emphasise 'the terminal nature of the illness or disease'. Despite these kinds of differences, the

10 This reflects laws in other jurisdictions. See, for example, *End of Life Choice Act 2019* (NZ) s 35; *Voluntary Assisted Dying Act 2019* (WA) s 12.

11 The Commission had regard to both the Qld Parliamentary Committee's Report No 33 (2020) and its Report No 34 (2020). The latter recommended that the draft legislation submitted to it by Professors White and Willmott be considered as 'the basis for a legislative scheme for voluntary assisted dying'. For ease of reference, we call this the 'White and Willmott Model', and have had regard to it, along with Professors White and Willmott's more recent research and writing about legislative schemes for voluntary assisted dying.

eligibility criteria across the legislative models are largely the same and seek to achieve the same policy goals.

Viewing the proposed legislation as a whole

An important point in assessing the terms and operation of legislation in other jurisdictions, and in designing ‘the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland’, is that a system of regulation operates as a whole.

As Professors White and Willmott and their co-authors have recently observed:¹²

...a system of regulation operates holistically. This means that looking at a single aspect of the eligibility criteria without understanding its role in the framework can be misleading. That is, it is important to examine eligibility criteria cumulatively and in context...

Taking a holistic view is also an important consideration more generally when designing [voluntary assisted dying] regulation. While it may be politically attractive to add numerous safeguards to [voluntary assisted dying] legislation, including in the eligibility criteria, there is a risk of what we have called elsewhere ‘policy drift by a thousand cuts’ if the cumulative effect of these individual safeguards is not properly considered. For example, **it is possible that a series of provisions designed to make [voluntary assisted dying] legislation safe, when aggregated, can in fact make access to [voluntary assisted dying] cumbersome or even unworkable.** (emphasis added)

The best legal framework for Queensland

In recommending the best legal framework for a voluntary assisted dying scheme in Queensland, we were not constrained by similar laws in other Australian states. We recognise the desirability of achieving reasonable consistency with the legislation in other Australian states and in comparable countries like New Zealand. However, the proposed law should be the best it can be to serve the Queensland community.

It would have been a simpler task to adopt, with some minor modifications, legislation from another state or overseas jurisdiction. However, this was not our task.

We developed our recommendations about a scheme for Queensland by first identifying the values, principles and policies that should underpin any scheme.

The legislation must suit Queensland’s unique conditions, including its geography, population diversity, access to qualified health professionals and public and private hospital systems. Legislation that may operate in a place like New Zealand or Victoria may not be suited to a large, decentralised state like Queensland, many of whose citizens live in remote areas.

Another guiding principle we adopted is that the legislation be clear and no more complex than it needs to be to achieve its purposes.

Legislation should be in a form that can be reasonably understood by those who may wish to use it and by those who must apply its provisions. Processes and safeguards should be clear and workable so that they can be applied in cases of individuals whose health may be declining rapidly.

The safe and workable operation of any legislation that is enacted will need to be supported by guidelines and information that are accessible to, and understood by, individuals wishing to access the scheme, and by family, friends, carers and health professionals who support those individuals.

The system must be workable in Queensland. Therefore, it is important that Queensland not adopt provisions from another jurisdiction that, on analysis, are unnecessary or run counter to the policies that the legislation aims to implement.

The draft Bill has been informed by the ongoing research and writing by experts who have thought deeply about these issues and who have studied the experience of similar legislation in other jurisdictions.

Our recommendations are based on the operation of legislation in other jurisdictions. This has included consideration of reports of the Victorian Voluntary Assisted Dying Review Board about the operation of the Victorian Act, discussions with participants in schemes in comparable jurisdictions, and consideration of the research of independent scholars into the implementation and practical operation of those schemes.

The Commission has aimed to develop draft legislation that is **compassionate, safe and practical**.

Purposes and principles

The main purposes of the draft Bill are:

- (a) to give persons who are suffering and dying, and who meet eligibility criteria, the option of requesting medical assistance to end their lives;
- (b) to establish a lawful process for eligible persons to exercise that option;
- (c) to establish safeguards to ensure that the process is accessed only by persons who are assessed to be eligible and to protect vulnerable persons from coercion and exploitation;
- (d) to provide legal protection for health practitioners who choose to assist, or not to assist, persons to exercise the option of ending their lives in accordance with the Act; and
- (e) to establish a Voluntary Assisted Dying Review Board and other mechanisms to ensure compliance with the Act.

The draft Bill states that the principles that underpin it are:

- (a) human life is of fundamental importance;
- (b) every person has inherent dignity and should be treated equally, with compassion and respect;
- (c) a person's autonomy, including autonomy in relation to end of life choices, should be respected;
- (d) every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life;
- (e) access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland;
- (f) a person should be supported in making informed decisions about end of life choices;
- (g) a person who is vulnerable should be protected from coercion and exploitation;
- (h) a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

The Commission's work

The Queensland Law Reform Commission is an independent statutory body that undertakes law reform reviews referred to it by the Attorney-General.¹³ The reviews referred are matters that raise complex legal or social issues, or both. They require detailed research, analysis, consultation, and consideration.

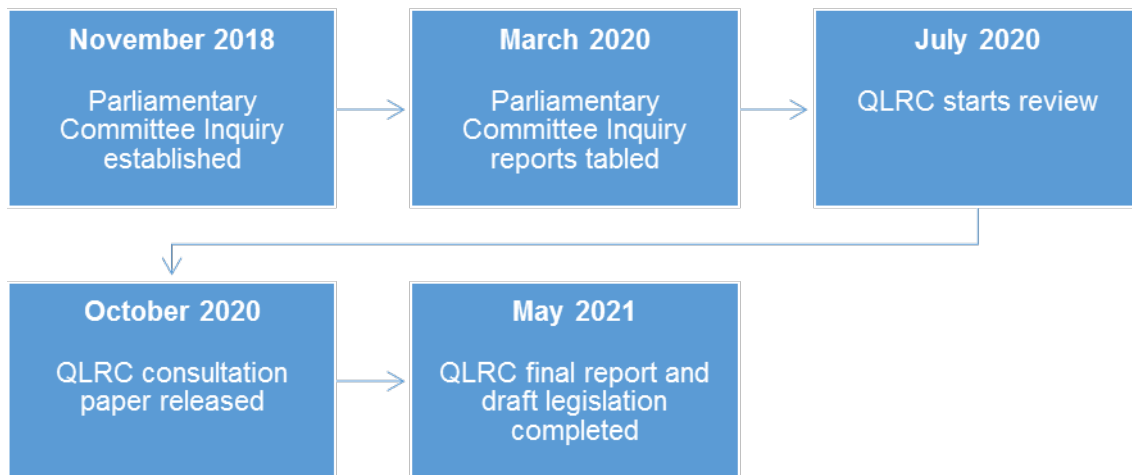
The Commission consists of part-time members who are supported by a small Secretariat.

Our review

On 21 May 2020, we were given terms of reference to develop 'an appropriate scheme for voluntary assisted dying and to prepare draft voluntary assisted dying legislation to give effect to its recommendations'. The terms of reference are in Appendix A to the report.

Our review was required to start on 1 July 2020 with an original reporting date of 1 March 2021. Due to the size and complexity of the task, the reporting date was extended to 10 May 2021.

Timeline of Queensland's consideration of voluntary assisted dying legislation



The Parliamentary Committee Inquiry

In November 2018, the Legislative Assembly referred an inquiry into aged care, end-of-life and palliative care and voluntary assisted dying to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the 'Parliamentary Committee').¹⁴

The Parliamentary Committee's terms of reference required it to report to the Legislative Assembly on:¹⁵

- the delivery of aged care, end-of-life and palliative care in Queensland across the health and ageing service systems; and
- Queensland community and relevant health practitioners' views on the desirability of supporting voluntary assisted dying, including provisions for it being legislated in Queensland and any necessary safeguards to protect vulnerable persons.

¹³ *Law Reform Commission Act 1968* (Qld) s10(3)(b), (e).

¹⁴ Qld Parliamentary Committee Report No 34 (2020) 1.

¹⁵ *Ibid* 1–2.

After extensive consultation and research on the various matters covered by its inquiry,¹⁶ the Parliamentary Committee tabled in March 2020 separate reports on aged care, end-of-life and palliative care,¹⁷ and voluntary assisted dying.¹⁸

In its report on voluntary assisted dying, the Parliamentary Committee noted that ‘the final stages of life can involve a range of pain and other symptoms and, for around five per cent of people, this suffering can be severely distressing’. It also noted that ‘even with access to the best quality palliative care ... sometimes not all suffering can be palliated’.¹⁹

After considering the evidence given to the inquiry, and the experiences of governments and individuals in other jurisdictions with operating voluntary assisted dying schemes, the Parliamentary Committee found that, ‘on balance, the Queensland community and health practitioners are supportive of voluntary assisted dying and for it to be legislated in Queensland’.²⁰

The Parliamentary Committee, by majority, made 21 recommendations.²¹ Its principal recommendation was that the Queensland Government use the model draft legislation submitted to the inquiry by Professors Ben White and Lindy Willmott (the ‘White and Willmott Model’)²² as ‘the basis for a legislative scheme for voluntary assisted dying’.²³

Its other recommendations related to specific aspects of the proposed new voluntary assisted dying framework, including the eligibility criteria for access;²⁴ safeguards against coercion, abuse, and fear of being a burden on others; qualifications and training requirements for health practitioners; the voluntary assisted dying process; and oversight and review mechanisms.

The Commission’s consultations

The process of consultation is a vital part of our work on any review. We consulted the public, stakeholders, experts and people who practise in end of life care, and sought information about many issues. The issues are listed in the Preface to the Report. Public consultation was mainly through a 176-page Consultation Paper that posed 50 important questions. On 16 October 2020, our Consultation Paper invited submissions on the key issues outlined in it. Submissions closed on Friday 27 November 2020.

16 The Parliamentary Committee’s consultation activities for the inquiry included the release of an issues paper on ‘aged care, end-of-life, palliative care and voluntary assisted dying’. The issues paper posed 38 questions, nine of which related to voluntary assisted dying. The Parliamentary Committee accepted 4719 written submissions for the inquiry, conducted 34 public and private hearings and briefings and heard evidence from 502 invited witnesses: *ibid* 2–3. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary Assisted Dying (Issues Paper No 3, 2019)*.

17 Qld Parliamentary Committee Report No 33 (2020).

18 Qld Parliamentary Committee Report No 34 (2020).

19 *Ibid* 42. The Victorian Legislative Council Legal and Social Issues Committee and the Western Australian Joint Select Committee on End of Life Choices made similar findings in their respective inquiries: Vic Parliamentary Committee Final Report (2016) [8.2]; WA Joint Select Committee on End of Life Choices Report (2018) 107, Finding 23.

20 Qld Parliamentary Committee Report No 34 (2020) 105.

21 *Ibid* viii, x–xii. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary assisted dying: Findings and recommendations (Report No 34)* (Paper No 5, March 2020) 6–12, which provides a summary of the Parliamentary Committee’s findings and recommendations on voluntary assisted dying.

Two members of the Parliamentary Committee, Martin Hunt MP and Mark McCardle MP, dissented from the report of the majority on various grounds, including opposition to the separation of the discussions on palliative care and voluntary assisted dying in the Parliamentary Committee’s reports for the inquiry: Qld Parliamentary Committee Report No 34 (2020) 186–96.

Another member of the Parliamentary Committee, Michael Berkman MP, made a statement of reservation in relation to some matters about which he had divergent views or on which he provided more detailed commentary: Qld Parliamentary Committee Report No 34 (2020) 197–203.

22 The White and Willmott Model was submitted by Professors Ben White and Lindy Willmott as part of their submission (Submission No 1199, dated 24 April 2019) to the Parliamentary Committee’s inquiry, and is set out in Qld Parliamentary Committee Report No 34 (2020) app A. The explanatory material accompanying the White and Willmott Model states that it was developed as model draft legislation to ‘convey in practical terms [the authors’] proposed policy framework for permitting and regulating voluntary assisted dying’, rather than to be ‘the source of detailed procedural steps about how it is provided’.

23 Qld Parliamentary Committee Report No 34 (2020) 105, Rec 1. The Parliamentary Committee referred to the White and Willmott Model as ‘a starting point for devising the legislation’: 105.

24 While the Parliamentary Committee recommended that the voluntary assisted dying legislation should limit eligibility to a person with decision-making capacity, it also recommended further research into improving end of life options for people who do not have decision-making capacity, particularly in relation to Advance Health Directives: 127, Recs 6, 7. In a statement of reservation, Michael Berkman MP also supported further research into improving end of life options for minors who are terminally ill: Qld Parliamentary Committee Report No 34 (2020) 199–200.

We received 126 responses, many of which addressed all 50 questions. The respondents included researchers with a detailed knowledge of this complex topic (who supplemented their submissions with articles), professional bodies representing a range of health practitioners and disciplines, organisations that support or oppose voluntary assisted dying, religious bodies, unions, members of the public who have experienced suffering themselves or witnessed it in members of their family, health practitioners, including practitioners in the field of palliative care, disability advocates, lawyers' groups, public authorities, ethicists, and members of the public. The analysis of submissions was a time-consuming task that extended into early 2021.

The Commission's process

The Commission consists of part-time members²⁵ who usually meet monthly. Because of our reporting date, it has had to meet more frequently than normal in order to complete the review. Between meetings, each member independently considered substantial written materials and the issues that were identified for consideration. They also sought further information from the Commission's staff. At fortnightly meetings the members discussed each issue on its merits and considered how the various parts of any piece of legislation might interact. Provisional views were reached on issues. As materials and analysis developed, issues were revisited. Some provisional views changed. Proposals were reviewed and refined.

The Commission's staff

We were given additional resources for this review, including a Principal Legal Officer on secondment from the Department of Justice and Attorney-General, an additional Senior Legal officer, two Senior Legal Officers on secondment from Queensland Health, and an additional administrative officer. The Secretariat, as well as the seconded officers, worked hard to progress matters and to inform the deliberations of Commission members.

We also engaged Dr Jayne Hewitt from Griffith University as a consultant. Dr Hewitt is an experienced registered nurse with many years of critical care experience and personal knowledge of how the law affects health care practitioners and the patients for whom they care. Her academic work in this area and her practical experience in nursing and training health practitioners complemented the Commission's staff.

Acknowledgments

The Secretariat and the legal officers seconded to the Commission displayed a high level of experience in legal research and analysis and policy development.

The leader of this review has been the Commission's Assistant Director, Mrs Cathy Green, who has worked tirelessly on it since July 2020. She maintained a high standard of work and productivity, coordinated staff, facilitated the flow of information into the Commission, and continued consultations with many people in Queensland and in other jurisdictions. The members of the Commission wish to especially acknowledge Mrs Green's work and the work of those who benefitted from her example and direction.

Our Director, Mr David Groth, also worked tirelessly. He and other Commission staff worked incredibly long hours and on weekends to complete this review by 10 May 2021.

The skilled staff of the Office of the Queensland Parliamentary Counsel worked with great dedication and for long hours to draft a Bill based on our instructions. Like the Commission, that Office had to meet a challenging timeframe on a complex task.

We express our sincere appreciation for the time and effort taken by so many people and organisations whose submissions addressed the many questions posed in the Consultation Paper and often raised new issues.

During this review, we informed ourselves through meetings with experts and other individuals whose views were based on experience. This involved video conferences with health practitioners in Victoria and Western Australia, with people who had served on expert panels in those States, and with public servants who had been involved in the implementation of legislation. We also consulted with the Voluntary Assisted Dying Review Board and the Voluntary Assisted Dying Care Navigator Service in Victoria.

We are grateful to each of those individuals and organisations for the trouble and time they took to help us. We spoke to busy palliative care specialists, oncologists, physicians, general practitioners, and other health care professionals, who had different views about voluntary assisted dying. Some work in tertiary hospitals that do not provide access to voluntary assisted dying; others work in aged care facilities or in the suburbs. Their time is valuable. We are fortunate that they generously gave their time to speak to us and to inform our thinking.

The democratic dimension

Throughout this review, we have emphasised that our task is not to consider the desirability or otherwise of introducing voluntary assisted dying legislation in Queensland.

That is a decision for a democratically elected Parliament.

The Parliament will have access to the reports of its Committee that considered palliative care and voluntary assisted dying, the report of this Commission, reports from other bodies that have considered the issue in other states and overseas, research by scholars, and the views of individuals and organisations. Our report has attempted to summarise the submissions individuals and organisations made to the Parliamentary Committee and to us. This has resulted in a lengthy report but, we hope, a helpful one for citizens and legislators as a source of reference. The size of the report is also a function of the number of issues that had to be addressed. We trust that the report is a convenient repository of existing provisions, the recommendations of the Queensland Parliamentary Committee report, the White and Willmott Model, which the committee favoured, and developments that have occurred since that report.

The report uses terms like ‘the draft Bill’, ‘the proposed legislation’ or ‘the legislation’. This is intended to refer to the legislation that we have been required to draft.

We do not presume that legislation in that form will be introduced into the Parliament by the Government, let alone passed in that form. Those are decisions for the Government and representatives of the people.

We hope, however, that those who read the report will appreciate that the draft Bill seeks to balance competing interests and should be viewed as a whole.

The fact that the draft Bill does not contain a clause in identical terms to one in, say, Victoria, but has a provision that resembles one in Western Australia, or contains provisions that do not currently exist in either of those States, should be no surprise.

We have aimed to adopt what is good in principle and workable in practice from laws in other states and countries like New Zealand. We have not felt compelled to adopt provisions that seem wrong in principle or purely the result of political compromise in those places. We have developed some provisions that were thought about in other places but consigned to the ‘too hard basket’ or, due to pressure of time, left to be worked out in regulations and policy guidelines.

In terms of democratic process, our work builds on the Parliamentary Committee's investigations, consultations, reflections, and report.

There is another democratic dimension that applies in a federation like ours. It is the notion that the states are 'laboratories of democracy'²⁶ in which different policies can be enacted and tested in a state, as in a scientific experiment. If the policy is a failure, it does not affect any other state. If, however, the policy is a success, it might be expanded to another state. If improvements are made in that next state, they might be adopted in another.

The result is not necessarily uniform legislation across the states that adopt the policy. A state can identify the strengths and weaknesses of laws that were enacted in another.

The Commission, as required by our terms of reference, has considered legislation in other Australian states. The report identifies certain strengths and weaknesses in those laws to inform the democratic process in Queensland.

Development of voluntary assisted dying legislation

Voluntary assisted dying laws have been enacted²⁷ in Victoria, Western Australia, and Tasmania, and several overseas jurisdictions. Chapter 2 of the report summarises their development and what can be drawn from them.

It reports on the first 18 months of the operation of the law in Victoria: the number of people who have accessed that scheme, the number of doctors who are involved in it, and the period it takes for individuals to navigate the process. It notes the key role of the Care Navigator Service in Victoria.

Chapter 2 highlights the uncertain application of Commonwealth laws that were not aimed at lawful voluntary assisted dying, but impede the operation of state laws that did not exist when the Commonwealth laws were passed. The Victorian experience of the Commonwealth law's inhibition on access to a lawful end of life option is instructive for Queensland. The uncertain application of the Commonwealth law particularly affects individuals who are suffering and dying in remote and regional areas.

We have had the opportunity to assess the operation of the Victorian Act and have considered the reports of the Victorian Voluntary Assisted Dying Review Board, which we briefly summarise. We have considered academic research into the Victorian law's operation and consulted practitioners in Victoria who practise in the fields of palliative care and voluntary assisted dying.

Insights from the operation of the Victorian Act

The operation of the Victorian Act has been monitored and reported on by the Voluntary Assisted Dying Review Board in that State. The Board was established as an oversight body in July 2018 to review and monitor voluntary assisted dying in Victoria.²⁸ The Board collects data about voluntary assisted dying. After reporting to Parliament about the operation of the Act every six months for the first two years of operation, it now reports annually.²⁹

26 The phrase is attributed to Justice Louis Brandeis in *New State Ice v Liebmann* 285 US 262 (1932); see J Rosen, *Louis D Brandeis - American Prophet* (Yale University Press, 2016) 109.

27 Legislation is pending in South Australia. However in order to write the report, print it and provide it by our reporting date, we have adopted a legislation date of 30 April 2021. Therefore it is possible that South Australia will have passed laws by the time this report is publicly released.

28 Voluntary Assisted Dying Review Board, *Report of Operations 2018–2019* (Victorian Government, August 2019) 3.

29 *Ibid.*

The contents of its three six-monthly reports are informative.³⁰ The following section summarises parts of them to give a snapshot of how the Victorian Act has operated, particularly who has accessed it and some problems that have been encountered. Further information about these matters appears in sections of the report about specific aspects of the legislation and about implementation issues.

Persons accessing voluntary assisted dying

Between the commencement of the Victorian Act on 19 June 2019 and 30 December 2020:³¹

- 562 people have been assessed as eligible in the first assessment;
- 483 people have been assessed as eligible in the consulting assessment;
- 405 administration permits have been issued; and
- 224 people have died after administration of the substance.

Notably, of the people who were granted an administration permit and have subsequently died, 32 per cent did not ultimately administer the substance.³² This supports anecdotal reports that some people engage in the voluntary assisted dying assessment process to have administration as a fallback option at the very end of life.

More detail about the number of people accessing voluntary assisted dying at each stage of the process is set out in the table below:

Number of persons accessing voluntary assisted dying³³

Stage		Status	19 June – 31 December 2019	1 January – 30 June 2020	1 July – 31 December 2020	State total to date
Eligibility	First assessment	Eligible	136	205	221	562
		Ineligible	1	6	12	19
	Consulting assessment	Eligible	019	188	186	483
		Ineligible*	3	1	4	8
Permit applications	Self-administration permit	Issued	75	126	149	350
		Not issued	16	16	12	44
	Practitioner administration permit	Issued	11	19	25	55
		Not issued	4	5	7	16
Withdrawn	Case withdrawn from portal by medical practitioner or upon notification of death of applicant **		35	96	108	239

30 Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020* (Victorian Government, February 2021); Voluntary Assisted Dying Review Board, *Report of Operations January-June 2020* (Victorian Government, August 2020); Voluntary Assisted Dying Review Board, *Report of Operations July-December 2019* (Victorian Government, February 2020).

31 Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020* (Victorian Government, February 2021) 4.

32 Ibid 11.

33 Table adopted with permission, combining Table 1 in the January-June 2020 VADRB report and Table 1 in the July-December 2020 VADRB report: Ibid 5; Voluntary Assisted Dying Review Board, *Report of Operations January-June 2020* (Victorian Government, August 2020) 3.

Stage		Status	19 June – 31 December 2019	1 January – 30 June 2020	1 July – 31 December 2020	State total to date
Medications dispensed	For self-administration		57	97	127	281
Confirmed deaths#	Medication administered	Self-administered	37	70	74	184
		Practitioner administered	9	11	20	40

* Ineligible cases may be reassessed and later deemed eligible and so the total number of ineligible cases reported may decrease over time.

** The figure for withdrawn cases may include administrative errors, duplicate cases, applicants discontinuing the process or those who died before the process was complete.

If the medical practitioner certifying the death does not select that the person was a voluntary assisted dying permit holder, the Board is not notified by Births, Deaths and Marriages of the applicant's deaths. In these cases, confirmation of the manner of death is obtained from contact people or coordinating medical practitioners when following up any unused medication.

Demographics of applicants

Data collected by the Voluntary Assisted Dying Review Board gives an insight into the demographics of applicants, including:³⁴

- **Age:** ranged between 20 and 100 years, with an average age of 71 years;
- **Gender:** 52.4 per cent were male, 47.4 per cent were female, and 0.2 per cent were self-described;
- **Place of birth:** 70.3 per cent were born in Australia, 26.9 per cent were born overseas, 2.8 per cent did not report their place of birth;
- **Metropolitan, regional or rural:** 64.4 per cent were living in metropolitan Victoria and 35.6 per cent were living in regional or rural Victoria; and
- **Living situation:** 87.2 per cent were residing in a private household, 8.9 per cent were in a long-term care or assisted living facility, and 3.4 per cent were in a health service.

Diagnoses

Of the people who had been issued an administration permit and have since died:³⁵

- 77 per cent were diagnosed with cancer;
- 14 per cent were diagnosed with a neurodegenerative disease; and
- 9 per cent were diagnosed with another disease (such as pulmonary fibrosis, cardiomyopathy, or chronic obstructive pulmonary disease).

³⁴ Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020* (Victorian Government, February 2021) 10.
³⁵ Ibid 11.

Timeliness

As at December 2020, 25 per cent of voluntary assisted dying applications were progressed between the first and final request within 11 days, and 50 per cent within 17 days.³⁶ The timing of the remaining 50 per cent of applications was not reported.

Number of qualified, registered and actively involved medical practitioners

The availability of qualified and willing medical practitioners was reported to be a barrier to accessing voluntary assisted dying.³⁷

However, the number of medical practitioners who are qualified and actively involved in voluntary assisted dying cases has steadily increased (see table below).³⁸ There are now 455 medical practitioners who have registered for the online training program.³⁹ Of those medical practitioners, 210 are registered in the portal and 157 have been involved in one or more case as either a coordinating or consulting medical practitioner.⁴⁰

Medical practitioner training and involvement⁴¹

Stage	Description	19 June 2019 – 30 June 2020	1 July – 31 December 2020	Change (%)
Online training	Medical practitioner registered for the online training program	422	455	7.8%
Portal registration	Medical practitioner registered in the portal	175	210	20.0%
Active in the portal	Medical practitioner involved in one or more case as either coordinating or consulting medical practitioner	125	157	25.6%

Medical practitioners in rural and regional Victoria

The availability of qualified and willing medical practitioners in regional and remote areas is an issue. The Board reports that 36 per cent of medical practitioners registered in the portal are in regional and rural Victoria, reflecting the proportion of applicants who live in those areas.⁴² However, the spread of qualified and registered medical practitioners across regional and rural Victoria is inconsistent. The Board reports a lack of such medical practitioners in Eastern and Western Victoria (see figure below).⁴³

36 Ibid 9.

37 Voluntary Assisted Dying Review Board, *Report of Operations July-December 2019* (Victorian Government, February 2020) 7.

38 Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020* (Victorian Government, February 2021) 6.

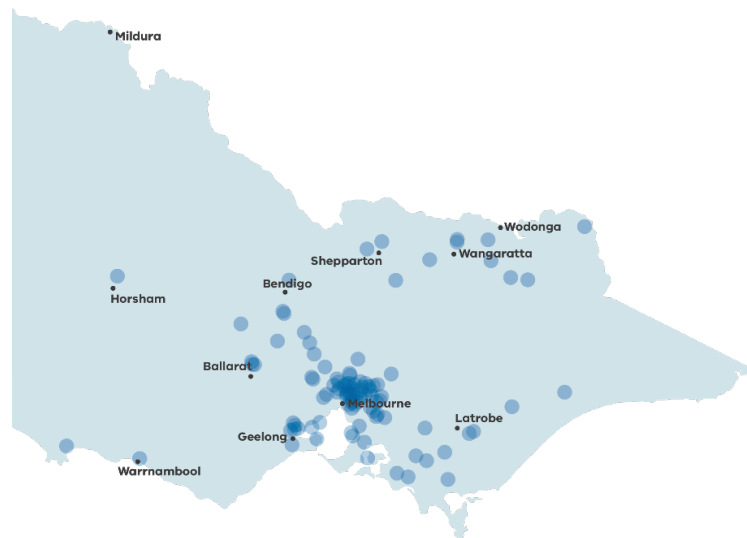
39 Ibid.

40 Ibid.

41 Table adopted with permission: Ibid.

42 Ibid 6.

43 Ibid.

Location of medical practitioners⁴⁴**Specialties of medical practitioners**

Of the medical practitioners who have acted as either a coordinating practitioner or consulting practitioner:⁴⁵

- 122 (53.3 per cent) specialise in **general practice**;
- 36 (15.7 per cent) specialise in **oncology**;
- 10 (4.4 per cent) specialise in **neurology**;
- 8 (3.5 per cent) specialise in **general medicine**;
- 6 (2.6 per cent) specialise in **respiratory and sleep medicine**;
- 6 (2.6 per cent) specialise in **haematology**;
- 5 (2.2 per cent) specialise in **palliative medicine**; and
- 36 (15.7 per cent) specialise in **another specialty**.

There remains a need for more qualified and registered specialists, such as neurologists, to assist in the process, particularly in rural and regional Victoria.⁴⁶

Care Navigator Service

The Care Navigator Service is a central component in the Victorian regime. Since the commencement of the Act, the service has provided support to over 1000 people seeking information about voluntary assisted dying.⁴⁷

44 Figure adopted with permission: Ibid 6.

45 Ibid 7.

46 Ibid.

47 Ibid 8; Voluntary Assisted Dying Review Board, *Report of Operations January–June 2020* (Victorian Government, August 2020) 5.

In response to feedback received in the first six months of the Act's operation, the service was expanded to include additional care navigators across regional Victoria.⁴⁸

Compliance

The Board analyses forms submitted to it and takes other steps to monitor compliance. Its data show 95 per cent of cases were compliant with the Act.⁴⁹ Between July and December 2020, six cases were identified as non-compliant. However, the Board determined that those cases were clinically appropriate, all eligibility requirements were met, and a misunderstanding had occurred that did not raise a concern about the completion of legal requirements.⁵⁰

Known unknowns

The limited data available to the Board means certain information is unknown, including the number of people who are:⁵¹

- unable to find a qualified medical practitioner to assist them;
- assessed as ineligible by a medical practitioner;
- in nursing homes or private or public hospitals and are not supported in accessing voluntary assisted dying; and
- told that if they wish to access voluntary assisted dying, they will have to leave the facility in which they are residing or are being cared for, such as a nursing home, hospital, or palliative care ward or organisation.

Commonwealth laws that impede access

Access to information and advice about voluntary assisted dying is critical to the operation of any scheme.

Chapter 20 of the report addresses in detail the uncertain possible application of Commonwealth 'carriage service' offences to conduct that is authorised by state voluntary assisted dying laws. This uncertainty is unsatisfactory. It led to the then Victorian Health Minister instructing doctors and other practitioners involved in voluntary assisted dying services to conduct all discussions, consultations and assessment face-to-face, so as to avoid potentially breaching the Commonwealth law.

The Victorian Board has made repeated calls for the Commonwealth to make an exemption to allow Victorians, especially those in regional Victoria, to be able to have 'important conversations about voluntary assisted dying over the phone or via teleconference'.⁵²

In general, it is preferable for all requests for, and provision of, information and advice about voluntary assisted dying to occur in face-to-face personal communications between the health practitioner and their patient. However, this may not be possible because of the location of the person and their inability to travel possibly long distances to consult a health practitioner or the inability of the health practitioner

48 Voluntary Assisted Dying Review Board, *Report of Operations January–June 2020* (Victorian Government, August 2020) 5.

49 Ibid 3.

50 Ibid 14.

51 Ibid 17.

52 Voluntary Assisted Dying Review Board, *Report of Operations January–June 2020* (Victorian Government, February 2020) 1, 16 https://www.bettersafecare.vic.gov.au/sites/default/files/202008/VADRB_Report%20of%20operations%20August%202020%20FINAL_0.pdf, *Report of Operations July–December 2020* (Victorian Government, February 2020) 4 https://www.bettersafecare.vic.gov.au/sites/default/files/202102/VADRB_Report%20of%20operations%20Feb%2021_FINAL.pdf.

to travel to speak to them in person. In such cases, information may need to be given by telephone, videoconference, email or some other form of electronic communication.

The need to use those forms of communication to request and provide information and advice will be greatest when the patient lives in a remote location. Without access to those forms of communication, persons living in remote and regional parts of the state may have greatly impaired access to voluntary assisted dying.

The Victorian experience of the Commonwealth law's inhibition on access to a lawful end of life option is instructive for Queensland. The uncertain application of the Commonwealth law has the greatest effect on individuals who are suffering and dying in remote and regional areas.

Legal frameworks, people and practices

Our task is to recommend 'the best legal framework' for people who are suffering and dying to choose the timing and circumstances of their death.

Legal frameworks are important because they determine what people are allowed to do.

However, the practical operation of any law is also governed by human behaviour and practices.

The law and personal choices in practice

Most people want to live for as long as possible without experiencing intolerable suffering.

This includes individuals with a terminal illness who are eligible to access voluntary assisted dying. The fact that they are eligible does not mean that they will proceed to prove their eligibility and proceed to administration as soon as possible after becoming eligible.

Laws might allow people to access voluntary assisted dying during what are expected to be the last 6 or 12 months of their lives. However, people who are eligible may leave it to the final weeks of their life to access voluntary assisted dying.

Also, some people may leave the process of assessment until it is too late. They may lose capacity or die before the process can be completed.

Others may be assessed to be eligible and able to proceed to administration, but choose not to. Voluntary assisted dying may be kept as an option. Another end of life option, such as continuing palliative care, may be chosen.

Legal frameworks

Voluntary assisted dying laws operate within a legal framework according to the individual preferences of patients and the professional practices of registered health practitioners.

The laws also operate in a context. For example, it is unlikely that an individual who is eligible for voluntary assisted dying will suddenly request it, without first receiving medical care and advice about their condition, their prognosis and treatment options.

If experience in other places like Victoria is any guide, many people will begin a discussion about voluntary assisted dying with their treating practitioner some time before they make a formal request to access it. Many will not request it until their condition is well-advanced, sometimes too far advanced to complete the process before they die.

Legal requirements set certain periods: for example, the minimum time between the first and last request is a requirement that confirms that the request is enduring. This does not mean that most cases

will complete the process in that minimum period. In fact, the nature of the process, with the need for two independent assessments and a formal written declaration by the person certified by two eligible witnesses, may mean it will take much longer.

Another example is the minimum qualifications of practitioners. The minimum will not be the average. That is unsurprising. For example, the minimum period of actual practice as a lawyer to be a Supreme or District Court Judge is 5 years, but most people who become judges will have practised for decades. As for voluntary assisted dying, if experience in Victoria is a guide, the practitioners who qualify and who are prepared to undertake the specific training to do eligibility assessments are likely to have had considerable experience in dealing with patients who are dying. They may be specialists in general practice or other fields where the scope of their practice brings them into contact with people who are dying. They may be experienced doctors who have been working for years in hospitals in areas like oncology, acute care of patients with chronic obstructive pulmonary disease, or in palliative care. They may be nurse practitioners with years of experience as registered nurses in similar fields before they became nurse practitioners. These doctors and nurses will have developed the clinical skills and the experience to deal compassionately and professionally with individuals who are dying, and who have to make informed choices about their options.

Practical issues: people and resources

A body like the Commission may recommend a 'legal framework' for voluntary assisted dying. The practical operation of any such scheme depends, however, on people and resources.

Any system must be properly resourced with information services, a care navigator service and information technology to support people who are dying (and also their families and friends) and the dedicated health professionals who are prepared to do this difficult work for little or no reward.

It depends on having sufficient qualified practitioners who are trained to undertake assessments or administer substances, or both.

Training about voluntary assisted dying should not be limited to coordinating and consulting practitioners. It should be given to junior doctors and to nurses who receive the initial queries from patients about voluntary assisted dying, and who provide ongoing support to a patient and their family through the process.

Other resourcing issues include:

- Communication services including qualified and trained interpreters;
- The establishment of a Statewide Pharmacy Service which can efficiently dispense prescribed substances and ensure their safe transportation, including to remote areas of the State;
- Telehealth and other services for particular use for patients in remote areas, or patients who cannot otherwise easily access face-to-face consultations with medical practitioners;⁵³
- The provision of places in hospitals or hospices at which persons seeking to access voluntary assisted dying can be transferred for the purpose of assessment or administration.

The process of implementing any legislation will be demanding and time-consuming if the Victorian and Western Australian experiences are a guide.

These resourcing and implementation issues are discussed in detail in Chapter 21 of the report. The present point is that a legal framework is simply that: a framework. It needs to be built upon. People and resources are needed to make any scheme work in practice.

As already noted, the provision of ‘compassionate, high quality and accessible palliative care for persons at their end of life is a fundamental right of the Queensland community’.

The resources required to ensure that any legislated scheme for voluntary assisted dying operates safely and compassionately should not be at the expense of palliative care services.

Some terms frequently used in the report

A full list of Abbreviations and a Glossary of Terms is at the start of the report. Some frequently used terms are listed here:

- **Coordinating practitioner** is the doctor who accepts the person’s first request for voluntary assisted dying and coordinates the process.
- **Consulting practitioner** is the doctor who independently completes the consulting assessment of the person.
- **Administering practitioner** is the doctor or nurse who administers the voluntary assisted dying substance to the person. The administering practitioner will be either the coordinating practitioner or the person to whom the role of administering practitioner is transferred.
- **Eligibility criteria** is the set of conditions that a person must meet to access voluntary assisted dying.
- **Request and assessment process** consists of the following steps:
 - a first request;
 - a first assessment;
 - a consulting assessment;
 - a second request; and
 - a final request.
- **First request** is the clear and unambiguous request a person makes to a doctor who is qualified and prepared to accept it for access to voluntary assisted dying.
- **First assessment** is the assessment completed by the coordinating practitioner to determine if a person meets the eligibility criteria for voluntary assisted dying. If the person is assessed as eligible, they will be referred for a consulting assessment.
- **Consulting assessment** is the independent assessment completed by the consulting practitioner to determine if a person meets the eligibility criteria for voluntary assisted dying. The consulting assessment occurs after the person has been assessed as eligible by the coordinating practitioner during the first assessment.
- **Second request** is the written request for access to voluntary assisted dying that a person makes after being assessed as eligible by the coordinating practitioner and the consulting practitioner. A second request, in the approved form, is witnessed and certified by two qualified witnesses.

- **Final request** is the third clear and unambiguous request a person makes to the coordinating practitioner for access to voluntary assisted dying.
- **Final review** is the review of the request and assessment process that the coordinating practitioner must complete after receiving the final request.
- **Administration decision** is the decision a person makes in consultation with their coordinating practitioner to either self-administer the prescribed substance or have it administered by a medical practitioner or nurse practitioner.
- **Self-administration** is where a person receives, prepares and ingests the substance.
- **Practitioner administration** is where a person is administered the substance by a doctor or nurse who is qualified and trained to act as administering practitioner.

INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING

Some think that health practitioners should be prohibited from initiating a discussion about voluntary assisted dying. They regard this as an extra safeguard against persons being unduly influenced to access it. To others, such a prohibition prevents health practitioners from doing their professional duty of telling patients about their end of life options and prevents persons making properly informed decisions.

The possible policies on this issue are:

- to have no such prohibition, leaving what a health practitioner says to be governed by professional duties and standards;
- to have a strict prohibition (as in Victoria) on health practitioners initiating a discussion about voluntary assisted dying;
- to have a qualified prohibition (as in Western Australia), which allows a medical practitioner or nurse practitioner to initiate a discussion about voluntary assisted dying, provided at the same time there is a wider discussion about the person's treatment and palliative care options and their likely outcomes.

The Commission prefers the third option. We also propose in Chapter 6 that, as in other states, a prohibition should not apply if information about voluntary assisted dying is provided to a person at the person's request.

ELIGIBILITY

Eligibility Overview

Chapter 7 of the report identifies who may access voluntary assisted dying in Queensland should the draft Bill be enacted. After a detailed analysis of expert reports and legislation in other places, and the extensive submissions made, we recommend five eligibility criteria. A person must:

1. have an eligible disease, illness or medical condition
2. have decision-making capacity
3. be acting voluntarily and without coercion
4. be aged at least 18 years

5. fulfil the residency requirement.

All five criteria, and each element within each criterion, must be met.

To fulfil the first criterion the person must have a condition that is advanced, progressive and will cause death, is expected to cause death within 12 months, and is causing suffering that the person considers to be intolerable. The timeframe of 12 months makes it clear that voluntary assisted dying is an option only for those who are at the end of life. It maintains the principle that the scheme is not a choice between life and death but a choice for those who are in the process of dying and wish to choose the time and circumstances of their death.

The person must be suffering intolerably. This level of suffering is to be determined by the person concerned. Suffering caused by the condition may be physical or mental, and it may be caused by treatment for the condition.

The second criterion—decision-making capacity—means that the person must understand the nature and effect of decisions about voluntary assisted dying; be capable of freely and voluntarily deciding to access the scheme; and be able to communicate that decision. For this reason, people who lack decision-making capacity (such as people suffering from dementia) or who lose decision-making capacity during the process are not eligible.

The third criterion serves to underline the voluntary nature of the scheme. The person must demonstrate that they are acting voluntarily and without coercion at all stages of the process.

The fourth criterion limits the scheme to adults. This is consistent with other relevant Queensland laws and the approach taken in other Australian states that permit voluntary assisted dying. It is based on the presumption that children do not have the capacity to understand fully what is proposed by voluntary assisted dying.

The final criterion is based on concern that, without it, the right of a Queensland resident to access the scheme and to access high quality end of life care might be compromised by excessive demand by persons from other jurisdictions on end of life care in Queensland hospitals. However, we propose that the legislation allow exemptions for difficult cases—for example, where a person lives near the Queensland border and has close family or treating doctors in Queensland.

As one of many safeguards to protect the vulnerable, the request and assessment process incorporates a substantial waiting period. Access to the scheme should not be available simply after one request. The request should be a settled one and endure over a reasonable period. This means people requesting access must discuss their desire with their health practitioner and make separate requests at separate times.

At various points during the process, the person must be assessed as still having decision-making capacity. The person must also be told, more than once, that they may decide at any time not to continue the process. These rules and their timing ensure that any request to access voluntary assisted dying is clear, communicated, and enduring.

As the requirement for the request to be enduring is firmly embedded in the draft Bill, it is unnecessary to make it an additional eligibility criterion. The process of request and assessment also means that the scheme will not be accessible by people whose suffering is merely temporary.

Persons are eligible only if they satisfy all five eligibility criteria. For example, a condition that will cause death but is in its early stages will not be 'advanced'. Even being diagnosed with what might be described as a 'terminal condition' that is advanced, progressive, and expected to cause death within 12 months is insufficient. Anyone being treated for the condition or receiving palliative care, and not experiencing intolerable suffering, will not be eligible.

Criterion One: Eligible disease, illness or medical condition

The first criterion should be that the person has been diagnosed with a disease, illness or medical condition that:

- is advanced, progressive and will cause death;
- is expected to cause death within 12 months; and
- is causing suffering that the person considers to be intolerable.

This combination of eligibility criteria about the person's disease, illness or medical condition makes it clear that voluntary assisted dying is an option only for people at the end of life, who are suffering and dying. It is not a choice between life and death. It is a choice for those who are dying to exercise some control over the timing and manner of their death. This approach strikes the appropriate balance between the fundamental value of human life and the values of individual autonomy and reducing suffering.

A condition that is advanced, progressive and will cause death

The requirement that the person must be diagnosed with a disease, illness or medical condition that is 'advanced, progressive and will cause death' means that a person is eligible only if they have a condition that is very serious and on a deteriorating trajectory. The term is clear, precise and reflects contemporary medical terminology.

It is not necessary for the term 'incurable' to be included in the eligibility criteria. The word does not materially add to them, and its addition could cause uncertainty and confusion. Also it is not necessary or desirable for the eligibility criteria to expressly refer to specific types of diseases, illnesses or medical conditions, such as 'terminal', 'chronic' or 'neurodegenerative' diseases.

Whether or not a person has a disease, illness or medical condition that is 'advanced, progressive and will cause death' is a clinical determination, made after taking into account the person's individual circumstances, including their condition, their comorbidities, and the available treatments that they are prepared to accept.

Timeframe until death

Some people who have thought deeply about these issues submit that including a timeframe until death is unnecessary or wrong in principle. For example, the Parliamentary Committee in Victoria considered that 'doctors are best placed to assess whether a patient is at the end of life' and that 'empowering doctors to make this assessment is preferable to allocating an arbitrary time limit'.⁵⁴

Some may consider that it is wrong in principle, and even cruel, to require someone who is dying and experiencing intolerable suffering to continue to suffer for months until they reach the time at which a doctor will say that they are expected to die within the next 6 or 12 months.

The Queensland Parliamentary Committee considered that specific timeframes for the eligibility period should be avoided due to the 'practical difficulties in obtaining a prognosis and timeframe of progression of some medical conditions, such as motor neurone disease'.⁵⁵ It recommended that:⁵⁶

54 Vic Parliamentary Committee Final Report (2016) 224, noting that 'this model would in practice apply to those with weeks or months to live, not years, as is the experience in overseas jurisdictions'.

55 Qld Parliamentary Committee Report No 34 (2020) 120.

56 Ibid Rec 5.

any voluntary assisted dying scheme in Queensland should not propose precise timeframes for a person's anticipated date of death within which voluntary assisted dying may be accessed due to the complex, subjective and unpredictable nature of the prognosis of terminal illness.

Many submissions were made on this issue. They are detailed in the report.

A number of respondents, including AMA Queensland, submitted that the eligibility criteria should require that the person is diagnosed with a disease, illness or medical condition that will cause death and that is expected to cause death within a specific timeframe. A specific timeframe in the eligibility criteria was said to provide clarity and guidance regarding eligibility, ensure consistency in interpretation and application, and appropriately limit access to voluntary assisted dying to people at the end of life, who are dying.

Go Gentle Australia submitted that the inclusion of a specific timeframe 'is essential for two reasons':

Firstly, it gives guidance to assessing medical practitioners and ensures consistency. By acting in this way as a fundamental safeguard, this provides confidence to the public and the Parliament.

Secondly, any law and particularly this law must be written with regard to the society for which it is framed.

Statistically, the majority of people who access these laws overseas, and in the first year of Victoria's law, are 60 and older, and dying of cancer or chronic cardio-respiratory failure...

It added:

Experience from the first year of Victoria's law shows that many people come to [voluntary assisted dying] late in their illness. In a number of cases, they have died before being able to get through the process...

For this reason, rather than there being a 6/12 month timeframe depending upon the nature of your illness, we believe that a 12 month timeframe of life expectancy for all eligible conditions will offer maximum palliative value and is appropriate.

Another respondent submitted that:

We appreciate that having a set timeframe such [as] six or 12 months can be arbitrary and clinically problematic, given that prognosis can be difficult to predict. Nevertheless, it will require medical practitioners and patients to turn their minds to the patient's prognosis with some precision. It sets some boundaries around eligibility and will be easier to implement in practice than eligibility criteria without a timeframe.

There would be potentially greater access to voluntary assisted dying without a timeframe. However, this needs to be balanced against the risk of over-inclusion and inconsistency in application of the eligibility criteria because of a broader interpretation. As death is a certain outcome of life, 'will cause death' could be open to much broader interpretation than is intended.

A different respondent submitted that:

From a medico-legal perspective, lack of specific timeframes may cause uncertainty around eligibility, raising the prospect of inconsistent interpretations.

Compellingly both the Victorian and Western Australian ministerial panels, containing a range of professional, legal and community interests and following wide consultation, recommended specific timeframes to ensure appropriate safeguards, clarity and consistency.

After considering all the submissions, we conclude that the person must have been diagnosed with a disease, illness or medical condition that is expected to cause death within 12 months.

A specific timeframe until expected death makes it clear that voluntary assisted dying is an option only for those who are at the end of life. It maintains the principle that voluntary assisted dying is not a choice between life and death but a choice for those who are dying to exercise some control over the timing of their death. A specific timeframe gives clear guidance to the community and the health profession about who is eligible.

A timeframe of 12 months is consistent with current health care practice and the end of life and palliative care framework in Australia. It also takes account of the clinical trajectories of different diseases, illnesses or medical conditions that are advanced, progressive and will cause death. A timeframe of six months may be more consistent with an end of life clinical trajectory for most advanced cancers. However, a timeframe of 12 months also encompasses the clinical trajectories of people with other types of eligible diseases, illnesses or medical conditions, including neurodegenerative diseases such as motor neurone disease, or chronic illnesses such as chronic heart failure.

The Victorian Panel recommended a single timeframe of 12 months, and this was included in the Victorian Bill as introduced. However, during the progress of the Bill through Parliament the timeframe was reduced to six months, with an extension to 12 months for neurodegenerative diseases, to account for the different clinical trajectories of those types of diseases. A similar approach was then adopted in Western Australia, despite the Western Australian Panel advising that differential treatment for different conditions is difficult and potentially discriminatory.

We agree with the expert panels in Victoria and Western Australia. We consider it preferable for the draft Bill to specify a single timeframe of 12 months, rather than discriminate between types of diseases, illnesses, or medical conditions.

Adopting different policies for different diseases, illnesses or medical conditions is undesirable as a matter of principle. For example, it is hard to see why a person who is dying and experiencing intolerable suffering from chronic heart failure or cancer should have to wait longer to qualify for access than someone who is dying and experiencing intolerable suffering from a motor neurone disease like multiple sclerosis.

We acknowledge the concerns of some that a timeframe is arbitrary and could potentially prolong a person's suffering until the person can satisfy this eligibility criterion. We consider, however, that a timeframe of 12 months is a compassionate and balanced response.

In those jurisdictions that do not include a specific timeframe until death, most people do not access voluntary assisted dying until they are close to death. Allowing people to begin the process during what is expected to be the last 12 months of their lives does not mean that they will proceed to the administration stage as soon as they become eligible. They are likely to wait until they are closer to death.

Whether a person has a condition that is expected to cause death within 12 months is a clinical determination based on the person's particular circumstances, including condition, comorbidities, and treatment choices.

We note the concerns of some that determining a person's prognosis can be complex, subjective, and unpredictable. While it is not possible to predict precisely when someone will die, a person who has been diagnosed with a condition that will cause death is usually given a prognosis and treatment options, and the expected outcomes of those options. Medical practitioners commonly use prognostication assessment tools to predict the likelihood of death within 12 months.

In summary, a timeframe of 12 months is a compassionate and balanced response. It will enable people who are dying to *begin* the voluntary assisted dying process at a time that suits their individual circumstances including the trajectory of their particular condition and level of suffering. At the same time, it ensures that eligibility is limited to people who are at the end of life.

Level of suffering

The eligibility criteria should also provide that the person's condition is causing intolerable suffering.

Whether the person's suffering is intolerable is a subjective assessment, to be determined by the person requesting access to voluntary assisted dying.

The person's suffering must be causally linked to the person's disease, illness or medical condition. However, it is not limited to the physical pain or symptoms caused by the condition. The draft Bill states that suffering may include physical or mental suffering, or suffering caused by the treatment provided for that condition.

This approach recognises that suffering is a personal experience best determined by the person themselves, and that it may take various forms. It respects the person's autonomy, reflects a person-centred approach to care and is consistent with the value of reducing suffering.

The Commission notes concerns that a person should not be able to access voluntary assisted dying only because, for example, they feel like a burden or are lonely. While the person's suffering may take many forms, including both physical and mental suffering, it must be caused by a disease, illness or medical condition that is advanced, progressive and will cause death, and that is expected to cause death within 12 months. Unrelated and pre-existing conditions like loneliness do not qualify.

The inclusion of a higher threshold requiring the person's suffering to also be 'enduring' is unnecessary and would be inconsistent with the compassionate purpose of the draft Bill. The separate requests required by the request and assessment process indirectly ensure that the intolerable suffering that prompts those separate requests is enduring, not temporary.

Mental illness or disability

To avoid doubt and to allay any concerns, the draft Bill states that a person is not eligible for access to voluntary assisted dying only because they have a disability or a mental illness. However, a person who has a disability or a mental illness may be eligible for access to voluntary assisted dying if they meet all the eligibility criteria (including that they have decision-making capacity for voluntary assisted dying). This makes it clear that people who have a disability or a mental illness have the same rights and protections as other members of the community, and should not be discriminated against or denied access to voluntary assisted dying if they meet all the eligibility criteria.

In some circumstances a person with a mental illness will lack the decision-making capacity to access voluntary assisted dying. Like anyone else who lacks the required decision-making capacity, such a person is ineligible.

Criterion Two: Decision-making capacity

Access to voluntary assisted dying should be limited to people who have decision-making capacity in relation to voluntary assisted dying.

This is one of the fundamental safeguards in the draft Bill. It recognises and protects individual autonomy. In conjunction with other safeguards, the requirement to have decision-making capacity will assist in ensuring that a person's decision is voluntary and protect people who might be vulnerable to coercion or exploitation.

The draft Bill states that, for the purposes of the legislation, a person has decision-making capacity in relation to voluntary assisted dying if the person is capable of three things:

- understanding the nature and effect of decisions about access to voluntary assisted dying; and
- freely and voluntarily making decisions about access to voluntary assisted dying; and
- communicating decisions about access to voluntary assisted dying in some way.

In addition to defining decision-making capacity, the draft Bill sets out a number of factors that are of particular relevance in determining whether or not a person has decision-making capacity for voluntary assisted dying. This list is not exhaustive, but highlights some important factors:

- a person may have decision-making capacity to make some decisions but not others;
- capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it;
- it should not be presumed that a person does not have decision-making capacity:
 - because of a personal characteristic such as age, appearance, or language skills;
 - because the person has a disability or illness; or
 - because the person makes a decision that others think unwise.

The draft Bill also provides that a person is capable of doing any one of the three things required to have decision-making capacity if the person is capable of doing it with 'adequate and appropriate support'. Examples of support include:

- (a) using information or formats tailored to the particular needs of a person;
- (b) communicating or assisting a person to communicate the person's decision;
- (c) giving a person additional time and discussing the matter with the person;
- (d) using technology that alleviates the effects of a person's disability.

This approach is consistent with voluntary assisted dying legislation in Victoria and Tasmania. It is also generally consistent with the *Guardianship and Administration Act 2000* and the associated Queensland capacity assessment guidelines.

Victorian guidelines explain that a medical practitioner should give a patient relevant information about their diagnosis, prognosis, and the options available and then 'check' their capacity. This may involve, for example, asking the patient to paraphrase their understanding of the information, explain their thoughts or views, and give reasons for their chosen option. These matters should be the subject of similar guidance to practitioners in Queensland in assessing whether a person has decision-making capacity for voluntary assisted dying.

Adults who lack or lose decision-making capacity

The draft Bill requires that a person must have decision-making capacity for voluntary assisted dying at each stage of the process.⁵⁷ This, therefore, renders ineligible persons who lack decision-making

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In particular, decision-making capacity is required at each stage of the request and assessment process, and also at the stage of practitioner administration.

capacity because of some condition (such as dementia), or who, having decision-making capacity at the start of the process, subsequently lose it and do not regain it.

A complex issue is whether a person who, at a certain stage, had the required decision-making capacity but lost it before the process could be completed should be allowed to access voluntary assisted dying on the basis of an advance health directive (or similar instruction) that was made when they still had capacity. The broader issue is whether the law should permit advance decision-making about voluntary assisted dying.

We address the complexities of that issue in Chapter 7. Many difficult issues arise that have not been satisfactorily addressed in other places. To give just one example, what should be the position if a person makes an advance decision about voluntary assisted dying but, at the time when the criteria for administration are met, objects to the administration? These issues might be particularly relevant to people who have dementia. It would place a terrible burden on a medical practitioner to decide whether a person should be administered a voluntary assisted dying substance in such a situation, despite the person's advance direction when they had decision-making capacity.

We are sympathetic to the views of respondents who advocated for decisions about voluntary assisted dying to be made in advance and those who identified concerns about people with dementia. However, we remain of the view that access to voluntary assisted dying should be limited to people who are assessed to have decision-making capacity at all stages throughout the voluntary assisted dying process.⁵⁸ Protection of the vulnerable requires this. This should remain the position until the complexities of making an advance directive about voluntary assisted dying are addressed and carefully considered.

Any voluntary assisted dying scheme in Queensland should be for people who have decision-making capacity and who can make an autonomous and voluntary decision to access the scheme. The draft Bill we propose makes it clear that a person who has applied for or been approved for access to voluntary assisted dying can change their mind at any time.

In our view, it would be best for any new legislation to be enacted for people with capacity, and for it to be monitored and reviewed to ensure that it is operating effectively, before further consideration of any extension of the scheme to permit advance decision-making about voluntary assisted dying.⁵⁹

In summary, our reasons for not making recommendations in this area are:

- This is a complex issue that has not been adequately addressed elsewhere and, as such, requires further careful thought, based on research.
- The appropriateness of an advance decision about access to voluntary assisted dying warrants careful assessment in conjunction with consideration of the scope and contents of advance health directives.
- The current difficulties associated with the operation of the *Powers of Attorney Act*. These relate to the limitations that Act places on the circumstances in which an advance health directive will be followed. Regardless of any approach that might be taken to advance decision-making for voluntary assisted dying, these broader issues should be resolved first. These matters were the subject of a QLRC report more than a decade ago and were commented on by the

⁵⁸ In forming these views, the Commission has reviewed and considered a broad range of material about this topic. This includes academic literature, the views expressed by other bodies such as the Victorian Ministerial Advisory Panel, Western Australian Ministerial Expert Panel, Council of Canadian Academies and Parliamentary Committee, and the views expressed in submissions and evidence given to the Parliamentary Committee. This material is cited in Chapter 7 of the report.

⁵⁹ See Chapter 19 about a review of the legislation's operation.

Parliamentary Committee that considered voluntary assisted dying.⁶⁰ They are overdue for attention.

- If a voluntary assisted dying scheme is enacted in Queensland, it will face enough challenges in being implemented for adults who have capacity at all stages of the process without having to deal in its initial years with additional complex and unresolved challenges of persons who lack capacity or lose it during the process.

Therefore, the scheme we propose relates only to adults who have, and are shown to have, decision-making capacity to request voluntary assisted dying and who clearly request it at different times as part of the process.

Criterion Three: Voluntary and without coercion

A person should be acting voluntarily and without coercion at all stages of the process, including when requesting access, undergoing the assessment process, making the decision to proceed, and having the substance administered.

The draft Bill's requirement that the person must be acting voluntarily and without coercion is in addition to the requirement that, to have decision-making capacity, a person must be capable of freely and voluntarily making decisions about access to voluntary assisted dying. As explained in Chapter 7 of the report, this additional criterion specifically relates to the person's actual condition when making decisions, rather than to their capacity to make such decisions. It is another key safeguard in the draft Bill.

The term 'voluntary' is an ordinary word and refers to something that is done 'of one's own accord or by free choice'

We recommend that the term 'coercion' in this context be defined to include 'threats, promises or intimidation of any kind, including by improper use of a position of trust or influence'. The requirement that the use of a position of trust or influence be 'improper' makes clear that the provision is directed at influence that is exploitative of a vulnerable person. It would not apply to the proper and well-intentioned exercise of influence. Many forms of well-intentioned and good advice by a friend, family member, or health practitioner (in whom a person justifiably places trust or confidence) will be inclined to influence a decision.

This third eligibility criterion also must be assessed as part of the process. It must be demonstrated that a person's choices and requests are made freely and of their own accord. Any vulnerability should not be exploited by coercion of any kind, and that includes, under the draft Bill, improper use of a position of trust or influence.

Criterion Four: Aged at least 18 years

Access to voluntary assisted dying should be limited to adults; that is, people who are at least 18 years of age.

Limiting access to adults is consistent with other relevant laws in Queensland and with laws in most other jurisdictions that permit voluntary assisted dying.

Having an eligibility criterion that someone must be aged at least 18 years to access voluntary assisted dying may seem arbitrary, and especially harsh on a mature 16- or 17-year-old who is suffering and

⁶⁰ See further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (Qld), Voluntary Assisted Dying, Report No 33 (March 2020) [21.4.1], 410, 421–2, Rec 76; QLRC, A Review of Queensland's Guardianship Laws, Report No 68 (2010) vol 2, Rec 11-3, and see generally ch 11. See also QLRC Consultation Paper No 79 (2020) [4.120]–[4.127].

dying. Any age requirement in a law, whether it be a law about wills or medical treatment, may have seemingly arbitrary and harsh outcomes. However, age requirements have a purpose.

In this context, the age requirement is designed to limit access to voluntary assisted dying to persons who are presumed, because of their age, to have sufficient understanding and intelligence to understand fully what is proposed, and to be able to give informed consent to a process that will end their lives. Children are not presumed to have such a capacity.

The issue of when a child has capacity to understand fully what is proposed, and to give voluntary and informed consent to it, is complex enough in the context of consent to medical treatment. It is more complex in the context of access to voluntary assisted dying.

Guidelines for deciding ‘Gillick competence’ for health-related decision-making may need to be adapted to the different context of voluntary assisted dying, which is an active process. These are important issues that have not been satisfactorily resolved to date in jurisdictions with laws that are comparable to the draft Bill. At present, there are gaps in the scientific, evidence-based research to inform the development of policy in this area.

The draft Bill, if implemented, will establish a new legal framework for access to voluntary assisted dying by eligible adults in Queensland. The appropriate course is for any new legislation to be properly reviewed and evaluated before any future consideration is given to the conditions on which access to the scheme might be permitted to minors with ‘Gillick competence’.

Therefore, the scheme we propose relates only to adults.

Criterion Five: Residency

The final criterion is based on concern that, without it, the right of a Queensland resident to access the scheme and to access high quality end of life care in Queensland hospitals might be compromised by excessive demand by persons from other jurisdictions. However, we propose that the legislation allow exemptions for difficult cases—for example, where a person lives close to the Queensland border and has close family or treating doctors in Queensland.

The eligibility criteria in the draft Bill require that:

- (a) the person:
 - (i) is an Australian citizen; or
 - (ii) is a permanent resident of Australia; or
 - (iii) has been ordinarily resident in Australia for at least three years immediately before making the ‘first request’; and
- (b) the person has been ordinarily resident in Queensland for at least 12 months immediately before making the ‘first request’.

The draft Bill also provides that the Director-General of the Department of Health or a delegate of the Director-General may exempt a person from the residency requirement if satisfied that the person has a substantial connection to Queensland and that the circumstances justify the granting of the exemption on compassionate grounds.

The inclusion of a residency requirement in any legislation should be reviewed as part of a future review of the legislation’s operation.

We recommend that regulations, guidelines and forms should be developed to meet proof-of-residency requirements.

The request to access voluntary assisted dying is enduring

The request and assessment process, which includes a waiting period, ensures the choice to access voluntary assisted dying is not a fleeting one. The draft Bill requires repeated requests over a substantial waiting period. At various points, the person must be assessed to have decision-making capacity. The draft Bill provides that a person may choose not to continue with the process at any time. They must be told this more than once. The draft Bill's processes, and their timing, ensure that any request to access voluntary assisted dying is clear, communicated, and enduring.

The policy that a person requesting access to voluntary assisted dying has, over time, discussed it with their health practitioner, and has made many requests of the same nature, is ensured by a process that achieves that goal. It is unnecessary to include a requirement that the request be 'enduring' as part of the eligibility criteria. It is firmly embedded in the draft Bill.

Eligibility criteria in practice

Chapter 7 undertakes an extensive comparative analysis of eligibility criteria in different jurisdictions, with attention to similarities and differences between the legal frameworks in Australian states that have enacted voluntary assisted dying laws. The purpose of that analysis is to develop, with the benefit of the extensive submissions we received, the best legal framework for eligibility criteria in any Queensland law and to identify who can access voluntary assisted dying.

Two resources may help in understanding how these criteria might be expected to work in practice.

The first are the reports of the Voluntary Assisted Dying Review Board in Victoria, which identify the types of diseases, illnesses, or medical conditions that have qualified persons to access voluntary assisted dying in that State. For ease of reference, the figures earlier quoted are repeated at this point.

Of the people who have been issued an administration permit in Victoria and have since died:⁶¹

- 77 per cent were diagnosed with cancer;
- 14 per cent were diagnosed with a neurodegenerative disease; and
- 9 per cent were diagnosed with another disease (such as pulmonary fibrosis, cardiomyopathy or chronic obstructive pulmonary disease).

Of those diagnosed with cancer, 21 per cent had a primary lung cancer, 11 per cent had primary breast cancer, 11 per cent had primary pancreatic cancer, 9 per cent had a primary colorectal cancer, 9 per cent had other gastrointestinal tract cancer, and 39 per cent had a range of other cancers.

The second resource is a recent article by several academics, including Professors White and Willmott, titled *Who is Eligible for Voluntary Assisted Dying? Nine Medical Conditions Assessed against Five Legal Frameworks*.⁶² The authors had earlier analysed eligibility criteria across five legal frameworks—laws in Victoria, Western Australia, Oregon, and Canada, along with the White and Willmott Model. Their companion article analysed whether each of the nine selected medical conditions could give an individual with the condition access to voluntary assisted dying.

61 Voluntary Assisted Dying Review Board, Report of Operations July-December 2020 (Victorian Government, February 2021) 11 https://www.bettersafecare.vic.gov.au/sites/default/files/202102/VADRB_Report%20of%20operations%20Feb%2021_FINAL.pdf.

62 BP White et al, 'Who is eligible for voluntary assisted dying? Nine medical conditions assessed against five legal frameworks', *University of New South Wales Law Journal* (forthcoming).

Of the nine medical conditions analysed, access to voluntary assisted dying was found to be possible for:

- Cancer;
- Motor Neurone Disease;
- Chronic Obstructive Pulmonary Disease; and
- Chronic Kidney Disease.

The authors found that access was highly unlikely (at least under the Australian frameworks) for:

- Alzheimer's Disease;
- Anorexia;
- Frailty;
- Spinal Cord Injury; and
- Huntington's Disease.

Their analysis showed a clear distinction between the Canadian model and all other models.

The reasons why these five conditions were thought by the authors to be very unlikely to make a person with any one of them eligible under the Australian frameworks are explained in detail in the article. In short summary:

- **Alzheimer's Disease:** the requirement to have decision-making capacity, and at the same time have a condition that is advanced and expected to cause death (with or without a timeframe until death) makes it very unlikely that the person will have decision-making capacity once Alzheimer's is at an advanced stage.
- **Anorexia:** a mental illness is not an eligible condition, and to the extent that physical conditions could be seen as distinct from the mental illness, an advanced case that was life-threatening would impair the person's decision-making capacity for voluntary assisted dying.
- **Frailty:** is not a single medical condition that will cause death.
- **Spinal Cord Injury:** disability alone is not an eligible condition; and the medical condition, while incurable, is not progressive.
- **Huntington's Disease:** This is a progressive neurodegenerative disease, and by its advanced stage the person would likely have lost decision-making capacity due to progressive cognitive decline.

The authors considered that an uncritical acceptance of the Victorian Act in developing frameworks in other Australian states should be avoided. They argued that testing the operation and boundaries of proposed laws against a range of medical conditions to determine which medical conditions might permit access to voluntary assisted dying, as well as those conditions that would not be eligible, can help ensure the framework operates as intended.

They also argue that such a comparative analysis suggests the potential redundancy of some criteria that are not required to control access to voluntary assisted dying and can add unnecessary complexity and uncertainty to assessing eligibility.

A requirement that the condition be ‘incurable’ is an example of part of a criterion that seems redundant and is unnecessary. Its inclusion may cause uncertainty about why it was added.

The eligibility criteria we recommend are essentially the same as those in Victoria, Western Australia, and Tasmania. If these criteria were enacted in a law in Queensland, one would expect a similar profile of qualifying conditions to those in Victoria. These conditions align with the medical conditions that Professors White and Willmott and their co-authors analysed as possible across the legal frameworks they analysed. Importantly, the criteria are very unlikely to permit access by persons with certain conditions, such as Alzheimer’s disease, because decision-making capacity for voluntary assisted dying is very unlikely to be retained by the time the condition reaches an advanced stage.

One difference between the eligibility criteria we recommend and the eligibility criteria that apply in Victoria is that we recommend a single timeframe until death of 12 months, whereas Victoria has a timeframe of six months or 12 months in the case of a person with a neurodegenerative condition. An important conclusion of the comparative analysis undertaken by Professors White and Willmott and their co-authors is that the existence of a specific timeframe until death is unlikely to alter the medical conditions that make access to voluntary assisted dying possible. Therefore, the recommended single timeframe is unlikely to alter the kind of medical conditions that may permit access to the scheme from those conditions that have allowed access in Victoria.

This conclusion may prompt the question of why we have recommended a timeframe until death, or why we did not simply recommend the same timeframe that applies in Victoria. We have done so because of the advice of expert panels in Victoria and Western Australia, which recommended a 12-month timeframe, and the point of principle that there should be a single timeframe in any legislation. We also explain in Chapter 7 why we prefer a 12-month timeframe.

In summary, a timeframe of 12 months avoids some of the problems associated with prognosis and is consistent with health care practice and the end of life and palliative care framework in Australia. It will allow people to begin the process of accessing voluntary assisted dying during what are expected to be the last 12 months of their lives, rather than continue to experience intolerable suffering for many months until medical practitioners are prepared to certify that death is expected within six months. One consequence of adopting a shorter six-month timeframe for certain conditions is that it may delay a person from embarking on the process of accessing voluntary assisted dying. An unexpected, or even expected, deterioration in their condition, coupled with certain forms of treatment, may mean that the person is not able to complete the voluntary assisted dying process before death or the loss of the required decision-making capacity.

Therefore, we recommend a timeframe of 12 months, as a compassionate and balanced measure.

Eligibility criteria in combination

Persons are eligible for access to voluntary assisted dying only if they satisfy all the eligibility criteria. The five eligibility criteria we recommend require a person to:

- have an eligible disease, illness or medical condition;
- have decision-making capacity;
- be acting voluntarily and without coercion;
- be aged at least 18 years; and
- fulfil the residency requirement.

Each element within a criterion must be satisfied.

For example, the first criterion requires the person to have been diagnosed with a disease, illness or medical condition that:

- is advanced, progressive and will cause death;
- is expected to cause death within 12 months; and
- is causing suffering that the person considers to be intolerable.

The person must satisfy each of these elements. A condition that will cause death but is in its early stages will not be 'advanced'. Even being diagnosed with what might be described as a 'terminal condition' that is advanced, progressive, and expected to cause death within 12 months is not enough. If the person is being treated for the condition or receiving palliative care and not experiencing intolerable suffering, they will not be eligible.

In considering 'the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland', it is important to appreciate that a system of regulation operates as a whole.

We have quoted earlier an article by Professors White and Willmott and their co-authors which includes these insightful words:⁶³

While it may be politically attractive to add numerous safeguards to [voluntary assisted dying] legislation, including in the eligibility criteria, there is a risk of what we have called elsewhere 'policy drift by a thousand cuts' if the cumulative effect of these individual safeguards is not properly considered. For example, **it is possible that a series of provisions designed to make [voluntary assisted dying] legislation safe, when aggregated, can in fact make access to [voluntary assisted dying] cumbersome or even unworkable.** (emphasis added)

We accept that some will regard our recommendations about eligibility criteria and other matters as overly conservative and placing too many hurdles in the path of people who are suffering and dying. Others will say that our recommendations do not go far enough to limit access.

The critical point is that our recommendations about eligibility and other matters, including the request and assessment process, operate as a whole.

The recommendations on eligibility identify who can potentially access voluntary assisted dying. Other parts of the draft Bill identify what those persons must do to be assessed as eligible, and, if they choose, continue through the process.

The eligibility criteria do not permit access to all persons who are suffering and dying.

Some will say that we should have extended our eligibility recommendations to:

- people with stable but devastating conditions that render their suffering intolerable;
- mature minors who have enough understanding to give informed consent to voluntary assisted dying;
- people who come from overseas or interstate to access voluntary assisted dying in Queensland; or

- people who lack or lose decision-making capacity for voluntary assisted dying but have given an advance directive about accessing it.

Our recommendations are determined by our terms of reference, which relate to ‘people who are suffering and dying’. They do not relate to people who suffer from conditions that make their lives unbearable but who are not dying.

Our recommendations about eligibility, like our other recommendations, seek to achieve a balance between the values of personal autonomy and protection of vulnerable individuals.

The eligibility criteria should be viewed in combination and in the context of the draft Bill as a whole.

REQUEST AND ASSESSMENT

We have to recommend ‘the process for access to voluntary assisted dying to be initiated, granted or denied’. In our view, access should be governed by a staged request and assessment process, similar to the process that is followed in Victoria, Western Australia and Tasmania

Chapter 8 of the report explains the process for making requests and having two independent eligibility assessments done by doctors who accept the roles of ‘coordinating practitioner’ and ‘consulting practitioner’. We also recommend a minimum waiting period of 9 days between the first and final request.

The ‘first request’ to access voluntary assisted dying must be clear and unambiguous. It must be made personally, not by someone else on the person’s behalf. It may be verbal, by gestures or other means of communication available to the person.

If the doctor is qualified and willing to accept the request, the doctor becomes the ‘coordinating practitioner’ and conducts an eligibility assessment. If the person meets the eligibility requirements they must be given certain information (set out in the chapter and the draft Bill), including

- their diagnosis and prognosis;
- the available treatment and palliative care options and their likely outcomes; and
- that they may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying.

If the person chooses to continue with the process, their eligibility is independently assessed by another doctor who is qualified and willing to act in the role of ‘consulting practitioner’.

If either the coordinating practitioner or the consulting practitioner is unsure whether the person has an eligible condition or has decision-making capacity for voluntary assisted dying, the practitioner must refer the person to a registered health practitioner who has appropriate skills to determine the matter. For example, if the doctor is unable to determine whether the condition is expected to cause death within 12 months, the issue would be referred to an expert in that specific condition. This referral process is a necessary safeguard to ensure that anyone who is assessed as eligible for access to voluntary assisted dying (or who goes on to access it) is in fact eligible.

A requirement to refer a person elsewhere when a practitioner cannot determine a matter is also consistent with good medical practice.

If the consulting practitioner finds that the person is eligible, they must also inform them of many matters. The person can then choose to make a ‘second request’. It is a formal declaration, witnessed and certified by two eligible witnesses. Ineligible witnesses include a person who knows or believes that

they are a beneficiary under a will of the person making the request; or may otherwise benefit financially or in any other material way from the person's death. An eligible witness must certify that the person appeared to be making the declaration freely and voluntarily.

If the person chooses to continue the process, they can then make a third (and final) request. Again, it must be clear, unambiguous and made personally to the coordinating practitioner. That doctor then must submit a final review form that certifies that the request and assessment process was completed in accordance with the legislation's requirements and that the doctor is satisfied that the person:

- has decision-making capacity in relation to voluntary assisted dying; and
- is acting voluntarily and without coercion.

That concludes the 'request and assessment process', after which a person may choose to proceed to the administration stage discussed in Chapter 10.

To some extent, the operation of the request and assessment process will naturally involve a period of time over which a person can consider (and must sustain) their decision. For example, the time required for two doctors who are prepared to conduct independent assessments may be significant. Still, we consider that, as in Victoria and Western Australia, there should be a minimum time that must elapse between a person's first and final requests.

A waiting period of nine days between the person's first and final requests represents an appropriate balance between the need to ensure a decision is well considered and to avoid prolonging a person's suffering.

In some circumstances a period of nine days may be too long. The waiting period should be able to be reduced if the person is likely to die or lose decision-making capacity for voluntary assisted dying within that period (for instance because their condition deteriorates and pain treatment for it will result in a loss of capacity). To require a person likely to lose decision-making capacity to wait would unreasonably preclude them from access, and also mean that the person will continue to suffer for some time afterward if their death is not imminent.

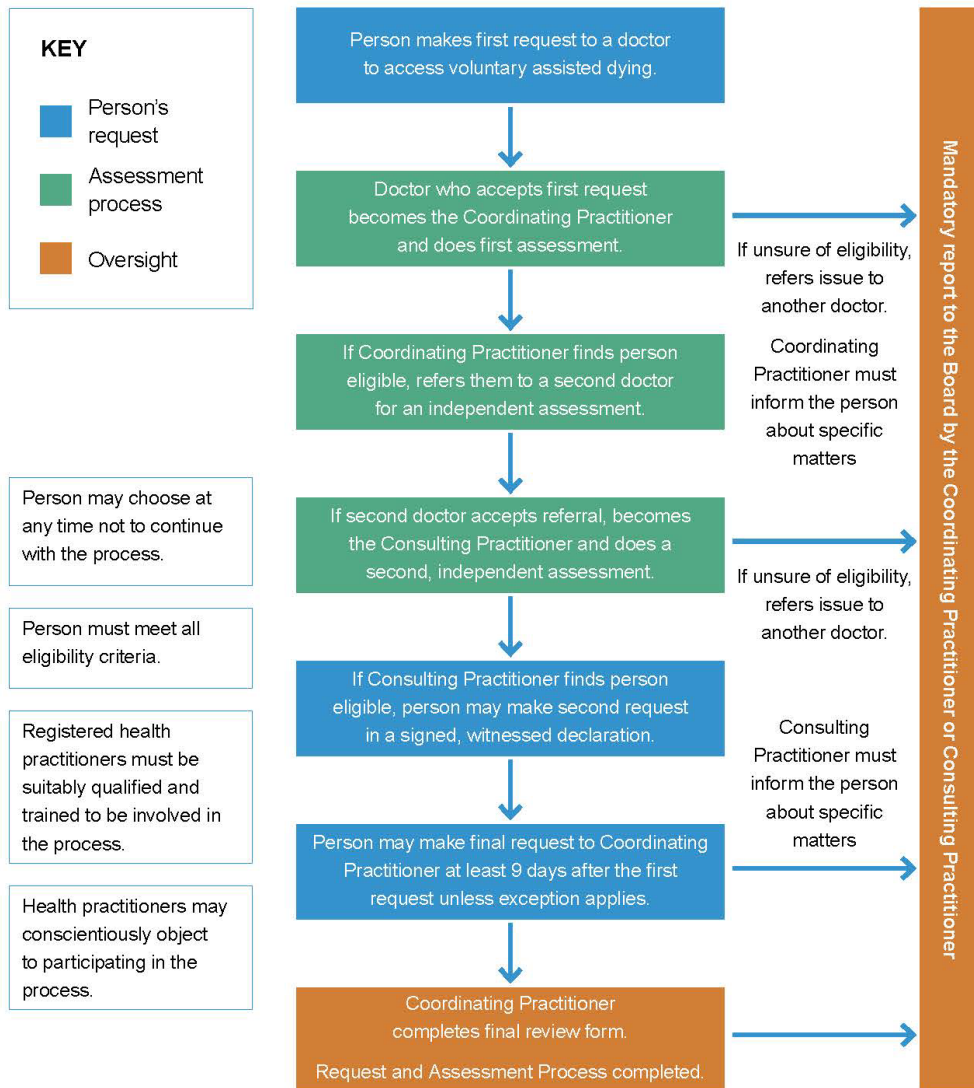
The law should make clear that participation in the process is voluntary and that a person may choose at any time not to continue with it. A person who has completed the request and assessment process and has been found eligible for access is not obliged to take any further step.

The draft Bill contains extensive reporting requirements for relevant practitioners to submit approved forms to the Review Board within a short period.

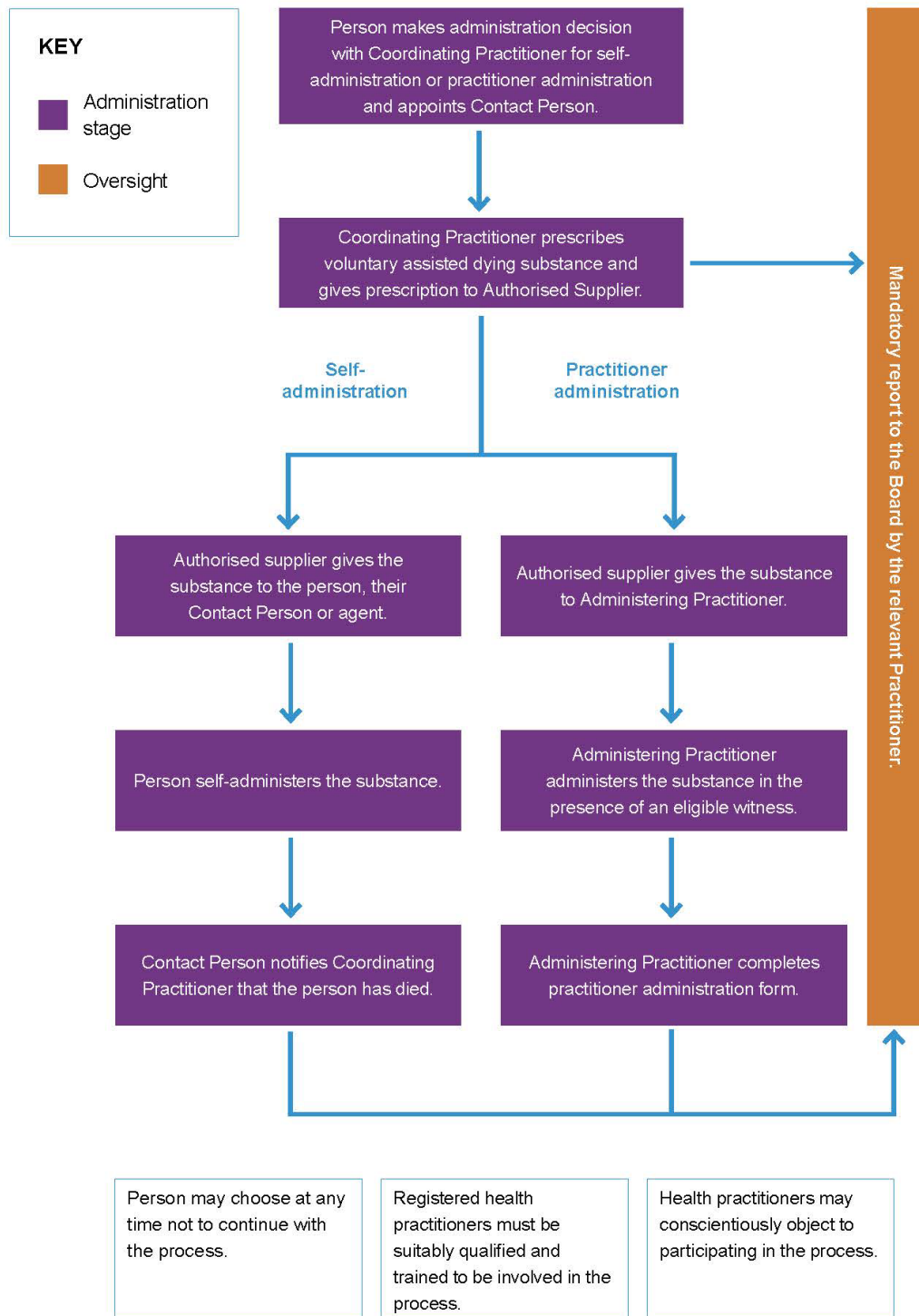
The proposed Request and Assessment Process is outlined in two diagrams at the start of this Report Summary. It is outlined in greater detail in the next diagram.

That diagram is followed by an overview of the administration stage of the process to which we now turn.

D.3 The proposed request and assessment process in detail



D.4 The proposed administration stage in detail



ADMINISTRATION OF THE SUBSTANCE

Chapter 10 concerns the final stage of the voluntary assisted dying process—the administration of the voluntary assisted dying substance. It considers what may follow the request and assessment process. We address:

- the choice between self-administration and practitioner administration;
- authorisation of the prescription, supply and administration of the substance; and
- requirements that must be met at the time of administration.

A person who is eligible, completes the request and assessment process, and wishes to proceed further, makes an 'administration decision'.

The options

The person may decide to take a voluntary assisted dying substance ('**self-administration**') or have a health practitioner administer it ('**practitioner administration**'). After that 'administration decision', the substance is prescribed and supplied.

To be clear: a health practitioner may be present with a person who self-administers, just as the person may choose to have a family member or friend present while they self-administer.

An important reason to offer the option to self-administer is to give autonomy to a patient at a time when the disease or illness from which they are dying is outside of their control.

As the aim of a voluntary assisted dying framework is to give individuals who are suffering and dying control over the timing of their death, self-administration should be the default method. The person chooses when the substance is administered, unaffected by any perceived need to meet the availability and timing of a busy health practitioner.

Self-administration has been described by the Victorian Panel as 'a powerful safeguard to ensure voluntary assisted dying is in fact voluntary'.

Laws and practices differ around the world. In Victoria, practitioner administration is allowed only if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance. In Western Australia and Tasmania, practitioner administration is permitted in broader circumstances, if self-administration is inappropriate. In the United States, self-administration is the required method. In other places, the person may choose either method.

Although in Canada persons can choose either, for historical reasons almost all cases are by practitioner administration.

In Victoria, 18 per cent of cases have been by practitioner administration.

There is a suggestion (largely based on a study of a limited number of cases in the 1990's) that practitioner administration is safer than self-administration. The evidence on that issue is discussed in Chapter 10. The findings of the study should be treated with caution. Reported complications from self-administration are few in number, and their nature are discussed in that chapter.

Different processes of administration are typically adopted as between self-administration and practitioner administration. In the case of self-administration, the person (or someone acting at their request if the person is unable to) prepares the substance, usually by mixing a powder and a liquid. However, the person must take the substance themselves. Not even a medical practitioner who is present may administer the substance to the person. Practitioner administration is usually by injection.

The proposed law on the choice between self-administration and practitioner administration

In recommending what any law in Queensland should be, our starting point is that a person should be able to make an informed decision about the method of administration best suited to them.

Self-administration should be the default method, as the act of self-administering the substance is itself another indication that the person is acting voluntarily. This option maximises the dying person's autonomy to control the timing and circumstances of their death.

The person should, however, be able to choose to have the substance administered to them if self-administration is inappropriate, subject to additional safeguards to ensure voluntariness. Practitioner administration should not be limited to where the person is physically incapable of self-administering or digesting the substance. It should be permitted in broader circumstances, and the relevant practitioner should have regard to the person's concerns about self-administering.

We adopt an approach similar to Western Australia. A practitioner administration decision may be made only if the coordinating practitioner advises the person that self-administration is inappropriate having regard to any of the following:

- the ability of the person to self-administer the substance;
- the person's concerns about self-administering the substance;
- the method for administering the substance that is suitable for the person.

This means that the person will discuss their wishes and concerns with the doctor and make an informed choice about the method of administration best suited to them. This approach maximises the person's autonomy, while also ensuring that the method of administration is clinically appropriate for the person.

Authorisation process

As with laws in other states, we propose controls to ensure that the prescription, supply and administration of a voluntary assisted dying substance is authorised only after the requirements of the request and assessment process have been complied with, and an administration decision has been made. At a later stage the person can change their administration decision, for example to request practitioner administration. The Victorian system, which requires an additional permit from a government department, is bureaucratic and causes additional delay. There are many other controls, noted in Chapters 10 and 11. We favour the Western Australian process which is more streamlined, while providing appropriate safeguards and clear guidance about the prescription, supply and administration of a voluntary assisted dying substance.

Requirements for self-administration

In Victoria, Western Australia and Tasmania, there is no requirement for the coordinating practitioner or another health practitioner to be present when the person self-administers. We also favour this approach.

If it is appropriate for the person to self-administer and this option is chosen, the person should be able to receive the substance and take it at a time of their choosing. A person ultimately may choose not to self-administer. For some people, simply having the substance available and in their control can reduce their suffering.

This approach maximises the dying person's autonomy to control the timing and circumstances of their death, including who is present.

Under the draft Bill, the presence of the coordinating practitioner or another health practitioner is neither required nor precluded.

This supports autonomy in choosing the time and circumstances of death. The person does not have to fit into a medical practitioner's availability and a scheduled time for self-administration.

We were also persuaded by respondents who submitted that a requirement for the practitioner to be present may cause difficulties in rural, regional and remote areas where the medical workforce is limited. Such a requirement would be a significant obstacle to access for voluntary assisted dying in many parts of Queensland.

The draft Bill also contains provisions to ensure the safe collection, storage, return and disposal of the voluntary assisted dying substance supplied for self-administration.

Requirements for practitioner administration

There should be additional requirements for practitioner administration to ensure the person is acting voluntarily and to provide transparency. The draft Bill provides that the 'administering practitioner' is authorised to administer the substance, in the presence of an eligible witness, if the administering practitioner is satisfied at the time of administration that:

- the person has decision-making capacity in relation to voluntary assisted dying; and
- the person is acting voluntarily and without coercion.

The administering practitioner must certify these things and give a copy of the form to the Board within two business days after administering the substance.

Requiring a witness for practitioner administration is an extra safeguard for the person and, in particular, the administering practitioner. At the same time, the witness requirements should not be so onerous that they create a barrier to access or are unduly obtrusive. A person is eligible to witness the administration if at least 18 years of age. The witness may be a family member of the person accessing voluntary assisted dying, another health practitioner or some other adult.

The witness is required to certify in the required form that the person appeared to be acting voluntarily and without coercion, and that the practitioner administered the substance in the presence of the witness.

The requirement to have an eligible witness present may intrude on a person's preference to die without anyone other than the practitioner present. Still, the witness may be someone they know well: a family member or a friend.

We should add that administering the substance is likely to be challenging, emotionally, for the administering practitioner, especially if they have been the patient's treating doctor for a long time. Experience suggests that an administering practitioner may appreciate the presence of another practitioner for emotional support. While that may mean that such a person may be perceived to be less independent to act as a witness than someone who is a total stranger to both patient and practitioner, such a person should not be ineligible to act as a witness. Their presence may be more welcome to the patient and their family than a stranger who is asked to act as a witness.

MANAGEMENT OF THE SUBSTANCE

Chapter 11 considers the best way to regulate the prescription, supply, storage, administration and disposal of the voluntary assisted dying substance. The draft Bill contains extensive provisions about those matters for the reasons given at length in that chapter. These include a requirement for a person to appoint a 'contact person'.

The draft Bill should support a person to self-administer, without requiring the coordinating practitioner or another health practitioner to be present, and ensure the voluntary assisted dying substance is managed safely. To enable this, the draft Bill provides for the appointment of a contact person where a self-administration decision has been made. This ensures a clear chain of responsibility for the substance once it has been supplied, and in particular, the safe return and disposal of any unused or remaining substance.

A key aspect of a contact person's role where a self-administration decision has been made is to return the voluntary assisted dying substance, or any unused or remaining substance, to an authorised disposer as soon as practicable or within 14 days of the person's death or decision not to self-administer.

A contact person should also act as a point of contact for the Board, assisting in its oversight and monitoring role.

We recommend that where a self-administration decision has been made and not revoked, the contact person must inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or some other cause. Where a practitioner administration decision has been made and not revoked, the contact person must inform the coordinating practitioner if the person dies from a cause other than practitioner administration of the substance.

NOTIFICATION AND CERTIFICATION OF DEATH

The death of a person as a result of accessing voluntary assisted dying raises questions about how the death should be recorded and registered with the Registry of Births, Deaths and Marriages. It is also necessary to determine how the Voluntary Assisted Dying Review Board will be notified of the death.

Respect for privacy of the deceased person's family, as well as ensuring accurate and consistent reporting of the cause of death are important considerations.

Chapter 12 of the report gives an overview of the death notification, registration and certification process. It considers how a death through access to voluntary assisted dying is recorded, the potential impact on insurance and superannuation contracts, and other policy implications.

Its recommendations about the contents of medical certificates of cause of death are consistent with the general principle contained in the draft Bill that a person who dies as a result of administration of a voluntary assisted dying substance in accordance with the legislation:

- does not die by suicide; and
- is taken to have died from the disease, illness or medical condition from which they were dying and which made them eligible to access voluntary assisted dying.

HEALTH PRACTITIONERS' QUALIFICATIONS AND TRAINING

Chapter 13 addresses the minimum qualifications, experience and training required for health practitioners to perform particular roles. It backgrounds the regulation and experience of registered health practitioners. The chapter then addresses the requirements for the coordinating practitioner and the consulting practitioner who must assess the person's eligibility for access to voluntary assisted dying. It also considers the requirements for health practitioners to be authorised to administer a voluntary assisted dying substance in the role of administering practitioner.

Given the nature of voluntary assisted dying, inexperienced practitioners should not be eligible for any of those roles. Practitioners should meet specified eligibility requirements.

In addition to minimum qualification and experience requirements stated in the draft Bill, to perform the relevant role the practitioner must also meet requirements approved by the chief executive of the Department of Health.

The Commission's recommendations seek to ensure that practitioners who undertake eligibility assessments have appropriate skills and qualifications, and that these requirements do not act as a barrier to access voluntary assisted dying.

The doctors who have the minimum qualifications to perform these roles will typically have spent many years in practice, gaining experience in end of life care.

The draft Bill also provides that, the practitioner must not begin an eligibility assessment unless they have completed approved training about voluntary assisted dying.

It would be an unnecessary barrier to a dying person's access to the scheme to require practitioners who undertake eligibility assessments, in addition to having the required qualifications and experience, to be a specialist practitioner in a specific disease, illness or medical condition. For example, a highly experienced doctor who has spent several years in specialist training in hospitals to be an oncologist or a highly experienced doctor who has treated many patients dying of cancer over the years, should be eligible to act if they meet all the requirements.

If a coordinating practitioner or consulting practitioner is unable to determine a specific matter related to eligibility, they must refer the matter to another practitioner for determination. This might be the case if a coordinating practitioner or consulting practitioner is unsure about the expected period before the person dies from a certain cancer. They can refer that matter to an oncology specialist to determine.

This balances the need for practitioners to meet specified minimum qualification and experience requirements, and the need for access.

Requiring the coordinating practitioner or consulting practitioner to be a specialist in a specific disease could be a barrier to access the scheme, particularly in regional and remote areas of Queensland. Instead, the opinion of a specialist in a specific field can be sought. This is also consistent with good medical practice.

The draft Bill provides that to act as a coordinating practitioner or consulting practitioner a medical practitioner must:

- hold specialist registration and have practised for:
 - at least one year as the holder of that registration; or
 - at least five years as the holder of general registration; or
- hold general registration and have practised for: at least five years as the holder of that registration; or
- be an overseas-trained specialist who holds limited registration or provisional registration.

To have the last form of registration, an overseas-trained specialist must be enrolled in a specialist pathway. They must also meet the medical practitioner requirements approved by the chief executive of the Department. Those requirements ensure that any overseas-trained specialist has the necessary knowledge, clinical skills and professional attributes to perform the role. This form of registration facilitates having suitably qualified specialists in areas of need in regional, rural and remote areas.

To qualify on any of the above bases, the medical practitioners probably will have practised for several years before attaining the registration.

The expertise and experience required at the administration stage is different. The administering practitioner, unlike the assessing practitioner, does not have to assess that the person has an eligible disease, or the expected timeframe until death.

The draft Bill provides that to act as an administering practitioner the person must be:

- a medical practitioner who is eligible to act as a coordinating practitioner; or
- a nurse practitioner who meets the approved nurse practitioner requirements; or
- a registered nurse who has practised in that profession for at least five years and meets the approved nurse requirements.

Administering practitioners must also meet any additional requirements approved for this purpose by the chief executive of the Department of Health and complete the approved training. These additional requirements will ensure that nurse practitioners and registered nurses who participate in the administration of substances will have relevant and current experience and expertise.

The draft Bill states the *minimum* qualifications and experience a practitioner must have. If experience in Victoria is a guide, the practitioners who qualify and who are prepared to undertake the specific training to participate in the voluntary assisted dying process are likely to have experience well in excess of the minimum required. They may be specialists in general practice or other fields where the scope of their practice brings them into contact with people who are dying. They may be experienced doctors who have been working for years in hospitals in areas like oncology, acute care of patients with chronic obstructive pulmonary disease, or in palliative care. They may be nurse practitioners with years of experience as registered nurses in similar fields before they became nurse practitioners. These doctors and nurses will have developed the clinical skills and the experience to deal compassionately and professionally with individuals who are suffering and dying.

They will have the clinical skills and experience to conduct assessments or administer substances (as the case may be). These doctors and nurses will have a professional interest in end of life care. They will also have to undertake specific training about voluntary assisted dying.

PARTICIPATION BY INDIVIDUALS AND CONSCIENTIOUS OBJECTION

Access to voluntary assisted dying depends on access to information and to suitably qualified persons to provide advice, conduct assessments and administer substances.

For various reasons, individuals may be unable or unwilling to participate in one or more of these ways. For example, a health practitioner will not be able to be an assessing practitioner if they do not hold the required qualifications or if they have not completed the required voluntary assisted dying training. Some health practitioners will be qualified and willing to participate, but at times be unavailable or not have the time to deal with a request for advice or services related to voluntary assisted dying.

The unwillingness of a health practitioner to participate may be for personal reasons and be a conscientious objection. Generally, a conscientious objection is constituted by a refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner's personal beliefs, values or moral concerns.⁶⁴ A variety of concerns may found a

conscientious objection by a practitioner to voluntary assisted dying. They include secular or professional reasons.⁶⁵

Chapter 14 discusses:

- whether the draft Bill should provide for conscientious objection by a health practitioner or other individual to voluntary assisted dying;
- the scope of any conscientious objection provision;
- whether any right of a health practitioner to conscientiously object should be coupled with a requirement:
 - to inform the person of their objection; and
 - to refer the person elsewhere, or to transfer the person's care.

We propose that the draft Bill address those issues as follows.

Subject to a requirement to inform a patient of certain things, a registered health practitioner who has a conscientious objection to voluntary assisted dying should have the right to refuse to do any of the following:

- provide information about voluntary assisted dying;
- participate in the request and assessment process;
- participate in an administration decision;
- prescribe, supply, or administer a voluntary assisted dying substance; or
- be present at the time of the administration of a voluntary assisted dying substance

A practitioner who refuses to do one of those things should be required:

- to inform the person that other health practitioners, health service providers or services may be able to assist them; and
- to provide the person with:
 - information about a health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to provide the requested assistance; or
 - the details of an official voluntary assisted dying care navigator service which is able to provide the person with information, including the name and contact details of a health practitioner, health service provider or service who may be able to assist.

This does not necessarily require the health practitioner who has a conscientious objection to give the person information about another health practitioner, health service provider or service, or to refer the person to another practitioner. In some circumstances, the health practitioner who has a conscientious objection will find it convenient to give the person information about another practitioner, perhaps one

who practises in the same or a nearby clinic. In other circumstances, the requirement will be satisfied by giving the person the details of an official voluntary assisted dying care navigator service.

There should be similar rights to refuse to participate and similar requirements to inform for speech pathologists, who are not registered health practitioners. Those provisions should recognise the role speech pathologists typically play in facilitating communication between a health practitioner and a patient, and the fact that they are likely to be employed or engaged by a health service, rather than the patient.

PARTICIPATION BY ENTITIES

Access to voluntary assisted dying depends on the extent to which entities allow access to information and services. For a variety of reasons, entities may choose not to provide access to voluntary assisted dying. Their reasons may be pragmatic, based on the non-availability of qualified staff who are prepared to provide assessments or administer substances. The decision may be based on an objection in principle to providing or promoting voluntary assisted dying. This kind of objection is sometimes styled 'institutional conscientious objection'.

This gives rise to a potential conflict between, and a need to reconcile, competing rights and interests. On the one hand, there are the rights of individuals to access information about voluntary assisted dying, request it if they choose, then engage in the assessment process and, finally, if eligible, to administer the substance. On the other hand, there are the rights and interests of entities to not provide services they do not wish to provide and to not facilitate their provision by others.

One approach to the conflict, which prioritises individual autonomy and the public interest in practical access to voluntary assisted dying as an end of life option, is to prevent an entity from banning entry to its facility of any health practitioner for the purpose of discussing voluntary assisted dying with a person, assessing eligibility or administering the substance, or to prevent an entity from prohibiting a person from self-administering the substance on its premises.

Another approach, which places pre-eminence on the rights of entities to not provide or otherwise promote voluntary assisted dying, would be to permit institutional objections without qualification. This would extend to not even requiring such entities to refer an individual to a service, entity or practitioner where they might obtain information about voluntary assisted dying.

Between these extremes are forms of regulation that seek to accommodate the competing rights and interests. The most appropriate form of regulation depends on consideration of the competing interests, and the context in which the issue arises.

In Chapter 15 we first discuss these issues of principle in general terms. However, the circumstances of individuals and entities differ widely. For example, some individuals will reside at a place and be in a physical condition where they are free to choose between entities that provide voluntary assisted dying and those which do not. They will be able to move to a facility that offers access to voluntary assisted dying and do so without any great detriment or inconvenience. Other individuals, however, may be close to death and in great pain, and be at a certain facility out of necessity. In such circumstances, being required to transfer to a different hospital, hospice or other institution, if a place is available there, may subject them to pain and distress, and deny them, in a practical sense, access to voluntary assisted dying.

The circumstances of entities also differ. They range from public hospitals, private hospitals and hospices operated by private entities, to long-term care facilities such as nursing homes and residential aged care facilities. For some individuals, these places will be their home. Statutory regulation or contract may provide these individuals with security of tenure. An insistence by the entity which operates such a facility that the individual go elsewhere to access advice and assistance would require

that individual to leave their home and to attempt to find a new home when they may be in an extremely vulnerable state. Depending on the circumstances, insisting that the person go elsewhere in the final stages of life may be inconsistent with the person's legal right of residence at the facility.

The term 'entity' is used in Chapter 15 to refer to a non-natural person, typically a corporation or a body given legal status. The entity may provide a health service, residential aged care or personal care service for reward (such as assistance with mobility or taking medicine), or own a facility at which such services are provided. The position of such a 'non-natural person' is different to a natural person, for example, a doctor who owes professional and ethical duties. Those duties and the individual right to refuse to do certain things on the grounds of a conscientious objection are addressed in Chapter 14.

Chapter 15 relates to the rights and interests of a different kind of individual, namely a patient or resident, and the rights and interests of such an entity.

Our approach is to create processes by which certain rights and interests are assumed and reasonably accommodated. The draft Bill accommodates the rights and interests of individuals to access a scheme that is lawful and the rights and interests of an entity to not provide voluntary assisted dying at its facility.

In devising processes, it is appropriate to have different rules for different stages. For example, different considerations apply to receiving information (which the patient or resident requests but which the entity does not provide) to being assessed (assuming the entity does not provide access to the request and assessment process at the facility). Different considerations apply if the person is requesting access to a coordinating practitioner when the person is in a private hospital to when they are in their own home, such as an aged care facility in which they have security of tenure.

In general terms, the processes to accommodate a patient's or a resident's right to access a lawful end of life option and the entity's right to not provide that option at its facility involves either the entity taking reasonable steps to facilitate a transfer to a place outside the facility or allowing reasonable access to a qualified registered health practitioner who is willing to attend if a transfer would not be reasonable in the circumstances.

For example, if a person is not a permanent resident at the facility and the entity does not provide access to the request and assessment process at its facility, it must:

- take reasonable steps to facilitate the transfer of the person to a place outside the entity's facility for the purpose of undergoing an eligibility assessment and, if requested, facilitate the return of the person to the facility after the assessment is completed; or
- allow access to the facility by the coordinating practitioner to conduct the assessment when transfer to a place outside the facility for the purpose of assessment would not be reasonable.

In determining whether it is reasonable for the person to be transferred to a place outside the entity's facility for an eligibility assessment, regard must be had to whether or not:

- the transfer would be likely to cause serious harm to the person, for example, significant pain or a significant deterioration in the person's condition;
- the person's access to voluntary assisted dying might be adversely affected by the transfer, for example, because the transfer would be likely to result in a loss of capacity, or because the transfer would require pain relief or other medication that would affect the person's decision-making capacity for voluntary assisted dying;
- the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

- no alternative place is reasonably available, for example, because another facility within a reasonable distance does not have a suitable place to which to admit the person or cannot provide the level of care required by the person for the relevant period;
- the person would incur financial loss or costs because of the proposed transfer.

We favour a legislative approach to clarifying the rights of individuals and entities when an entity chooses not to provide or facilitate voluntary assisted dying. The benefit of legislation, supported by more detailed regulations and policy statements, is that it informs individuals and entities of the basic ground rules by which their respective rights and interests are reconciled and the process which applies.

REVIEW OF CERTAIN DECISIONS BY QCAT

Chapter 16 considers whether there should be a right of review to the Queensland Civil and Administrative Tribunal ('QCAT') for certain decisions about a person's eligibility.

Any review mechanism should be timely and accessible, with appropriate limits to minimise unnecessary distress and delay.

The draft Bill includes QCAT review for certain non-clinical decisions made by a coordinating practitioner or consulting practitioner in the request and assessment process. To leave every decision of an assessing practitioner open to review by the tribunal would add an unnecessary layer of complexity to the process and cause uncertainty and delay.

Tribunal review of a practitioner's non-clinical decisions should not be a routine part of the request and assessment process.

Decisions that should be reviewable

The eligibility criteria that are assessed by the practitioner involve varying degrees of judgment and questions of fact. Some are more appropriate for review than others. We address each and conclude that the law should enable an eligible person to apply to QCAT for review of a decision of the coordinating practitioner (in a first assessment or in a final review) or of a consulting practitioner (in a consulting assessment) that the person:

- was—or was not—**ordinarily resident in Australia** for at least three years immediately before making the first request;
- was—or was not—**ordinarily resident in Queensland** for at least 12 months immediately before the person makes the first request;
- has—or does not have—**decision-making capacity** in relation to voluntary assisted dying; or
- is—or is not—**acting voluntarily and without coercion**.

We considered whether a decision of an administering practitioner about whether the requesting person meets the requirements for practitioner administration should also fall within the scope of the review mechanism. The purpose and character of the administration stage of the process differs from the request and assessment stage. The administering practitioner must be satisfied of the relevant matters at the point in time immediately before administering the substance. A person's capacity may fluctuate or diminish. Therefore, substituting a decision of the tribunal for that of an administering practitioner would be problematic.

Neither the Victorian nor Western Australian legislation extends tribunal review to decisions of the administering practitioner. Those Acts similarly require the administering practitioner to be satisfied of the relevant matters at the time of administration. For reasons given in Chapter 16, it is neither necessary nor desirable for the QCAT review mechanism to apply to decisions of an administering practitioner.

Who may apply for review

The review mechanism should not become a means of unjustified interference or delay. The range of potential applicants should be kept small. The draft Bill provides that an application for review may be made by the person who is the subject of the decision; an agent of the person; or 'any other person who has a sufficient and genuine interest in the rights and interests of the person in relation to voluntary assisted dying'. In addition to the person making the request, there may also be a small number of other persons who have a direct, relevant and genuine interest in upholding the requesting person's rights and interests. The third category of applicant should be confined to those persons who have a special interest. They might include, for example, another member of the person's health care team, a spouse or other close family member, or carer.

As in other jurisdictions, simply being a member of the person's family will not, by itself, entitle a person to bring an application. Whether a family member, health practitioner or other person has a sufficient and genuine interest that meets the test will depend on the individual circumstances and the decision of the tribunal.

Other matters

Chapter 16 also addresses many procedural aspects, such as the short time within which a review application must be made, the effect of an application, what the tribunal may decide and the effect of its decisions. Because of the seriousness of the subject matter, the tribunal should be constituted by at least one legally qualified member, and one would expect the President of QCAT to constitute a tribunal hearing a challenge to a decision about decision-making capacity with a tribunal member with experience in that field. Hearings should be in private.

QCAT should be given the additional resources that are needed to ensure the effective operation of the proposed new review jurisdiction.

COMPLIANCE AND PROTECTION FROM LIABILITY

We had regard to compliance monitoring and 'appropriate safeguards and protections, including for treating health practitioners'. Chapter 17 considers criminal offences for specified conduct, protections from liability, and notifications of concerns to the Health Ombudsman.

Our general approach to compliance and enforcement under the draft Bill recognises that health practitioners are subject to a comprehensive legal, regulatory and ethical framework and that there are existing mechanisms to deal with concerns about health practitioners' conduct. The recommended Voluntary Assisted Dying Review Board would refer identified issues to appropriate agencies for investigation or follow up. The Board is not intended to have a dispute resolution or enforcement role.

We also recognise that, if enacted, voluntary assisted dying legislation will introduce significant changes to the current law. This will necessitate adjustments to the criminal law to deal with conduct that is authorised by the voluntary assisted dying law. It will also require protections from liability for certain persons who act in good faith and without negligence under the new legislative framework.

Finally, the creation of specific offences in the draft legislation does not affect the operation of existing criminal laws for conduct which is not protected. Therefore, individuals who act outside the legal framework for voluntary assisted dying will still be subject to homicide and other laws.

AN OVERSIGHT BODY: THE VOLUNTARY ASSISTED DYING REVIEW BOARD

We were asked to consider ‘appropriate safeguards’ and ‘ways in which compliance with the Act can be monitored’. An oversight body is essential to achieving these objectives.

Chapter 18 deals with the establishment, functions and powers of an oversight body to support the safe, practical and transparent operation of the voluntary assisted dying scheme.

The need for an oversight body in a voluntary assisted dying framework is uncontroversial. Instead, the issues to be determined surround its establishment, membership, functions and powers, reporting requirements and procedural aspects.

We consider that the best approach is to establish a Voluntary Assisted Dying Review Board as an independent statutory board under the legislation. This has the advantage of flexibility, independence, and delivering a robust oversight mechanism as part of an integrated legislative framework.

We recommend that the Board be constituted by at least five but no more than nine members (including the chairperson) with an appropriate mix of expertise and experience.

The Board’s functions will likely be wide-ranging, but should focus on monitoring, reporting, and advising on voluntary assisted dying. We recommend that the Board’s functions should include:

- **monitoring** the Act’s operation;
- **reviewing** completed cases retrospectively;
- **referring** relevant matters to entities such as the Commissioner of Police, the State Coroner, and the Health Ombudsman;
- **recording** and **keeping** information about requests for, and provision of, voluntary assisted dying; **analysing** this information; and **researching** matters related to the Act;
- **providing information, reports and advice** to the Minister or chief executive of the Department about the operation of the Act, the Board’s functions, or the improvement of the processes and safeguards;
- **annual reporting** obligations; and
- **promoting compliance** with the Act; **promoting continuous improvements** of the Act; and **consulting and engaging** with the community and other entities.

The Board should have all the powers necessary to perform its functions.

OTHER MATTERS INCLUDING A FUTURE REVIEW

Chapter 19 deals with various matters including the accreditation and qualifications of interpreters. It discusses technical legal issues about the making of regulations and prescribed forms. It also proposes that the effectiveness of any legislation that is enacted be reviewed after it operates for three years.

COMMONWEALTH LAWS THAT IMPEDE ACCESS

Access to information and advice about voluntary assisted dying is critical to the operation of any scheme.

Chapter 20 addresses in detail the uncertain possible application of Commonwealth 'carriage service' offences to conduct that is authorised by state voluntary assisted dying laws. This uncertainty is unsatisfactory. It led to the then Victorian Health Minister instructing doctors and other practitioners involved in voluntary assisted dying services to conduct all discussions, consultations and assessment face-to-face, so as to avoid potentially breaching the Commonwealth law.

As noted, the Victorian Board has made repeated calls for the Commonwealth to make an exemption to allow Victorians, especially those in regional Victoria, to be able to have 'important conversations about voluntary assisted dying over the phone or via teleconference'.

In general, it is preferable for all requests for, and provision of, information and advice about voluntary assisted dying to occur in face-to-face personal communications between the health practitioner and their patient. However, this may not be possible because of the location of the person and their inability to travel possibly long distances to consult a health practitioner or the inability of the health practitioner to travel to speak to them in person. In such cases, information may need to be given by telephone, video link, email or some other form of electronic communication.

The need to use those forms of communication to request, and provide, information and advice will be greatest when the patient lives in a remote location. Without access to those forms of communication, persons living in remote and regional parts of the state may have greatly impaired access to voluntary assisted dying.

The uncertain application of the Commonwealth law particularly affects individuals who are suffering and dying in remote and regional areas.

The Commonwealth law was enacted before voluntary assisted dying laws were introduced in different states. Therefore it is doubtful that a death that is authorised by such a state law is 'suicide' within the meaning of the Commonwealth law. The Commonwealth Parliament cannot be said to have intended that because the state laws did not exist at the time.

The report recommends that Queensland and other states with voluntary assisted dying laws raise the issue of legal uncertainty at forums with senior members of the Commonwealth Government with a view to the Criminal Code (Cth) being amended and clarified. The effect of the amendments would be that the term 'suicide' in the relevant Commonwealth provisions does not apply to a death that is assisted in accordance with state or territory voluntary assisted dying laws.

We also recommend, as an interim measure, that the Commonwealth Director of Public Prosecutions be asked to consider issuing prosecutorial charging guidelines. The risk of prosecution would be removed by a guideline that the Commonwealth offences will not be prosecuted where a health practitioner or other person is acting in accordance with a procedure that is authorised under state voluntary assisted dying laws.

IMPLEMENTATION

Effective implementation is essential for a compassionate, safe and practical voluntary assisted dying legal framework. For example, the Voluntary Assisted Dying Review Board in Victoria noted the work involved in translating:⁶⁶

the complex Voluntary Assisted Dying Act into forms that are easy to understand and processes that are easy to follow for both patients and doctors, but still rigorous enough to reassure the wider community.

The Parliamentary Committee observed that Queensland is well placed to learn from the implementation experiences of Victoria and Western Australia, including ‘the extent and types of material needed to guide both community members and medical practitioners’.⁶⁷ However, as noted by the Western Australian Panel:⁶⁸

the uniqueness of Western Australia in its geography and great diversity of cultures and languages will present its own challenges for implementation and as such the Victorian process cannot be followed indiscriminately.

Any implementation process must be fit for purpose for Queensland’s geographic, cultural and health care environment.

Queensland is the second largest state in Australia after Western Australia, covering over 1.7 million square kilometres. More than half of Queensland’s population lives outside the greater metropolitan area of Brisbane—a large proportion compared with the rest of highly urbanised Australia.

In the 2016 Census, Aboriginal and Torres Strait Islander people made up four per cent of the population. As at 2016, 21.6 per cent of Queensland’s population was born overseas and 11.2 per cent of Queenslanders spoke a language other than English at home.

While some elements are the same, the legislative framework proposed by the draft Bill differs from that in Victoria and Western Australia. Even provisions that are very similar to those in other States will need to work in practice. They must be tailored to suit Queensland’s unique demographics and geography.

To facilitate the efficient and effective implementation of voluntary assisted dying legislation, new bodies will need to be created. They should be established well before the commencement of provisions that permit access to voluntary assisted dying. They include:

- the Voluntary Assisted Dying Review Board;
- a Statewide Care Navigator Service; and
- a Statewide Pharmacy Service.

As noted, the **Voluntary Assisted Dying Review Board** will have functions of monitoring, review and referral, data collection and research, reporting and advice, and community engagement.

The **Care Navigator Service** is essential. The inherent complexities of any voluntary assisted dying framework require a dedicated body to help people who are at the end of life to navigate the process. The body will also support practitioners and service providers (such as interpreters) to meet the challenges of participating in the process.

The care navigator service should be established under the umbrella of Queensland Health as early as possible as part of the implementation process to ensure the timely engagement and training of skilled and culturally competent navigators and the development of information and other resources. Its staff will include compassionate and skilled nurses and social workers.

67 Qld Parliamentary Committee Report No 34 (2020) 149.

68 WA Ministerial Expert Panel Final Report (2019) 102.

The service should be properly resourced to provide services in rural and regional areas. That will help ensure access to the scheme by all Queenslanders.

Without a well-resourced care navigator service, any scheme of voluntary assisted dying in Queensland is unlikely to work as envisaged.

A **Statewide Pharmacy Service** would facilitate the supply of the voluntary assisted dying substance across Queensland. It also would provide a central source of information about those substances for people accessing voluntary assisted dying, as well as for their loved ones and medical practitioners. Queensland's size and population distribution will need to be considered in establishing the service.

In addition to these crucial bodies, **policies, training, guidelines and educational materials** will need to be developed to ensure health practitioners are suitably trained, and information about the scheme, eligibility and how to access it is readily available across Queensland.

A critical element for the practical operation of any scheme is **Information and Communications Technology** ('ICT').

A dedicated, well-designed and tested ICT system that supports the voluntary assisted dying scheme is essential to its operation in Queensland. It should work efficiently from the time the scheme begins to operate and busy health practitioners are required to access it, with the need for only minor refinements as the scheme continues. The primary purpose of the ICT system is to enable the submission of relevant forms to the Board at the various stages of the voluntary assisted dying process.

A dedicated ICT system is needed that can be used easily by practitioners to comply with time-sensitive processes that require relevant documentation to be submitted to the Board. The system will enable the coordinating practitioner, the Board and other relevant entities to track a person's progress through the voluntary assisted dying process.

A robust, user-friendly ICT system, with ongoing technical support to address issues with the system as they arise, should be developed to ensure the submission of forms required by the legislation and that the scheme operates efficiently from its inception.

If not, the process will become unworkable, and practitioners who might otherwise have been willing to participate in it will not do so. The process will be delayed and protracted. In some cases, unnecessary delay in being able to submit forms through a dedicated portal and to proceed further through the process will result in persons dying or losing capacity before they can access voluntary assisted dying.

The experience of other States demonstrates the importance of allowing enough time to establish effective bodies, an ICT system and processes, to train people to understand the inherent complexities of the system, and to then make the system work safely, compassionately and efficiently in practice. It is possible to learn from Victoria and Western Australia about the many things that need to be completed during the implementation period. Those lessons are useful but do not significantly reduce the time needed to implement a new system in Queensland.

We are conscious of concerns about delay in implementation—that individuals will miss out on accessing voluntary assisted dying because, for them, it comes too late.

Based on all that needs to be done, its complexity, and the experience of other States, an implementation period of at least 18 months would be appropriate.

The implementation period depends on the date when any legislation is passed and what is done by Queensland Health before then in anticipation of its passage.

Irrespective of the implementation period and the date from which it is measured (eg the provision of this report, introduction of legislation, passage of legislation), the implementation process will be a challenging one.

It will require the dedication of people and resources to overcome the challenges of implementing a scheme in Queensland's unique conditions.

