A legal framework for voluntary assisted dying

REPORT NO 79
MAY 2021

Queensland
Law Reform Commission

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To: The Honourable Shannon Fentiman MP
Attorney-General and Minister for Justice
Minister for Women and
Minister for the Prevention of Domestic and Family Violence

In accordance with section 15 of the *Law Reform Commission Act 1968*, the Commission is pleased to present its Report, *A legal framework for voluntary assisted dying.*

The Hon Justice Peter Applegarth AM
Chairperson

The Hon A/Justice Anthony Rafter SC
Member

Ms Penelope White
Member

Mr Mark Hinson QC
Member

Ms Clare Endicott
Member

The Report's Essence

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.

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 docto**r 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 it clear that VAD is an option only for those who are at the end of life. The VAD 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 dispensed 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 VAD.

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 VAD 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.

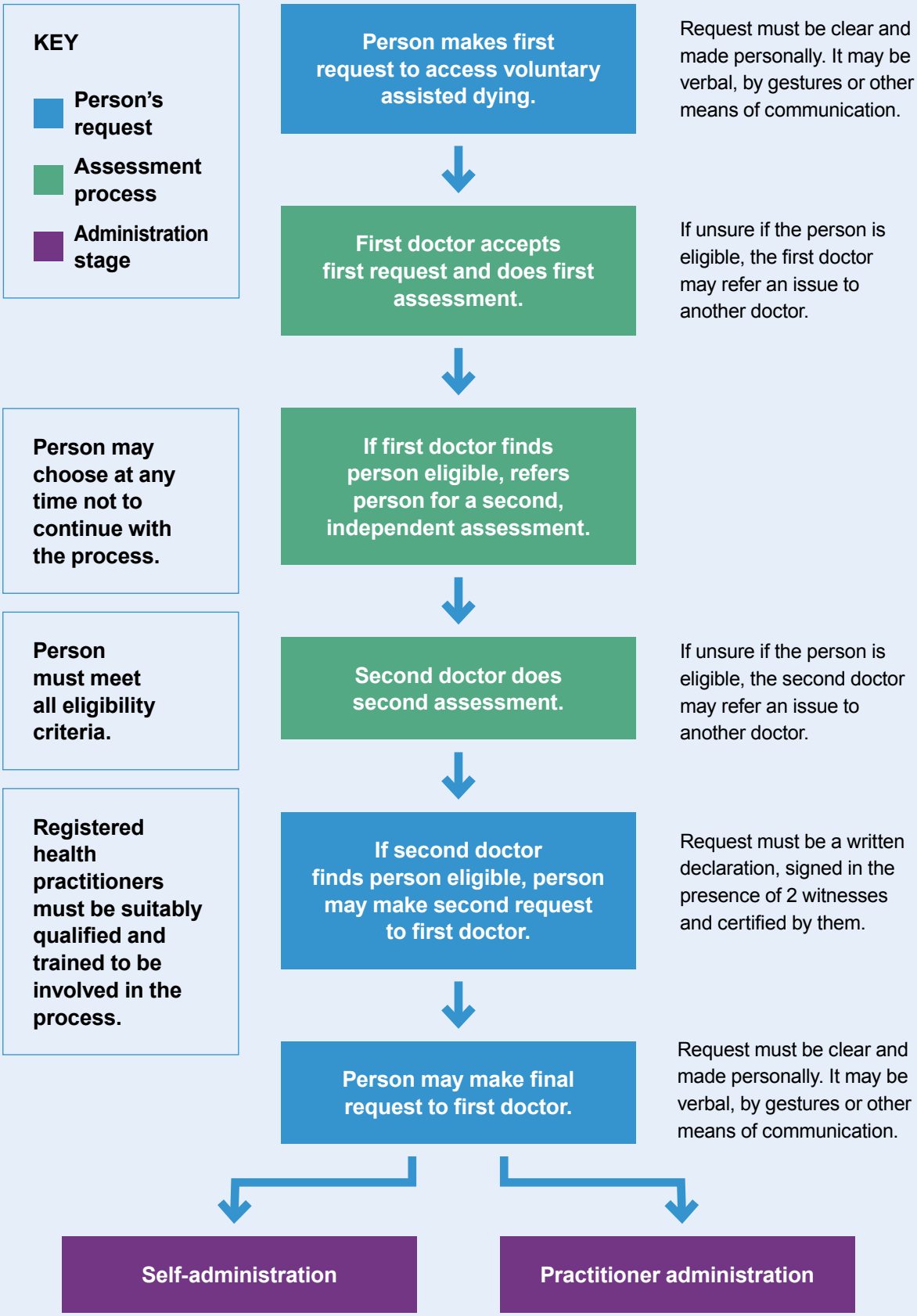
The Commission was asked to recommend '**the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland**' should voluntary assisted dying become law in this State.

This report details the principles on which the Bill is based, VAD 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**.

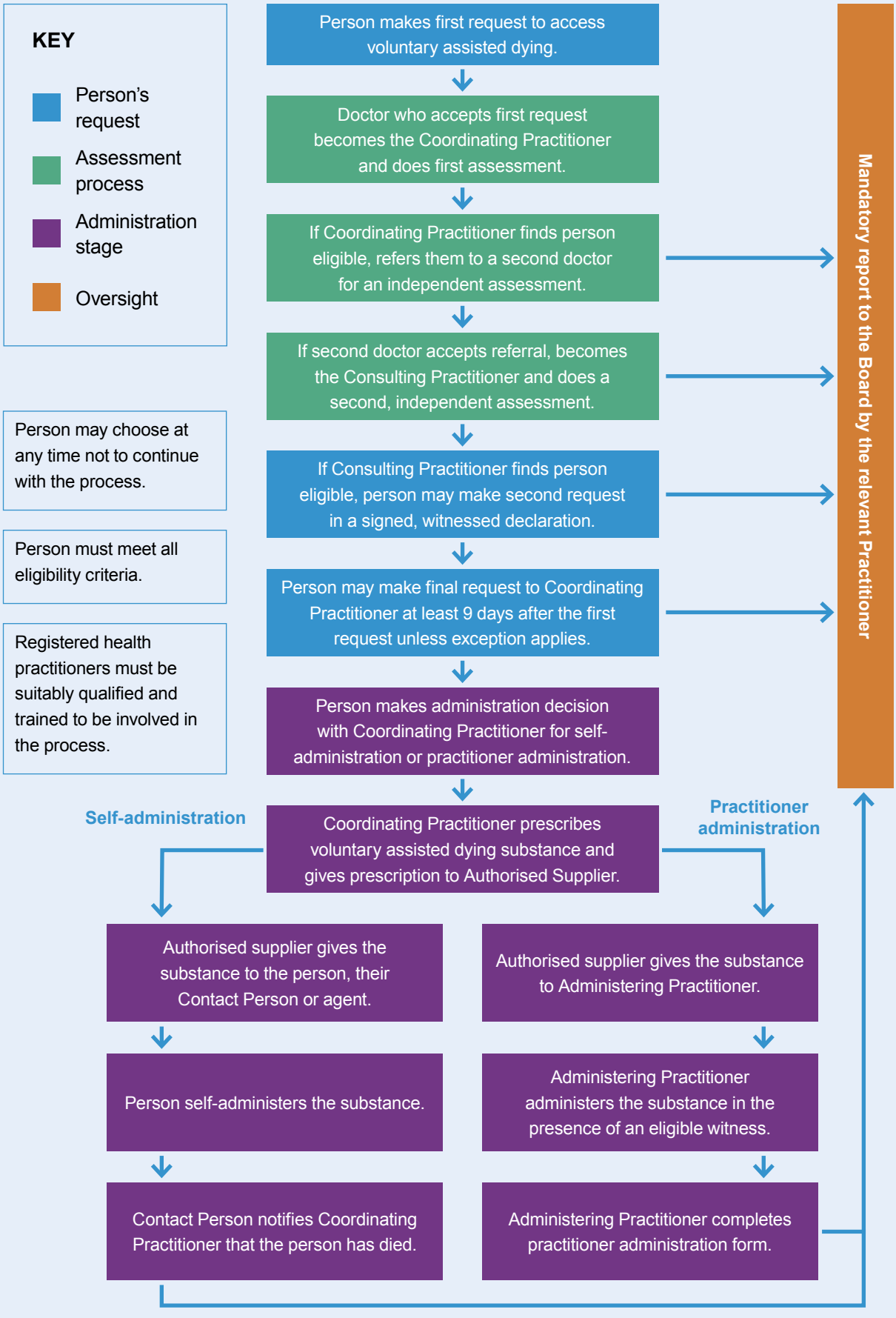
The process it recommends appears on the following diagrams.

The proposed process



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

The proposed process in detail



Preface

The Queensland Law Reform Commission is an independent statutory body that undertakes law reform reviews referred to it by the Attorney-General.[1] 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 and is supported by a small Secretariat.

TERMS OF REFERENCE

On 21 May 2020, the Commission received terms of reference to develop 'an appropriate legislative scheme for voluntary assisted dying' and 'to prepare draft voluntary assisted dying legislation to give effect to its recommendations'.[2] The terms of reference provide:

> **Scope**
>
> The provision of compassionate, high quality and accessible palliative care for persons at their end of life is a fundamental right for the Queensland community.
>
> The Queensland Law Reform Commission is asked to make recommendations about an appropriate voluntary assisted dying scheme and to prepare draft voluntary assisted dying legislation to give effect to its recommendations, with particular regard to:
>
> 1. the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland;
> 2. identifying who can access voluntary assisted dying;
> 3. process for access to voluntary assisted dying to be initiated, granted or denied;
> 4. the legal and ethical obligations of treating health practitioners;
> 5. appropriate safeguards and protections, including for treating health practitioners;
> 6. ways in which compliance with the Act can be monitored;
> 7. timeframes for implementation of a scheme in Queensland, if progressed.

In preparing draft legislation, we had to consider:

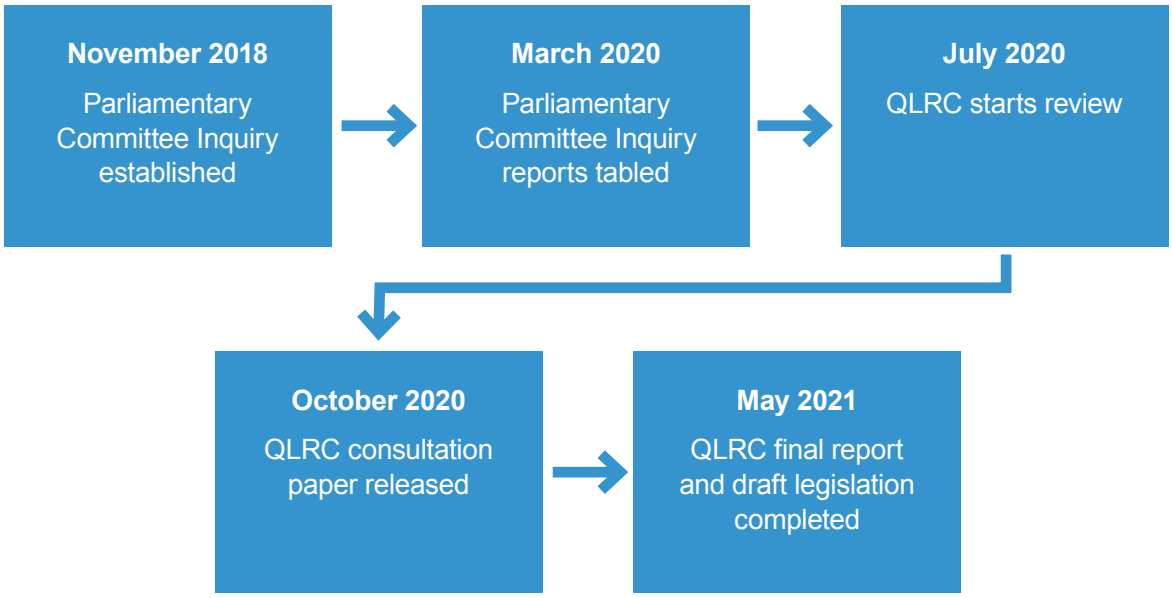
> A. The Parliamentary Committee's Report No 34, *Voluntary assisted dying*, including the draft legislation in Appendix A of the Report (VAD Report) and Information Paper No 5, *Summary of the findings and recommendations from Report No 34 on Voluntary assisted dying* (Information Paper No 5);
>
> B. The Parliamentary Committee's Report No 33, *Aged care, end-of-life and palliative care* (AEP Report);
>
> C. Consultation with stakeholders and the community that occurred during the Parliamentary Committee's consideration of the matter;
>
> D. Views of experienced health and legal practitioners;
>
> E. Views of the Queensland public;
>
> F. Legislative and regulatory arrangements in other Australian and international jurisdictions.

1 *Law Reform Commission Act 1968* (Qld) s 10(3)(b), (e).

2 The full terms of reference are set out in Appendix A. The terms of reference required the Commission to commence the review on 1 July 2020.

Our review started 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. The process leading to our final report is outlined below.

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').[3]

The Parliamentary Committee's terms of reference required it to report to the Legislative Assembly on:[4]

a. the delivery of aged care, end-of-life and palliative care in Queensland across the health and ageing service systems; and

b. 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.

After extensive consultation and research on the various matters covered by its inquiry,[5] the Parliamentary Committee tabled in March 2020 separate reports on aged care, end-of-life and palliative care,[6] and voluntary assisted dying.[7]

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

4 Ibid 1–2.

5 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': Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying (Issues Paper No 3, February 2019). The issues paper posed 38 questions, 14 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.

6 Qld Parliamentary Committee Report No 33 (2020).

7 Qld Parliamentary Committee Report No 34 (2020).

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'.[8]

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'.[9]

The Parliamentary Committee, by majority, made 21 recommendations.[10] 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')[11] as 'the basis for a legislative scheme for voluntary assisted dying'.[12]

Its other recommendations related to specific aspects of the proposed voluntary assisted dying scheme, including the eligibility criteria for access;[13] 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 PROCESS

Issues for consultation

The process of consultation is a vital part of the Commission's work on any review. The terms of reference called on us to consult with any group or individual, in or outside Queensland.

We consulted the public and stakeholders and sought information about many issues. These included:

- who should be eligible to access the scheme: eligibility criteria in legislation typically include a disease, illness or medical condition that is advanced and will cause death; a timeframe until death; being aged at least 18; decision-making capacity; and residency;
- safeguards to ensure that decisions are voluntary and made without coercion;
- the process of requesting access to voluntary assisted dying, including eligibility assessments by two independent and suitably qualified health professionals;
- the qualifications and training of health practitioners in this field;

8 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) 206–7, 213, Rec 49; WA Joint Select Committee on End of Life Choices Report (2018) 107, Finding 23.

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

10 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.

11 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'.

12 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.

13 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 adults who do not have decision-making capacity, particularly in relation to Advance Health Directives: Qld Parliamentary Committee Report No 34 (2020) 117, 127, Recs 2, 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: ibid 199–200.

- access to information about voluntary assisted dying and to suitably qualified persons to provide advice, conduct assessments, and administer a voluntary assisted dying substance;
- participation by health practitioners in the voluntary assisted dying process, and the right of a health practitioner to refuse to participate on the grounds of a conscientious objection;
- whether the right of a health practitioner to conscientiously object to voluntary assisted dying should be coupled with a requirement:
  - to inform the person of their objection; and
  - to refer the person elsewhere or to transfer their care;
- the rights and obligations of entities that do not wish to provide access to voluntary assisted dying to individuals under their care;
- access to information and advice, particularly in remote and regional areas of Queensland;
- the implications of the Commonwealth Criminal Code for the use of videoconferencing, email or telephone communications between health practitioners and patients about voluntary assisted dying, particularly in remote and regional areas of Queensland;
- the need for laws, guidelines and practices to address the cultural and linguistic diversity in Queensland;
- the need to establish a voluntary assisted dying care navigator service that can provide individuals with information, including the name and contact details of medical practitioners or health-service providers who may be able to give them information and advice;
- appropriate safeguards and protections, including for health practitioners who act in accordance with the legislation;
- new offences to enforce compliance with the legislation;
- an independent oversight body to monitor compliance with the legislation;
- guidelines to assist individuals, practitioners, and others to understand the legislation and to ensure that it works in practice;
- the implementation of a scheme if one is legislated.

The process of consultation

We consulted the public and stakeholders 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 the paper. Submissions closed on Friday 27 November 2020.

We received 126 submissions, 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.

Analysis of submissions and consideration of issues

The analysis of submissions was a time-consuming task that extended into early 2021. It involved tabulating and reading submissions, summarising them, quoting salient extracts from many of them, and distilling the issues that emerged from them. We also considered the Parliamentary Committee's extensive public consultations.

The Secretariat developed material to assist the Commission members to consider issues in a proper sequence. This entailed the drafting and development of a large volume of material.

The Commission consists of part-time members,[14] 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. She has undertaken research and developed voluntary assisted dying training in Victoria. 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, Ms 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 Ms Green's work and the work of those who benefitted from her example and direction.

The skilled staff of the Office of the Queensland Parliamentary Counsel worked with great dedication to draft a Bill. 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 with 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.

14 I was appointed as a full-time member after 1 February 2021 to help enable the review to be completed.

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 own 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 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 and their complexity. 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 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 this 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 places 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'[15] 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.

Justice Peter Applegarth AM
Chair

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

Abbreviations and Glossary

AHPRA	Australian Health Practitioner Regulation Agency, which administers the National Health Practitioner Regulation Law in force in each Australian state and territory
AMA	Australian Medical Association
Belgian Euthanasia Act 2002	Unofficial English translation by DyingForChoice.com (July 2018) <https://dyingforchoice.com/docs/Belgium_Euthanasia_Act_as-at_July_2018.pdf>
Board	As context requires: In Victoria, the Voluntary Assisted Dying Review Board, established under section 92 of the Voluntary Assisted Dying Act 2017 (Vic); In Western Australia, the Voluntary Assisted Dying Board, established under section 116 of the Voluntary Assisted Dying Act 2019 (WA) (and which is to commence operation on a day to be fixed by proclamation); and In relation to the Commission's recommendations, the Voluntary Assisted Dying Review Board proposed to be established by cl 116 of the draft Bill.
the draft Bill	Voluntary Assisted Dying Bill 2021 (QLRC), contained in Appendix F
HR Act	*Human Rights Act 2019* (Qld)
Luxembourg Law on Euthanasia and Assisted Suicide 2009	English translation published in Ministry of Health et al (Luxembourg), *Euthanasia and assisted suicide: Law of 16 March 2009—25 questions 25 answers* (June 2010), Appendix 1
MBA	Medical Board of Australia
QCAT	Queensland Civil and Administrative Tribunal
QCAT Act	*Queensland Civil and Administrative Tribunal Act 2009*
Qld Capacity Assessment Guidelines (2020)	Department of Justice and Attorney-General (Queensland), *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020)
Qld Parliamentary Committee Report No 33 (2020)	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Aged care, end-of-life and palliative care* (Report No 33, March 2020)
Qld Parliamentary Committee Report No 34 (2020)	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary assisted dying* (Report No 34, March 2020)
QLRC Consultation Paper No 79 (2020)	Queensland Law Reform Commission, *A legal framework for voluntary assisted dying*, Consultation Paper, WP No 79 (October 2020)
the Tasmanian Act	*End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas)
Tasmanian Panel	Tasmanian VAD Review Panel, University of Tasmania
Tas Review Panel Report (2021)	Tasmanian VAD Review Panel, *Independent Review of the End of Life Choices (Voluntary Assisted Dying) Bill 2020* (University of Tasmania, Report, February 2021)

The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001	English translation published in Regional Euthanasia Review Committees (The Netherlands), *Euthanasia Code 2018: Review procedures in practice* (April 2018) Annexe
the New Zealand Act	*End of Life Choice Act 2019* (NZ)
the Parliamentary Committee	Except where otherwise specified, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, which conducted the inquiry into aged care, end-of-life and palliative care and voluntary assisted dying
the Victorian Act	*Voluntary Assisted Dying Act 2017* (Vic)
VCAT	Victorian Civil and Administrative Tribunal
Vic Guidance for Health Practitioners (2019)	Victoria, Department of Health and Human Services, *Voluntary assisted dying: Guidance for health practitioners* (July 2019)
Vic Ministerial Advisory Panel Final Report (2017)	Victorian Voluntary Assisted Dying Ministerial Advisory Panel, *Final Report of the Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, Department of Health and Human Services, July 2017)
Vic Parliamentary Committee Final Report (2016)	Legislative Council, Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into end of life choices* (Final Report, June 2016)
Victorian Panel	Victorian Voluntary Assisted Dying Ministerial Advisory Panel
Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021)	Voluntary Assisted Dying Review Board, *Report of operations: July–December 2020* (Safer Care Victoria, February 2021)
Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020)	Voluntary Assisted Dying Review Board, *Report of operations: January–June 2020* (Safer Care Victoria, August 2020)
Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020)	Voluntary Assisted Dying Review Board, *Report of operations: June–December 2019* (Safer Care Victoria, February 2020)
Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019)	Voluntary Assisted Dying Review Board, *Report of operations: 2018–19* (Safer Care Victoria, August 2019)
White and Willmott Model	Professors Ben White and Lindy Willmott, Submission No 1199 to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying* (24 April 2014) attachment 'Voluntary Assisted Dying Bill 2019' and 'Explanatory Notes'. The White and Willmott Model is set out in Qld Parliamentary Committee Report No 34 (March 2020) app A.

WA Joint Select Committee on End of Life Choices Report (2018)	Western Australian Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice, Report of the Joint Select Committee on End of Life Choices* (Report, August 2018)
WA Ministerial Expert Panel Final Report (2019)	Western Australian Ministerial Expert Panel on Voluntary Assisted Dying, *Final Report of the Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, Department of Health, 2019)
the Western Australian Act	*Voluntary Assisted Dying Act 2019* (WA)
Western Australian Panel	Western Australian Ministerial Expert Panel on Voluntary Assisted Dying

** Except where otherwise indicated, references to legislation in this Report are references to Queensland*

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CHAPTER 1

What is Voluntary Assisted Dying?

Chapter 1: What is Voluntary Assisted Dying?

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

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

1.3 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.

1.4 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.[1] 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.

1.5 '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.

1.6 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.

1.7 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, including the vulnerable.

VALUES AND PRINCIPLES

1.8 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.

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

1.10 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.

1.11 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.

1 Terms of Reference para 1.

PALLIATIVE CARE

1.12 The Commission's 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'.

1.13 The importance and value of palliative care for people experiencing unrelenting pain or suffering from terminal illness or a degenerative condition was also noted by submitters 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.[2]

1.14 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'.[3]

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

LEGISLATIVE DESIGN

1.16 As required, we have had regard to the Parliamentary Committee's report about voluntary assisted dying[4] and to legislative and regulatory arrangements in other Australian and international jurisdictions.

1.17 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, 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.

1.18 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'.[5] Despite these kinds of differences, the eligibility criteria across the legislative models are largely the same and seek to achieve the same policy goals.

2 See especially Qld Parliamentary Committee Report No 34 (2020) 106–8.

3 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).

4 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 model 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.

5 WA Ministerial Expert Panel Final Report (2019) 34, Rec 7.

VIEWING THE PROPOSED LEGISLATION AS A WHOLE

1.19 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.

1.20 As Professors White and Willmott and their co-authors have recently observed:[6]

> 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

1.21 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.

1.22 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.

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

1.24 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.

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

1.26 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.

1.27 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 any system, and by family, friends, carers and health professionals who support those individuals.

1.28 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.

6 Ibid.

1.29 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.

1.30 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.

1.31 We have aimed to develop draft legislation that is compassionate, safe and practical.

WHAT IS VOLUNTARY ASSISTED DYING?

1.32 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.

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

1.34 **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.[7]

1.35 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

1.36 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.[8] Depending on the circumstances, a person who administers the substance at the person's request may commit the offence of murder or manslaughter.[9]

1.37 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;

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

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

8 Criminal Code (Qld) s 311.

9 Criminal Code (Qld) ss 300, 302, 303. 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 a 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.'

1.39 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

1.40 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, our terms of reference and used in legislation in Victoria and Western Australia. It is a fitting description.

1.41 Legislation in Tasmania and New Zealand uses different terms in their titles.[10] For example, the New Zealand law is titled *End of Life Choice Act 2019*, but uses the term **assisted dying** which is defined to mean:[11]

> (a) 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
>
> (b) the self-administration by the person of medication to relieve their suffering by hastening death.

1.42 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**.

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

1.44 **Euthanasia** refers to the intentional taking of a person's life by another person in order to end intolerable suffering.[12] Euthanasia covers various practices including:

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

1.45 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.

1.46 **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 a lethal dose of medications 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 information supplied 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.

1.47 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 to die is given by health

10 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas).
11 *End of Life Choice Act 2019* (NZ) s 4.
12 AMA, *Position Statement: Euthanasia and Physician Assisted Suicide* (2016) 1, note 2; Australian Human Rights Commission, *Euthanasia, human rights and the law* (Issues Paper, May 2016) 3.

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

1.48 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.[13] 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 voluntary assisted dying substance. Usually, the person self-administers the substance, but in some circumstances the law allows, at the person's request, practitioner administration.

SOME TERMS FREQUENTLY USED IN THIS REPORT

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

- ***Coordinating practitioner*** is the doctor who accepts the person's first request for voluntary assisted dying, conducts the first assessment 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 requirements 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 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 eligible witnesses.

13 See, eg, AMA, *Position Statement: Euthanasia and Physician Assisted Suicide* (2016) note 2, [2.2].

- ***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 trained and qualified to act as administering practitioner.

A DYING PERSON WHO CHOOSES THIS OPTION DOES NOT DIE BY SUICIDE

1.50 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.

1.51 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 to determine the timing of their death by hastening it so as to end intolerable suffering when a person is close to death.

1.52 The Western Australian Act provides:[14]

> For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.

1.53 The New Zealand Act provides:[15]

> A person who dies as a result of assisted dying is, for the purposes of any life insurance contract, or any other contract, —
>
> (a) taken to have died as if assisted dying had not been provided; and
>
> (b) taken to have died from the terminal illness referred to in section 5(1)(c) from which they suffered.

1.54 We consider that the draft Bill should be to the same effect. It 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.

1.55 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.

14 *Voluntary Assisted Dying Act 2019* (WA) s 12
15 *End of Life Choice Act 2019* (NZ) s 35.

RECOMMENDATIONS

1-1 A person should be 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.

1-2 The draft Bill provides that for the purposes of the law of Queensland, and for the purposes of a contract, deed or other instrument entered into in Queensland or governed by its law, a person who dies as the result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act:

(a) does not die by suicide; and

(b) 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.

CHAPTER 2

Voluntary assisted dying laws: their development and operation

Chapter 2: Voluntary assisted dying laws: their development and operation

CHAPTER SUMMARY

Voluntary assisted dying laws have been enacted[1] in Victoria, Western Australia, and Tasmania, and several overseas jurisdictions. This chapter 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.

Finally, the chapter 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 has the greatest effect on individuals who are suffering and dying in remote and regional areas.

DEVELOPMENT OF VOLUNTARY ASSISTED DYING LEGISLATION

2.1 Voluntary assisted dying legislation has been enacted in three Australian States: Victoria, Western Australia, and Tasmania. Several overseas jurisdictions have enacted similar legislation. A comparison of the voluntary assisted dying legislation in selected jurisdictions, including Victoria, Western Australia and Tasmania, is set out in the table in Appendix C.

Victoria

2.2 In December 2017, Victoria became the first Australian State to enact voluntary assisted dying legislation.[2] The Victorian Act commenced on 19 June 2019, after an 18-month implementation period.[3]

2.3 The Act followed an extensive inquiry into end of life choices conducted by the Victorian Parliament's Legal and Social Issues Committee in 2015–2016. In its final report, the Committee recommended that Victoria enact voluntary assisted dying legislation and proposed a legislative framework for capable adults in certain circumstances.[4]

2.4 In response, the Victorian Government announced that it would introduce the legislation and established an expert ministerial advisory panel to develop a 'compassionate and safe' legislative framework, using the framework proposed by the Committee as the starting point.[5]

1 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.

2 *Voluntary Assisted Dying Act 2017* (Vic). The Northern Territory enacted similar a similar law in 1995, but it was rendered inoperative when the Federal Parliament passed the *Euthanasia Laws Act 1997* (Cth).

3 The *Voluntary Assisted Dying Act 2017* (Vic) was assented to on 5 December 2017, with some initial provisions to establish the framework commencing on 1 July 2018 and the remainder of the Act commencing on 19 June 2019.

4 Vic Parliamentary Committee Final Report (2016) xxvii, xxxiv–xxxviii, Rec 49 and Annex 1.

5 Vic Ministerial Advisory Panel Final Report (2017) 5, 33, 35.

2.5 The Victorian Panel consulted widely on the development of a 'compassionate, safe and practical' voluntary assisted dying legislative framework.[6] In July 2017, it released its final report, which contained 66 recommendations.[7] The Panel later contributed to the drafting of the Voluntary Assisted Dying Bill 2017 (Vic), which implemented its recommendations.[8]

Western Australia

2.6 The Western Australian Act[9] was passed and received Royal Assent on 19 December 2019. Its operative provisions are expected to commence on July 2021. This has allowed an 18 month period to implement the scheme.[10]

2.7 As in Victoria, in Western Australia the law was enacted after a series of comprehensive reviews. In August 2017, a Joint Select Committee of the Parliament of Western Australia was appointed to conduct an inquiry into the need for laws regarding end of life choices for Western Australians. In August 2018, the Joint Select Committee tabled its report, *My Life, My Choice*.[11] That report made 24 recommendations to improve the way the Western Australian health system delivers end of life and palliative care, including introducing legislation for voluntary assisted dying and the appointment of a ministerial expert panel to advise on key issues for the legislation. The Joint Select Committee proposed a framework to support the new legislation.[12]

2.8 The Western Australian Panel was subsequently appointed to advise about the development and implementation of the new law. Its role did not extend to drafting the legislation, and it did not focus on the detail of its implementation.[13] The focus of its work was on the Joint Select Committee's recommendations and proposed legislative framework. It also examined the approach taken under the Victorian Act and used it as the basis for the design of the new legislation, with some modifications.[14]

2.9 After an extensive consultation process, the Panel delivered its final report, with recommendations on the elements of the proposed legislation, in June 2019.[15]

Tasmania

2.10 In late August 2020, the End of Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) was introduced as a Private Member's Bill, into the Legislative Council of Tasmania.[16] The Legislative Council passed an amended version of the Bill in November 2020.

2.11 In the same month, the Tasmanian Government asked the University of Tasmania to complete an independent review of the Tasmanian Bill. The review was finished in February 2021.[17]

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6 In January 2017, the Victorian Panel released a discussion paper on voluntary assisted dying, which received 176 written submissions: Victorian Voluntary Assisted Dying Ministerial Advisory Panel, *Voluntary Assisted Dying Bill* (Discussion Paper, Department of Health and Human Services, January 2017) <https://www2.health.vic.gov.au/about/publications/researchandreports/voluntary-assisted-dying-bill-discussion-paper>.
The Panel also conducted 14 forums and a series of roundtables with more than 300 stakeholders across Victoria. The Panel did not repeat the consultations conducted by the Legal and Social Issues Committee, which received more than 1000 submissions, conducted 17 days of public hearings and heard evidence from 154 witnesses. See the consultation overview in Victorian Voluntary Assisted Dying Ministerial Advisory Panel, *Interim Report of the Ministerial Advisory Panel on Voluntary Assisted Dying* (Interim Report, Department of Health and Human Services, May 2017) <https://www2.health.vic.gov.au/~/media/Health/Files/Collections/Policies%20and%20guidelines/V/voluntary-assisted-dying-bill-interim-report> 10–11.

7 Vic Ministerial Advisory Panel Final Report (2017) 22–32.

8 M O'Connor et al, 'Documenting the process of developing the Victorian voluntary assisted dying legislation' (2018) 42 *Australian Health Review* 621, 624.

9 *Voluntary Assisted Dying Act 2019* (WA).

10 Department of Health (WA), 'Voluntary assisted dying' (30 April 2021) <https://ww2.health.wa.gov.au/voluntaryassisteddying>. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (WA) 1.

11 WA Joint Select Committee on End of Life Choices Report (2018).

12 Ibid [7.89], Recs 19–24.

13 WA Ministerial Expert Panel Final Report (2019) 1–2, app 2.

14 Ibid.

15 Ibid xi–xxiv, 2.

16 The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) was introduced into the Legislative Council on 27 August 2020 by the Hon MV Gaffney.

17 Tas Review Panel Report (2021).

2.12 On 4 March 2021, the Tasmanian Bill was passed by the House of Assembly with further amendments. The Bill, as amended, was debated in the Legislative Council and passed on 23 March 2021 and assented to on 22 April 2021.[18]

2.13 The Tasmanian law differs in some respects from, but has a similar framework to, voluntary assisted dying laws in Victoria and Western Australia.

Legislative developments in other Australian jurisdictions

2.14 In 1995, the Northern Territory enacted the *Rights of the Terminally Ill Act 1995* (NT) to allow an eligible terminally ill adult ask for help from a qualified medical practitioner to end their own life voluntarily. However, that Act was short-lived, as it was overturned in 1997 by the federal Parliament in the exercise of its constitutional powers to make laws for the territories by enacting the *Euthanasia Laws Act 1997* (Cth).[19]

2.15 In 2016 and 2017, voluntary assisted dying legislation was introduced into parliament in New South Wales[20] and South Australia, respectively,[21] but both attempts were defeated.

2.16 In December 2020, the Voluntary Assisted Dying Bill 2020 (SA) was tabled in both houses of the South Australian Parliament. It was debated in each house in March 2021. At the time this report was finalised, debate was expected to resume on 5 May 2021 when the Bill will be considered in the committee stage: too late for any further amendments or progress of the South Australian Bill to be included in this report.

Overseas jurisdictions

2.17 Voluntary assisted dying laws are operational in some places, including the Netherlands, Belgium, Luxembourg, and Canada, as well as California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington in the United States.[22] Legislation has also recently been passed in Spain, as well as New Mexico in the United States, but is not due to take effect until later in 2021.

2.18 New Zealand has also passed legislation to regulate and permit assisted dying in certain circumstances. The commencement of the *End of Life Choice Act 2019* (NZ) was subject to a referendum held on 17 October 2020.[23] As a majority voted in favour of the assisted dying legislation, the Act received royal assent on 16 November 2020 and will come into force on 6 November 2021, following a 12 month implementation period.

2.19 Although international experience can be instructive, caution should be exercised in

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

19 In addition to overturning the *Rights of the Terminally Ill Act 1995* (NT), the *Euthanasia Laws Act 1997* (Cth) also amended the *Northern Territory (Self-Government) Act 1978* (Cth), and the equivalents in the Australian Capital Territory and Norfolk Island, to remove the ability of territory parliaments to enact assisted dying laws in the future: *Euthanasia Laws Act 1997* (Cth) s 3, schs 1–3 (commencing 27 March 1997).
In November 2017, the ACT Legislative Assembly formed a Select Committee to inquire into and prepare a report on end of life choices in the ACT. The Select Committee made 24 recommendations on advance care planning and palliative care. It noted that, until s 23(1A)–(1B) of the *Australian Capital Territory (SelfGovernment) Act 1988* (Cth) is amended by the Federal Parliament to allow a scheme for voluntary assisted dying to be considered by the ACT Legislative Assembly, no legislative action can be taken to enact such a scheme. A majority of the Select Committee suggested that if such amendments were made the ACT Legislative Assembly should give serious consideration to establishing an appropriate voluntary assisted dying legislative scheme and outlined various matters that should be included in any ACT scheme: Select Committee on End of Life Choices in the ACT, Legislative Assembly of the ACT, *Report* (March 2019) [8.16], 76–7, [9.34], [9.40], 94–6 <https://www.parliament.act.gov.au/__data/assets/pdf_file/0004/1334992/9th-EOLC-Report.pdf>.

20 On 21 September 2017, the Voluntary Assisted Dying Bill 2017 (NSW) was introduced into the New South Wales Legislative Council by the Hon T Khan as a Private Member's Bill. The Bill sought to allow eligible terminally ill persons to request and receive medical assistance to end their lives voluntarily. Unlike most other laws of this type, only persons aged 25 years and over would have been eligible to make a request. There was also a requirement for a formal request certificate to be completed confirming the person's request at least seven days after the initial request, and the right for a close relative to challenge the request in the Supreme Court on particular grounds. The Bill was defeated on 16 November 2017.

21 On 20 October 2016, the Assisted Dying Bill 2016 (SA) (previously named the Death with Dignity Bill 2016 (SA) was introduced into the South Australian House of Assembly by the Hon Dr D McFetridge as a Private Member's Bill. The Bill was defeated on 17 November 2016.

22 Some overseas jurisdictions permit assisted dying but have not enacted specific legislation. For example, in Switzerland, 'right to die' societies provide voluntary assisted dying services within the framework of the existing criminal law. An accessible summary of the history of voluntary assisted dying legislation in Europe and other jurisdictions is contained in Section 2 of the Tas Review Panel Report (2021).

23 *End of Life Choice Act 2019* (NZ). See also New Zealand Government, End of Life Choice referendum (2020) <https://www.referendums.govt.nz/endoflifechoice/index.html>.

drawing too close a parallel between the development of voluntary assisted dying legislation in overseas jurisdictions and in Australia. Australian jurisdictions have a distinct approach to voluntary assisted dying frameworks. It is this Australian approach that has most guided us in our task.

DRAWING ON LEGISLATION IN OTHER AUSTRALIAN JURISDICTIONS

2.20 As appears in the more detailed discussion of specific elements of the legislative schemes in other Australian states, the Victorian legislation at the time of its passage was said to contain 68 safeguards, more than similar legislation in any other place in the world.[24]

2.21 The legislation in Victoria and Western Australia did not always follow the recommendations of parliamentary committees or expert advisory panels. The reasons for that are many and varied, and some will be discussed in this report in considering the development of certain provisions. Some involved a measure of political compromise so as to ensure the legislation's passage.

2.22 The Tasmanian legislation took a different course, starting life as a Private Member's Bill, and being subject to a short, but impressive, independent review in late 2020 and early 2021 by the Tasmanian Policy Exchange at the University of Tasmania. The Tasmanian Panel conducting the review undertook consultations and raised specific matters in the Bill for consideration. It did not make recommendations about amendments and did not address all aspects of the then Bill. The Tasmanian Government did not have a policy position on whether voluntary assisted dying legislation should be enacted. It did, however, provide agency advice and critical comments on numerous aspects of the Bill.[25]

2.23 The law, as passed on 23 March 2021, did not address all the matters raised by the independent review or the Tasmanian Government. Given the process associated with its development and amendment, and the fact that it has only recently been passed, the Tasmanian legislation has not been used as a major reference point in our consideration of draft legislation for Queensland. The Tasmanian Bill and amendments to it were monitored, however, during our review, and the insights provided by the February 2021 Independent Review assisted the Commission.

2.24 Neither the Victorian Act nor the Western Australian Act was used as our starting point. Instead, issues of principle were our first point of reference. Still, the Victorian and Western Australian Acts (along with legislation in Canada, New Zealand, and Tasmania) were important points of reference. Where appropriate in specific contexts, the draft Bill has modelled its provisions on comparable provisions in the Victorian and Western Australian Acts. As might be expected, the Western Australian legislation had regard to criticisms of some aspects of the Victorian Act.

2.25 We have analysed the legislation in comparable jurisdictions and benefited from consultations with individuals and organisations in Victoria and Western Australia who are familiar with the development of the laws in those States.

24 R McDougall and B Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation' (2020) 21 BMC Medical Ethics, Article 38 online <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5>.

25 Tasmanian Government, *Tasmanian Government Agency Advice on the End of Life Choices (Voluntary Assisted Dying) Bill 2020* (February 2021) <http://www.dpac.tas.gov.au/__data/assets/pdf_file/0011/570962/Tasmanian_Government_Agency_Advice_on_the_End_of_Life_Choices_Voluntary_Assisted_Dying_Bill_2020.PDF>.

2.26 As noted, the Western Australian Act is expected to come into operation on 1 July 2021 after an 18 month implementation period. We have had the benefit of assessing the practical steps that have been taken leading up to the law's pending operation. The Commission recommends that the implementation and operation of that law be the subject of ongoing consideration, since Western Australia, like Queensland, has large distances between population centres, and many remote and regional communities.

2.27 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 are later briefly summarised. 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.

2.28 In summary, we have considered the genesis and development of legislation, particularly in Victoria and Western Australia, and, to the extent possible, its actual or anticipated operation.

INSIGHTS FROM THE OPERATION OF THE VICTORIAN ACT

2.29 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.[26] 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.[27]

2.30 The contents of its three six-monthly reports are informative.[28] 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 this report about specific aspects of the legislation and about implementation issues.

Persons accessing voluntary assisted dying

2.31 Between the commencement of the Victorian Act on 19 June 2019 and 30 December 2020:[29]

- 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.

2.32 Notably, of the people who were granted an administration permit and have subsequently died, 32 per cent did not ultimately administer the substance.[30] 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.

2.33 More detail about the number of people accessing voluntary assisted dying at each stage of the process is set out in this Table.

26 Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019) 3.
27 Ibid 11.
28 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021); Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020); Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020).
29 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 5.
30 Ibid 11.

Table 2.1: Number of persons accessing voluntary assisted dying[31]

Stage		Status	19 June–31 December 2019	1 January–30 June 2020	1 July–31 December 2020	Total to date
Eligibility	First assessment	Eligible	136	205	221	**562**
		Ineligible	1	6	12	**19**
	Consulting assessment	Eligible	109	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**
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

2.34 Data collected by the Voluntary Assisted Dying Review Board provide insight into the demographics of applicants, including:[32]

- **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.

31 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.

32 Voluntary Assisted Dying Review Board Report of Operations June–December 2020 (2021) 10.

Diagnoses

2.35 Of the people who had been issued an administration permit and have since died:[33]

- 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).

Timeliness

2.36 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.[34] The timing of the remaining 50 per cent of applications was not reported.

Number of qualified, registered and actively involved medical practitioners

2.37 In the first six months of the Victorian Act's operation, the Board highlighted reports that the availability of qualified and willing medical practitioners was a barrier to accessing voluntary assisted dying.[35]

2.38 However, the number of medical practitioners who are qualified and actively involved in voluntary assisted dying cases has steadily increased (see Table 2.2).[36] There are now 455 medical practitioners who have registered for the online training program.[37] 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.[38]

Table 2.2: Medical practitioner training and involvement[39]

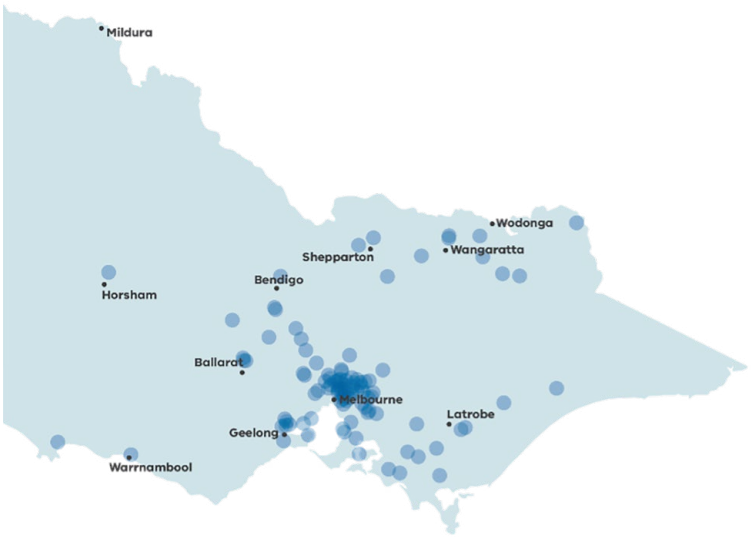
Stage	Description	19 June 2019–30 June 2020	1 July–31 December 2020	Change (%)
Online training	Medical practitioner registered for the online training program	422	455	7.8%
Portal registration	Medical practitioner registered in the portal	175	210	20.0%
Active in the portal	Medical practitioner involved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

Medical practitioners in rural and regional Victoria

2.39 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.[40] 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 2.1).[41]

33 Ibid 11
34 Ibid 9.
35 Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 7.
36 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 6.
37 Ibid.
38 Ibid.
39 Ibid. Table adopted with permission.
40 Ibid.
41 Ibid.

Figure 2.1: Location of medical practitioners[42]



Specialties of medical practitioners

2.40 Of the medical practitioners who have acted as either a coordinating or consulting practitioner:[43]

- 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**.

2.41 There remains a need for more qualified and registered specialists, such as neurologists, to assist in the process, particularly in rural and regional Victoria.[44]

Care navigator service

2.42 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.[45]

2.43 In response to feedback received in the first six months of the Victorian Act's operation, the service was expanded to include additional care navigators across regional Victoria.[46]

42 Ibid 6. Figure adopted with permission.
43 Ibid 7.
44 Ibid.
45 Ibid 8; Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 5.
46 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2020) 3.

Compliance

2.44 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.[47] 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.[48]

Known unknowns

2.45 The limited data available to the Board means certain information is unknown, including the number of people who are:[49]

- 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 INHIBIT ACCESS

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

2.47 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 assessments face-to-face, so as to avoid potentially breaching the Commonwealth law.

2.48 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'.[50]

2.49 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, videoconference, email or some other form of electronic communication.

2.50 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.

2.51 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.

47 Ibid 3.
48 Ibid 3, 14.
49 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 17.
50 Ibid 1, 16; Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 4.

CHAPTER 3

Legal frameworks, people and practices

Chapter 3: Legal frameworks, people and practices

3.1 Our task is to recommend 'the best legal framework' for people who are suffering and dying to choose the manner and timing of their death.[1]

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

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

THE LAW AND PERSONAL CHOICES IN PRACTICE

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

3.5 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 then obtain the substance and administer it as soon as possible after becoming eligible.

3.6 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.

3.7 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.

3.8 Some people 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

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

3.10 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.

3.11 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.

3.12 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 people 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.

1 Terms of reference para 1.

3.13 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 participate in the voluntary assisted dying process 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 end of life options.

PRACTICAL ISSUES: PEOPLE AND RESOURCES

3.14 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.

3.15 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.

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

3.17 Training about voluntary assisted dying should not be limited to coordinating practitioners 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.

3.18 Other resourcing issues include:

- Communication services including qualified and trained interpreters;
- The establishment of a Statewide Pharmacy Service that 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;[2]
- 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.

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

3.20 These resourcing and implementation issues are discussed in greater detail in Chapter 2. The present point is that a legal framework is simply that: a framework. It needs to be built upon. That requires the people and other resources to make any scheme work in practice.

2 The scope to use telehealth and other forms of electronic communications for certain consultations is the subject of consideration in Chapter 20 in the context of the carriage service provisions of the Criminal Code (Cth).

PALLIATIVE CARE

3.21 As already noted, the Commission's 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 for the Queensland community'.

3.22 We agree with the Parliamentary Committee 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'.[3]

3.23 Any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care.

3.24 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.

3 Qld Parliamentary Committee Report No 34 (2020) 109. See further, the Parliamentary Committee's recommendations on palliative care and end of life care in Qld Parliamentary Committee Report No 33 (2020).

CHAPTER 4

Principles

Chapter 4: Principles

CHAPTER SUMMARY

This chapter outlines the principles that have guided the Commission in developing draft legislation.[1]

The draft legislation is about individuals who are 'suffering and dying'.[2] For this reason, certain considerations apply that would not apply or have the same weight in other circumstances.

The State's interest in preserving human life ordinarily justifies prohibitions on assisting another person to end their life. The interest in reducing human suffering for those who are dying involves an additional consideration. The law may permit 'the hastening of death through medication provided this is necessary to relieve pain and suffering, and it is the health professional's intention to relieve pain rather than cause the person's death'.[3] In that context, it has been recognised that 'the value of reducing human suffering may trump that of life in some circumstances'.[4]

Where a person is healthy and free of pain, the State's interest in preserving life ordinarily outweighs other interests such as personal autonomy. It may be argued that the balance is different when:

- the person has a condition that is advanced, progressive and will cause death;
- the condition is causing suffering to the person that cannot be relieved in a manner the person considers tolerable;
- the person forms the view that the value of their life is outweighed by their suffering;
- the person has the required decision-making capacity;
- a decision to seek medical assistance to end life is made voluntarily and without coercion; and
- the decision is a settled one that endures over a reasonable period.

When a person is dying and experiencing intolerable suffering, the interest in personal autonomy has greater weight.

It is appropriate to outline the principles that inform this balance. They serve to identify the main policies and objects of the draft legislation.

THE COMMISSION'S GUIDING PRINCIPLES

4.1 We identified the following guiding principles to help inform our approach:[5]

- the importance of upholding and respecting human rights and the dignity and autonomy of individuals;
- the need for safeguards to protect individuals who might be vulnerable to coercion or exploitation;
- recognising that health practitioners are subject to a comprehensive legal, regulatory and ethical framework;

1 See also Chapter 5, which considers whether the draft Bill should include a statement of principles to aid its interpretation and operation.

2 See Chapter 1 and terms of reference in Appendix A.

3 L Willmott and B White, 'Assisted Dying in Australia: A Values-based Model for Reform' in I Freckelton and K Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 498, citing B White and L Willmott, 'Double Effect and Palliative Care Excuses' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2nd ed, 2014) [15.20]. See also Criminal Code (Qld) s 282A.

4 Willmott and White, above n 3.

5 QLRC Consultation Paper No 79 (2020) [3.2].

- recognising, and not detracting from, the importance of high quality and accessible palliative care at the end of life;
- respecting the diversity of individuals' and health practitioners' views, values and beliefs, and avoiding value judgments about others' lives and choices;
- the need for the legislation to be clear and no more complex than it needs to be to achieve its purposes;
- the desirability of achieving reasonable consistency with the legislation in other Australian jurisdictions; and
- the need for the legislation to be well adapted to Queensland's geographic, cultural and health care environment.

4.2 The Consultation Paper asked what principles should guide the Commission's approach.[6] Many respondents expressed general or qualified support for some or all of the principles and considerations in the Consultation Paper. A few respondents supported the values reflected in the White and Willmott Model. Some respondents emphasised particular matters or suggested other considerations, including the right to life, patient-centred decisions, disability rights principles, social work principles, and evidence-informed design.

4.3 The Commission's guiding principles have been informed by Queensland's legal and human rights framework, relevant professional ethics and standards applying to health practitioners, and practical considerations for a workable legislative framework in Queensland.

4.4 Some principles may conflict with each other and will need to be reconciled and balanced in the specific context of a voluntary assisted dying framework for persons who are suffering and dying in Queensland.

LEGAL AND HUMAN RIGHTS FRAMEWORK

Values that underpin the legal system

4.5 Good laws reflect fundamental values. A key value is the inherent dignity of every individual.

4.6 The law should protect the right to life and the right to liberty. In a society governed by the rule of law, the freedom of the individual should not be subject to unnecessary restraints. A legal system should place a high value on personal autonomy, not simply in the limited sense of freedom from interference with a person's bodily integrity, but in the broader sense of self-determination.

4.7 The right to be treated with equal concern and respect follows from the inherent dignity of every individual. This inherent dignity is also a foundation for the law's protection of the vulnerable. It is associated with equality before the law and equal access to services without discrimination.

4.8 These principles are embedded in our culture and should be reflected in our laws. They inform the development of good legislation and judge-made law. For example, protection of the vulnerable may be said to be the foundation of tort law.[7] Personal autonomy is reflected in the general principle of freedom of contract, while protection of the vulnerable qualifies that principle. It justifies legislative and general law protections against undue influence, coercion and exploitation of the vulnerable.

The *Human Rights Act 2019*

4.9 The *Human Rights Act 2019* ('HR Act') is an important source of guidance for

6 Ibid Q-1.
7 J Stapleton 'The golden thread at the heart of tort law: Protection of the vulnerable' (2003) 24 *Australian Bar Review* 135.

developing Queensland legislation. It gives statutory expression to fundamental personal rights, including:[8]

- the right to life and the right not to be arbitrarily deprived of life;
- the right to liberty and security;
- freedom from torture and cruel, inhuman or degrading treatment;
- the right to enjoyment of human rights without discrimination, to equal protection of the law without discrimination and to equal and effective protection against discrimination (equality rights);
- the right to access health services without discrimination;
- the right not to have the person's privacy unlawfully or arbitrarily interfered with; and
- the right to freedom of thought, conscience, religion and belief.

4.10 The HR Act also recognises the right to protection of families and children, and cultural rights, including those of Aboriginal and Torres Strait Islander peoples.[9]

4.11 These rights are all based on international human rights instruments[10] and are similar to those included in human rights statutes in the Australian Capital Territory and Victoria.[11]

4.12 Underlying these rights are the core principles of equality and respect for the inherent dignity of every individual.

4.13 The rights under the HR Act are not absolute. They must be balanced with other rights and interests. They may be subject to limits, but only those that are 'reasonable' and 'can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom'.[12] The factors that may be relevant in deciding whether a limit is reasonable and justifiable are:[13]

(a) the nature of the human right;

(b) the nature of the purpose of the limitation, including whether it is consistent with a free and democratic society based on human dignity, equality and freedom;

(c) the relationship between the limitation and its purpose, including whether the limitation helps to achieve the purpose;

(d) whether there are any less restrictive and reasonably available ways to achieve the purpose;

(e) the importance of the purpose of the limitation;

(f) the importance of preserving the human right, taking into account the nature and extent of the limitation on the human right;

(g) the balance between the matters mentioned in paragraphs (e) and (f).

4.14 As the HR Act governs the interpretation of other statutes,[14] the human rights stated in it will influence the interpretation of any voluntary assisted dying statute. All statutory provisions must, to the extent possible that is consistent with their purpose, be interpreted in a way that is compatible with human rights.[15]

8 *Human Rights Act 2019* (Qld) ss 15–17, 20, 25(a), 29(1), 37(1).
9 *Human Rights Act 2019* (Qld) ss 26(1)–(2), 27–28.
10 Explanatory Notes, Human Rights Bill 2018 (Qld) 3–5. See *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966 (entered into force 23 March 1976) and, as to the right to health services, *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), 16 December 1966 (entered into force 3 January 1976).
11 See *Human Rights Act 2004* (ACT); *Charter of Human Rights and Responsibilities Act 2006* (Vic).
12 *Human Rights Act 2019* (Qld) s 13(1).
13 *Human Rights Act 2019* (Qld) s 13(2).
14 *Human Rights Act 2019* (Qld) s 48.
15 *Human Rights Act 2019* (Qld) s 48(1).

4.15 The rights referred to in the HR Act relate to individuals, not corporations.[16]

4.16 The rights and freedoms in the HR Act are in addition to rights and freedoms under other laws.[17]

4.17 The HR Act binds all persons, including the State.[18]

PROFESSIONAL ETHICS AND GOOD MEDICAL PRACTICE

4.18 As indicated by the terms of reference, voluntary assisted dying legislation should take into account relevant ethical and professional standards that apply to health practitioners.[19]

4.19 Four key principles are commonly recognised in medical ethics:[20]

- respect for autonomy—respecting and enabling an individual's right to hold views and make their own decisions based on their values and beliefs;
- beneficence—relieving or preventing harm and doing the best for the individual patient (or acting in the patient's best interests);
- non-maleficence—doing no harm, that is, avoiding acts that cause harm to the individual's interests and justifying any harmful actions; and
- justice—equity and the fair distribution of benefits, risks and costs, with a focus on the interests of the community as well as the individual patient.

4.20 Other core values of medical practice, which have particular significance in end of life care, include:[21]

- compassion and empathy, including relief of the patient's distress; and
- non-abandonment—the principle that the doctor-patient relationship involves an ongoing commitment by the doctor to care for the patient, and that a doctor should not abandon the patient without making or allowing time for other arrangements.

4.21 Medical practitioners should not deny a terminally ill patient access to available pain relief and palliative care.[22] In the context of end of life care, medical practitioners 'do not have a duty to try to prolong life at all cost',[23] and should 'try to ensure that death occurs with comfort and dignity'.[24]

4.22 Medical and other health practitioners are subject to a comprehensive legal and regulatory framework.[25] One of the obligations of a registered health practitioner is to comply with professional standards, including codes of ethics and conduct.[26] This includes the MBA's Code of Conduct for Doctors, which sets out core standards for good medical practice.[27] The code is consistent with the above principles and emphasises that good medical practice is 'patient-centred'.[28] Patient-centred care includes:[29]

16 *Human Rights Act 2019* (Qld) s 11.
17 *Human Rights Act 2019* (Qld) s 12.
18 *Human Rights Act 2019* (Qld) s 5(1).
19 Terms of reference para 4.
20 TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (Oxford University Press, 8th ed, 2019) 13, 104, 155, 158, 217–18, 267–8; KJ Breen, SM Cordner and CJH Thomson, *Good Medical Practice: Professionalism, Ethics and Law* (Australian Medical Council, 4th ed, 2016) 34–5, [3.4]. See also, in the context of voluntary assisted dying, J Rutherford, 'Conscientious participants and the ethical dimensions of physician support for legalised voluntary assisted dying' (November 2020, online) *Journal of Medical Ethics* 1, 2–4.
21 Breen et al, above n 20, 36–7 [3.5.2], [3.5.3], [3.5.5]. See also TE Quill and CK Cassel, 'Nonabandonment: A Central Obligation for Physicians' (1995) 122(5) *Annals of Internal Medicine* 368.
22 Breen et al, above n 20, 489–90 [25.1], 509 [25.12.4].
23 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.13.4].
24 AMA, *Code of Ethics* (2016) [2.1.14].
25 See further Chapters 13 and 17 below.
26 See Health Practitioner Regulation National Law (Queensland) pt 5 div 3, pt 6. Non-compliance may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional and, in turn, may result in disciplinary action: see Health Practitioner Regulation National Law (Queensland) pt 8 divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107.
27 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [1.1]. See also AMA, *Code of Ethics* (2016).
28 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [2.1]. See also [3.1], [4.2].
29 Australian Commission on Safety and Quality in Health Care, 'Person-centred care' (2019) <https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care>.

> respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.

4.23 Ethical standards give general guidance, rather than absolute or rigid rules. They change over time with shifting community attitudes and are interpreted in light of prevailing circumstances.[30]

4.24 The professional ethics and standards of health practitioners apply whenever they provide a health service. These ethical principles and professional standards include respecting the patient's choice, protecting their privacy and communicating with them effectively.[31]

PRINCIPLES

The fundamental value of human life

4.25 The fundamental and inherent value of every human life is undoubted. The right to life is recognised as the most basic and supreme human right.[32] It is protected by criminal laws that prohibit unlawful killing. Upholding the value of human life is also a cornerstone of medical practice.

4.26 However, the right to life is not absolute. The HR Act protects a person from arbitrary deprivation of life, but not all acts that end in death will infringe this right.[33] Overseas jurisdictions suggest that voluntary assisted dying legislation is neither required nor precluded by the right to life, but that adequate limits and safeguards should be in place.[34]

4.27 It is important to avoid value judgments about others' lives. Voluntary assisted dying recognises that death is a part of life and takes into account the notion of quality and dignity of life, as determined by the person themselves.[35] It is focused on giving people, in certain limited circumstances, a degree of choice and control over the timing and manner of their death.

4.28 There are divergent views about whether voluntary assisted dying is ethical.[36] There are other end of life practices, such as the withdrawal or withholding of life-sustaining treatment in certain circumstances, that may have the secondary consequence of hastening death. In the balance between the principles of non-maleficence and beneficence, the ending of unendurable pain and suffering through death might for some people be a benefit, rather than a harm.[37]

4.29 Several respondents referred to the importance of upholding and respecting the sanctity of, or right to, life. The tension between valuing life and individual autonomy was also evident. For example, one respondent commented that there is not a 'right to die' under the HR Act, while another commented that there is not a 'duty to live'. The Anglican Bishop of North Queensland explained the tension between the principles of valuing life and individual autonomy in this way:

> in drawing up legislation to permit [voluntary assisted dying] there is necessarily going to be a tension between individual rights and the interest of the state (representing

30 Breen et al, above n 20, 40–41 [3.6], [3.9].

31 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.1.5], [3.2.5], [4.2.3], [4.3.1], [4.3.4], [4.3.7].

32 See generally Human Rights Committee, *General Comment No 36, Article 6: right to life*, 124th sess, UN Doc CCPR/C/GC/36 (3 September 2019) [2].

33 See generally Queensland Human Rights Commission, 'Right to life' (28 June 2019) <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-life>.

34 See, eg, *Carter v Canada (Attorney-General)* [2012] BCSC 886 (Smith J), upheld in *Carter v Canada (AttorneyGeneral)* [2015] 1 SCR 331.

35 See, eg, *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519, 629–30 (Cory J dissenting); *Rodriguez v British Columbia (Attorney General)* (Court of Appeal for British Columbia, 8 March 1993); [1993] 76 BCLR (2d) 145, [51] (McEachern CJ dissenting).

36 See, eg, AMA, *Position Statement: Euthanasia and Physician Assisted Suicide* (2016) [3.2].

37 See, eg, Beauchamp and Childress, above n 20, 188–90.

> the broader community) in protecting and preserving life. There are of course limits on both the right to end life and the interest in preserving life to be seen in current law. For example, we respect the right of an individual to reject medical treatment even if it hastens death: the preservation of life can never be absolute, given we all will die. On the other hand, if a person is not competent then our health system does what it can to prevent self-harm, including prevention of suicide. Indeed the prevention of suicide even by competent persons is seen as a desirable end of public health policy.
>
> Legislation on [voluntary assisted dying] is therefore trying to regulate a shift in the boundary between the community interest in protecting and preserving life, and the individual right to autonomously determine their own fate, including the right to die. If the legislation is too conservative it will prevent those with rational good reasons (such as painful terminal illnesses) from controlling their own fate—but if it is too liberal people will die (such as people who are not competent) to whom the state rightly owes a duty of care and protection. Getting this balance right is the task of this legislation.

Respect for individual autonomy

4.30 Individual autonomy is a central value in contemporary liberal democracy and reflects the value of human dignity. In law, autonomy can relate to:[38]

- bodily integrity—a person has a right to be protected from nonconsensual interference with their body; or
- self-determination—a person is entitled to have their wishes and choices respected and acted upon.

4.31 The HR Act provides that every person has the 'right to liberty and security'.[39] A person should be protected from arbitrary limits by the State on their individual freedom and interference with their bodily integrity. The right to liberty and security includes concerns about both physical and psychological integrity.[40] In Canada, this right has been held to encompass concerns about quality of life and noninterference with personal medical decisions including voluntary assisted dying.[41]

4.32 Patient autonomy has become a central feature of medical practice.[42] Providing good patient care includes '[r]ecognising and respecting patients' rights to make their own decisions'.[43] This includes the right to refuse medical treatment.

4.33 The principle of autonomy recognises that people who are dying and suffering intolerable pain should have some control over the timing and manner of their death. Since death is part of life, 'choices about the manner of their dying and the timing of their death are, for many people, part of what is involved in taking responsibility for their lives' and, thereby, exercising their autonomy.[44]

4.34 Many respondents submitted that one of the Commission's guiding principles should be the importance of upholding and respecting human rights and the dignity and autonomy of individuals. Several respondents referred to human rights and individual autonomy (or dignity, integrity, self-empowerment, self-determination, freedom, or choice) as key principles.

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38 See, eg, Willmott and White, above n 3, 479, 491. See also, eg, J Herring and J Wall, 'The nature and significance of the right to bodily integrity' (2017) 76(3) *Cambridge Law Journal* 566.

39 *Human Rights Act 2019* (Qld) s 29(1).

40 Queensland Human Rights Commission, 'Right to liberty and security of person' (28 June 2019) <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-liberty-and-security-of-person>. See also, eg, *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519, 587–8 (Sopinka J for the majority), quoted in *Carter v Canada (Attorney-General)* [2012] BCSC 886, [1293] (Smith J).

41 *Carter v Canada (Attorney-General)* [2015] 1 SCR 331, 365–6, 368–71; *Carter v Canada (AttorneyGeneral)* [2012] BCSC 886, [1291]–[1304] (Smith J).

42 See, eg, Breen et al, above n 20, 42 [3.7].

43 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.1.5]. See also AMA, *Code of Ethics* (2016) [2.1.5]; and Breen et al, above n 20, 34 [3.4].

44 Stanford Encyclopedia of Philosophy, 'Voluntary Euthanasia' (6 January 2020) [3] <https://plato.stanford.edu/entries/euthanasia-voluntary/>.

4.35 For example, an academic submitted that '[t]he over-arching principle is that [voluntary assisted dying] is not a medical or legal issue—but a fundamental human rights issue, merely the other side of our fundamental right to live'.[45] Another member of the public suggested the guiding principle should be 'that a person owns his/her life' and 'has a right to decide when to die', and that '[t]he purpose of the legislation should be to make that easy'.[46]

4.36 A member of the public, with terminal cancer and complications arising from multiple surgeries, expressed the view that:

> I would like to see legislation introduced that helps me keep my dignity intact, that I maintain quality of life over quantity of life.

4.37 Health Consumers Queensland explained that, in its consultations with consumers and carers on end of life care and dying, 'autonomy and self-determination' were 'strongly expressed' and '[c]onsumers stated that they need trust, independence and choice'.

4.38 Christians Supporting Choice for Voluntary Assisted Dying submitted that:

> The overriding principle should be that a patient should be in control of their suffering as much as possible and have autonomy to the maximum extent possible. It has been demonstrated that simply having the option of [voluntary assisted dying] has important palliative value in its own right.

4.39 However, the principle of autonomy is not absolute and must be balanced with other principles. Autonomy does not mean that people should be allowed to do anything they want without any limitations or safeguards.

Safeguards against abuse or exploitation and protecting vulnerable people

4.40 Safeguards are necessary to protect against coercion or exploitation. Decisions to request or access assisted dying must be voluntary and not, for example, the result of undue pressure.

4.41 There was widespread support in submissions for safeguards to protect individuals who might be vulnerable to coercion or exploitation. For example, it was submitted that 'society's responsibility is the protection of those who are most vulnerable', that '[s]afeguards to protect vulnerable patients are crucial', that there should be protections 'around undue influence, duress, and elder abuse', and that safeguards are required 'to ensure that vulnerable people are not pressured or coerced into making decisions that they do not want'.

4.42 AMA Queensland commented on the desirability of protecting vulnerable patients, 'such as those who may be coerced or be susceptible to undue influence' or 'who may consider themselves to be a burden to their families, carers or society', and 'patients and doctors who do not want to participate' in voluntary assisted dying.

4.43 The Democratic Labour Party submitted that 'there should be protection from improper coercion for both patients and doctors'. They expressed concern that terminally ill patients and elderly people may be susceptible to coercion, especially if they do not have access to adequate support services:

> The care of those who are terminally ill, who cannot be cured but can be supported to have the best possible quality of life until they die remains paramount. It is of great concern for the DLP, that the resource allocation in the context of competing healthcare demands and of under-provision, can create coercive contexts that lead to a feeling of lack of worth or purpose in ones-self.
>
> …

45 (Emphasis in original).
46 (Emphasis omitted).

> … When elderly people require a great deal of care, they are concerned they have become a burden on their loved ones. The feeling of guilt can be particularly profound. Home care packages to assist the elderly through State Government funding is essential so that elderly people do not feel the pressure to consider euthanasia as a way out.

4.44 Similarly, Australian and New Zealand Society for Geriatric Medicine identified concerns such as:

- Placing pressure on frail older people who may feel they are 'a burden' on others. Such feelings are often due to underlying depression, financial concerns or family dynamics.
- The risks of involuntary or non-voluntary euthanasia in patients with cognitive impairment, dementia or reduced capacity.

4.45 However, it was also submitted that, while there is a need for robust safeguards to protect against potential misuse, these should not be 'so complex and so onerous that access to [voluntary assisted dying] becomes impossible for Queenslanders'. Some respondents commented that unnecessary complexity could lead to delays and impede access to the scheme. Many respondents agreed that a guiding principle should be that the legislation in Queensland is no more complex than it needs to be to achieve its purposes.

Informed decision-making

4.46 Recognising an individual's right to make decisions about the manner and timing of their death also requires consideration of the need for that decision to be informed.

4.47 The administration of a drug or provision of other medical treatment ordinarily requires informed consent. This is reflected in the legal and ethical framework governing health practitioners.[47] It is also recognised in the right to 'protection from torture and cruel, inhuman or degrading treatment' under the HR Act, which provides that a person 'must not be subjected to medical … treatment without the person's full, free and informed consent'.[48]

4.48 Informed consent involves giving information in a way the person can understand.[49] It also emphasises that the person should understand all the available options. If a decision is not properly informed, it will not necessarily reflect a truly voluntary choice.

Equality and non-discrimination

4.49 The HR Act includes the right to recognition and equality before the law.[50] All people have the same rights and deserve the same level of respect. Laws and policies must be neither discriminatory nor enforced in a discriminatory way. This reflects one of the principles of the rule of law, that the law should apply equally to all people.[51] Principles of non-discrimination are also recognised under anti-discrimination and other rights-based legislation.[52]

47 See, eg, *Rogers v Whitaker* (1992) 175 CLR 479, 489; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102103; LexisNexis Australia, *Halsbury's Laws of Australia* [280–3000] (10 February 2016); MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.5]; AMA, *Code of Ethics* (2016) [2.1.4].

48 *Human Rights Act 2019* (Qld) s 17. See also Queensland Human Rights Commission, 'Right to protection from torture and cruel, inhuman or degrading treatment' (28 June 2019) <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-protection-from-torture-and-cruel,-inhuman-or-degrading-treatment>.

49 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.5.1].

50 *Human Rights Act 2019* (Qld) s 15.

51 See, eg, Law Council of Australia, *Policy Statement: Rule of Law Principles* (March 2011) 2 [2]; R Stein, 'Rule of Law: What Does it Mean?' (2009) 18(2) *Minnesota Journal of International Law* 293, 296–302; T Bingham, *The Rule of Law* (Penguin, 2011) pt II ch 5.

52 See, eg, *Anti-Discrimination Act 1991* (Qld). See also, eg, *Disability Services Act 2006* (Qld) pt 2, s 18(1); *Guardianship and Administration Act 2000* (Qld) s 11B (general principle 2).

4.50 Voluntary assisted dying legislation should not unfairly discriminate against particular groups of people. For example, it should not be assumed that a person with a disability is unable to make a voluntary decision about assisted dying.

4.51 The Public Advocate supported the guiding principles in the Consultation Paper and suggested that the *Guardianship and Administration Act 2000* also be used to guide the draft legislation:

> The 2019 amendments to the *Guardianship and Administration Act* come into force on 30 November 2020 and contain a set of General Principles that the community is encouraged to apply.[53]
>
> The General Principles in the *Guardianship and Administration Act* were revised to more closely align with the *Convention on the Rights of Persons with Disabilities*. They articulate the presumption of capacity and that people with impaired capacity have the same fundamental rights and freedoms as people without disability. These rights, along with those in the *Human Rights Act*, will need to be balanced with other rights and interests, as articulated in the Consultation Paper. (note added)

4.52 The HR Act specifically recognises the right to access health services without discrimination.[54] Access to high quality health services is also recognised as part of the national framework of health care regulation.[55] This may present particular challenges for people living in rural, regional and remote areas of Queensland.

High quality and accessible palliative care at the end of life

4.53 Several respondents commented on the importance of high quality and accessible palliative care at the end of life.

4.54 Many respondents agreed that recognising, and not detracting from palliative care, should be a guiding principle for the Commission. For example, Palliative Care Queensland submitted that 'lack of access to palliative care services could mean that some Queenslanders choose [voluntary assisted dying] out of fear that they will not be adequately cared for as they die'.

4.55 Other respondents expressed concerns that:

- end of life and palliative care are presently under-resourced, and people do not always have access to high quality care;
- the introduction of voluntary assisted dying could impact the availability or delivery of quality palliative care; and
- voluntary assisted dying is distinct from palliative care and should not be viewed as an alternative to quality palliative care at the end of life.

4.56 Several respondents submitted that the introduction of voluntary assisted dying should be accompanied or preceded by additional funding for palliative care.

Privacy and communication

4.57 The HR Act requires that a person's privacy not be interfered with unlawfully or arbitrarily. The right to privacy protects a variety of interests, including personal information and data collection, a person's private life and non-interference with a person's physical and mental integrity.[56]

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53 See *Guardianship and Administration Act 2000* (Qld) s 11B, as inserted by the *Guardianship and Administration Other Legislation Amendment Act 2019* (Qld) ss 7, 8.

54 *Human Rights Act 2019* (Qld) s 37(1). See also Queensland Human Rights Commission, 'Right to Health Services' (28 June 2019) <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services>.
This right is not included in the human rights Acts of the other Australian jurisdictions, and there is limited guidance about its scope. It is narrower than a general right to health but is likely to refer to health services of good quality: see TC Beirne School of Law, *Human Rights Act 2019 (Qld): A Guide to Rights Interpretation* (February 2020) 81.

55 See generally Office of the Health Ombudsman, 'About us' <https://www.oho.qld.gov.au/about-us>; Australian Commission on Safety and Quality in Health Care, 'Australian Charter of Healthcare Rights' (2019) <https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights>.

56 *Human Rights Act 2019* (Qld) s 25. See Queensland Human Rights Commission, 'Right to privacy and reputation' (28 June 2019) <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-privacy-and-reputation>.

4.58 Statutory information privacy obligations are imposed on public entities, health service providers and some private organisations.[57] Patient confidentiality also forms part of a health practitioner's ethical responsibilities.[58]

4.59 The need for good patient communication is also relevant. Good medical practice recognises the importance of open dialogue between a health practitioner and patient, and meeting a patient's individual language, cultural and communication needs.[59] It also involves appropriate respect and consideration for relatives, carers and others close to the patient.[60] In end of life care, '[d]octors have a vital role in assisting the community to deal with the reality of death and its consequences'.[61]

Freedom of conscience

4.60 The HR Act recognises the right of an individual to 'freedom of thought, conscience, religion and belief', including the freedom to demonstrate the person's religion or belief in observance or practice.[62]

4.61 The right of a health practitioner to conscientiously object to participation in medical treatments or procedures is reflected in other legislation[63] and is recognised in health practitioners' codes of ethics.[64] The 'value of conscience suggests that doctors … should not be required to participate in assisted dying where doing so is contrary to their conscience'.[65]

4.62 However, the right to freedom of conscience is not absolute. For example, the principle of non-abandonment suggests that a health practitioner who conscientiously objects to participating in voluntary assisted dying may still have obligations to ensure their patient is referred to another practitioner or service.[66]

4.63 Several respondents commented on the importance of recognising 'freedom of conscience', especially for medical and other health practitioners. For example, Catholic Health Australia submitted that there should be 'robust provisions' to respect practitioners' choice not to participate in voluntary assisted dying. Some respondents also supported the right of other staff or institutions to refrain from participating in voluntary assisted dying.

4.64 The Queensland Nurses & Midwives' Union submitted that it is possible for voluntary assisted dying legislation to respect the rights of both individuals and health practitioners:

> The right to life is a fundamental human right. Therefore, for some, there is an obvious tension between requesting access to voluntary assisted dying and the obligation to protect life. To deny a person the right to end their life in the manner and time they wish to, may limit their human rights. And yet, the rights of the patient seeking voluntary assisted dying may impact the rights of the health practitioner's own beliefs about assisted dying, which is why the legislation must allow for conscientious objection.
>
> … It is undoubtedly a complex and emotive issue. However, with careful design to balance the patient's right to life and access to treatment, Queensland laws may allow for assisted dying without arbitrarily contravening the right to life.

57 See the *Privacy Act 1988* (Cth); and *Information Privacy Act 2009* (Qld).
58 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.4]; AMA, *Code of Ethics* (2016) [2.2.2].
59 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.3].
60 Ibid [4.10].
61 Ibid [4.13].
62 *Human Rights Act 2019* (Qld) s 20.
63 See *Termination of Pregnancy Act 2018* (Qld) s 8.
64 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.4.6].
65 Willmott and White, above n 3, 492.
66 See, eg, C McLeod, 'Demanding Referral in the Wake of Conscientious Objection to Abortion' in JC Cohen and JE Keelan (eds), *Comparative Program on Health and Society Lupina Foundation Working Papers Series 2004–2005* (University of Toronto, January 2006) 130, 134–5.

> For the individual choosing voluntary assisted dying and the health practitioner involved in this scheme, every action taken towards a person at the end of life must be with respect for them and recognition of their rights and freedoms. This must also be applied to the health practitioners and their right to be treated respectfully from colleagues regardless of their right to conscientiously object or conscientiously participate in voluntary assisted dying. (notes omitted)

Clarity of the law

4.65 As a general principle, legislation should be 'unambiguous and drafted in a sufficiently clear and precise way'.[67] The community 'should be regarded as the ultimate user of a law'.[68]

4.66 It is especially important for voluntary assisted dying legislation to be comprehensible to individuals, their families and carers, health practitioners and health services. The issues involved in end of life care mean that any voluntary assisted dying legislation is likely to be complex. To the extent possible, the legislation should be structured clearly. Community engagement and education will be of particular importance in implementing a practical framework for Queensland.[69]

Reasonable consistency with other jurisdictions

4.67 Voluntary assisted dying legislation has been enacted in three Australian states and in New Zealand. Although there are differences, there are also many similarities between the legislative frameworks.

4.68 Ideally, any legislation in Queensland should be reasonably consistent with the frameworks in other Australian states and comparable jurisdictions like New Zealand.

4.69 Several respondents supported this noting, for example, that it would help avoid confusion and would streamline training.

The need for legislation to be well adapted to Queensland's geographic, cultural and health care environment

4.70 While it is desirable to achieve reasonable consistency with the frameworks in comparable jurisdictions, the draft legislation must be suited to Queensland.

4.71 A few respondents recognised that consistency with other jurisdictions will not always be optimal and that departures from those frameworks may be required. Professors White and Willmott submitted that 'reform based on principles and values should be prioritised over the principle of consistency across jurisdictions'. There are also practical considerations. Many respondents agreed that one of the guiding principles should be that the legislation is well adapted to Queensland's geographic, cultural and health care environment.

4.72 Legislation must be adapted to Queensland's unique conditions. Provisions drafted for New Zealand or Victoria may not be suited to a large, decentralised state like Queensland, many of whose citizens live in remote areas.

4.73 Legislation must be appropriate for Queensland's geography, the spread of its population in regional and remote areas, and its public and private health systems. It must also account for availability and accessibility of suitably qualified and eligible health practitioners to participate in the request and assessment and administration processes of the legislation.

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67 *Legislative Standards Act 1992* (Qld) s 4(3)(k). Section 4 of that Act sets out what are known as 'fundamental legislative principles'.

68 Office of Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook* (2008) [2.16.1]. See generally T Bingham, *The Rule of Law* (Penguin, 2011) pt II ch 3.

69 See, eg, Qld Parliamentary Committee Report No 34 (2020) 132, Rec 9 as to the inclusion of 'comprehensive education campaigns to inform health practitioners and the general public about the scheme'.

4.74 As such, another consideration is the availability of services and information to persons whose first language is not English, including Aboriginal and Torres Strait Islander peoples living in remote areas of Queensland.

4.75 The principle of equality of access warrants legislation that supports the provision of services without discrimination based on where people live in Queensland. The scheme should be accessible to individuals of diverse cultures throughout the State.

PRINCIPLES AND POLICIES

4.76 The values, principles and considerations outlined above inform and underpin the draft voluntary assisted dying legislation. Similar concepts underpin voluntary assisted dying legislation in other jurisdictions.[70]

4.77 Some respondents to the Parliamentary Committee's Issues Paper submitted that voluntary assisted dying legislation should be 'values-based'[71] or informed by principles[72] such as autonomy, protecting the vulnerable, and reducing human suffering. Other respondents mentioned various principles or values, including:[73]

- the value or sanctity of human life;
- dignity, 'patient centredness', and compassion;
- autonomy, self-determination, and the right to choose;
- respect for different personal and religious beliefs and values;
- informed choice;
- the protection of vulnerable people and not devaluing others' lives;
- medical ethics principles; and
- transparency and clarity.

4.78 Many submissions to the Commission also emphasised these and similar values.

4.79 Professors White and Willmott argue that voluntary assisted dying laws should be based on several core 'values': life; autonomy; freedom of conscience; equality; the rule of law; protecting the vulnerable; and reducing human suffering.[74] These values informed the framework in the White and Willmott Model.[75] The authors explain that these values 'are derived from existing Australian legal principle' and in some cases must be balanced against each other. They also recognise that, for some issues, the values 'provide a higher policy level direction for a legislative regime but do not provide guidance in relation to its specific details'.[76]

4.80 The distinction between a principle and a policy in this context is somewhat elusive.

4.81 In a recent article about the Victorian Act, Professors White and Willmott and their co-authors noted that the legislative principles in that Act give insight into the policy goals underpinning the framework. They distilled the principles into six (sometimes overlapping) policy goals, set out in the following table.

70 In some jurisdictions, a list of similar principles is included in the legislation: see Chapter 5.
71 See, eg, Submissions 1199, 1201, 1206 to the Parliamentary Committee.
72 See, eg, Submissions 189, 1200 to the Parliamentary Committee.
73 See, eg, Submissions 219, 263, 277, 278, 282, 387, 399, 439, 719, 876, 1209 to the Parliamentary Committee.
74 Willmott and White, above n 3, 489 ff.
75 See White and Willmott Model, Explanatory Notes 1.
76 Willmott and White, above n 3, 489, 499.

Table 4.1: 'Six Policy Goals Derived From 10 Principles'[77]

Six policy goals	Relevant principles
1. To respect all human life	• Valuing every human life equally
2. To respect personal autonomy	• Respecting autonomy • Supporting informed decision making • Promoting genuine choices • Encouraging open discussions about dying, death and people's preferences • Supporting conversations with health practitioners and family about treatment and care preferences
3. To safeguard the vulnerable and the community	• Protecting individuals from abuse
4. To provide high-quality care	• Providing quality care that minimises suffering and maximises quality of life • Supporting therapeutic relationships • Encouraging open discussions about dying, death and people's preferences • Supporting conversations with health practitioners and family about treatment and care preferences
5. To respect individual conscience	• Respecting diversity of beliefs and values, including among health practitioners
6. To alleviate human suffering (compassion)	• Providing quality care that minimises suffering and maximises quality of life

BALANCING COMPETING PRINCIPLES

4.82 The many values and principles outlined in the preceding sections may sometimes conflict with each other. As such, they must be reconciled and balanced in developing legislation. That balance must be struck in the context of someone who is dying and seeking relief from intolerable suffering.

4.83 In such a situation the value in preserving human life may be outweighed by other values such as personal autonomy and reducing suffering.[78]

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

4.85 The context of someone who is suffering and dying also directs attention to the vulnerability of such a person and the need for safeguards to ensure their vulnerability is not exploited.

4.86 Procedural and other safeguards, including eligibility criteria, are needed 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 voluntarily and without coercion;
- make choices that are informed about other end of life options, such as further treatment and palliative care; and
- demonstrate that any choice to request voluntary assisted dying is enduring.

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

4.88 It is important to recognise that persons who are frail, depressed by the fact that they are dying, disabled or otherwise vulnerable will seek access to a voluntary assisted

77 Reproduced from B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 424 Table 1 (emphasis omitted).

78 See, eg, Willmott and White, above n 3, 490, 499, 505.

dying scheme. The fact of an individual's vulnerability is not a sufficient reason to render them ineligible. It is, however, a reason to have safeguards of the kind discussed.

4.89 The Commission has aimed to draft legislation in accordance with the values, principles and other considerations identified in this chapter.

4.90 The need to reconcile and balance these many considerations is reflected in the Commission's specific recommendations about eligibility, the process of request and assessment, administration and other matters, and also in their cumulative effect.

COMPASSIONATE, SAFE AND PRACTICAL LEGISLATION

4.91 Many respondents supported the development of legislation that is compassionate, safe, practical, or some combination of those things. For example, the United Workers Union submitted that:

> UWU fundamentally believes that giving people who are at the end of their lives a real choice about the timing and circumstances of their death, whilst ensuring strong protections and safeguards, is the compassionate thing to do. UWA supports the development of legislation that is compassionate, safe and practical and that can be reasonably understood and applied by both those who wish to access it and those who must comply with it in a professional setting.

4.92 In contrast, several respondents challenged the notion that voluntary assisted dying legislation could be 'compassionate, safe and practical'. The Archbishop of Brisbane expressed the view that constructing a framework that is compassionate, safe and practical 'is impossible on each of those three counts and that the Commission has therefore been asked by the Government to do the impossible'. Catholic Health Australia also submitted that it 'dispute[s] the idea that compassion includes notions associated with intentional killing'.

4.93 The Australian Psychological Society emphasised the importance of compassion and safety:

> The APS supports a compassionate and safe assisted dying framework, whereby voluntary assisted dying is available as part of a full range of care options, including the highest quality palliative care and the most competent psychological assessment and psychosocial support. The APS endorses a best practice approach to end-of-life care, wherein the person fully understands the alternatives and the main ramifications of their decisions. Ultimately, the APS emphasises the importance of a process that is characterised by care, compassion and considered decision-making over time.

4.94 Go Gentle Australia submitted that the focus should be on practicality:

> that the first principle of any legislation is that it needs to be practically useful for the eligible person: providing sufficient safeguards to protect the wider good, but not to the point that the law becomes too onerous for those who need it.

CONCLUSION

4.95 Any voluntary assisted dying legislation should be firmly based on values and principles that apply in the case of an individual who is suffering and dying. The provisions, in both their particular respects and combined effect, should be consistent with these values and principles.

4.96 The legislation should also be a workable implementation of these values and principles so they can be reconciled and balanced in the context of someone who is suffering and dying. This includes the relief of suffering that is intolerable.

CHAPTER 5

A legislative statement of purposes and principles

Chapter 5: A legislative statement of purposes and principles

CHAPTER SUMMARY

This chapter considers whether the draft Bill should include a statement of purposes or principles to aid the interpretation or operation of the legislation, or both. We consider that it should include both.

The draft Bill states that its main purposes 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 also states that the principles that underpin the Bill include:

(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.

OTHER JURISDICTIONS

Overseas jurisdictions

5.1 Voluntary assisted dying laws in overseas jurisdictions do not generally include statements of guiding principles. Some Acts include declarations or a statement of purposes which broadly refer to relevant principles. For example, the New Jersey legislation begins with a declaration referring to 'individual dignity, informed consent, and the fundamental right of competent adults to make health care decisions', and to the

need for safeguards to 'protect vulnerable adults from abuse' and ensure the process is 'entirely voluntary'.[1]

5.2 The New Zealand Act does not contain a statement of principles. The Act states that its purpose is:[2]

(a) to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives; and

(b) to establish a lawful process for assisting eligible persons who exercise that option.

Victoria and Western Australia

5.3 The Victorian Act simply states that its 'main purposes' are:[3]

(a) to provide for and regulate access to voluntary assisted dying; and

(b) to establish the Voluntary Assisted Dying Review Board; and

(c) to make consequential amendments to various Acts.

5.4 The Western Australian Act does not have a statement of the Act's objects or purposes.

5.5 Both the Victorian Act and the Western Australian Act include a statement of principles. The principles are intended to underpin the interpretation and operation of the legislation.[4]

5.6 The Western Australian principles are based on those in the Victorian Act. With some drafting differences and additions in the Western Australian Act, they are in the same terms in both Acts.

5.7 Each of those Acts provides that 'a person exercising a power or performing a function' under the Act 'must have regard to the following principles' (with the words in <u>underlining</u> appearing only in the Western Australian Act):[5]

	Vic	WA
every human life has equal value;	s 5(1)(a)	s 4(1)(a)
a person's autonomy, <u>including autonomy in respect of end of life choices</u>, should be respected;	s 5(1)(b)	s 4(1)(b)
a person has the right to be supported in making informed decisions about the person's medical treatment, and should be given, in a manner the person understands, information about medical treatment options including comfort and palliative care <u>and treatment</u>;	s 5(1)(c)	s 4(1)(c)
every person approaching the end of life should be provided with high quality care <u>and treatment, including palliative care and treatment</u>, to minimise the person's suffering and maximise the person's quality of life;	s 5(1)(d)	s 4(1)(d)
a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained;	s 5(1)(e)	s 4(1)(e)

1 *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019,* NJ Stat Ann § 26:16-2(a), (c)(3)–(4).

2 *End of Life Choice Act 2019* (NZ) s 3.

3 *Voluntary Assisted Dying Act 2017* (Vic) s 1.

4 See Victoria, *Parliamentary Debates,* Legislative Assembly, 21 September 2017, 2951 (J Hennessy, Minister for Health); Western Australia, *Parliamentary Debates,* Legislative Assembly, 7 August 2019, 5136–7 (RH Cook, Minister for Health). See also Vic Ministerial Advisory Panel Final Report (2017) 46, Rec 1; WA Ministerial Expert Panel Final Report (2019) 12, Rec 1.

5 The principles in *Voluntary Assisted Dying Act 2017* (Vic) ss 5(1)(f)–(i) refer to 'individuals' rather than 'persons'.

	Vic	WA
a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding their care, treatment and end of life should be encouraged and promoted;	s 5(1)(f)	s 4(1)(f)
a person should be supported in conversations with the person's health practitioners, family and carers and community about treatment and care preferences;	s 5(1)(g)	s 4(1)(g)
persons are entitled to genuine choices regarding their treatment and care and end of life, irrespective of where the person lives in [the State] and having regard to the person's culture and language;	s 5(1)(h)	s 4(1)(h)
a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in the metropolitan region;	—	s 4(1)(i)
there is a need to protect persons who may be subject to abuse or coercion;	s 5(1)(i)	s 4(1)(j)
all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.	s 5(1)(j)	s 4(1)(k)

5.8 Unlike the Victorian Act, the Western Australian legislative principles include additional references to equality of access, particularly for people in regional areas. As noted, the legislation provides that:[6]

- a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in Western Australia and having regard to the person's culture and language; and
- a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in the metropolitan region.

5.9 It was observed in submissions to the Western Australian Panel that equality of access 'may be impacted by disability, age, geographical location [or] language'.[7]

Tasmania

5.10 With one minor modification, the Tasmanian Act adopts the same list of principles as the Western Australian Act.[8] A person exercising a power or performing a function under the Act must have regard to these principles.

5.11 The Tasmanian Act also contains a statement of the objectives of the legislation. These are:[9]

(a) to provide, to persons who are eligible to access voluntary assisted dying, an efficient and effective process to enable them to exercise their choice to reduce their suffering by ending their lives legally; and

(b) to ensure that the process provided for the exercise of that choice protects and prevents persons from having their lives ended unwittingly or unwillingly; and

6 *Voluntary Assisted Dying Act 2019 (WA) s 4(1)(h), (i).*

7 WA Ministerial Expert Panel Final Report (2019) 11. The panel recommended the following principle (at 12): People are entitled to genuine choices regarding their treatment and care; this should be regardless of their geographic location and take into account their ability as well as individual cultural and linguistic needs.

8 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 3(2). Section 3(2)(g) uses the term 'members of the person's family' rather than 'family'.

9 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 3(1).

(c) to provide, in certain circumstances, legal protection for persons who choose to assist, or who choose not to assist, such persons to exercise their choice to end their lives in accordance with that process.

QUEENSLAND

5.12 The Parliamentary Committee did not recommend whether any legislation should include a statement of principles. However, it recommended that the White and Willmott Model be used as the basis for a legislative scheme.[10]

5.13 The White and Willmott Model provides that its 'main objects' are to:[11]

(a) provide access to voluntary assisted dying for persons with an incurable, advanced and progressive medical condition that will cause death;

(b) establish safeguards to ensure that voluntary assisted dying is accessed only by persons who meet this Act's eligibility criteria;

(c) establish the Voluntary Assisted Dying Review Board to provide oversight of voluntary assisted dying under this Act;

(d) provide protections from liability for registered health practitioners and other persons who facilitate voluntary assisted dying in accordance with this Act; and

(e) enable registered health practitioners and entities who provide a health service, residential service or professional care service to refuse to participate in voluntary assisted dying without incurring liability.

5.14 It also provides that a person exercising a power or performing a function or duty under the Act 'must have regard to' the following principles:[12]

(a) human life is of fundamental importance and should be valued;

(b) a person's autonomy should be respected;

(c) freedom of conscience should be respected, including choosing to—

(i) participate in voluntary assisted dying; and

(ii) not participate in voluntary assisted dying;

(d) a person's equality should be respected and they should be free from discriminatory treatment;

(e) persons who are vulnerable should be protected from coercion and abuse;

(f) human suffering should be reduced; and

(g) the provision of voluntary assisted dying should reflect the established standards of safe and high-quality care.

5.15 In their submission, Professors White and Willmott continued to support those principles, but added that this 'does not imply that we do not support the additional concepts added in the Western Australian principles'.

10 Qld Parliamentary Committee Report No 34 (2020) 105, Rec 1.
11 White and Willmott Model cl 4.
12 White and Willmott Model cl 5.

PURPOSES AND PRINCIPLES

5.16 Many statutes include a statement of purposes. This aids the interpretation of the statute by the persons to whom it applies, public authorities that administer it, courts and tribunals called upon to interpret one or more of its provisions and members of the general public. The *Acts Interpretation Act 1954* provides that the interpretation of a provision that 'will best achieve the purpose of the Act is to be preferred to any other interpretation'.[13] Therefore a statement in an Act about its purpose or purposes may aid its interpretation. The purpose or purposes of an Act may also be determined by the terms of the relevant provisions, viewed in their statutory context, or, in some circumstances, by extrinsic material.[14]

5.17 As a matter of general legal principle, a person or body upon whom a statutory power is conferred may lawfully exercise that power only for the purpose for which it was conferred. Therefore, a statement of an Act's purposes may aid both its interpretation and its effective operation.

5.18 However, an Act may have more than one purpose and a statement of its purposes will not necessarily resolve difficult issues of interpretation. Chief Justice Gleeson stated the following in a frequently cited passage about the rule of interpretation that 'a construction that would promote the purpose or object underlying the Act is to be preferred':[15]

> That general rule of interpretation, however, may be of little assistance where a statutory provision strikes a balance between competing interests, and the problem of interpretation is that there is uncertainty as to how far the provision goes in seeking to achieve the underlying purpose or object of the Act. Legislation rarely pursues a single purpose at all costs. Where the problem is one of doubt about the extent to which the legislation pursues a purpose, stating the purpose is unlikely to solve the problem. For a court to construe the legislation as though it pursued the purpose to the fullest possible extent may be contrary to the manifest intention of the legislation …

5.19 A statement of an Act's purposes may be brief or elaborate. The Victorian Act's stated purposes are few and simply expressed. The Tasmanian Act's statement of objectives is more detailed and informative. An excessively lengthy statement of purposes may lack utility and come to resemble a summary of the Act or an Explanatory Memorandum.

5.20 A statement of an Act's purposes is different from a statement of the principles to which a person exercising a power or performing a function under the Act must have regard. The latter may aid interpretation to some extent but is directed to persons exercising powers or performing functions.

5.21 A list of principles that is too long may lack utility. It might contain principles that conflict, leaving a person called upon to perform a particular function uncertain as to which principle should prevail. It might also contain matters not relevant to the specific task or decision at hand. This may leave the person exercising a particular power or performing a particular function to wonder why they are required to have regard to a matter which seems irrelevant. This kind of confusion or uncertainty may impede, rather than improve, the operation of the Act.

5.22 Confusion or uncertainty might also arise where the list of principles is shorter but expressed in terms that are overly broad or general. References to such broadly stated principles as 'respect for a person's autonomy' or that 'human suffering should be reduced' may leave doubt about how those matters are to be given effect in the particular instance, especially if those matters may reasonably point in different directions.

13 *Acts Interpretation Act 1954* (Qld) s 14A(1).
14 *Acts Interpretation Act 1954* (Qld) s 14B.
15 *Carr v Western Australia* (2007) 232 CLR 138, 142–3 [5] (notes omitted), approved in *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue* (2009) 239 CLR 27, 47 [51].

5.23 In Victoria, Western Australia and Tasmania, as under the White and Willmott Model, the legislation provides that a person exercising a power or performing a function under the Act 'must have regard to' the principles. Similar provision is made in some other Acts in Queensland.[16] For example, the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* contain a statement of 'general principles' that 'must be applied by a person or other entity that performs a function or exercises a power' under those Acts, such as an attorney or guardian.[17] This provides a ground upon which decisions made by those persons might be challenged.[18]

5.24 Requiring a person who exercises a power or performs a function under voluntary assisted dying legislation to 'have regard to' a list of principles may be said to have the benefit of making persons reflect on the proper exercise of a power and the principles to which they should have regard. A requirement to 'have regard' means what it says. It leaves the decision-maker to decide what weight, if any, should be given to a particular consideration and how to balance competing considerations.

5.25 A potential complexity in requiring any person exercising a power or performing a function under voluntary assisted dying legislation to 'have regard to' a long list of principles is that the requirement would apply to a variety of persons in different situations. It differs from requiring a person exercising a specific power or function to have regard to certain defined considerations which are relevant to that specific power or function.

SUBMISSIONS

5.26 The Consultation Paper asked whether the draft legislation should include a statement of principles:[19]

- that aids in the interpretation of the legislation;
- to which a person must have regard when exercising a power or performing a function under the legislation (as in Victoria and Western Australia).

5.27 It also asked what the principles should be (if any), and what the practical and possibly unintended consequences might be of requiring a person to have regard to those principles.[20]

The inclusion of principles in the legislation

5.28 Most respondents who addressed these questions agreed that the draft legislation should include a statement of principles; and that the principles should aid in the interpretation of the legislation, or that a person who is exercising a power or performing a function under the legislation should be required to have regard to the principles, or both.

16 See, eg, *Disability Services Act 2006* (Qld) ss 17, 19; *Domestic and Family Violence Protection Act 2012* (Qld) s 4; *Guardianship and Administration Act 2000* (Qld) ss 11B, 11C, 34; *Powers of Attorney Act 1998* (Qld) ss 6C, 6D; *Mental Health Act 2016* (Qld) ss 5–7.
The *Mental Health Act 2016* (Qld) and *Domestic and Family Violence Protection Act 2012* (Qld) provide that the stated principles apply to the 'administration' of the Act. Additionally, the *Mental Health Act 2016* (Qld) requires that, in performing a function or exercising a power under that Act, a person is to 'have regard to' the stated principles. The *Guardianship and Administration Act 2000* (Qld) and *Powers of Attorney Act 1998* (Qld) require such persons to 'apply' the stated principles (see also n 17 below). The *Disability Services Act 2006* (Qld) provides that particular entities are 'encouraged to have regard to', or to 'apply and promote', the stated principles.

17 *Guardianship and Administration Act 2000* (Qld) ss 11B(1), 34(1); *Powers of Attorney Act 1998 (Qld) s 6C,* as amended and inserted by the *Guardianship and Other Legislation Amendment Act 2019* (Qld) ss 7, 8, 19, 43, 56, 69, 80. Additionally, the general principles are to be applied by a person making a decision for an adult on an informal basis, and the community is 'encouraged to apply and promote' the principles: *Guardianship and Administration Act 2000* (Qld) s 11B(2)–(3).
Separately from the statement of principles that must be applied by particular entities, the *Guardianship and Administration Act 2000 (Qld) contains a brief statement of adults' rights and capacities that the Act 'acknowledges', as well as a brief statement of the Act's purposes: see ch 2 ss 5–7.*

18 An attorney or guardian who acts honestly and reasonably may in some circumstances be relieved from liability: *Guardianship and Administration Act 2000* (Qld) s 58; *Powers of Attorney Act 1998* (Qld) s 105. As to protections from liability under voluntary assisted dying legislation, see Chapter 17 below.

19 QLRC Consultation Paper No 79 (2020) Q-2.

20 Ibid Q-3, Q-4.

5.29 The Anglican Bishop of North Queensland considered a statement of principles would 'be of considerable assistance' in interpreting the legislation, submitting that:

> This is important because there is a fine balancing act between competing principles and a multitude of difficult cases. Trying to legislate for each hard case will make for impossibly convoluted legislation: better to have principles to guide courts and tribunals so that abuses are curtailed and the spirit of the law can be followed.

5.30 Other respondents made similar comments. For example, the Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that a legislative statement of principles 'will assist in decision-making in the case of situations that have not been predicted', and Palliative Care Nurses Australia Inc. submitted that a statement of principles would 'support understanding and transparency'. Dying With Dignity Victoria Inc commented that '[e]ven with careful drafting an overview can be helpful'.

5.31 Two academics jointly submitted that a statement of principles is needed to ensure the legislation is interpreted and applied consistently with Queensland's human rights framework:

> The Consultation Paper notes that the overseas jurisdictions it reviewed do not contain statements of principles. Notably, however, those jurisdictions generally have stand-alone constitutionally embedded human rights protections. Despite Queensland having recently become the third jurisdiction in Australia to implement a Human Rights Act, that Act does not take precedence over all other legislation within Queensland: instead, it has equal priority, and in the event legislation is found to be inconsistent with it, the primary remedies it offers are identification of the inconsistency to the parliament.
>
> To ensure that the [voluntary assisted dying] legislation is interpreted and applied in accordance with those principles, the legislation needs to either specifically reference the Human Rights Act or, better yet, identify the principles at a greater level of specificity within the [voluntary assisted dying] legislation itself.
>
> The logical place for this to occur is in a section containing a statement of principles to be considered in interpreting the legislation, or in exercising powers or performing duties under the legislation.

5.32 Another respondent expressed qualified support for legislative principles, submitting that, '[u]nless worded very carefully, statements of principles become tools for pedants to use to make mischief'. Some other respondents commented on the need for such principles to be comprehensible by ordinary members of the community.

5.33 Palliative Care Social Work Australia supported the inclusion of legislative principles but submitted that an additional purpose provision 'outlining the intent of the [voluntary assisted dying] Act would be helpful'.

5.34 However, some respondents opposed the inclusion of legislative principles. A member of the public, opposed to voluntary assisted dying, submitted that legislative principles 'are only as good as the principles that are included in the list'. This respondent suggested principles are likely to be written 'emotively, purposively [and] idealistically', from the perspective of those who support voluntary assisted dying and 'with a very low effort required to comply with them'. In their view, such principles would be an 'easy out' and would undermine the safeguards in the legislation.

5.35 In a joint submission, two members of the public submitted that a legislative statement of principles is unnecessary given a statement of objects and the existence of the HR Act:

> Statutory interpretation is guided by legislation. Section 14A of the *Acts Interpretation Act 1954* (Qld) favours an interpretation that achieves the intended purpose of an Act. The draft proposed in the W&W Model cl 4 sets out the main objectives of the new legislation. A preamble is also included in the W&W Model. These sources describe the intended purpose of the legislation in a clear and concise manner. Therefore, the inclusion of additional principles to aid interpretation is not necessary. Furthermore, the passage of the *Human Rights Act 2019* (Qld) provides that a court and tribunal must

> have regard to Human Rights when interpreting legislation. It is therefore unnecessary duplication to include a set of Human Rights principles for statutory interpretation of voluntary assisted dying legislation.

5.36 They noted that other Queensland Acts, including the *Guardianship and Administration Act 2000*, contain legislative principles but submitted that the need for such an approach is removed by the HR Act:[21]

> [Those Acts] were passed prior to the introduction of the *Human Rights Act 2019* (Qld). Consequently, there was a need to include separate principles in individual Acts of Parliament. This is no longer a current requirement as Parliament is required to scrutinise new legislation in accordance with Human Rights.

An obligation to 'have regard to' the principles

5.37 Many respondents considered that a person who is exercising a power or performing a function under the draft legislation should be required to have regard to the principles.

5.38 For example, Palliative Care Social Work Australia submitted that this would 'remind people how the power with the legislation should be exercised' and that '[i]f there are no principles, then dominant viewpoints can overshadow the process, leading to potential harm'.

5.39 The Democratic Labour Party submitted that a 'statement of reasons' should also be required:

> that any person exercising a power or performing a function under the legislation (including preparing and submitting a report or applying for a voluntary assisted dying permit) should be required to prepare a statement of reasons explaining why they consider that the principles support the decision they have made. … [A]s is the normal requirement for a statement of reasons, the instrument giving the reasons must also set out the findings on material questions of fact and refer to the evidence or other material on which those findings were based.
>
> The reason for this suggestion is to help ensure that decisions made under the legislation will be properly reasoned, having regard to the principles, and not made impressionistically.

5.40 However, some respondents opposed a requirement for particular persons to have regard to the principles. For example, Dying With Dignity Victoria Inc submitted that the legislation itself and a set of principles to aid its interpretation 'should be sufficient'. Another respondent considered specific obligations should be stated and described within the relevant substantive provisions of the legislation, rather than in a 'generic list' of principles.

5.41 In a joint submission, two members of the public submitted that it is unnecessary to include principles to which a person must have regard because they 'are already reflected' in the HR Act and the Australian Charter of Healthcare Rights.[22] They also expressed concern about how a person would demonstrate their consideration of the principles, and the increased regulatory burden that such a requirement would impose:

> The requirement that a person *must* have regard to a set of principles imposes a positive obligation. In the context of a health professional performing a function under the legislation, a professional would be required to consider whether their actions are in conformance with those principles. This raises some potential issues. Firstly, how would a health professional show they have considered the set of principles? Secondly, there would be an extra regulatory burden on an already heavily regulated healthcare industry.

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21 Referring to the *Guardianship and Administration Act 2000* (Qld); *Powers of Attorney Act 1998* (Qld); *Mental Health Act 2016* (Qld); and *Domestic and Family Violence Protection Act 2012* (Qld). See n 16 above.

22 See Australian Commission on Safety and Quality in Health Care, 'Australian Charter of Healthcare Rights' (2019) <https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights>. See also Chapter 4 above.

5.42 There were mixed responses about the possible practical or unintended consequences of a requirement for particular persons to have regard to legislative principles.

5.43 Some respondents suggested there may be no unintended consequences. Others considered there would be positive effects. In particular, it was suggested that a requirement to have regard to legislative principles would provide guidance and clarity for decision-makers and the community. For example, Go Gentle Australia submitted that:

> The practical consequence is that the principles will speak to, and guide, the medical community, families, institutions and the general public in their thinking about—and approach to—end-of-life care.

5.44 In this respect, Health Consumers Queensland observed that principles are 'a key element' used in making 'complex and ethical decisions'. It submitted that:

> This also helps to translate to the community how decisions about voluntary assisted dying will be made with them. It helps to act as a bridge to translate communications between expert health professionals and the community both generally regarding the legislation introduction as well as in its specific implementation.

5.45 It referred to the existence of the Australian Charter of Healthcare Rights and submitted that '[a] Charter outlining principles for voluntary assisted dying would clarify and assist in the understanding and trust building for such legislation to the public'.[23]

5.46 Two academics jointly submitted that a statement of principles would assist the courts and others to interpret the legislation and would demonstrate 'good faith' in safeguarding the interests of people at the end of life.

5.47 Other respondents identified potential difficulties and challenges with a requirement for persons to have regard to legislative principles, including that:

- principles would provide insufficient guidance and may be confusing or involve interpretation difficulties;
- there may be difficulty in balancing different principles;
- there may be evidentiary difficulties in showing a person has had regard to the principles;
- a practitioner who did not have regard to the principles may be liable for contravening the legislation;
- such uncertainties in applying the principles, and the additional obligation imposed on practitioners, may delay or impede access to voluntary assisted dying; and
- principles concerning equality of access may give rise to an expectation of access that can not or will not be met in practice.

5.48 For example, STEP Queensland and STEP Australia submitted that:

> A person seeking to exercise a power or perform a function under the legislation may feel paralysed in trying to balance the value of human life and the reduction of human suffering, for example. In practical terms, this may mean that the exercising of a power or the performance of a function may be unnecessarily delayed.

5.49 They suggested, however, that 'thorough training … ought to reduce unintended consequences'.

5.50 Two other respondents submitted that a requirement to have regard to the principles 'has the potential to create greater uncertainty', and that:

> health professionals may be risk averse to performing a function under the legislation if there is uncertainty. This may have an unintended consequence of decreasing access

23 This respondent also referred to the Queensland Digital Health Consumer Charter, developed by Health Consumers Queensland.

> to voluntary assisted dying. Furthermore, a health professional who does not have regard to a statement of principles could not be considered as acting in accordance with the legislation. … This may expose health professionals to unintended criminal or civil liability or disciplinary proceedings for unprofessional conduct or professional misconduct.

5.51 In a joint submission, two academics submitted that:

> the term 'have regard to' is not determinative—a decision-maker or actor could indeed have regard to the principles, and still make a decision which is arguably inconsistent with those principles on the basis that they gave greater regard to other factors in reaching their decision. There are also evidentiary difficulties with establishing whether a person did indeed 'have regard to' the relevant principles or matters when making the decision.

5.52 The same academics noted that, if principles are adopted, 'the government will be expected to adhere to them' and that this would 'require investment in palliative care and [voluntary assisted dying] services, particularly in remote and rural areas, and for [I]ndigenous and … non-English speaking or migrant communities'. Another respondent observed, however, that the investment required 'to ensure equal access' might not be available.

5.53 Others suggested that a requirement to have regard to a statement of principles could undermine the dignity and right to life of vulnerable people:

> Unintended consequences would include legislating a definition of human dignity and quality of life that introduces degrees of human dignity, for example, certain changes in bodily functions such as capacity to feed oneself or toilet without assistance may be regarded as diminishing quality of life and with it human dignity. The law then indicates that all who were born with or have acquired a disability that may have these same effects has less quality of life and this may foster a 'better off dead' mentality with regard to perceptions of the rights of such people to receive treatment that is life sustaining.

The principles that should be included

5.54 There were various and mixed responses on what principles should be included or how they should be worded.

5.55 Some respondents expressed general or qualified support for the principles in the Victorian Act, the Western Australian Act, the White and Willmott Model, or some combination of those sources.

5.56 For example, STEP Queensland and STEP Australia supported the White and Willmott Model 'because it is succinct and potentially less complex than either the Victorian or Western Australian principles' and as such 'aligns with the aim of the proposed legislation to be easy to understand'.

5.57 Christians Supporting Choice for Voluntary Assisted Dying submitted that they 'like the brevity' of the White and Willmott Model, 'but feel the more each state [voluntary assisted dying] Act is consistent with other states (and territories) the better'. They preferred the wording of the Western Australian Act.

5.58 As noted, Professors White and Willmott submitted that they 'continue to support the White and Willmott Model principles and approach' but that '[t]his does not imply that we do not support the additional concepts added in the Western Australian principles'.

5.59 Two academics jointly submitted that the formulation of principles in the Western Australian Act is 'more robust' and is preferable because it recognises 'the right to provision of palliative care', 'equality of access … regardless of where in the state the patient is located', 'the importance of not discriminating against people in the provision of end of life choices on the basis of culture and language', and the need for 'protection

from coercion, as well as abuse'.

5.60 However, some respondents disagreed with or were critical of the principles in the Victorian or Western Australian legislation or in the White and Willmott Model. For example, Catholic Health Australia expressed the view that the Victorian and Western Australian principles 'are equally deficient' in that '[m]any of the principles are incompatible with [voluntary assisted dying]'. A member of the public suggested that the principles in Victoria and Western Australia 'confuse principles with the implementation model, which is ownership and control by the medical profession'.

5.61 Various comments were made about the principles in the Victorian and Western Australian legislation and the White and Willmott Model, with some respondents noting concerns about, or qualifying their support for, specific principles. The responses reveal some of the underlying complexities and different ways broadly framed general principles may be interpreted and applied. For example, it was submitted that:

- 'the right to life is *the* fundamental human right' and the law should not suggest that 'there are degrees of dignity influenced by arbitrary assessment[s] of quality of life';[24]
- the principles should include some expression of respect for an adult's autonomy, dignity or freedom of choice—but should not create 'a "rule" that autonomy is paramount',[25] recognising that 'there are contested views in ethics regarding its definition and limits as well as the weight it should be given among a variety of ethical principles which are used to determine good healthcare outcomes';[26]
- '[p]eople should be able to make informed choices about the end of their life'—but the principles should not refer to voluntary assisted dying as 'medical treatment';
- '[a]ccess to quality information to support decision making is also of key importance to consumers',[27] recognising, for example, that '[a]n individual can only make a choice based on the information to which they have access';[28] and that the 'availability of all options assumes an environment where a person has palliative care options', as well as other clinical and medical services;[29]
- one of the principles should be 'that all people approaching the end of life are provided with high quality palliative care to minimise their suffering and maximise their quality of life'—but palliative care and voluntary assisted dying are distinct, and 'the emphasis on palliative care as an alternative to euthanasia has no place in legislation *about* euthanasia';[30]
- maintenance of the therapeutic relationship between doctor and patient is important, but may not be attainable in practice, and the expression of this principle could be 'ambiguous' with respect to a medical practitioner's freedom of conscience;[31]
- core values should include that '[o]pen discussion about death and dying should be encouraged and promoted' and that '[e]nd of life care should address the needs of families and carers';
- the additional inclusions in the Western Australian Act about equality of access and 'genuine choices' for people in regional areas are favourable,[32] recognising that 'Western Australian and Queensland share geographical similarities'—but

24 (Emphasis in original), referring to *Voluntary Assisted Dying Act 2017* (Vic) s 5(1)(a); *Voluntary Assisted Dying Act 2019* (WA) s 4(1)(a); and QLRC Consultation Paper No 79 (2020) [3.17], [3.19].

25 Referring to White and Willmott Model cl 5(b).

26 Referring to *Voluntary Assisted Dying Act 2017* (Vic) s 5(1)(b); *Voluntary Assisted Dying Act 2019* (WA) s 4(1)(b).

27 Another respondent submitted that 'people's right to adequate and appropriate support for decision-making' is included in the *Guardianship and Administration Act 2000* and should apply to a voluntary assisted dying decision 'where the person has sufficient capacity (with support) for that decision'.

28 See White and Willmott Model cl 5(f).

29 Referring to QLRC Consultation Paper No 79 (2020) [3.28][3.30]. Some respondents also submitted that a higher threshold for 'informed consent' should be required in relation to voluntary assisted dying decisions.

30 (Emphasis in original).

31 See *Voluntary Assisted Dying Act 2017* (Vic) s 5(1)(e); *Voluntary Assisted Dying Act 2019* (WA) s 4(1)(e).

32 See *Voluntary Assisted Dying Act 2017* (Vic) s 5(1)(h); *Voluntary Assisted Dying Act 2019* (WA) s 4(1)(h)–(i). See also White and Willmott Model cl 5(d).

this should refer to a person's 'identity eg. LGBTIQ+' as well as their culture and language, and 'without real access to adequate healthcare options' the 'notion of genuine choices' would further contribute to '[d]iscrimination through lack of access to palliative care';[33]

- the principles should refer to the need to protect people from abuse or coercion—but protections from coercion or undue influence are difficult to enforce and the only safeguard is 'to ensure that people have access to health and aged care institutions where they are guaranteed that they will not be offered or pressured into [voluntary assisted dying]';[34] and
- the principles should support respect for an individual's beliefs and values and health care workers' freedom of conscience.

Alternative formulations

5.62 Some respondents proposed alternative formulations.

5.63 For example, Dying With Dignity NSW suggested the following principles, drawing on the Victorian Act, the Western Australian Act and the White and Willmott Model:

1. Autonomy and dignity of the person requesting [voluntary assisted dying]
2. Relief of suffering
3. Freedom of conscience for both patients and medical practitioners
4. The right to the best palliative care
5. Equality of access to any scheme
6. Sensitivity to the diversity in society, including recognition of the cultural values of Indigenous peoples
7. Legal protection for medical practitioners who participate in any scheme
8. Protection for people from coercion and abuse
9. Conformity to medical ethics and best practice
10. Not making the scheme so complicated that it sets up barrier to access

5.64 The Queensland Law Society submitted that the legislation should expressly state, and require a person to act in accordance with, the following two principles, which 'require a careful balancing':

- The legislation must support and uphold the right of an individual, including autonomy and self-determination, with respect to healthcare, choice and decision-making; and
- Appropriate safeguards must be included in the framework that effectively protect an individual and ensure that a decision to access the scheme is made voluntarily and without coercion.

5.65 One respondent, a retired nurse, suggested the principles should be based on those in the White and Willmott Model and the following 'guiding principles' of Palliative Care Australia:[35]

> People living with a life-limiting illness are supported and respected whether or not they choose to explore or access voluntary assisted dying.
>
> People exploring voluntary assisted dying will not be abandoned

33 Referring to QLRC Consultation Paper No 79 (2020) [3.31]–[3.33].
34 Referring to QLRC Consultation Paper No 79 (2020) [3.26]–[3.27].
35 Referring to Palliative Care Australia, *Guiding principles for those providing care to people living with a life-limiting illness (June 2019)* <https://palliativecare.org.au/pca-guiding-principles-voluntary-assisted-dying>.

> Respectful and professional behaviour towards colleagues and coworkers regardless of their views on voluntary assisted dying
>
> Effective communication is an important part of quality care
>
> Ongoing development of knowledge, skill and confidence is required to provide competent and safe care to people living with a life-limiting illness
>
> Self-care practice is a shared responsibility between individuals, colleagues and organisations
>
> Continue to learn from evidence and evolving practice to drive quality improvement in voluntary assisted dying

5.66 Another respondent submitted that the principles 'should be determined by disabled people ourselves, not non-disabled people making assumptions'.

5.67 A couple of respondents suggested that the legislative principles should be the same as those the Commission identified to guide and inform our recommendations.[36]

THE ISSUES

5.68 The general issue is whether the draft legislation should include a statement of purposes or principles to aid its interpretation or operation, or both.

5.69 The words 'aid the interpretation' may be understood in a broad sense as aiding an understanding of the legislation by the general public, participants in the scheme and authorities about a number of things. They include:

- the purposes of the Act;
- how it is intended to operate; and
- the principles that underpin it.

5.70 Many respondents addressed this issue in that broad sense, rather than the narrow sense of a court or tribunal interpreting a piece of legislation.

5.71 Part of what a legislative statement of principles is hoped by some to achieve can be achieved by a legislative statement of purposes and with supporting materials outside the Act.

5.72 The purpose or purposes of an Act are usually stated in its opening sections. Those purposes can be more succinctly and helpfully stated by a purpose provision than in a lengthy statement of principles.

5.73 Guidance about how the Act is intended to operate can more usefully be provided in supporting materials that do not form part of the Act. For example, they might explain in simple terms the eligibility criteria, the request and assessment process and the administration of substances. Supporting materials might use words, diagrams and pictures that are able to be understood by individuals with varying levels of literacy and in different languages.[37]

5.74 There remains, however, a role for an accessible statement of the principles that underpin the legislation. The issue for the Commission is to identify what might be the beneficial and the detrimental consequences of including such a statement in addition to a purposes provision. This centres on the aim of a statutory statement of principles, assuming a statement of purposes is included in the draft Bill.

5.75 Our Consultation Paper and many submissions addressed whether a statement of principles might aid the operation of the draft Bill. The proposition is that it might influence decisions and practices.

36 See QLRC Consultation Paper No 79 (2020) [3.2]. The Commission's guiding principles are discussed in Chapter 4 above.
37 See also Chapter 21 below.

5.76 The aim of influencing decisions and practices so that they are made in accordance with principle is commendable. However, principled guidance on decisions and practices is best given in the context of a specific decision or practice. It may be in the form of a principle or set of principles, and accompanying guidelines, that are developed for the exercise of a particular power or function.

5.77 Also, as previewed in [5.21]–[5.22] above, a list of principles containing matters which may conflict, be irrelevant to the task or decision at hand or be stated in overly broad terms may lead to confusion or uncertainty that impedes, rather than improves, the operation of the Act.

5.78 Therefore, there is an argument that specific principles and obligations should be stated within the relevant substantive provisions of the draft Bill, rather than in what one respondent described as a 'generic list' of principles.

5.79 The case for a statement of principles has been articulated by a number of respondents. Such a statement informs and educates the public and participants about the principles that inform the draft Bill's provisions. It provides general guidance to those wishing to access the scheme and those who exercise powers and perform functions under the draft Bill.

5.80 The issue is whether those benefits are outweighed by disadvantages. Those disadvantages have been identified in submissions and may be summarised as follows.

5.81 First, if persons exercising a power or performing a function are bound to have regard to a long list of principles, many of which are expressed at a level of generality or abstraction, they may 'feel paralysed' in trying to balance a range of matters, and delay performing their function. Also, they may be risk averse about performing such an uncertain balancing act where there may be criminal or civil consequences of being accused of not having had regard to one or more of the principles.

5.82 Second, the inclusion of a list of principles to which regard must be had leaves uncertain the extent to which those principles qualify other specific provisions in the draft Bill. The argument is that these matters should be the subject of specific and clear provisions, not clouded by general principles. For example, a patient's right to continuity of care and the responsibilities and protections of an institution that does wish to assist in the process of voluntary assisted dying are matters mentioned in submissions in the context of principles. Should they be the subject of specific provisions, rather than included in a list of principles?

5.83 Third, general principles about equality of access to services and high quality palliative care throughout the State may give rise to an expectation of investment in those services. That expectation may be unrealised if governments do not make the required investment.

5.84 It is hard to divorce arguments about whether the draft Bill should contain a statement of principles and whether they should be principles to which a person 'must have regard' from the issue of what those principles should be.

5.85 An associated issue is whether certain principles should not be stated in the draft Bill because they are stated or belong elsewhere. The individual human rights stated in the HR Act guide the interpretation of legislation, and it has been argued that it is unnecessary to restate them. Other statutes or guidelines govern health care rights, disability rights and rights against discrimination.

THE COMMISSION'S VIEW

5.86 The draft Bill should include a statement of purposes or objectives to aid its interpretation. We propose the following:

> The main purposes of the Act 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.

5.87 There is also a role for a statement of the principles that underpin the draft Bill. Such a statement informs and educates the public and participants about the principles that inform the draft Bill. It also provides general guidance to those wishing to access the scheme and those who exercise powers and perform functions under the draft Bill.

5.88 However, requiring every person who exercises a power or performs a function under the draft Bill to have regard to a long list of principles, some of which may be irrelevant to the task or decision at hand, is likely to cause confusion and uncertainty, and impede, rather than improve, the operation of the draft Bill.

5.89 Guidance on decisions and practices is best given in the context of a specific decision or practice. It may form part of the relevant legislative provision or be contained in accompanying guidelines developed for the exercise of a particular power or function. Therefore, we do not recommend that a person exercising a power or performing a function under the draft Bill 'must have regard to' all the principles stated at the start of the draft Bill.

5.90 The general statement of principles to be included at the start of the draft Bill should be like those in the Western Australian Act and the White and Willmott Model. They should not unnecessarily restate principles that are in other laws, such as the HR Act, or laws that govern health care rights, disability rights and rights against unlawful discrimination.

5.91 Some principles may be said to be aspirational and require resources to be realised. However, this is not a reason to not state them.

5.92 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'.[38]

5.93 The Parliamentary Committee recognised that:[39]

> palliative care needs to be adequately resourced and supported irrespective of whether voluntary assisted dying legislation is introduced or not 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.

5.94 The Commission agrees. Therefore, any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative

38 See terms of reference, scope.

39 Qld Parliamentary Committee Report No 34 (2020) 109. See further the Parliamentary Committee's recommendations on palliative care and end of life care in Qld Parliamentary Committee Report No 33 (2020).

care. People who are approaching the end of life should have the choice to access high quality care, including palliative care. The introduction of a process for voluntary assisted dying should not reduce the availability of palliative care or place pressure on individuals to choose that option because they feel they are a burden on others.

5.95 We propose the following legislative statement of principles:

The principles that underpin the Act 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.

RECOMMENDATIONS

5-1 The draft Bill includes a statement of purposes or objectives to aid its interpretation. 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.

5-2 In addition, the draft Bill includes a statement of the principles that underpin the legislation. Those principles 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.

CHAPTER 6

Initiating a discussion about voluntary assisted dying

Chapter 6: Initiating a discussion about voluntary assisted dying

CHAPTER SUMMARY

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; or
- 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 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.

VICTORIA

The Victorian provision

6.1 The Victorian Act prohibits a registered health practitioner, in the course of providing a health service to a person, from initiating a discussion about voluntary assisted dying:[1]

> (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person—
>
> (a) initiate discussion with that person that is in substance about voluntary assisted dying; or
>
> (b) in substance, suggest voluntary assisted dying to that person.
>
> (2) Nothing in subsection (1) prevents a registered health practitioner providing information about voluntary assisted dying to a person at that person's request.

1 *Voluntary Assisted Dying Act 2017* (Vic) s 8.

6.2 The prohibition has a broad scope. It applies to registered health practitioners, including medical practitioners, who are providing health services or professional care services[2] to a person.[3]

6.3 Such services would appear to cover almost any service or any consultation that a registered health practitioner would provide to their patient.[4]

6.4 A contravention of the prohibition is unprofessional conduct under the Health Practitioner Regulation National Law.[5] This may have potentially serious consequences for the practitioner, including the suspension, cancellation of, or imposition of conditions on, the practitioner's registration.[6]

6.5 The Victorian Act does not specify what amounts to initiating a discussion that is 'in substance about voluntary assisted dying'. However, the use of the words 'in substance' would suggest that the health practitioner does not need to use the phrase 'voluntary assisted dying' to contravene the prohibition. It would likely cover informing the patient about eligibility requirements and the steps the patient must take to start the process. The prohibition also covers providing written material about voluntary assisted dying to the patient unless the patient has requested that material.[7]

6.6 The prohibition adopts the Victorian Panel's view that 'a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship'.[8]

6.7 The aim of the prohibition is to ensure that a person is not coerced or unduly influenced into accessing voluntary assisted dying.[9] The Panel explained that:[10]

> a person should be able to seek information about voluntary assisted dying with a medical practitioner they trust and with whom they feel comfortable before beginning a formal process to access voluntary assisted dying. This will allow a person to consider information without feeling pressured to commence the process. To prevent coercion or inadvertent pressure, a health practitioner will not be able to raise or initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

6.8 The Panel believed that ensuring requests for access to voluntary assisted dying were voluntary was a key means of protecting those who may be vulnerable to abuse, including elder abuse. In that context, the prohibition may guard against families influencing health practitioners to introduce the topic to a patient who might be feeling a burden on their family.[11]

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2 'Health service' and 'professional care services' include matters such as the assessment of a person's physical, mental or psychological health, the prevention or treatment of a person's illness, injury or disability, a health related disability, a palliative care or an aged care service, the prescribing or dispensing of a drug or medicinal preparation, a therapeutic counselling and psychotherapeutic service, a service provided under a disability service under the *Disability Act 2006* (Vic) and a service provided by a registered NDIS provider within the meaning of the *National Disability Insurance Scheme Act 2013* (Cth): *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definitions of 'health service' and 'professional care services'); *Health Complaints Act 2016* (Vic) s 3 (definition of 'health service'). Professional care services are those provided under a contract of employment or a contract for services.

3 A 'registered health practitioner' means a person registered under the Health Practitioner Regulation National Law to practise a health profession (other than as a student): *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of 'registered health practitioner'). A 'health profession' means the following professions, and includes a recognised specialty in any of the following professions: Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist); medical; medical radiation practice; midwifery; nursing; occupational therapy; optometry; osteopathy; paramedicine; pharmacy; physiotherapy; podiatry; and psychology: Health Practitioner Regulation National Law s 5 (definitions of 'health practitioner' and health profession'). The types of practitioner to whom this prohibition would apply include a medical practitioner, a nurse, an allied health practitioner, a psychologist, a paramedic and a pharmacist.

4 C Johnston and J Cameron, 'Discussing voluntary assisted dying', (2018) 26 *Journal of Law and Medicine* 454, 456.

5 *Voluntary Assisted Dying Act 2017* (Vic) s 8(3). See the discussion of the Health Practitioner Regulation National Law below in relation to concerns about health practitioners' conduct.

6 Health Practitioner Regulation National Law (Victoria) pt 8.

7 Johnston and Cameron, above n 4, 2.

8 Vic Ministerial Advisory Panel Final Report (2017) 91, Rec 8.

9 Ibid 91.

10 Ibid 15.

11 H Platt, 'The Voluntary Assisted Dying Law in Victoria–A Good First Step But Many Problems Remain' (2020) 27 *Journal of Law and Medicine* 539, 541.

6.9 Some commentators are concerned about the potential uncertainty for health practitioners in determining whether a person has raised voluntary assisted dying sufficiently for the health practitioner to be able to discuss it with the person.[12]

Voluntary assisted dying: guidance for health practitioners

6.10 The Victorian guidance for health practitioners explains that the patient must make a clear and unambiguous request for assistance to deliberately end their life. However:[13]

> Patients might ask about voluntary assisted dying in a variety of ways; they may not use the exact phrase 'voluntary assisted dying'. If the health practitioner is unsure about what the patient is asking about, they should clarify with the patient and seek to elicit more information, relying on their existing clinical skills in having end-of-life care conversations, and using open-ended questions such as: 'Can you tell me more about that?', 'What do you mean by that?', 'Tell me more about what you mean' or 'What are you asking me about?'.

6.11 It also explains how the prohibition is to be applied in practice, with examples of patient utterances that would and would not constitute patient requests for information or access to voluntary assisted dying.

6.12 The following examples are said to be not clear enough to allow the health practitioner to provide information about voluntary assisted dying:[14]

> Can you give me all of the options?
>
> I'm tired of life and just want to die.
>
> I've had enough of this. I just want to get it over with.
>
> Isn't there something you can do to put an end to this?
>
> If animals can be put down when they're suffering, why can't I?

6.13 The guidance suggests that, in the above situations, the practitioner should use open-ended questions to explore what the patient wants, having regard to the context in which the statement is made, and provide information about the patient's end of life care options but excluding voluntary assisted dying. The practitioner might also refer the patient to the Department of Health and Human Services end of life care website for further information.

6.14 The following statements, while dependent on context, may amount to a request for voluntary assisted dying information:[15]

> I would like you to assist me to die.
>
> Can you help me die?
>
> How do I get that pill they say you can get to end it all that I can take when it all gets too much?

6.15 The guidance suggests that, in the above circumstances, if the health practitioner is clear that the patient is asking for information about voluntary assisted dying, the health practitioner, if qualified to do so, should:[16]

> explore and clarify the patient's situation, encourage them to talk about how they are feeling, and address any specific concerns or needs they may have. The health practitioner can talk about all the options for treatment and care.

12 Ibid 539; B Moore, C Hempton and E Kendal, 'Victoria's Voluntary Assisted Dying Act: navigating the section 8 gag clause' (2020) 212(2) *Medical Journal of Australia* 67.

13 Vic Guidance for Health Practitioners (2019) 13.

14 Ibid 14.

15 Ibid. Conversations, including the exact nature of the patient's request, should always be recorded in the patient's medical record: 15.

16 Ibid 14. See also 17: The medical practitioner should listen without judgement; ensure the patient understands his or her prognosis and all their treatment and care options, explore the patient's current circumstances, treatment and care preferences and motivation for the request.

6.16 It also states, '[o]nly a registered medical practitioner can accept and act on a patient's specific request to access voluntary assisted dying'.[17]

6.17 If a medical practitioner has been told by another health practitioner that the patient has asked about voluntary assisted dying, the medical practitioner does not need to wait until the patient raises the issue during later consultations. The intention of the prohibition is to protect individuals who may be open to suggestion or coercion, not to discourage open discussions driven by the individual.[18]

Criticisms of the provision in point of principle

6.18 Professors White and Willmott and Drs Del Villar and Close analysed the prohibition in Victoria against the objectives of the Act and concluded that it is problematic. This is because:[19]

- It conflicts with the policy goal of respecting autonomy, particularly by preventing a person who asks about all possible end of life options from being informed about voluntary assisted dying, unless they know to ask about it and do so.
- It undermines the policy goal of providing high quality care by preventing open discussions between practitioners and patients about end of life care.
- A similar prohibition does not exist in relation to any other lawful medical service.
- There is no comparable prohibition in any overseas jurisdictions that have legalised voluntary assisted dying.
- The uncertainty surrounding the scope of the prohibition is concerning and may have a chilling effect on open dialogue between practitioners and patients about end of life care.

6.19 Professor White and his co-authors conclude:[20]

> In summary, although this prohibition may align with the policy goal of safeguarding the vulnerable (and some may dispute the premise that medical practitioners would be influential in a person's decision to make a request), the significant conflict with respecting autonomy and the risk to high-quality care means it is not consistent with the *[Voluntary Assisted Dying] Act's* policy goals overall.

The provision in practice

6.20 The Voluntary Assisted Dying Review Board reported feedback it had received from applicants, contact people, and medical practitioners suggesting improvements to the experience of people accessing the scheme. It suggested that medical practitioners be allowed to initiate a conversation about voluntary assisted dying.[21]

6.21 Consultations with knowledgeable participants in Victoria indicated that the Victorian provision is problematic in practice.

6.22 A recent study into the perspectives and experiences of Victorian doctors during the first 12 months of the operation of the Victorian Act provides some insight into how doctors were dealing with the prohibition.[22] Of the 25 doctors participating in the study, 14 frequently mentioned the prohibition when talking of their experiences of participating in voluntary assisted dying.[23] Many suggested that the prohibition should be repealed.

17 Ibid 16.
18 Ibid 16.
19 B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 440.
20 Ibid.
21 Voluntary Assisted Dying Review Board Report of Operations January-June 2020 (2020) 16.
22 J Rutherford, 'Doctors and the *Voluntary Assisted Dying Act 2017* (Vic): Knowledge and General Perspectives' (2020) 27 *Journal of Law and Medicine* 952. For the purposes of the study, 25 Victorian doctors from a range of specialities were interviewed, most of whom had at least 5–10 years of practising experience.
23 Ibid 964.

6.23 Study participants considered that the prohibition can act as an access barrier for those seeking voluntary assisted dying because it requires the patient to be able to frame and articulate their request correctly, have health literacy, and not be in an anxious state, which may be an issue for some end of life patients. Participants believed that the prohibition has a disproportionate effect on the socio-economically disadvantaged.[24] Another concern is that it delays eligibility assessments from beginning until the doctor is sure an unequivocal request for voluntary assisted dying has been made. A doctor cannot properly explore that request and ensure that the patient's choice is fully informed.[25]

6.24 Participants also questioned the policy rationale for the prohibition, namely that it helps ensure the voluntariness of the patient's request. The prohibition assumes that patients will be able to raise the issue of voluntary assisted dying when gravely ill and that patients are aware of the legal requirement to raise the issue first.[26]

6.25 Similarly, the prohibition is said to work against the policy goal of providing high quality care.[27] Some argue that while the prohibition may protect against coercion or undue influence, it may be at the expense of excluding a cohort of people who might be interested but are never made aware that this option is available to them.[28]

6.26 The study's findings are supported by a qualitative survey of Victorian clinicians conducted before the legislation commenced. The survey found that doctors were not comfortable with the prohibition, believing that it challenges good doctor–patient communication.[29] Some doctors believed that the prohibition could disadvantage vulnerable patients.[30]

WESTERN AUSTRALIA

6.27 The Western Australian Joint Select Committee recommended against a prohibition on health practitioners initiating a discussion about voluntary assisted dying.[31] It considered that requiring health professionals to discuss the full range of responses to the challenges encountered by patients at the end of life was the best way to achieve optimal clinical outcomes for a patient.[32]

6.28 The Ministerial Expert Panel did not support the Victorian prohibition. It agreed with the Joint Select Committee that health practitioners should not be restricted in their ability to have comprehensive end of life discussions with a patient.[33] This position aligns with views arising from consultation.[34]

6.29 Ultimately, the Panel recommended that a practitioner should be allowed to raise the topic of voluntary assisted dying with a patient, when appropriate, to ensure that the patient can make fully informed end of life decisions. It considered that health practitioners have a professional duty to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying, which would be a legal option for some people.[35]

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24 Ibid.
25 Ibid.
26 Ibid.
27 White et al, above n 19, 440.
28 Johnston and Cameron, above n 4, 463.
29 R McDougall and B Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation' (2020) 21 *BMC Medical Ethics*, Article 38 online <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5>, citing R McDougall et al, '"This is uncharted water for all of us": challenges anticipated by hospital clinicians when voluntary assisted dying becomes legal in Victoria' (2020) 44 *Australian Health Review* 399. In this study, hospital clinicians in two Melbourne hospitals were asked about the perceived challenges of the then yet to commence Victorian legislation. See also, Johnston and Cameron, above n 4; Moore, Hempton and Kendal, above n 12, 67.
30 McDougall and Pratt, above n 29. See also R McDougall et al, above n 31, 399 D Table 3, which reports that a junior doctor wondered 'If we are not able to educate them that [voluntary assisted dying] exists or discuss it as an option, doesn't that mean we are being biased in our medical service to those who are educated and knowledgeable?'
31 WA Joint Select Committee on End of Life Choices Report (2018) [6.78]–[6.79].
32 Ibid [6.79].
33 WA Ministerial Expert Panel Final Report (2019) 31.
34 Ibid 30.
35 Ibid 31, Rec 6.

6.30 The Western Australian Bill did not originally include a prohibition on starting a discussion about voluntary assisted dying. When the Bill was introduced, it was noted in the Parliament that:[36]

> There should not be an attempt to censor the conversations that health practitioners have with their patients and they should be able to raise and discuss voluntary assisted dying in the same way as other serious health or medical decisions at end of life.

6.31 During the parliamentary debates, however, the Bill was amended to include a new clause that was enacted as section 10 of the Western Australian Act.

6.32 The amendment was explained:[37]

> Preventing a medical practitioner from informing a patient about a legally valid option [as is the case in Victoria] is an extraordinary measure that is fundamentally out of step with the basic principles of informed decision-making. It is fundamental to the proposed model for voluntary assisted dying in Western Australia that the patient's decision will be well informed. … This is not about a medical practitioner suggesting voluntary assisted dying to a patient—it is about appropriately informing patients about their choices in a manner consistent with professional standards and in alignment with existing informed consent responsibilities. The bill has been drafted to enable appropriate access and provide essential safeguards.

6.33 The amendment was proposed after issues were raised in the Lower House about the potential for coercion and improper influence over vulnerable persons, and consultations with stakeholders, including the AMA. It was said to reflect good clinical practice and the current holistic context in which doctor–patient discussions occurred.[38]

6.34 Like Victoria, the Western Australian Act prohibits the initiation of a discussion about voluntary assisted dying by a health care worker in the course of providing services to the person unless the practitioner is providing information about voluntary assisted dying to the person at their request.[39] A contravention of the prohibition may be unprofessional conduct under the Health Practitioner Regulation National Law (Western Australia).[40]

6.35 In contrast to Victoria, the Western Australian prohibition does not prevent a medical practitioner or nurse practitioner initiating a discussion about voluntary assisted dying if, at the same time, they also inform the person about:[41]

(a) the treatment options available to the person and the likely outcomes of that treatment; and

(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

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36 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health); Western Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 7433 (S Dawson, Minister for Environment).

37 Western Australia, *Parliamentary Debates*, Legislative Council, 21 November 2019, 9121–2 (S Dawson, Minister for Environment).

38 Ibid 396 (S Dawson, Minister for Environment).

39 *Voluntary Assisted Dying Act 2019* (WA) s 10(2), (4). The Western Australian prohibition has a wider ambit than the Victorian provision as it applies to a registered health practitioner and any other person who provides health services or professional care services: s 10(1) (definition of 'health care worker'). A 'health service' has the meaning given in the Health Services Act 2016 (WA) s 7: *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'health service'). A 'health service' is 'a service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing'. It includes a service provided to a person at a hospital or any other place; a service dealing with public health; a support service and provision of goods for a service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing. 'Professional care services' is defined in s 5 of the *Voluntary Assisted Dying Act 2019* (WA) to mean any of the following provided to another person under a contract of employment or a contract for services:

(a) assistance or support, including the following—
  (i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals;
  (ii) assistance for persons with mobility problems;
  (iii) assistance for persons who are mobile but require some form of assistance or supervision;
  (iv) assistance or supervision in administering medicine;
  (v) the provision of substantial emotional support;

(b) a disability service as defined in the Disability Services Act 1993 s 3.

40 *Voluntary Assisted Dying Act 2019* (WA) s 10(5). See also Health Practitioner Regulation National Law (Western Australia) pt 8. Section 10(5) overrides s 11(1) of the *Voluntary Assisted Dying Act 2019* (WA), which provides that:

> A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Western Australia).

41 *Voluntary Assisted Dying Act 2019* (WA) s 10(3).

6.36 This allows a medical practitioner or a nurse practitioner to initiate a discussion about voluntary assisted dying as part of a wider discussion about the person's treatment and palliative care options and their likely outcomes. Other health care workers, however, remain subject to the prohibition.

TASMANIA

6.37 Section 17(1) and (2) of the Tasmanian Act provides:[42]

> (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing the services to the person—
>
> (a) initiate discussion with the person that is in substance about the voluntary assisted dying process; or
>
> (b) in substance, suggest to the person that the person may wish to participate in the voluntary assisted dying process
>
> (2) Nothing in subsection (1) prevents a medical practitioner from taking an action referred to in subsection (1) if, at the time of taking the action, the medical practitioner also informs the person about—
>
> (a) the treatment options available to the person and the likely outcomes of that treatment; and
>
> (b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

6.38 In contrast to Victoria and Western Australia, section 17(3) then provides:[43]

> (3) Nothing in subsection (1) prevents a registered health practitioner who is not a medical practitioner from taking an action referred to in subsection (1) in relation to a person if the registered health practitioner, before the conclusion of the discussion, with the person, in which the action is taken, informs the person that a medical practitioner would be the most appropriate person with whom to discuss the voluntary assisted dying process and care and treatment options for the patient.

6.39 A contravention of the prohibition is capable of constituting unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Tasmania).[44]

6.40 The Tasmanian prohibition was introduced during the passage of the Bill through the Legislative Council. During the second reading debate, it was noted that the limitation in the Victorian Act on discussing voluntary assisted dying as an option with patients was both an oversight and a hindrance to patient care and autonomy. Thus, in Tasmania, as in Western Australia, doctors may discuss the legality and potential availability of

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42 A 'registered health practitioner' means a person registered under the Health Practitioner Regulation National Law (Tasmania) to practise a health profession (other than as a student): *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5 (definition of 'registered health practitioner'). A 'health service' includes services such as a hospital service, a medical service, a paramedical service, a community health service, the supply or fitting of any prosthesis or therapeutic device, any other service (including any service of a class, or description, that is prescribed) relating to the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in, or injury to, persons but does not include a service prescribed to not be a health service: *Tasmanian Health Service Act 2018* (Tas) s 3 (definition of 'health service'); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5 (definition of 'health service'). A 'professional care service' means any of the following services provided to another person under a contract of employment or contract for services:
(a) assistance or support, including the following:
(i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or preparing or eating meals;
(ii) assistance for persons with mobility problems;
(iii) assistance for persons who are mobile but required some form of assistance or supervision;
(iv) assistance or supervision in administering medicine; (v) the provisions of substantial emotional support;
(b) a specialist disability service, within the meaning of the *Disability Services Act 2011* (Tas).
A 'medical practitioner' means a person who is registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession (other than a student) and who is not a psychiatrist.

43 Nothing in subsection (1) prevents a person from providing to a person, at the person's request, information about the voluntary assisted dying process: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 17(4).

44 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 17(5).

voluntary assisted dying as an option with patients and 'all the options regarding end of life care must be fully explained'.[45]

6.41 In its independent review, the Tasmanian Panel noted that the safeguards built into the proposed process for requesting, assessing eligibility for, and accessing voluntary assisted dying are among the most rigorous in the world.[46]

6.42 Participants involved in the Panel's consultations supported the Tasmanian provision on the basis that all people should have access to information so that they can weigh up all options when making their treatment decisions and that discussions about death and dying should be open, transparent and encouraged.[47] As for the Victorian prohibition, participants commented that:[48]

> Victorian doctors were concerned about improperly discussing [voluntary assisted dying] and that sometimes this left patients and families 'in the dark' as some health professionals were reluctant to talk about [voluntary assisted dying] even after the initial request had been made by the patient.

OVERSEAS JURISDICTIONS

New Zealand

6.43 The New Zealand Act states a health practitioner providing any health service to a person must not, in the course of providing that service to the person:[49]

(a) initiate any discussion with the person that, in substance, is about assisted dying under this Act; or

(b) make any suggestion to the person that, in substance, is a suggestion that the person exercise the option of receiving assisted dying under this Act.

6.44 It does not make provision for a medical practitioner or nurse practitioner to initiate a discussion about voluntary assisted dying if that occurs at the same time and as part of a wider discussion about the person's treatment and palliative care options, and their likely outcomes.[50]

6.45 A contravention of the prohibition does not constitute an offence under the Act. However, it may amount to a breach of the Code of Health and Disability Services Consumers' Rights by providing services that do not comply with relevant legal standards and may be the subject of disciplinary proceedings for professional misconduct under the *Health Practitioners Competence Assurance Act 2003* (NZ).[51]

6.46 The Justice Committee inquiry into the New Zealand Bill noted the possible conflict between the *Crimes Act,* which criminalises inciting or counselling suicide, and the Code of Health and Disability Services Consumers' Rights, which states that patients have the right to be informed.[52]

6.47 The Commission considers that this possible conflict is addressed in the draft Bill by providing that authorised voluntary assisted dying is not suicide for the purposes of the Queensland Criminal Code and other legislation. [53]

45 Tasmania, *Parliamentary Debates*, Legislative Council, 15 September 2020, 62 (M Gaffney).
46 Tas Review Panel Report (2021) 11.
47 Ibid 77–8.
48 Ibid 78.
49 *End of Life Choice Act 2019* (NZ) s 10(1). 'Health service' and 'health practitioner' have the meanings given to them by the *Health Practitioners Competence Assurance Act 2003* (NZ) s 5(1) and *End of Life Choice Act 2019* (NZ) ss 4 (definition of 'health practitioner'), 10(4). 'Health service' means a service provided for the purpose of assessing, improving, protecting, or managing the physical or mental health of individuals or groups of individuals. 'Health practitioner' means a person who is, or is deemed to be, registered with an authority as a practitioner or a particular health profession.
50 The provision was one of a number inserted by Supplementary Order Paper No 259, dated 30 July 2019, seeking to amend the End of Life Choice Bill at the Committee of the whole House Stage.
51 *End of Life Choice Act 2019* (NZ) s 10(3).
52 Justice Committee, Parliament of New Zealand, End of Life Choice Bill (April 2019) 37.
53 See Chapter 1 above.

Other overseas jurisdictions

6.48 In other overseas jurisdictions that regulate voluntary assisted dying, health practitioners are not prohibited from initiating a discussion about the topic.

Canada

6.49 In Canada, health care professionals do not commit an offence if they provide information to a person on the lawful provision of medical assistance in dying.[54] Section 241(5.1) of the Criminal Code provides that:

> 241(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.

6.50 There appears to be no restrictions on when the provision of the information about medical assistance in dying can occur. The Canadian Association of MAiD Assessors and Providers (CAMAP) guidance for health practitioners states:[55]

> There is no provision in the law that prohibits healthcare professionals from initiating a discussion about MAiD or responding to questions about MAiD from a patient. All healthcare professionals have a professional obligation to respond to questions about MAiD from patients. Only physicians and nurse practitioners (jointly referred to hereafter as clinicians) involved in care planning and consent processes have a professional obligation to initiate a discussion about MAiD if a patient might be eligible for MAiD. The discussion should include all treatment options, including palliative care and the option of MAiD. The appropriate timing of initiating a discussion about MAiD is determined by the clinical context. Healthcare professionals must not discuss MAiD with a patient with the aim of inducing, persuading, or convincing the patient to request MAiD.

6.51 The CAMAP guidance goes on to state:[56]

> In order for consent to be considered informed the patient must receive information that a reasonable person in the same circumstances would require in order to make a decision about treatment. Such information must include the details of the treatments or other courses of action available, material risks, expected benefits, and side effects of the available treatments. Clinicians should consider whether MAiD should be raised as part of informed consent discussions when a patient appears to be eligible for MAiD.

6.52 Precisely when the issue of MAiD is raised with a potentially eligible patient will usually depend on all the circumstances of the patient and, to avoid harming the medical practitioner–patient relationship, should take place with an understanding of the patient's values, beliefs, goals and fears, as well as previously expressed wishes.[57]

Europe

6.53 In European jurisdictions, there are no provisions about who can initiate a discussion about voluntary assisted dying.[58]

6.54 In Belgium, the physician must ensure that the request is formulated voluntarily, thoughtfully and repeatedly, and does not result from external pressure.[59] It also provides that the physician must, in advance and among other things, inform the patient of their state of health and life expectancy, consult with the patient on the request for

54 *Canada Criminal Code*, RSC 1985, c C-46, ss 241(2), (5.1).
55 Canadian Association of MAiD Assessors and Providers, *Clinical Guidance: Bringing up Medical Assistance in Dying (MAiD) as a clinical care option* (2020) 1.
56 Ibid 3.
57 Ibid 6.
58 See Johnston and Cameron, above n 4, 456, discussing various statutes including *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2; *Belgian Euthanasia Act 2002* art 3(1).
59 *Belgian Euthanasia Act 2002* art 3(1).

euthanasia, and discuss possible therapeutic and palliative care options and their consequences with the patient.[60] The Luxembourg laws are similar.[61]

6.55 In the Netherlands, the physician must be satisfied that the patient's request is voluntary and well-considered.[62] The Netherlands Criminal Code notes that the patient must make the request and cannot ask someone else to do so on the patient's behalf. The Code then states that:[63]

> others may however alert the physician to the fact that the patient has a wish for euthanasia, so that the physician can initiate discussion of the matter with the patient …

6.56 The implication is that the physician will need to raise the issue of euthanasia with a patient in such circumstances, and that there is no restriction on the physician doing so.

United States of America

6.57 State legislation in the United States does not prohibit health practitioners initiating discussion about assisted dying. Each statute requires the person to make a voluntary request to initiate the process.[64] However, there is little attention given to what occurs before the request is made.[65] The focus appears to be on ensuring patients are provided with information about all their options.[66]

6.58 Commentators suggest this approach favours people being fully informed about voluntary assisted dying in order to decide what is in their own interests, whereas a prohibition is more paternalistic and prioritises protecting patients from the influence of their health practitioner.[67]

QUEENSLAND

6.59 The Parliamentary Committee recommended that:[68]

> any voluntary assisted dying scheme in Queensland stipulates that discussion with a medical practitioner about accessing voluntary assisted dying can be instigated only by the person wishing to access voluntary assisted dying.

6.60 In contrast to both the Parliamentary Committee's recommendation and the Victorian Act, the White and Willmott Model does not prohibit the initiation of a discussion about voluntary assisted dying by a health practitioner. Such a prohibition was said to impede the frank discussions between a practitioner and their patient that are necessary for safe and high quality end of life care.[69]

6.61 The MBA's Code of Conduct recognises good communication as underpinning every aspect of good medical practice.[70] Queensland Health also regards communication

60 *Belgian Euthanasia Act 2002* art 3(2)(1).

61 *Luxembourg Law on Euthanasia and Assisted Suicide 2009* arts 2.1(2), 2.2.

62 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2.

63 *The Netherlands Criminal Code* s 3.2 n 20.

64 See, for example, the United States legislation discussed in Johnston and Cameron, above n 4, 456, including *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.805.2.01; *Washington Death with Dignity Act 2008*, RCW § 70.245.020; *California End of Life Option Act 2016*, Cal Health and Safety Code § 443.3; *Vermont Patient Control and Choice at the End of Life Act 2013*, 18 VT Stat Ann § 5283(a); *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-104(1)(c); *Hawaii Our Care, Our Choice Act 2018*, Haw Rev Stat § 2140.2.

65 Johnston and Cameron, above n 4, 456.

66 In Vermont, not only is there recognition that patients have a right to be informed of all their end of life options, doctors who provide the necessary information are protected from liability: *Vermont Patient Control and Choice at End of Life Act 2013*, 18 VT Stat Ann § 5282.

67 Johnston and Cameron, above n 4, 456.

68 Qld Parliamentary Committee Report No 34 (2020) 141, Rec 16. The Parliamentary Committee noted that a number of stakeholders had commented on the restriction on practitioners being able to initiate discussions about voluntary assisted dying: 141.

69 White and Willmott Model, Explanatory Notes 6, referring to the discussion of s 8 of the *Victorian Assisted Dying Act 2017* (Vic) cited in Johnston and Cameron, n 4, 456.

70 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [2.1] Effective communication is an important part of the doctor–patient relationship. It involves interactions which include Informing patients of the nature of, and need for, all aspects of their clinical management: MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.3]. See also Nursing and Midwifery Board of Australia, Code of Conduct for Nurses (March 2018) [2.3].

between health practitioners and patients as important to the health care of patients generally, not just when they are at the end of life. Providing information to patients allows them to make decisions about the most appropriate health care for them.[71] Informed consent is an integral component of the provision of quality, patient-centred health care.[72]

6.62 Also, as a matter of policy and reflective of ethical and legal principles, it is always the patient's[73] decision whether they want to receive health care. No examination, investigation, procedure, intervention or treatment should be provided without the informed agreement or informed consent of an adult patient who has capacity to make decisions.[74]

6.63 Patients must be given sufficient information, in simple terms, that a reasonable patient requires to make a reasonably informed decision about their treatment. Health practitioners are advised to tailor the information to the patient by finding out about their needs, wishes and priorities, and level of understanding about their condition, prognosis and options.[75]

PRACTITIONER CODES OF CONDUCT AND GUIDELINES FOR PATIENTS AT THE END OF LIFE

6.64 Queensland Health's end of life care guidelines state that all patients facing end of life choices have a right to be informed about their condition and their treatment options in an open, honest and compassionate way and that this should include family members. It provides:[76]

> Ideally, discussion with families about treatment options for a patient will have occurred before the patient loses the capacity to determine their end-of-life views and wishes. Uncertainty about prognosis or likely response to treatment should be communicated to the patient's family (preferably in non-technical language) as early as possible.

6.65 Despite the need for honest and well-balanced discussion, practitioners are advised to be sensitive when giving potentially distressing information:[77]

> For example, in end of life situations, discussions with patients may be phrased in such a way as to emphasise a move towards palliative care rather than continuing futile active treatment.

6.66 The importance of early discussion with the patient and family is evident in guidelines and policies about end of life care. They advise that:[78]

> early open, frank and honest communication with patients and families about goals, prognosis and options can improve patient care by identifying, respecting and protecting patients' choices.

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71 Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.2].

72 Queensland Health, Clinical Excellence Division, 'Informed Consent' (22 November 2019) <https://clinicalexcellence.qld.gov.au/resources/informed-consent>.

73 Or that of their substituted decision-maker if the patient lacks capacity to make a decision about their care and treatment.

74 While not directly relevant to the end of life or voluntary assisted dying framework, the information provided to the patient should include, among other things, information about the diagnosis, the recommended health care, including the expected benefits, common side effects and alternative health care options, the material risks of the recommended health care and alternative health care options. It also advises about any significant long term physical, emotional, mental, social, sexual or other expected outcomes the anticipated recovery implications: Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.3].
This approach aligns with the AMA Code of Ethics 2016 [2.1.4] which requires 'doctors to communicate effectively with the patient and obtain their consent before undertaking any tests, treatments or procedures…'. It notes 'For consent to be valid, it must be informed, voluntary and made with appropriate decision-making capacity. To ensure consent is fully informed, the patient should be provided with sufficient information relevant to the decision at hand'.

75 Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.6.1].

76 Queensland Health, Clinical Excellence Division, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*, Document No QH-GDL-462:2019 (January 2018) 102.

77 Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.6.4].

78 Queensland Health, Clinical Excellence Division, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*, Document No QH-GDL-462:2019 (January 2018) 60.

6.67 Queensland Health clinical guidelines regarding Advance Care Planning (ACP)[79] state:[80]

> Ideally, ACP discussions should be initiated early for those with life-limiting illness to optimise the person's quality of life and minimise potentially burdensome and unwanted treatment.

6.68 The ACP clinical guidelines also envisage doctors having a vital role to ensure successful ACP, including initiating conversations about dying: 'First and foremost, they must lead and promote open conversations about dying, death and individual choice that are a prerequisite for effective ACP'.[81]

6.69 Queensland Health guidelines for health professionals in hospital settings about best practice care for people in the last days and hours of life were developed to ensure that people experience the best possible care in this final stage.[82] This involves the use of a care plan covering a range of measures. The guidelines include how the health care team clinically assesses whether a person is 'actively dying'. The determination that a person is 'actively dying' is a prompt to communicating with the patient and family about the care plan.[83] It is implicit that the discussions can be, and generally will be, initiated by the health care team. The guidelines state:[84]

> if death is considered a potential outcome it is important that the healthcare team supports proactive planning. This includes clear communication with the dying person (if appropriate) and/or family/carer(s) about the potential for the person to die, and shared decision making about an appropriate plan of care.

6.70 While health practitioners must provide sufficient and relevant information to patients to make informed decisions about their care and treatment, doctors must recognise the power imbalance in the doctor–patient relationship and must not exploit patients in any way, including physically, emotionally, sexually or financially.[85]

6.71 The Queensland Health guidance also recognises that health practitioners are in positions of power within any health care relationship. The power imbalance can be greater where the patient is vulnerable or from a different cultural or linguistic background than that of the health practitioner.

SUBMISSIONS

6.72 Our Consultation Paper asked whether the draft legislation should prohibit a registered health practitioner from initiating a discussion about voluntary assisted dying with a person while providing health or professional care services to the person.[86]

6.73 Most submissions that responded to this question did not support the inclusion of such a restriction in the draft Bill.

Support for a prohibition on initiating a discussion about voluntary assisted dying

6.74 There was some support among respondents for the prohibition.[87] A common reason

79 Advance care planning (ACP) is a person-centred approach for planning current and future health and personal care that reflects the person's values, beliefs and preferences. The Queensland Health advanced care planning clinical guidelines for Queensland health clinicians seek to establish best practice principles for health practitioners and services that instil ACP into routine practice not limited to those who are at the end of life: Queensland Health, *Advanced care planning clinical guidelines for Queensland health clinicians* (January 2018) 6.

80 Ibid 5.

81 Ibid 45.

82 The care plan covering comfort measures, anticipatory prescribing of medications to manage common symptoms, discontinuation of inappropriate interventions, and psychological and spiritual support of the person and family: Queensland Health, Clinical Excellence Division, *Care Plan for the Dying Person: Health Professional Guidelines* (February 2019) 6.

83 Queensland Health, Clinical Excellence Division, *Care Plan for the Dying Person: Health Professional Guidelines* (February 2019) 6.

84 Ibid 7.

85 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.2.6].

86 QLRC Consultation Paper No 79 (2020) Q-15.

87 Further, although some respondents appeared to believe that health practitioners should be able to discuss the range of options available with their patient, respondents were not always clear about who can initiate the conversation.

was the safeguard it provides against coercion and improper influence by health practitioners. For example, a member of the public submitted that:

> Coercion by medical professionals remains a problem. In Canada, Roger Foley has recorded multiple conversations where medical professionals suggest euthanasia to him over his frequent refusals and objections. It stands to reason many others do not covertly record these conversations, or may simply give in to the pressure and the authority that physicians represent.

6.75 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld also expressed concern about the power imbalance between health practitioners and patients and the esteem in which health practitioners are often held by their patients. It submitted:

> We do not support a health practitioner being able to initiate discussion about voluntary assisted dying as an end of life option. The power dynamic of a health practitioner and patient relationship needs to be considered in this draft legislation. There is the potential for coercion and subtle pressure being applied by any initiation of a conversation about voluntary assisted dying within the context of a therapeutic relationship. This imbalance of power is recognised in the Queensland Health *Guide to Informed Decision-making in Health Care* (2017) which states that the respect by many cultures for a health practitioner's authority and position may act as an impediment to patients making informed decisions.

6.76 One respondent noted the influence a doctor may have over a patient's options, and submitted:

> It is therefore appropriate that doctors be prohibited from initiating the discussion of [voluntary assisted dying] to ensure that patients' fears are not further amplified by a perception that the doctor believes [voluntary assisted dying] to be appropriate for them or in their best interests; particularly as the family members of a patient may already be supporting such a decision unbeknownst to the doctor.

6.77 A medical practitioner submitted that:

> If a treating clinician raises the possibility of voluntary assisted dying with a patient there is potential for this to fracture the therapeutic relationship as it can be interpreted as meaning that the doctor has "given up" and holds no hope …
>
> Thus, it is essential that the patient must be the one to initiate discussion about voluntary assisted dying as an end of life option.

Opposition to a prohibition on initiating a discussion about voluntary assisted dying

6.78 Respondents who opposed a prohibition for medical practitioners initiating a discussion about voluntary assisted dying with their patients expressed various reasons for their opposition.

Providing all relevant information to patients

6.79 A common theme was the potential for prohibition to deny a patient full knowledge of all their end of life options. The Clem Jones Group explained:

> We believe that no medical practitioner should be constrained in providing full professional advice to a patient and that any restriction as proposed in relation to [voluntary assisted dying] would compromise the standard of medical care and advice offered to a patient.

6.80 Similarly, two members of the public noted:

> A prohibition on health professionals initiating a discussion about voluntary assisted dying is inconsistent with the stated objectives. The aim of the legislation is to provide access to voluntary assisted dying. However, a person cannot access the scheme if

> they do not know that it exists … Additionally, a fundamental principle of healthcare is the right to make an informed decision about one's own medical care …

6.81 A retired medical practitioner considered that although 'the gag' is designed to prevent doctors trying to persuade their patient to consent to voluntary assisted dying, it might actually contribute to delays in decision-making at the end of life and increase a patient's suffering. By contrast, early discussion of all possible options can provide comfort to a patient by giving the person a sense of control over their treatment. He argued that the prohibition places a doctor in an unethical position of being unable to provide information of all legally available end of life options and obtain properly informed consent to treatment: 'Provided the doctor discusses voluntary assisted dying in the context of all possible options, particularly the availability and benefits of palliative care, no 'gag' should exist'.

Discharge of duty of care to patients

6.82 Some respondents, including a retired nurse, considered that preventing a health practitioner from discussing a person's full range of options at the end of their life would prevent the practitioner from properly discharging their duty of care to the patient in providing all relevant information to allow the patient to give informed consent.

6.83 Other respondents noted that if voluntary assisted dying is a legal option and a patient is eligible to access it, then, as Dying with Dignity NSW submitted, 'there can be no justification for a medical practitioner withholding information about the process that is perfectly lawful.'

Avoiding inequities and discrimination among patients

6.84 Some respondents considered that not allowing health practitioners to start a discussion about voluntary assisted dying with a patient had the potential to discriminate between those patients who were well educated about health matters and those who were not, particularly those with low levels of literacy and from lower socio-economic backgrounds. Dying with Dignity Victoria submitted:[88]

> We are concerned that some of the more marginalised, less English literate of our patients may be missing out because they are unaware of their rights. It is hard to see a downside to allowing doctors to tell patients about all their options.

6.85 Professors White and Willmott also noted the likely implications of that prohibition on patients who are less health literate or who have English as their second language.

6.86 Several respondents noted that some people have difficulty communicating their needs and wishes, particularly in situations where they are extremely anxious and vulnerable. As part of a clinical study, an academic noted:

> According to participants, [a prohibition of this type] can act as an access barrier for people seeking [voluntary assisted dying], because it requires the patient to be health-literate, not in an anxious state, able to articulate their request for assistance correctly and to communicate it physically, which can be difficult for some end of life patient populations. The access barrier that section 8 creates also disproportionately affects people with lower levels of socioeconomic advantage and literacy, according to participants.
>
> Patient impacts perceived by participants include doctors being unsure about the intent of a poorly expressed request, delay in assessment until the person makes an unequivocal request, and concern that the person might not be making a fully informed treatment choice… The literature recognises that clinical communication is one of the primary domains of [voluntary assisted dying] practice, and emphasises doctors' role

88 Similarly, Christians Supporting Choice for Voluntary Assisted Dying argued that a 'well educated person is more likely to be aware of the VAD option, whereas a less well educated person, or one for whom English is a second language may be unaware of the VAD option.'

> in understanding the request, addressing untreated symptoms, discussing alternatives, explaining the law, talking with family members, and framing [voluntary assisted dying] as a last-resort option.

Exception if the practitioner informs the person about all available treatment options

6.87 Our Consultation Paper also asked, if a prohibition was included, whether it should provide that a discussion about voluntary assisted dying can be initiated with a patient if the patient is informed about their available treatment options and palliative care and treatment options and their likely outcomes.[89] This is the Western Australian approach.[90]

6.88 Supporters of a prohibition mostly believed there should be no exception to it. For example, the Lutheran Church of Australia, Queensland District, submitted that:

> For a medical practitioner to 'normalise' [voluntary assisted dying] as an option, or to first raise it, is and should remain an offence under the Queensland Criminal Code and no exemption allowed for [voluntary assisted dying].

6.89 Some respondents who opposed the prohibition contended that there should be an exception to any prohibition. The underlying theme of their submissions was the need to ensure that end of life patients are informed of all the treatment options available and their likely outcomes.

6.90 For example, AMA Queensland submitted:[91]

> AMA Queensland believes doctors should not be prohibited from initiating a discussion about voluntary assisted dying and similar to Western Australia, the practitioner should be able to inform the patient about other care options including palliative care and treatment options available to the patient at the same time.

6.91 Go Gentle Australia went further and submitted that the legislation should mandate 'that in addition to discussing [voluntary assisted dying], in the same consultation... all other appropriate treatment options be discussed, including, particularly, palliative care'.

DISCUSSION

6.92 The Victorian prohibition was based on concerns about the need to prevent coercion or inadvertent pressure by health practitioners on patients, particularly those vulnerable to abuse.[92]

6.93 By contrast, the Western Australian Ministerial Expert Panel strongly recommended against a prohibition because it risked creating more barriers to timely end of life care planning discussions.[93] The provision introduced during the passage of the legislation through the Legislative Council was essentially a compromise between protecting the vulnerable from undue influence and coercion and ensuring that a medical practitioner or nurse practitioner may inform a dying person about all their treatment options. The prohibition continues to apply to other health care workers.

89 QLRC Consultation Paper No 79 (2020) Q-16.
90 *Voluntary Assisted Dying Act 2019* (WA) s 10.
91 MIGA, although not taking a position on this question, noted that the Western Australia approach of discussing all available healthcare options would avoid some inevitable 'grey areas' associated with determining whether a patient has requested voluntary assisted dying.
92 Vic Ministerial Advisory Panel Final Report (2017) 91–2, Rec 8.
93 WA Ministerial Expert Panel Final Report (2019) 30–1, Rec 6.

6.94 There has been considerable commentary and research around the dynamics of the health practitioner and patient relationship. Health practitioners, particularly medical practitioners, are in a position of considerable trust and influence in their therapeutic relationship and have the relevant clinical knowledge and information crucial to the care and treatment of the patient. Some commentators have noted the power of clinical language and that:[94]

> Health care providers can sway their patients through their words, even unintentionally.

6.95 The power imbalance is more notable in medical practitioners' interactions with vulnerable people, some people with a disability and members of certain cultures. In some cultures, the health practitioner is held in high esteem and as 'knowing best'. This can result in the person being reluctant to openly disagree or ask even basic questions. Some may feel embarrassed about not understanding so do not ask for clarification.[95] The Western Australian Panel noted feedback from stakeholders in the Kimberley region about the particular challenges for the doctor–patient relationship in Aboriginal communities.[96]

6.96 The Victorian Ministerial Advisory Panel noted concerns about elder abuse and considered that the prohibition may guard against families influencing health practitioners to introduce the topic to patients who might already think they are a burden on their families.[97]

6.97 Some suggest that introducing the topic of voluntary assisted dying might be interpreted as the doctor believing that the patient's life is no longer worth living. This may influence the patient to pursue voluntary assisted dying 'if she understands the clinician to be recommending that … is the best choice for her'.[98] A prohibition on the clinician introducing the topic may counter this possibility.

6.98 Comments have been made about the potential for a loss of trust in the practitioner or damage to the patient–doctor relationship, particularly if voluntary assisted dying conflicts with the patient's morals or religious views.[99]

6.99 Conversely, it may be argued that:[100]

> The … prohibition on initiating discussions about voluntary assisted dying may deter health practitioners from having … open and honest [end of life] discussions. This may undermine therapeutic relationships and trust and confidence in health practitioners.

6.100 Commentators have stated that fears about the misuse of power and the impact on the therapeutic relationship do not respect medical practitioners' ability to sensitively conduct end of life conversations, the timing of which is determined by the clinical context.[101]

6.101 Relevant research supports the principle that people should have all the necessary information to make informed decisions about their end of life care. Patients often

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94 ER Brassfield and M Buchbinder, 'Clinical discussion of Medical Aid-in-Dying: minimizing harms and ensuring informed choice' (2021) 104(3) *Patient Education and Counselling* 671, 672.

95 This can also apply to Aboriginal and Torres Strait Islander patients: Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [5.3.3], [5.4].

96 WA Ministerial Expert Panel Final Report (2019) 30-31. The Aboriginal Health Council of Western Australia also noted the risk that the use of complex medical terms when discussing voluntary assisted dying with Aboriginal people as well as the power imbalance could cause patients to feel influenced to make decisions they may not agree with and that practitioner education and training in this dimension needed careful planning.

97 Vic Ministerial Advisory Panel Final Report (2017) 88. See also H Platt, above n 11, 541. The Western Australian Ministerial Expert Panel's consultations with health practitioners found that some health practitioners did not wish to be seen to be unduly influencing patients but it was also considered that patients needed to have an informed choice among end of life options: WA Ministerial Expert Panel, Final Report 31. See also, J Rutherford, L Willmott, B White, 'Physician attitudes to voluntary assisted dying: a scoping review' (2020) *BMJ Supportive and Palliative Care* 15, citing various studies considered in their scoping review.

98 Brassfield and Buchbinder, above n 95, 673.

99 Ibid.

100 Johnston and Cameron, n 4, 462. See also McDougall and Pratt, ', above n 30. While health practitioners have no legal obligation to present patients with all available or possibly relevant treatment options, prohibiting initiated discussion of a specific lawful option does appear to undermine ethical standards regarding communication with patients: Moore, Hempton and Kendal, above n 12, 67.

101 H Platt, above n 11, 541; Canadian Association of MAiD Assessors and Providers, *Clinical Guidance: Bringing up Medical Assistance in Dying (MAiD) as a Clinical Care Option* (2020).

want to have discussions with their medical practitioners about matters such as their condition, prognosis, preferences and all alternative treatment options.[102] Many submissions considered that people at the end of life should have full knowledge of all their lawful options and that not all patients are in the position to start the conversation.

6.102 Practitioner codes of conduct and guidelines around the care and treatment of persons at the end of life clearly recognise those persons' right to be provided with relevant, sufficient, and clear information about their options to enable them to make informed choices. The MBA Code of Conduct states that effective communication is an important part of the doctor–patient relationship. It involves discussing with patients their condition and the available management options.[103] Arguably, preventing medical practitioners from raising the subject of voluntary assisted dying when it is an option for their patient is contrary to the Code of Conduct.[104]

6.103 Health practitioners have ethical obligations not to misuse their position of power. For example, the MBA Code of Conduct states that doctors must recognise the power imbalance in the doctor–patient relationship and must not exploit patients in any way.[105]

6.104 Some commentators consider that preventing a health practitioner from initiating discussion about voluntary assisted dying with patients compromises patients' health knowledge.[106] Canadian research suggests the possibility that not raising the option of assisted dying may itself cause harm to patients if they suffer for longer or the patient has an unacceptable end of life experience.[107]

6.105 Researchers who explored the experiences of medically assisted dying laws in Canada among people living in poverty, including illicit substances users, found that participants had low levels of knowledge about end of life options such as palliative care, hospice, and medically assisted dying. They identified stigma and lack of autonomy as barriers to accessing end of life support.[108]

6.106 There appears to be a lack of awareness and understanding in the community about end of life treatment options.[109] Research suggests that up to 60 per cent of Australians have low levels of individual health literacy.[110] This means that many eligible patients may not know voluntary assisted dying is an option.[111]

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102 L Willmott et al, 'Restricting conversations about voluntary assisted dying: implications for clinical practice' (2020) 10 *BMJ Supportive & Palliative Care* 105, 106. See also, H Platt, above n 11, 560.

103 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.2]. See also, AMA *Code of Ethics* (2016) [2.1.4].

104 H Platt, above n 11, 539 quoting what was then s 3.3 of the AHPRA Code of Conduct. In Canada, where there is no legislative prohibition on initiating health practitioners raising a discussion about assisted dying with patients, the Canadian Association for Medical Aid-in-Dying Providers (CAMAP) have stated that informing eligible patients about assisted dying alongside all other treatment options is an ethical responsibility and a prerequisite to fully informed treatment decisions: Brassfield and Buchbinder, above n 95, 671.
Some practitioner guidelines emphasise the importance of early discussions around care and treatment options for people with end of life illnesses, particularly while the person still has the capacity to make the best possible decisions. The Queensland Health care plan for the dying person guidelines do, possibly due to the imminence of the person's death, state that if death is considered a potential outcome it is important that the healthcare team supports proactive planning which includes clear communication with the person, their family or carers about the potential for dying: Eg, Queensland Health, Clinical Excellence Division, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*, Document No QH-GDL-462:2019 (January 2018) 60; Queensland Health, Advanced care planning clinical guidelines for Queensland health clinicians (January 2018) 5; Queensland Health, Clinical Excellence Division, *Care Plan for the Dying Person: Health Professional Guidelines* (February 2019) 7. The UK Royal College of Physicians has also noted that when future loss of mental capacity is anticipated, early conversations [around prognosis, palliative care and end-of-life] become more pressing and physicians need to be proactive in initiating them: Royal College of Physicians (UK), *Talking about dying: How to begin honest conversations about what lies ahead* (Report, October 2018) 13.

105 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.2.6]. See also, Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [5.3.3], [5.4].

106 McDougall and Pratt, above n 30.

107 Canadian Association of MAiD Assessors and Providers, *Clinical Guidance: Bringing up Medical Assistance in Dying (MAiD) as a Clinical Care Option* (2020); Brassfield and Buchbinder, above n 95, 671, also referring to S MacDonald, 'Leo died the other day', (2019) 191(2) CMAJ E49–E50.

108 J Shaw et al, 'Perceptions and Experiences of Medical Assistance in Dying Among Illicit Substance Users and People Living in Poverty' (November 2019, online) OMEGA: Journal of Death and Dying.

109 Johnston and Cameron, n 4, 458.

110 Ibid.

111 Ibid.

6.107 Even if a patient is aware of the option, many patients at the end of life are elderly, frail and very ill. Others may have low literacy levels or come from non-English speaking backgrounds. Some of those patients hold their medical practitioner in high esteem and may be nervous about raising the topic with the practitioner.[112]

6.108 Contrary to the notion that patients facing terminal conditions may find talking about end of life care or hastening death upsetting, open conversations about palliative care and end of life are often welcomed by patients as a chance to gain more information and have some choice about their treatment.[113] A recent Canadian study of advance-stage cancer patients found that almost 80 per cent felt it to be quite or extremely important for the clinician to proactively assess the wish to hasten death and to discuss the matter.[114] Further, honest end of life discussions between the health practitioner and patient help to engender patient trust in their ability to express their fears.[115]

6.109 During the Tasmanian Panel's consultations, workshop participants commented that the prohibition made Victorian doctors concerned about improperly discussing voluntary assisted dying and some were reluctant to talk about it even when the patient made an initial request. This sometimes left patients and families 'in the dark'.[116] Similarly, research suggests that some practitioners may fear that if a doctor explores a patient's distress 'they will be misinterpreted as having 'initiated' conversations [regarding voluntary assisted dying]'.[117]

6.110 The Victorian prohibition is regarded as a significant barrier to accessing voluntary assisted dying.[118] From a policy standpoint, it has been said to not align with the underlying goal of respecting a person's autonomy to make informed end of life choices by providing all medically effective and legally available treatment options and the provision of high quality health care.[119] Certain guiding principles in the Victorian Act arguably conflict with the prohibition.[120]

6.111 The contradiction between the state, on the one hand, establishing voluntary assisted dying as a lawful choice but, on the other, prohibiting practitioners from initiating discussion of the option has been noted by several commentators.[121] In addition, the Victorian Act, like voluntary assisted dying legislation in other jurisdictions, contains a number of safeguards and offence provisions designed to protect people against the exercise of improper influence and coercion by health practitioners and others.[122]

6.112 The prohibition seems to be inconsistent with the approach taken in other Victorian legislation dealing with end of life options, such as palliative sedation, withdrawal

112 Ibid 463. See also McDougall and Pratt, above n 30. It has been suggested that certain groups, including persons with low levels of health literacy, could potentially miss out on information that could impact on their end of life choices: Moore, Hempton and Kendal, above n 12, 68.

113 Royal College of Physicians (UK), *Talking about dying: How to begin honest conversations about what lies ahead* (Report, October 2018) 4.

114 J Porta-Sales et al, 'The clinical evaluation of the wish to hasten death is not upsetting for advanced cancer patients: A cross-sectional study' (2019) 33(6) *Palliative Medicine* 570.

115 Willmott et al, above n 103, 106.

116 Tas Review Panel Report (2021) 77–8.

117 McDougall et al, above n 30, Table 3, quote from a senior doctor at Health Service 2.

118 Johnston and Cameron, above n 4, 463; McDougall and Pratt, above n 30; H Platt, above n 11, 541.

119 White et al, above n 19, 439–40; Johnston and Cameron, above n 4, '462–3; McDougall and Pratt, above n 30; Willmott et al, above n 103, 105. See also, Canadian Association of MAiD Assessors and Providers, '*Bringing up Medical Assistance in Dying (MAiD) as a clinical care option*'. The approach to discussions of assisted dying in Victoria has been contrasted with the very different attitude of lawmakers in Canada where there is no legislative prohibition on raising a discussion about assisted dying with a patient although counselling a patient to die by suicide is unlawful under the Criminal Code.

120 Johnston and Cameron, above n 4, 462. The most relevant principles are:
(b) a person's autonomy should be respected;
(c) a person has the right to be supported in making informed decisions about the person's medical treatment, and to be given, in a manner the person understands, information about medical treatment options including comfort and palliative care; and
(f) individuals should be supported in conversations with the individual's health practitioners, family and carers and the community.

121 See, Eg, Moore, Hempton and Kendal, above n 12, 68.

122 For example, it must be the person seeking access to voluntary assisted dying who makes the request for access and the person's eligibility must be assessed by two separate medical practitioners. An important eligibility criterion is that the request for access must be voluntary. Offence provisions include inducing a person by dishonesty or undue influence to request voluntary assisted dying.

of sustenance or withdrawal of life support, where there is no restriction on health practitioners initiating a discussion. Given that these measures also may hasten death, it has been argued that there seems no 'compelling reason to view discussion of [voluntary assisted dying] as more likely to unduly influence patients or otherwise cause harm than the discussion of such alternative end-of-life options'.[123]

THE COMMISSION'S VIEW

A prohibition should not apply if the person requests information about voluntary assisted dying

6.113 Consistent with the approach in other jurisdictions, a prohibition should not apply if information about voluntary assisted dying is provided to a person at the person's request.

Health practitioners may initiate a discussion about voluntary assisted dying if, at the same time, they inform the person about other options

6.114 We support the Western Australian approach of prohibiting health practitioners from initiating a discussion about voluntary assisted dying but permitting a medical practitioner or nurse practitioner to do so, if, at the same time, they also inform the person about:[124]

- the treatment options available to the person and the likely outcomes of that treatment; and
- the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

6.115 This approach is preferable to a complete prohibition on all registered health practitioners (including medical practitioners) initiating discussions about voluntary assisted dying. The Victorian prohibition applies even if, at the same time, the registered health practitioner informs the person about available treatment options (and their likely outcomes) and available palliative care and treatment options (and their likely outcomes).

6.116 The Victorian approach of extending the prohibition to include medical practitioners might allay concerns about the potential for undue influence and coercion regarding vulnerable patients. The potential for misuse of power may be particularly heightened by the dynamics and power imbalance in a typical doctor–patient relationship. As discussed earlier, some patients may feel that a medical practitioner is recommending voluntary assisted dying, even if this is not intended. In addition, the therapeutic relationship may suffer if a patient perceives the doctor is raising voluntary assisted dying as an indication that the doctor has 'given up' on them.

6.117 We recognise the importance of those issues. They do not, however, justify a total prohibition on all health practitioners initiating discussions about voluntary assisted dying. Instead, they justify a qualified prohibition, which does not apply if, at the same time, the person is provided with information about their treatment and palliative care options. This is consistent with professional standards and codes of ethics regarding informed consent and respect for patient choice. Those requirements include that patients should be provided with all the necessary information to make informed decisions about their condition, prognosis, preferences and all alternative treatment options.

123 Brassfield and Buchbinder, above n 95, 672.

124 *Voluntary Assisted Dying Act 2019* (WA) s 10(3). Section 17(2) of the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) mirrors s 10(3) of the Western Australian Act. However, as discussed above, s 17(3) of the Tasmanian Act then provides that a registered health practitioner who is not a medical practitioner can initiate a discussion about the voluntary assisted dying process or in substance, suggest voluntary assisted dying to a person provided that, during the discussion, they inform the person that a medical practitioner is the most appropriate person with whom to discuss the voluntary assisted dying process and care and treatment options for the patient.

6.118 There is some evidence, noted above, that doctors oppose being prevented from raising the topic of voluntary assisted dying, particularly when patients may not be aware of the existence of legal voluntary assisted dying because of their illiteracy, a poor command of English, anxiety around their condition, or pronounced illness and frailty.

6.119 There is no reason in principle for voluntary assisted dying to be treated differently from other lawful end of life options given that the person's death is the usual outcome of other processes such as withdrawal of life support, voluntary cessation of eating and drinking, and palliative sedation.

6.120 The principles that underpin the draft Bill of:

- respecting a person's autonomy, including autonomy in relation to end of life choices; and
- being supported in making informed decisions about end of life choices

do not support a prohibition of the kind that currently exists in Victoria. Rather, the principles support a qualified prohibition that enables professional and registered health practitioners to provide information about all lawful end of life options.

6.121 A qualified prohibition protects the vulnerable from being informed by a practitioner about only one option: voluntary assisted dying. Vulnerable individuals are also protected from improper influence and coercion by several other safeguards and offence provisions in the draft Bill. Those safeguards are reinforced in the case of registered health practitioners by codes of ethics and professional standards and processes to enforce them.

Scope of the prohibition

6.122 The prohibition in Victoria on initiating a discussion applies to a 'registered health practitioner'. The prohibition in Western Australia applies to 'a health care worker', which means a registered health practitioner or 'any other person who provides health services or professional services'. Those terms are defined and are discussed below.

6.123 It might be argued that anyone in a position of trust or influence in their relationship with a person should be prohibited from initiating a discussion about voluntary assisted dying. For example, a solicitor may have had a longstanding fiduciary relationship with their client for whom they may draft a will or assist in explaining an advanced health directive. There is potential, in that context, for the solicitor to raise voluntary assisted dying, and unintentionally use their position of trust and influence. However, extending the scope of the prohibition to anyone who is in a position of trust or influence would have unintended and unfortunate consequences. It would prevent family members and close friends from initiating a discussion about voluntary assisted dying in the context of a loving, intimate relationship with the person. The several safeguards in the draft Bill will be enough to protect the vulnerable from coercion and improper influence by family, friends, advisers, and others with whom they have a trusting relationship.

6.124 There is significant potential for voluntary assisted dying to be raised by someone in a therapeutic relationship with a person, whether it be in the context of providing health services or professional care services. Some providers, particularly those delivering professional care services (eg, bathing, showering, feeding a client under a home care package) may not be clinically skilled or sufficiently qualified to properly raise end of life treatment options and outcomes, including voluntary assisted dying, with a client. Professional care service providers deliver a range of intimate care services in people's homes or in residential aged care facilities. Occasions may arise where it might seem appropriate to such a provider to initiate a discussion about voluntary assisted dying with a client who has a life-limiting condition and is suffering severely from it.

6.125 The justification for a prohibition applying to health care providers (suitably defined) is that they are likely to be influential and trusted in a discussion with a person for whom they provide care about health matters, including end of life options.

Victorian provision

6.126 The Victorian prohibition is limited to 'registered health practitioners' providing 'health services' or 'professional care services'.[125] It would not cover any other person who provides those services. The effect of the Victorian provision is that a person who, for example, is employed to bathe, dress or feed a sick client in their home, and who is not a 'registered health practitioner', may initiate a discussion about voluntary assisted dying with the client, but a registered health practitioner providing those services cannot.

6.127 'Health service' has a broad meaning under the Victorian Act. It includes matters such as the assessment of a person's physical, mental or psychological health, the prevention or treatment of a person's illness, injury or disability, a health related disability, a palliative care or an aged care service, the prescribing or dispensing of a drug or medicinal preparation, a therapeutic counselling and psychotherapeutic service. It also covers services that are ancillary to other services.[126]

6.128 'Professional care services' means services provided to another person under a contract of employment or a contract for services, such as support or assistance; special or personal care; or a disability service.[127]

Western Australian provision

6.129 The Western Australian Act provides that the prohibition applies to a 'health care worker'. A health care worker is a registered health practitioner or any other person who provides health services or professional care services.[128]

6.130 Section 10(1) of the Western Australian Act provides:

> **10. Health care worker not to initiate discussion about voluntary assisted dying**
>
> (1) In this section —
>
> ***health care worker*** means —
>
> (a) a registered health practitioner; or
>
> (b) any other person who provides health services or professional care services.

6.131 A 'registered health practitioner' means a person registered under the Health Practitioner Regulation National Law (Western Australia) to practise a health profession (other than as a student).[129] A 'health profession' is defined broadly, encompassing, among other professions, medical, Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice, occupational therapy, physiotherapy, and podiatry.[130]

6.132 A 'health service' is a service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing, and includes a service provided to a person at a hospital or any other place.[131]

6.133 'Professional care services' is widely defined to mean any of the following provided to another person under a contract of employment or a contract for services:[132]

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125 *Voluntary Assisted Dying Act 2017* (Vic) s 8(1). Section 17(1) of the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) also confines the prohibition to a 'registered health practitioner' who provides health services or professional care services to a person.

126 *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definition of 'health service'); *Health Complaints Act 2016* (Vic) s 3 (definition of 'health service').

127 *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definition of 'professional care services').

128 *Voluntary Assisted Dying Act 2019* (WA) s 10(1).

129 *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'registered health practitioner').

130 Health Practitioner Regulation National Law (WA) Act 2010 (WA), Sch, pt 1, s 5 (definition of 'health profession').

131 A 'health service' has the meaning given in the *Health Services Act 2016* (WA) s 7. See *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'health service').

132 *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'professional care services').

(a) assistance or support, including the following —

(i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals;

(ii) assistance for persons with mobility problems;

(iii) assistance for persons who are mobile but require some form of assistance or supervision;

(iv) assistance or supervision in administering medicine;

(v) the provision of substantial emotional support;

(b) a disability service as defined in the Disability Services Act 1993 section 3.

Possible approaches in Queensland

6.134 One possible approach is to apply the prohibition to a 'health practitioner' as defined by the *Health Ombudsman Act 2013* (Qld), that is, 'a registered health practitioner under the National Law or another individual who provides a health service'.[133]

6.135 A 'health service' is defined as:[134]

(1) A health service is a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing.

(2) A health service may be provided to a person at any place including a hospital, residential care facility, community health facility or home.

(3) A health service includes a support service for a service mentioned in subsection (1).

(4) Also, without limiting subsection (1), a health service includes —

(a) a service dealing with public health, including a program or activity for —

(i) the prevention and control of disease or sickness; or

(ii) the prevention of injury; or

(iii) the protection and promotion of health; and

Example of health service mentioned in paragraph (a)—

a cancer screening program

(b) a service providing alternative or complementary medicine; and

(c) a service prescribed under a regulation to be a health service.

(5) A health service does not include a service prescribed under a regulation not to be a health service.

6.136 A different approach would be to apply the prohibition both to 'a registered health practitioner' and to any other person who provides health services or personal care services.

6.137 We favour this approach. As indicated above, the prohibition extends to registered health practitioners as they are likely to be influential and trusted in a discussion with a person, for whom they provide health care, about health matters, including end of life options. The same rationale applies to persons that provide health services or personal care services to a person.

6.138 The term 'health service' should have the same meaning as provided for in section 7 of the *Health Ombudsman Act 2013* (Qld). The term 'personal care services' should be based on the definition of 'professional care services' in section 5 of the Western

133 *Health Ombudsman Act 2013* (Qld) s 8(a).
134 *Health Ombudsman Act 2013* (Qld) s 7.

Australian Act (noted in [6.133] above). The definition in section 5(a) is sufficiently broad. The second limb of the definition in section 5(b) is not required. Therefore, 'personal care services' should be defined to mean:

> assistance or support provided to another person under a contract of employment or a contract for services, including the following —
>
> (a) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals;
>
> (b) assistance for persons with mobility problems;
>
> (c) assistance for persons who are mobile but require some form of assistance or supervision;
>
> (d) assistance or supervision in administering medicine;
>
> (e) the provision of substantial emotional support.

Scope of the exception to the prohibition

6.139 For the exception to apply, the practitioner is required to inform the person about the person's treatment and palliative care options and *their likely outcomes*. While some registered health practitioners who are not medical practitioners or nurse practitioners (such as experienced registered nurses) might be expected to be well equipped to discuss, in general terms, end of life options, they cannot be expected to provide advice about various treatment outcomes. Therefore, the prohibition on initiating a discussion about voluntary assisted dying should apply to them and they should not be subject to the same exception as a medical practitioner or nurse practitioner.

6.140 Permitting only medical practitioners and nurse practitioners to initiate a discussion about voluntary assisted dying also addresses concerns about allied health practitioners and professional care service providers initiating such discussions.

6.141 We do not see the need to add a further provision based on section 17(3) of the Tasmanian Act, which applies to a registered health practitioner who is not a medical practitioner, such as a registered nurse. This section provides that the prohibition does not prevent such a practitioner from initiating a discussion if, before the conclusion of the discussion, the person to whom health services or professional care services are being provided is informed that 'a medical practitioner would be the most appropriate person with whom to discuss the voluntary assisted dying process and care and treatment options'. We consider that it is simpler to have a prohibition on registered nurses (who are not nurse practitioners) initiating a discussion about voluntary assisted dying.

6.142 If the topic of voluntary assisted dying is raised by a patient with such a nurse, then the nurse can respond without breaching the prohibition, and might be expected to do what the Tasmanian provision requires—namely, refer the person to a medical practitioner or nurse practitioner.

Breach of the prohibition

6.143 A breach of the prohibition on initiating a discussion about or, in substance suggesting, voluntary assisted dying to a person under the Victorian and Western Australian Acts is not an offence. It may be dealt with, instead, as unprofessional conduct under the National Health Practitioner Regulation Law applying in each state and territory (the 'National Law').[135] The potential consequence of a finding of unprofessional conduct may be the suspension, or cancellation of, or imposition of conditions on, the practitioner's registration.[136]

6.144 A contravention of the proposed prohibition by a registered health practitioner may constitute unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Queensland). One can imagine various possible contraventions, ranging from a wilful breach that has serious consequences through to a technical breach that may or may not warrant disciplinary action. There should not be an automatic conclusion that a contravention of the provision, however minor, is unprofessional conduct. Whether it is or not may warrant investigation into all the circumstances.

6.145 Not all persons who provide a 'health service' or a 'personal care service' will be a 'registered health practitioner' enabling them to be dealt with under the National Law. Many will be unregistered health care workers. In Queensland, persons who provide a health service and who are not registered under the National Law may be the subject of a health service complaint under the *Health Ombudsman Act 2013*.

6.146 Section 31 of that Act provides that a health service complaint is a complaint about a health service or other service provided by a health service provider. Examples of matters that may be the subject of a complaint are set out in section 31, including 'the health, conduct or performance of a health practitioner while providing a health service'.

6.147 If a health service provider (such as a person who is providing personal assistance to a person in that person's home) initiates a discussion about voluntary assisted dying in the course of providing the health service, in contravention of the prohibition, the contravening conduct may be the subject of a complaint to the Health Ombudsman.

6.148 In summary, a breach of the prohibition may be dealt with under the National Law (if it is committed by a registered health practitioner) or as a complaint investigated by the Health Ombudsman (if it is committed by another individual who provides a health service).[137]

135 *Voluntary Assisted Dying Act 2017* (Vic) s 8(3); *Voluntary Assisted Dying Act 2019* (WA) s 10(5). The health professions regulated under the National Law include the medical, nursing, paramedicine, pharmacy, and psychology professions (and recognised specialities within those professions): For Queensland, see Health Practitioner Regulation National Law (Queensland) ss 5 (definitions of 'health profession' and 'National Board'), 31; Health Practitioner Regulation National Law Regulation 2018 (Qld) s 4. See generally AHPRA & National Boards, 'National Boards' (5 January 2021) <https://www.ahpra.gov.au/National-Boards.aspx>.

136 Health Practitioner Regulation National Law (Victoria) pt 8.

137 A contravention by a registered health practitioner of the prohibition in the draft Bill can be taken into account by the Health Ombudsman in considering a matter about the professional conduct or performance of a registered health practitioner: see Chapter 17 below.

RECOMMENDATIONS

6-1 A health care worker who provides health services or professional care services to a person must not, in the course of providing those services to the person—

(a) initiate discussion with that person that is in substance about voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to that person.

6-2 That prohibition should not prevent a health care worker providing information about voluntary assisted dying to a person at that person's request.

6-3 That prohibition also should not prevent a medical practitioner or nurse practitioner initiating a discussion about voluntary assisted dying if, at the same time, they also inform the person about:

(a) the treatment options available to the person and the likely outcomes of that treatment; and

(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

6-4 For the purposes of the last three recommendations, the draft Bill provides:

health care worker means—

(a) a registered health practitioner; or

(b) another person who provides a health service or professional care service.

health service — see the *Health Ombudsman Act 2013*, section 7.

personal care service means assistance or support provided by a person to another person under a contract of employment or a contract for services, including the following—

(a) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals;

(b) assistance for persons with mobility problems;

(c) assistance for persons who are mobile but require some form of assistance or supervision;

(d) assistance or supervision in administering medicine; and

(e) the provision of substantial emotional support.

CHAPTER 7

Eligibility

Chapter 7: Eligibility

CHAPTER SUMMARY

This chapter identifies who may access 'voluntary assisted dying' in Queensland should the draft Bill be enacted.[1] After a detailed analysis of expert reports and legislation in other places, and the extensive submissions made, we have recommended 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 must be met 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 from people from other jurisdictions seeking 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.

1 Terms of reference, para 2.

At various points throughout the process, the person must be assessed as having decision-making capacity. The person must also be told, more than once, that they may decide 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 accessed 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

7.1 Voluntary assisted dying laws in Australia and overseas have eligibility criteria for the person's disease, illness or medical condition. These may include criteria about the person's diagnosis, prognosis and level of suffering.

7.2 A distinction can be drawn between jurisdictions that limit eligibility to people at the end of life who have been diagnosed with a particular condition that will cause death within a specific timeframe (for example, Victoria, Western Australia, Tasmania, New Zealand, and state legislation in the United States), and those that do not (for example, Belgium, Luxembourg, the Netherlands, and Canada).

7.3 Except for state legislation in the United States, the legislation in each jurisdiction also includes eligibility criteria for the person's level of suffering. In overseas jurisdictions that do not limit eligibility to a person who is diagnosed with a particular life-limiting condition, the person's level of suffering is a key criterion.

7.4 Like laws in Victoria, Western Australia, and Tasmania, the White and Willmott Model limits eligibility to persons diagnosed with a medical condition that will cause death. However, unlike those jurisdictions, it does not include a specific timeframe within which death must be expected. Professors White and Willmott have, however, included a higher threshold for the person's level of suffering, consistent with the approach in some overseas jurisdictions.

7.5 The main diseases, illnesses and medical conditions for accessing voluntary assisted dying are cancers, neurodegenerative diseases, and chronic heart and respiratory diseases.[2]

Overview of legislative approaches

7.6 The following table gives an overview of legislative approaches in Australia, overseas, and the White and Willmott Model.[3]

2 See, eg, Voluntary Assisted Dying Review Board Report of Operations July-December 2020 (2021) 11, and the figures quoted from it in the discussion of insights from the operation of the Victorian Act in Chapter 2. See also Oregon Health Authority, Public Health Division, Center for Health Statistics, *Oregon Death with Dignity Act 2019 Data Summary* (Report, 2020) 6, 10–11, Table 1; Health Canada, *First Annual Report on Medical Assistance in Dying in Canada* 2019 (2020) 21–2; Health Canada, *Fourth Interim Report on Medical Assistance in Dying in Canada* (2019) 6, 8–10, Tables 2, 3a, 3b; Regional Euthanasia Review Committees (the Netherlands), *Annual Report* (2018) (English translation) 12–15; N Francis, *Belgian euthanasia report for 2018 released*, Dying for Choice.com.

3 The table refers to the White and Willmott Model and the following selected voluntary assisted dying legislation that is currently in force in Australia and overseas: *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d), (2)–(4); *Voluntary Assisted Dying Act 2019* (WA) s 16(c), (2); *End-of-Life Choices Act 2021* (Tas) ss 10(1)–(2), 6, 14; *End of Life Choice Act 2019* (NZ) s 5(1)(c)–(e), (2); *Belgian Euthanasia Act 2002* § 1; *Luxembourg Law on Euthanasia and Assisted Suicide 2009* § 1(3), 2(3); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(b); *Canada Criminal Code*, RSC 1985, c C-46 s 241.2(1)(c), (2), (2.1); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.1.01(12), 127.805.2.01. Oregon is presented as an example of State legislation in the United States of America, as it was the first to introduce legislation permitting voluntary assisted dying (over 20 years ago) and has been used as a model in other jurisdictions in the United States of America.

	Eligible disease, illness or medical condition	Timeframe until death	Level of suffering caused
Victoria	incurable, advanced, progressive and will cause death includes statement that disability or mental illness alone is not an eligible condition	6 months, or 12 months for a neurodegenerative condition	suffering cannot be relieved in a manner the person considers tolerable
Western Australia	advanced, progressive and will cause death includes statement that disability or mental illness alone is not an eligible condition	6 months, or 12 months for a neurodegenerative condition	suffering cannot be relieved in a manner the person considers tolerable
Tasmania	advanced, incurable, irreversible and expected to cause death includes statement that disability or mental illness alone is not an eligible condition	6 months, or 12 months for a neurodegenerative condition	persistent suffering that is, in the opinion of the person, intolerable; and no reasonably available treatment to lessen the suffering to an extent the person considers acceptable
New Zealand	terminal illness and 'is in an advanced state of irreversible decline in physical capability' includes statement that disability, mental illness, or advanced age alone is not an eligible condition	6 months	unbearable suffering that cannot be relieved in a manner the person considers tolerable
Oregon	'terminal disease', defined to mean an incurable and irreversible disease that will, within reasonable medical judgment, produce death within six months	6 months	N/A
Canada	'grievous and irremediable medical condition', defined to include a 'serious and incurable' illness, disease or disability, and the person is in an 'advanced state of irreversible decline in capability'. includes statement that a mental illness is not considered to be an illness, disease or disability for these purposes	N/A	'grievous and irremediable medical condition', defined to include an illness, disease, disability, or a state of decline that causes the person intolerable and enduring physical or psychological suffering that cannot be relieved under conditions that the sufferer considers acceptable
The Netherlands	N/A	N/A	unbearable suffering with no prospect of improvement
Belgium	medically futile condition resulting from a serious and incurable disorder caused by illness or accident	N/A	constant and unbearable physical or mental suffering that cannot be alleviated
Luxembourg	severe and incurable terminal medical situation from an accidental or pathological disorder	N/A	constant and unbearable physical or mental suffering without prospects of improvement
White and Willmott Model	incurable, advanced, progressive and will cause death	N/A	intolerable and enduring suffering

Victoria, Western Australia, Tasmania

7.7 In Victoria and Western Australia, one of the eligibility criteria for access to voluntary assisted dying is that the person has been diagnosed with a disease, illness or medical condition that:[4]

- is 'advanced, progressive and will cause death' (plus, in Victoria, 'incurable');
- is expected to cause death within six months, or 12 months if the condition is neurodegenerative; and
- is 'causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'.

7.8 This reflects the policy that voluntary assisted dying is 'intended to provide an option that can limit suffering at the end of life, not a way to end life for those who are otherwise not dying.[5]

7.9 The criterion makes it clear that voluntary assisted dying is a choice for those who are dying and suffering, for whom death is 'inevitable and imminent'.[6] In Victoria, it was explained that:[7]

> The recommended eligibility criteria ensure voluntary assisted dying will allow a small number of people, at the end of their lives, to choose the timing and manner of their death. There is no intention to give people who are not dying access, and the legislation will not give these people an option to choose between living and dying. The eligibility criteria ensure the voluntary assisted dying framework provides a compassionate response to people who are close to death and choose to request voluntary assisted dying to give them greater control over the timing and manner of their death.

7.10 The stringent eligibility criteria and other safeguards, including that voluntary assisted dying is an option only at the end of life for people who are dying, are the basis of the view that the Victorian law is compatible with the right to life.[8]

7.11 Victoria's Voluntary Assisted Dying Review Board has reported that, since the commencement of voluntary assisted dying in Victoria, 77 per cent of applicants who had a permit issued and subsequently died had a malignancy diagnosis and 23 per cent had a non-malignant diagnosis.[9]

7.12 The eligibility criteria in the Tasmanian Act similarly require the person to have a 'relevant medical condition'.[10] This is defined to mean a 'disease, illness, injury or medical condition' that is 'advanced, incurable and irreversible' and 'is expected to cause the death of the person' within six months, or 12 months if the condition is neurodegenerative.[11]

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4 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d), (4); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c).

5 Vic Ministerial Advisory Panel Final Report (2017) 70, quoting Vic Parliamentary Committee Final Report (2016) 237 (and see [8.6.4]). It has been noted that voluntary assisted dying can be distinguished from, and should not be conflated with, assisted suicide: WA Joint Select Committee on End of Life Choices Report (2018) [5.103], Finding 40; Vic Ministerial Advisory Panel Final Report (2017) 8. See also Qld Parliamentary Committee Report No 34 (2020) 61.

6 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5134 (RH Cook, Minister for Health); Vic Ministerial Advisory Panel Final Report (2017) 52, Rec 2 and 8.

7 Vic Ministerial Advisory Panel Final Report (2017) 13–14. See also Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2949 (J Hennessy, Minister for Health), making a similar statement.

8 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2944 (Hennessy, Minister for Health), explaining that the right to life includes an obligation on the government to refrain from conduct that results in the arbitrary deprivation of life, as well as a positive duty to introduce appropriate safeguards to minimise the risk to loss of life. See also Vic Ministerial Advisory Panel Final Report (2017) app 2; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 9. In Queensland, see *Human Rights Act 2019* (Qld) s 16, which is in the same terms as the right to life in the Victorian Act and provides that 'every person has the right to life and has the right not to be arbitrarily deprived of life'.

9 Of the malignancy group, 21% had a primary lung malignancy, 11% had primary breast malignancy, 11% had primary pancreatic malignancy, 9% had a primary colorectal malignancy, 9% had other gastrointestinal tract malignancy and 39% had a range of other malignancies. Of the non-malignant group, 62% had a neurodegenerative disease and 38% had other diseases such as pulmonary fibrosis, cardiomyopathy or chronic obstructive pulmonary disease: Voluntary Assisted Dying Review Board Report of Operations July-December 2020 (2021) 11.

10 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 10(1)(e).

11 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 6(1)(a)–(b).

Advanced, progressive and will cause death

7.13 Whether a person has a condition that is advanced, progressive and will cause death:[12]

> is a clinical assessment based on an individual's own particular circumstances, including their condition, their comorbidities, and the available treatments that they are prepared to accept, noting the right to refuse medical treatment.

7.14 The term 'advanced, progressive and will cause death' was recommended by both the Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel after extensive consultation with the community and the health profession. The Victorian Panel considered that this wording reflects contemporary health care terminology used and understood in Australia and is more precise than terminology used in overseas legislation (such as 'serious and incurable'[13] or 'terminal'[14]).[15]

7.15 The words 'advanced and progressive' make clear that the condition must be 'very serious and on a deteriorating trajectory'.[16] In Victoria, guidance for health practitioners explains that:[17]

> 'Advanced' refers to a point in the trajectory of the patient's medical condition, and 'progressive' indicates that the patient is experiencing an active deterioration such that they will continue to decline and not recover.

7.16 The words 'will cause death' make clear that eligibility for access to voluntary assisted dying is limited to conditions that are terminal, in the sense that the disease, illness or medical condition 'is expected to lead to a foreseeable or imminent death'.[18]

7.17 The Victorian Panel also considered that:[19]

> use of the words 'disease, illness or medical condition' better describes the conditions intended to be captured by voluntary assisted dying legislation. If a person is suffering from an advanced, progressive condition that will cause death and is causing suffering, they should not be precluded from accessing voluntary assisted dying because it is considered a medical condition, rather than a disease or illness. The Panel recommends the use of the words 'medical condition', rather than just 'condition' to clarify that voluntary assisted dying cannot be accessed for suffering associated with decline as a result of ageing or frailty for example. The Panel is of the view that although a disability may be the result, or a symptom, of a disease, illness or medical condition, the disability itself should not be considered a disease, illness or medical condition for the purposes of the eligibility criteria.

7.18 The Western Australian Joint Select Committee recommended that the legislation should define an eligible condition to mean an advanced and progressive 'terminal', 'chronic' or 'neurodegenerative' illness or disease.[20] However, the Western Australian Panel noted that differences in the interpretation of the word 'terminal' (which some members of the community thought was confined to a person with cancer) led, in part, to including 'chronic' and 'neurodegenerative' in the eligibility criteria. The Panel recommended that 'there should not be a reference to a particular type of disease or illness' in the eligibility criteria, noting that this 'is not helpful' and 'may cause undue

12 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3–4. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5.

13 Vic Ministerial Advisory Panel Final Report (2017) 67, in which the Panel observed that the term 'serious' is 'too broad and subjective, making it difficult to define in a way that would provide useful and consistent guidance to the community and health practitioners'. The Panel also considered that only diseases, illnesses and medical conditions that will cause death should be included in the eligibility criteria, and that a 'serious and incurable' condition will not always cause death: 69.

14 Ibid 70, in which the Panel noted that for some people 'terminal' might be taken to mean that a person is close to death, while for others it may mean that the disease, illness or medical condition is not curable. See also WA Ministerial Expert Panel Final Report (2019) 33.

15 Ibid 66–70.

16 WA Ministerial Expert Panel Final Report (2019) 34.

17 Vic Guidance for Health Practitioners (2019) 37. See also Vic Ministerial Advisory Panel Final Report (2017) 69.

18 WA Ministerial Expert Panel Final Report (2019) 33, Rec 7.

19 Ibid 68.

20 WA Joint Select Committee on End of Life Choices Report (2018) [7.89], Rec 24. See also [7.30].

concern'. It recommended adopting the Victorian formulation of 'advanced, progressive and will cause death'.[21]

Incurable

7.19 In Victoria, the criteria also state that the disease, illness or medical condition must be 'incurable'.[22]

7.20 The Victorian Parliamentary Committee recommended that the eligibility criteria should include a criterion that the person is suffering from a 'serious and incurable' condition.[23] The Victorian Panel considered that the term 'serious' was imprecise. Instead, it recommended the term 'advanced, progressive and will cause death'. However, it chose to retain the word 'incurable', noting that it:[24]

> is well understood by medical practitioners to mean a medical condition that cannot be cured. Medical treatment for a person suffering from an incurable medical condition … may have the effect of delaying a person's death; however, it will not cure the person's medical condition. Instead, the medical treatment aims to manage the symptoms of the medical condition to promote the person's quality of life and ensure their comfort.

7.21 The Panel did not consider that it was necessary for the legislation to define 'incurable'. However, it explained that whether a disease, illness or medical condition is 'incurable' is to be determined only by taking into account treatments that are available and acceptable to the person. It does not require that all treatment options to manage the person's symptoms must be exhausted or proven futile. Such an interpretation would be inconsistent with an individual's right to refuse medical treatment that is not acceptable to them. A person may refuse medical treatment options that are available but not acceptable to them and should not be prevented from accessing voluntary assisted dying on that basis.[25]

7.22 The eligibility criteria in Western Australia do not include a requirement that the disease, illness or medical condition be incurable. Two reasons were given during the Parliamentary Debates for this:[26]

> Firstly, the Western Australian bill already requires that the person have a disease, illness or medical condition that is advanced and progressive and will cause death within a time frame of six months or 12 months in neurodegenerative conditions. Secondly, it is not appropriate to require a person to exhaust all treatment options which may result in the disease, illness or medical condition being completely cured and through which the person's quality of life would be significantly compromised or lost. Every person should be able to determine which treatment options they wish to adopt. An adult patient of sound mind may refuse medical treatment even if that refusal may lead to their death. The bill does not require a patient to undergo treatment that will prolong their life or that might cure them, because to do so would cut across the fundamental principle of patient autonomy. The issue around 'incurable' essentially is that if that term were included, it would therefore potentially require a patient to undergo treatment options that they may not wish to undergo.

7.23 The Tasmanian Act requires the person to have a disease, illness, injury or medical condition that is 'advanced, incurable and irreversible' and 'is expected to cause the death of the person'.[27] It provides:[28]

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21 WA Ministerial Expert Panel Final Report (2019) 33–4, Rec 7.
22 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(i).
23 Vic Parliamentary Committee Final Report (2016) Rec 49.
24 Vic Ministerial Advisory Panel Final Report (2017) 67. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3.
25 Vic Ministerial Advisory Panel Final Report (2017) 67. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3–4; Vic Guidance for Health Practitioners (2019) 37.
26 Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6586 (M McGowan, Premier). See further 6587 (M McGowan, Premier), and 6603 (R Cook, Minister for Health).
27 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 6(1)(a)–(b).
28 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 6(2).

> For the purposes of this Act, a disease, illness, injury, or medical condition, of a person is incurable and irreversible and is expected to cause the death of the person if there is no reasonably available treatment that —
>
> (a) is acceptable to the person; and
>
> (b) can cure or reverse the disease, illness, injury or medical condition and prevent the expected death of the person from the disease, illness, injury or medical condition.

Mental illness or disability

7.24 The legislation in Victoria, Western Australia, and Tasmania[29] makes it clear that a mental illness or disability is not an eligible condition for the purposes of accessing voluntary assisted dying.[30] However, having a mental illness or disability does not exclude a person from accessing voluntary assisted dying if the person otherwise satisfies all the eligibility criteria (including having an eligible condition that is advanced, progressive and will cause death, and having decision-making capacity for voluntary assisted dying).[31] The Victorian Health Minister explained, for example, that:[32]

> While disability may be caused by, or be a symptom of, a disease, illness or medical condition, disability itself will not constitute a disease, illness or medical condition. For example, a person with motor neurone disease may have a range of disabilities that are a result of their disease. These disabilities are not the reason the person may be eligible. The motor neurone disease, which is a disease that will cause death, is what would make the person eligible.

7.25 This approach ensures that people with a mental illness or disability are afforded the same rights and protections as other members of the community and are not discriminated against or denied access to voluntary assisted dying if they meet all the eligibility criteria.[33]

Overseas jurisdictions

7.26 Like Victoria, Western Australia and Tasmania, laws in New Zealand and the United States limit eligibility to a person who is at the end of life and has been diagnosed with a life-limiting disease or illness that is expected to cause death within a specific timeframe.

7.27 In New Zealand, the person must have been diagnosed with a 'terminal illness that is likely to end the person's life within six months', be in 'an advanced state of irreversible decline in physical capability' and be experiencing 'unbearable suffering that cannot be relieved in a manner that the person considers tolerable'.[34] The law also states that a person is not eligible for assisted dying by reason only that the person 'is suffering from any form of mental disorder or mental illness', or 'has a disability of any kind', or 'is of advanced age'.[35]

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29 *Voluntary Assisted Dying Act 2017* (Vic) s 9(2), (3); *Voluntary Assisted Dying Act 2019* (WA) s 16(2); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 10(2). The wording in Tasmania differs. It provides that that 'for the purposes of this Act, a person is not eligible to access voluntary assisted dying by reason only that the person has a mental illness'. The legislation in Victoria, Western Australia and Tasmania provides, respectively, that 'mental illness' has the same meaning as within the *Mental Health Act 2014* (Vic), or as defined in section 4 of the *Mental Health Act 2014* (WA), or as withing the meaning of the *Mental Health Act 2013* (Tas). The legislation in Victoria and Tasmania provides, respectively, that 'disability' has the same meaning as within section 3(1) of the *Disability Act 2006* (Vic), or within the meaning of the *Disability Services Act 2011* (Tas). The term 'disability' is not defined in the *Voluntary Assisted Dying Act 2019* (WA).

30 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 4; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 6. See also Vic Ministerial Advisory Panel Final Report (2017) 68, 80–82, 83–5, Recs 5, 6; WA Ministerial Expert Panel Final Report (2019) 40, Rec 10.

31 It was also noted that there are strong safeguards for people who have a mental illness as they must have decision-making capacity and, if the assessing medical practitioner is in doubt about whether they have decision-making capacity, there is a requirement for a referral to an appropriate specialist: Vic Ministerial Advisory Panel Final Report (2017) 82.

32 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (J Hennessy, Minister for Health).

33 Vic Ministerial Advisory Panel Final Report (2017) 81–2, 83–5; WA Ministerial Expert Panel Final Report (2019) 40. In Queensland, see the *Human Rights Act 2019* (Qld) s 15 for the right to recognition and equality before the law.

34 *End of Life Choice Act 2019* (NZ) s 5(1)(c)–(e). See further Explanatory notes, End of Life Choice Bill 2019 (NZ) 1; Attorney-General (NZ), Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill (Report, August 2017) 2.

35 *End of Life Choice Act 2019* (NZ) s 5(2).

7.28 Various state laws in the United States provide that the person must be suffering from a 'terminal' disease or illness that is 'incurable and irreversible' and will, within reasonable medical judgement, 'result in' or 'produce' death within six months.[36]

7.29 In contrast, under the legislation in Belgium, Luxembourg, the Netherlands, and Canada:[37]

> People access [voluntary assisted dying] because of the seriousness of their condition and the suffering that results from their total circumstances, not because they have a particular medical condition.

7.30 The legislation variously provides that the person must:

- In *Belgium*—be in a 'medically futile situation' and report 'a constant and unbearable physical or psychological suffering' that 'cannot be alleviated and that results from a serious and incurable accidental or pathological affliction';[38]
- In *Luxembourg*—be in a severe and incurable terminal medical situation and 'have constant and unbearable physical or mental suffering without prospects of improvement';[39]
- In *The Netherlands*—be experiencing 'unbearable suffering without prospect of improvement';[40] or
- In *Canada*—have a 'grievous and irremediable medical condition', which is defined to mean that:[41]
  - (a) they have a serious and incurable illness, disease or disability;
  - (b) they are in an advanced state of irreversible decline in capability; and
  - (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under the conditions that they consider acceptable.

7.31 Until recently, the federal legislation in Canada also required that the person's natural death had become 'reasonably foreseeable'. This requirement was found to be unconstitutional.[42]

7.32 In those jurisdictions, eligibility for access to voluntary assisted dying is not limited to a person who is diagnosed with a particular life-limiting disease, illness or medical condition. The key criterion is their level of suffering and the seriousness of their condition.

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36 See *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.1(q), 443.2(a)(1); *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25 48 102(16), 25 48 103(a); *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7-661.01(16), 7-661.03 (a)(1)(A); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L-1 (definition of 'terminal disease'), 327L-2; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140(2)(M), (4); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.1.01(12), 127.805.2.01; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann §§ 5281(10), 5283(a)(5)(A); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(13), 70.245.020(1). See also *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann §§ 26:16 3, 26:16 4, which similarly requires that the person is terminally ill, which is relevantly defined to mean that the patient is 'in the terminal state of an irreversibly fatal illness, disease, or condition with a prognosis, based upon reasonable medical certainty, of a life expectancy of six months or less'.

37 Dying with Dignity Tasmania, Voluntary Assisted Dying—Overview of the Current Situation (August 2020) 7.

38 *Belgian Euthanasia Act 2002*, Article 3, § 1.

39 *Luxembourg Law on Euthanasia and Assisted Suicide 2009*, Article 2 ss 1(3), 4(3). See further Ministry of Health and Ministry of Social Security (Luxembourg), Euthanasia and assisted suicide law of 16 March 2009: 25 questions 25 answers (June 2010, English translation) 13.

40 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*, s 2(1)(b). It has been held that 'suffering' must have a medical dimension; that is, 'there must be a state that can be described as a disease or medical condition'. However, there is no requirement that the person have a single life-threatening disease, illness or medical condition: Regional Euthanasia Review Committees (Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) 22.

41 *Canada Criminal Code*, RSC 1985, c C46, s 241.2(1)(c), (2). Cf The legislation in Quebec which requires, among other things, that the person must suffer from a 'serious and incurable' illness and 'be in an advanced state of irreversible decline in capability' to access medical aid in dying: Quebec Act respecting end-of-life care, RSQ, c S32.0001, s 26(4)–(5).

42 See [7.90] below.

7.33 In some jurisdictions (for example, Belgium, Luxembourg, and the Netherlands), a person may seek to access voluntary assisted dying solely because of a mental illness.[43]

7.34 The federal legislation in Canada was recently amended to specify that persons whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying.[44] This was prompted by the repeal of the eligibility criterion that the person's natural death must have become reasonably foreseeable, broadening medical assistance in dying beyond the end of life context.[45] However, the Amending Act includes a clause to repeal this provision automatically on 17 March 2023 (two years after the day on which it received royal assent) (17 March 2021). It was considered that:[46]

> further consultation and deliberation are required to determine whether it is appropriate and, if so, how to provide medical assistance in dying to persons whose sole underlying medical condition is a mental illness in light of the inherent risks and complexity of the provision of medical assistance in dying in those circumstances.

7.35 The inherent risks and complexities include:[47]

> suicidality being a symptom of some mental illnesses, the impossibility of predicting whether in any given case symptoms will improve or not and the increased difficulty of capacity assessments.

7.36 The Amending Act provides that there must be an independent expert review about 'protocols, guidance and safeguards to apply to requests made for medical assistance in dying by persons who have a mental illness', to report to the Minister of Justice and the Minister of Health no later than one year after 17 March 2021.[48]

Parliamentary Committee and the White and Willmott Model

7.37 In Queensland, the Parliamentary Committee found that most Queenslanders supported legislating for voluntary assisted dying in Queensland as an end of life option for people who are dying, to reduce unnecessary suffering.[49] It recommended that any scheme in Queensland should require that, to be eligible, a person 'must be diagnosed by a medical practitioner as having an advanced and progressive terminal, chronic or neurodegenerative medical condition' that will cause death.[50]

7.38 The Parliamentary Committee also considered that:[51]

> people should not be automatically excluded from voluntary assisted dying simply

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43 However, most people who access assisted dying in these jurisdictions have cancers, neurodegenerative diseases or chronic heart or respiratory diseases. In the Netherlands, there were 6126 notifications of euthanasia in 2018. Of those, 67 (1%) cases involved patients with psychiatric disorders: Regional Euthanasia Review Committees (The Netherlands), *Annual Report* (2018) (English translation) 5, 11, 15, 40–2. In Belgium, there were 2357 reports in 2018. Of those, 'requests for euthanasia on the basis of mental disorders and behaviour remain marginal (2.4% of all euthanasia)': J Eyckmans, 'Belgian euthanasia—Figures for the year 2018', Dying for Choice (Blog post, 28 February 2019) <https://dyingforchoice.com/blogs/belgian-euthanasia-report-2018-released>. See further Council of Canadian Academies, *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition*, Report (2018) ch 5.

44 *Canada Criminal Code*, RSC 1985, c C-46 s 241.2(2.1) (as inserted by *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, s 1(2).

45 Canada, Parliament, *House of Commons Debates*, 43rd Parl, 2nd Sess, Vol 150, No 64 (23 February 2021) 1034 (D Lametti, Minister of Justice). Although there was previously no such provision, a person with a mental illness as their sole underlying condition was unlikely to satisfy all the eligibility criteria for access to medical assistance in dying, given that it was limited to people at the end of life whose natural death had become reasonably foreseeable: See further Council of Canadian Academies, *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition*, Report (2018) ch 4.

46 *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, preamble, s 1(2). See further Canada, Parliament, *House of Commons Debates*, 43rd Parl, 2nd Sess, Vol 150, No 64 (23 February 2021) 1034–1039 (D Lametti, Minister of Justice).

47 Canada, Parliament, *House of Commons Debates*, 43rd Parl, 2nd Sess, Vol 150, No 64 (23 February 2021) 1034 (D Lametti, Minister of Justice).

48 It also provides that there must be a comprehensive parliamentary committee review, including about the issue of mental illness as a sole underlying cause for access to medical assistance in dying: *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, 3.1(1)–(3), 5(1)–(6).

49 Qld Parliamentary Committee Report No 34 (2020) [5.1], [5.3], [6.1]. The Committee received 4 719 submissions and held 34 hearings and forums: [1.5]–[1.6]. It defined 'end of life' care to mean 'care provided to a patient with a life-limiting illness during the last stages of life': Glossary.

50 Ibid 120, Rec 4.

51 Ibid 133.

> because they have been diagnosed as having a mental illness. Similarly, people with a mental illness diagnosis should not automatically be considered eligible for voluntary assisted dying because of their illness. Their eligibility to access voluntary assisted dying needs to be considered on the same basis as anyone else seeking to access voluntary assisted dying.

7.39 The Committee recommended that any voluntary assisted dying scheme in Queensland should provide that:[52]

> a person who is otherwise eligible to access the scheme not be rendered ineligible only because the person has a mental health condition, provided that the person has decision-making capacity.

7.40 Like Victoria, the White and Willmott Model provides that the person must be diagnosed with a medical condition that is 'incurable' and 'advanced, progressive and will cause death'.[53] Clause 10(1) states that:

> Whether a person's medical condition will cause the person's death is to be determined by reference to available medical treatment that is acceptable to the person.

7.41 The explanatory notes state that 'many of the key policy decisions are explained in the book chapter "A Values-based Model for Reform",' and are not repeated in the explanatory notes.[54] That article predates the drafting of the White and Willmott Model and the Victorian and Western Australian legislation. In the article, the authors favoured including as one of the eligibility criteria a requirement that the person has a 'serious and incurable medical condition that will cause the person's death'.[55] This differs from the form of words used in the White and Willmott Model. The authors do not explain why they adopted the form of wording that the medical condition must be 'incurable' and 'advanced, progressive and will cause death', other than noting that 'the starting point for drafting the eligibility criteria in clause 9 was broadly the approach in the *Voluntary Assisted Dying Act 2017* (Vic)'.[56]

7.42 However, in the article, the authors explain that an approach that limits eligibility to those diagnosed with a condition that will cause death is justified by the need to balance the value of life with the values of autonomy and reducing suffering:[57]

> A justifiable approach is to recognise that the state's interest in preserving life is weighty where a person is healthy, well and free from pain. But that interest is outweighed by other values such as autonomy and reducing suffering when both: (1) the person has a condition that will inevitably cause death, and (2) the person too has formed the view that the value of his or her life is outweighed by the disvalue of his or her suffering ... In such a case, the value of life would yield to the collective weight of the values of autonomy (as expressed in that person's choice to die) and reducing suffering.

7.43 Unlike Victoria, Western Australia and Tasmania, the White and Willmott Model does not state that persons are not eligible to access voluntary assisted dying only because they have a disability or a mental illness. In the article, the authors explained that:[58]

> If a person with a disability has a medical condition which, if untreated, would result in death, and that person satisfies the other eligibility requirements, we consider there to be no justification for excluding that person from assisted dying should they choose it.

52 Ibid Rec 10.
53 White and Willmott Model cl 9(e)(i)–(ii).
54 Explanatory Notes, White and Willmott Model, 2, referring to L Willmott and B White, 'Assisted Dying in Australia: A Values based Model for Reform' in I Freckelton and K Petersen (eds) *Tensions and Traumas in Health Law* (The Federation Press, 2017).
55 L Willmott and B White, 'Assisted Dying in Australia: A Values based Model for Reform' in I Freckelton and K Petersen (eds) *Tensions and Traumas in Health Law* (The Federation Press, 2017) 503.
56 Explanatory Notes, White and Willmott Model, 3.
57 L Willmott and B White, 'Assisted Dying in Australia: A Values based Model for Reform' in I Freckelton and K Petersen (eds) *Tensions and Traumas in Health Law* (The Federation Press, 2017) 502–3.
58 Ibid 504, 509.

Submissions

7.44 Our Consultation Paper asked whether the eligibility criteria should require the person to have been diagnosed with a disease, illness or medical condition that:[59]

(a) is incurable, advanced, progressive and will cause death (as in Victoria); or

(b) is advanced, progressive and will cause death (as in Western Australia).

7.45 We also asked whether the eligibility criteria should state that a person with a disability or a diagnosed mental illness alone is ineligible for voluntary assisted dying.[60]

7.46 Some respondents submitted that the eligibility criteria should provide that the person must be diagnosed with a disease, illness or medical condition that is 'incurable, advanced, progressive and will cause death', as in Victoria and the White and Willmott Model.[61]

7.47 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that:

> end of life should be based on the incurable nature of a disease with a known rapid progression.

7.48 Palliative Care Social Work Australia submitted that:

> 'Incurable' is an appropriate criterion for inclusion, as it clarifies that there is an end to the person's life as opposed to having an advanced disease. An advanced disease may be chronic and last for many years. 'Incurable' as a term reminds all medical practitioners to consider whether the criteria is being fulfilled e.g. is the disease process incurable?

7.49 The Anglican Bishop of North Queensland submitted that 'incurable' should be included to ensure voluntary assisted dying is available only to people 'for whom there is no hope of further treatment'.

7.50 In contrast, some respondents preferred the Western Australian model: that the condition is 'advanced, progressive and will cause death'. They considered that the term 'incurable' should not be included because it does not meaningfully add to the eligibility criteria and could introduce uncertainty as to how it should be interpreted in the context of eligibility for voluntary assisted dying.

7.51 Two academics jointly submitted that:

> The addition of 'incurable' as an eligibility requirement does not add value to the proposed provision. Instead, to the extent it is not redundant with 'advanced', 'progressive' and 'will cause death', it raises questions about how incurability should be defined.

7.52 Avant Mutual Group Limited submitted that:

> The phrase 'advanced, progressive and will cause death' demonstrates that the disease or illness is very serious and on a deteriorating trajectory. This phrase suggests that the disease or illness is incurable. The addition of 'incurable' is superfluous and will be harder for medical practitioners to determine with certainty.

7.53 In particular, some respondents expressed concern that 'incurable' should not be interpreted to mean that all treatment options must be exhausted, including novel or experimental treatments or treatments that are available but not acceptable to the person. Some of those respondents noted that often the treatment may itself cause suffering or side-effects, and that people have a right to refuse medical treatment and should be able to access voluntary assisted dying if they exercise that right.

59 QLRC Consultation Paper No 79 (2020) Q-5.
60 Ibid Q-6.
61 Palliative Care Nurses Australia Inc stated that this formulation 'is more descriptive'. A medical practitioner submitted that these terms are 'in common use in clinical settings' and are appropriate.

7.54 MIGA submitted that:

> The Western Australian approach of a disease, illness or medical condition which is advanced, progressive and will cause death avoids the inherent uncertainties of an 'incurable' condition. Use of 'incurable' leaves opens scope for arguments that any potential treatment that offers the prospect of a cure, however remote and whatever its efficacy or side effects, would render the relevant disease, illness or medical condition ineligible.

7.55 Dying with Dignity NSW submitted that:

> There may be cases where a condition might technically be curable, but the patient does not want to endure it. An example would be an elderly person with multiple medical conditions including acute myeloid leukaemia, for whom a bone marrow transplant is suggested. Such a person should have the right to refuse this very arduous treatment and also to make a valid request for [voluntary assisted dying].

7.56 An academic, Ms Jodhi Rutherford, reported the findings of a study of medical practitioners' general knowledge and perspectives of the Victorian Act. She submitted that participants in the study:[62]

> express concern about how patients might satisfy the requirement for an incurable illness if there are medical treatments available which may prolong life.

7.57 A few respondents submitted that, if the term 'incurable' is included in the draft legislation, it could be defined to provide some further clarification. Professors White and Willmott submitted that it could be defined to mean 'incurable by reference to available medical treatment that is acceptable to the person'. MIGA submitted that:

> If the 'incurable' criterion was used, a 'for the avoidance of doubt' provision should be included in the draft legislation, setting out that it is not intended to exclude diseases, illnesses or medical conditions where there is no reasonable expectation of a cure.

7.58 Respondents who submitted that the eligibility criteria should stipulate that the person must be diagnosed with a condition that is either 'incurable, advanced, progressive and will cause death' or 'advanced, progressive and will cause death' had differing views about whether the legislation should also state that persons with a disability or mental illness alone are not eligible to access the scheme.

7.59 Many respondents noted that it would be discriminatory to preclude a person who has a disability or a mental illness from accessing the scheme if they otherwise meet the criteria, including that they have been diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death, and have decision-making capacity for voluntary assisted dying. Some respondents considered that there should be additional support or safeguards for a person with a disability or mental illness who wishes to access the scheme.

7.60 Some respondents submitted that the legislation should state that mental illness or disability alone is not an eligible disease, illness or medical condition for the purposes of accessing voluntary assisted dying. However, this should not preclude a person who has a mental illness or disability if the person otherwise meets the eligibility criteria.

7.61 Queenslanders with Disability Network supported this approach, submitting that it:

> ensures that people with mental illness or disability have equitable access in the same way as others and will not be discriminated against or denied access to [voluntary assisted dying].

7.62 Some respondents submitted that the legislation could also state that persons who

62 See also J Rutherford, '*Doctors and the Voluntary Assisted Dying Act 2017* (Vic): Knowledge and Perspectives' (2020) 27(4) *Journal of Law and Medicine* 952. This article reports the findings of a qualitative study of 25 Victorian medical practitioners with no in-principle objection towards the legalisation of voluntary assisted dying. The participants on the study were recruited form a range of medical specialties which made them likely to encounter a request for voluntary assisted dying and were interviewed about their understanding and perspectives of the law.

have a mental illness or disability can access voluntary assisted dying if they meet the eligibility criteria.

7.63 Dying with Dignity NSW submitted that:

> it is undesirable that the legislation should send a message to disabled or mentally ill people that this option is not for them. Perhaps a clause could be included which says a disabled or mentally ill person can access [voluntary assisted dying] provided they meet the conditions of eligibility, which of course include having a medical condition that will lead to death.

7.64 A few respondents submitted that the legislation should also state that advanced age on its own does not make a person eligible.

7.65 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld submitted that:[63]

> Disability, mental health or frailty should not be in itself an eligibility criterion. This would significantly devalue the life and experience of people with a disability, the aged and frail, and people experiencing mental illness.

7.66 In contrast, some respondents submitted that a person should be able to access voluntary assisted dying because of mental illness or disability alone. For example, a retired medical practitioner submitted that a person should be able to choose to access the scheme if they are suffering from a severe and permanent condition that is not progressive or terminal—such as a severe spinal injury causing paralysis—or if they have suffered a stroke causing loss of bodily functions.

7.67 Two members of the public jointly submitted that a person should be able to access voluntary assisted dying solely on the grounds of a mental illness, such as chronic intractable depression, that has not responded to reasonable, extended treatment.

7.68 Some submitted that eligibility should not be limited to a person diagnosed with a particular life-limiting disease, illness or medical condition. Many of these respondents submitted that the key criteria should be the person's level of suffering and the seriousness of their condition, consistent with the approach in some overseas jurisdictions.

7.69 Several respondents submitted that a person should be eligible to access voluntary assisted dying because of loss of quality of life.[64] A few submitted that eligibility should not be based solely on medical reasons—that it should be the person's choice to access voluntary assisted dying.

The Commission's view

7.70 One of the eligibility criteria in the draft Bill 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.

7.71 This combination of eligibility criteria clarifies 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 an option for those who are in the process of dying to exercise some control over how and when they die. This approach strikes the right balance between the fundamental value of human life and the values of individual autonomy and reduced suffering.

63 This respondent submitted that eligibility for access to voluntary assisted dying should be limited to persons with physical pain that is unrelievable and considered intolerable for the person and that cannot be relieved from high quality palliative care.

64 Two members of the public jointly submitted that a person should be able to choose to access voluntary assisted dying in circumstances where they do not have a terminal condition but their quality of life is severely diminished, such as where a person has lost both their hearing and eyesight and no longer believes they have any quality of life.

7.72 Voluntary assisted dying is a complex issue with a diversity of views in the community as to who should be eligible to access it. This was reflected in the submissions we received, as well as those received by the Parliamentary Committee.[65] However, the Parliamentary Committee found that most Queenslanders supported legislating for voluntary assisted dying in Queensland as an end of life option for people who are dying, to reduce unnecessary suffering.[66] Similarly, most respondents to our Consultation Paper favoured a legislative approach that limits eligibility to people at the end of life who are suffering and dying.

7.73 The requirement that the person must be diagnosed with a condition that is 'advanced, progressive and will cause death' makes it clear that a person is eligible for voluntary assisted dying only if they have an eligible condition that is very serious, is on a deteriorating trajectory and will cause death. This term is consistent with the legislation in Victoria and Western Australia. It is clear, precise, and reflects contemporary medical terminology used and understood in Australia.

7.74 We do not consider it necessary to include the word 'incurable' in the eligibility criteria. It does not materially add to the other eligibility criteria, which require the person to be diagnosed with a disease, illness or medical condition that is 'advanced, progressive and will cause death', and that is expected to cause death within 12 months. The word 'incurable' could cause uncertainty and confusion about the extent to which a person must have exhausted all available treatment options before becoming eligible to access voluntary assisted dying, even though such an interpretation is inconsistent with a person's right to refuse medical treatment that is not acceptable to them.

7.75 Similarly, referring to specific diseases, illnesses or medical conditions, such as 'terminal', 'chronic' or 'neurodegenerative', is not necessary or desirable.

7.76 Whether a person has a disease, illness or medical condition that is 'advanced, progressive and will cause death' is a clinical determination made taking into account the person's individual circumstances, including their condition, comorbidities, and the available treatments that they are prepared to accept.

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

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

Timeframe until death

7.79 Many respondents argued that it was not necessary to include in the eligibility criteria a timeframe until death (that is, the person is expected to die from the disease, illness or medical condition within a certain period) since the condition must be advanced and progressive. Our reasons for considering that there should be a timeframe, and that the timeframe should be 12 months, are explained below.

65 The Commission received 126 submissions, and the Parliamentary Committee received 4 719 submissions and held 34 hearings and forums: see the discussion of the Commission's process in the Preface and Qld Parliamentary Committee Report No 34 (2020) [1.5]–[1.6].

66 Qld Parliamentary Committee Report No 34 (2020) [5.1], [5.3], [6.1]. The Committee defined 'end of life' care to mean 'care provided to a patient with a life-limiting illness during the last stages of life': Glossary.

Victoria and Western Australia

7.80 The eligibility criteria in Victoria and Western Australia include a requirement that the person be diagnosed with a disease, illness or medical condition that is expected to cause death within a specific timeframe. For Victoria, the person must be diagnosed with a condition that is expected to cause death within weeks or months, not exceeding six months, or 12 months for a neurodegenerative condition.[67] For Western Australia, the person must be diagnosed with at least one condition that will, on the balance of probabilities, cause death within a period of six months, or 12 months for a neurodegenerative condition.[68]

7.81 Whether a disease, illness or medical condition is expected to cause death within those timeframes is a clinical determination made by the medical practitioner, based on the person's circumstances, including condition, comorbidities and treatment choices.[69] In Victoria, the guidance for health practitioners explains that:[70]

> The medical practitioner is expected to use their clinical expertise and experience to determine if the patient's medical condition is expected to cause death within six months [or,] [i]f the patient's medical condition is neurodegenerative, … within twelve months.

Reasons for the inclusion of a specific timeframe until death

7.82 The Victorian Parliamentary Committee and the Western Australian Joint Select Committee considered that voluntary assisted dying legislation should not include a specific timeframe within which death must be expected.

7.83 The Victorian Committee recommended that voluntary assisted dying should be accessible to those who are at the end of life, which it defined as the final weeks or months of life.[71] However, it 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'.[72]

7.84 The Western Australian Committee considered that a prescribed time limit is 'too restrictive', noting that '[s]ome individuals experience intractable suffering for months or years prior to their death, particularly those with chronic or neurodegenerative conditions'.[73] It recommended that the legislation should require that death be reasonably foreseeable as a consequence of the condition.[74]

7.85 However, the inclusion of a specific timeframe was recommended by the Victorian

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67 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iii), (4). The current SA Bills are in substantially similar terms: Voluntary Assisted Dying Bill 2020 (SA) (HA Bill No 107) and Voluntary Assisted Dying Bill 2020 (SA) (LC Bill No 90) s 13(1)(d)(iii), (4).

68 *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c)(ii). See also Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6606 (RH Cook, Minister for Health), explaining that:

> In ongoing discussions with the expert panel and the Department of Justice, it was decided that 'balance of probabilities' provided the greatest clarity and the most utility in terms of defining this period.

See further Western Australia, *Parliamentary Debates*, Legislative Council, 26 November 2019, 9196 (S Dawson, Minister for Environment, Disability Services, Electoral Affairs).

69 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3–4. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5.

70 Vic Guidance for Health Practitioners (2019) 38. The Guidance further states that:

> It is important that in making any such determination, a medical practitioner acts within his or her scope of expertise or experience and should always consider seeking specialist opinion where appropriate.

71 Vic Parliamentary Committee Final Report (2016) 223–4, Rec 49, annex 1 [1.3]. It also recommended that the person must be suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable.

72 Ibid 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'.

73 WA Joint Select Committee on End of Life Choices Report (2018) [7.43]. It considered that '[a] criterion of advanced and progressive terminal or chronic or neurodegenerative illness that is causing grievous and irremediable suffering for the person, would be sufficient without a prescribed timeline until death': 213–14, Finding 50. The Committee also recommended that 'the eligibility requirement in the legislation include that the person is experiencing grievous and irremediable suffering related to an advanced and progressive terminal, chronic or neurodegenerative condition that cannot be alleviated in a manner acceptable to the person': [7.47], Rec 23.

74 Ibid [7.47], Rec 22.

Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel.[75] It was seen to be an important additional safeguard to ensure that voluntary assisted dying is:[76]

> restricted to those whose death is already imminent; that is, to maintain the distinction between this being a choice about the manner and timing of a person's death rather than a choice between life and death.

7.86 A specific timeframe also gave clear guidance to the community and medical practitioners as to who may access the scheme and ensured consistency of approach in applying and interpreting the eligibility criteria.[77]

7.87 The Victorian Panel and the Western Australian Panel did not support the use of a general provision requiring that the person's death must be 'reasonably foreseeable' as a result of the condition, without including a specific timeframe. A provision in those terms was included in the federal legislation in Canada, and required that the person's death must be 'reasonably foreseeable, taking into account all their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining'.[78]

7.88 The Victorian Panel considered that a general 'foreseeable future' timeframe 'does not provide any clear guidance' and 'places the onus on medical practitioners to determine what is foreseeable'.[79]

7.89 The Western Australian Panel noted that there has been considerable difficulty in interpreting and implementing the 'reasonably foreseeable' criterion in Canada, and that it has been the subject of legal challenge.[80]

7.90 The legal challenge was successful and the criterion was declared unconstitutional.[81] The Canadian Parliament has since repealed the criterion to allow a person whose death is not reasonably foreseeable but who is suffering intolerably to access medical assistance in dying, provided that the person otherwise meets all the eligibility criteria and subject to additional procedural safeguards.[82]

Reasons for the inclusion of a timeframe of six or 12 months

7.91 The Victorian Panel and the Western Australian Panel each recommended a specific timeframe of 12 months in the eligibility criteria.[83]

7.92 A 12-month timeframe was considered to be consistent with current health care

75 WA Ministerial Expert Panel Final Report (2019) 36, Rec 2. See further 36–7, explaining that the Panel 'worked from the basis that death is reasonably foreseeable as a consequence of the condition' as this was the recommendation made by the Joint Select Committee, and had been accepted by the Government.

76 Ibid 38. It was also considered that the inclusion of a specific timeframe will 'prevent expansion of this criterion through practice': Vic Ministerial Advisory Panel Final Report (2017) 72.

77 Vic Ministerial Advisory Panel Final Report (2017) 71–2; WA Ministerial Expert Panel Final Report (2019) 37 8.

78 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(2)(d) (repealed by *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, s 1(1)).

79 Department of Health and Human Services (Vic), *Ministerial Advisory Panel on Voluntary Assisted Dying*, Final Report (2017) 72.

80 WA Ministerial Expert Panel Final Report (2019) 38.

81 *Truchon v Attorney General of Canada* [2019] QCCS 3792. The legislation in Quebec required, among other things, that the person must be 'at the end of life': *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, s 26(3). That criterion was also declared unconstitutional by *Truchon v Attorney General of Canada*. The Quebec Superior Court decision came into full force and effect in Quebec on 26 March 2021: Department of Justice Canada, 'Joint Statement by Ministers Lametti and Hajdu on court ruling to extend the Truchon decision on medical assistance in dying' (25 February 2021) <https://www.canada.ca/en/department-justice/news/2021/02/joint-statement-by-ministers-lametti-and-hajdu-on-court-ruling-to-extend-the-truchon-decision-on-medical-assistance-in-dying.html>.

82 *Canada Criminal Code*, RSC 1985, c C-46 s 241.2(2)(d) (repealed by *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, s 1(1). See also J Nichol and M Tiedemann, 'Bill C-7: *An Act to amend the Criminal Code (medical assistance in dying)*', (Legislative Summary No 431C7E, Library of Parliament, Canada, 27 March 2020) 5, 6–9.

83 The Victorian Ministerial Advisory Panel recommended that one of the eligibility criteria for access to voluntary assisted dying should be that the person is diagnosed with a disease, illness or medical condition that 'is expected to cause death within weeks or months, but no longer than 12 months'. The Western Australian Ministerial Expert Panel recommended that the eligibility criteria should specify that 'death is reasonably foreseeable for the person within a period of 12 months': Vic Ministerial Advisory Panel Final Report (2017) Rec 2; WA Ministerial Expert Panel Final Report (2019) Recs 2, 9.

practice and the end of life and palliative care framework in Australia.[84] Both panels noted that health practitioners commonly use the 'surprise question' (that is: 'would I be surprised if my patient died in the next 12 months?') when planning and discussing the treatment and care of people who are at the end of life, as well as other prognostication assessment tools.[85] The Western Australian Panel considered that such tools have been shown to provide 'an accurate, yet conservative predictor of the risk of death within 12 months'.[86]

7.93 The panels also noted that the timeframe of six months was first introduced in Oregon, and subsequently adopted in other state legislation in the United States, because of administrative and funding requirements for hospice care. This consideration is not relevant in Australia.[87]

7.94 Another reason given in support of a 12 month timeframe is that it acknowledges the clinical trajectories of people with a non-cancer illness. The Victorian Panel explained that:[88]

> although a six month timeframe is more consistent with an end of life clinical trajectory for most advanced cancers, it does not necessarily reflect the clinical trajectories of people who have other non-malignant incurable diseases, illnesses or medical conditions that are advanced, progressive and will cause death, such as motor neurone disease or chronic heart failure. The Panel is of the view that the timeframe should, wherever possible, take into account the clinical trajectories of people with non-cancer illness and so does not support the use of a six-month timeframe.

7.95 In particular, the Victorian Panel noted that a 12 month timeframe, as opposed to a six month timeframe, 'is more likely to encompass the clinical trajectories of neurodegenerative diseases, such as motor neurone disease', and that it had received 'strong feedback that people with motor neurone disease should not be disadvantaged because of the nature and clinical trajectory of this disease'.[89] It was further noted that:[90]

> the average life expectancy from disease onset is 2.5 years. As people with motor neurone disease lose their fine motor skills relatively early in the disease's trajectory they may also lose the physical ability to self-administer the lethal dose of medication. It is important that people with diseases, illnesses and medical conditions that affect fine motor function are given sufficient time to consider all of their options, and a 12 month timeframe will give them this opportunity. (note omitted)

7.96 The Western Australian Panel did not consider that there should be more than one timeframe—for example, six months for some conditions and 12 months for others. In its view:[91]

> it is difficult and potentially discriminatory to weight the suffering of one terminal diagnosis above other terminal diagnoses.

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84 Vic Ministerial Advisory Panel Final Report (2017) 73; WA Ministerial Expert Panel Final Report (2019) 38, referring in particular to the Australian Commission on Safety and Quality in Health Care, *National consensus statement: essential elements for safe and high quality end of life care* (2015) 2, 17–18, app a (definition of 'endoflife care') <https://www.safetyandquality.gov.au/our-work/comprehensive-care/end-life-care/national-consensus-statement>. In Queensland, see Queensland Health, Statewide strategy for end-of-life care 2015 (May 2015). See also Queensland Government, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients: Guidance for health professionals* (Queensland Health, 2018), in relation to decision-making about withholding and withdrawing life-sustaining measures.

85 Vic Ministerial Advisory Panel Final Report (2017) 73; WA Ministerial Expert Panel Final Report (2019) 38, referring in particular to the Australian Commission on Safety and Quality in Health Care, *National consensus statement: essential elements for safe and high quality end of life care* (2015) 18 <https://www.safetyandquality.gov.au/our-work/comprehensive-care/end-life-care/national-consensus-statement>; and the Supportive and Palliative Care Indicators Tool ('SPICT') available at: <https://www.spict.org.uk> (University of Edinburgh, 2021). See also Victoria, *Parliamentary Debates*, Legislative Council, 21 November 2017, 6218 (G Jennings, Special Minister of State), referring to the Gold Standard Framework Prognostic Indicator Guidance.

86 WA Ministerial Expert Panel Final Report (2019) 38, referring to A Woolfield et al, 'Predicting those who are at risk of dying within six to twelve months in primary care: A retrospective case-control General Practice chat analysis' 22 (11) (2019), *Journal of Palliative Medicine*. It was also noted that 'other research shows that clinicians tend to overestimate survival times: 38, referring to NA Christakis and EB Lamont, 'Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study' (2000) 320 (7233) *British Medical Journal* 469.

87 See, eg, Vic Ministerial Advisory Panel Final Report (2017) 72; WA Ministerial Expert Panel Final Report (2019) 38. See also Vic Parliamentary Committee Final Report (2016) 223.

88 Vic Ministerial Advisory Panel Final Report (2017) 72.

89 Ibid 72-73.

90 Ibid 73.

91 WA Ministerial Expert Panel Final Report (2019) 39.

7.97 The Victorian Panel considered that a timeframe longer than 12 months should not be adopted as this would:[92]

> be inconsistent with the intention of the legislation, which is to apply to people who are at the end of life and close to death.

7.98 As introduced, the Victorian Bill provided for a single timeframe not exceeding 12 months, consistent with the recommendation of the Victorian Panel.[93] However, the Bill was amended to reduce the timeframe to six months:[94]

> to recognise that in the Legislative Assembly and in the second-reading debate in this chamber a number of members expressed concern about the time frame of the prognosis in which a patient may enter into the voluntary assisted dying scheme. Some people were concerned that the 12-month window of that prognosis was broader than it should be given the circumstances of what they believed was the dominant trajectory of pain and suffering and the likelihood of imminent death. This was, in their assessment, easier to limit to six months rather than 12 months.

7.99 Another amendment was made to extend the timeframe to 12 months for those diagnosed with a neurodegenerative disease, illness or medical condition. This amendment was made to address concerns that the six month timeframe was more suited to advanced cancers, and that a 12 month timeframe accounted for the different nature and clinical trajectories of neurodegenerative diseases.[95]

7.100 The approach in the Western Australian Act is consistent with the Victorian Act.[96]

7.101 Some academics have criticised the different treatment for different types of diseases, illnesses or medical conditions, observing that 'this cannot be justified by reference to the policy objectives'. In particular, they noted that this 'gives greater protection to the autonomous choices only of a narrow class of individuals'.[97]

Tasmania

7.102 In Tasmania, the legislation provides that the person must have a relevant medical condition (unless exempted by the Voluntary Assisted Dying Commission). A relevant medical condition is defined as a disease, illness, injury, or medical condition that is expected to cause death within six months, or 12 months if the disease is neurodegenerative.[98]

7.103 As introduced in the upper house, the Tasmanian Bill did not include a specific timeframe within which death must be expected.[99]

7.104 In a document prepared to accompany the debate, Go Gentle Australia considered

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92 Ibid 39.

93 Voluntary Assisted Dying Bill 2017 (Vic) s 9(1)(d)(iii) (as introduced).

94 Victoria, *Parliamentary Debates*, Legislative Council, 16 November 2017, 6097 (G Jennings, Special Minister of State). See further Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3432–3440; Victoria, *Parliamentary Debates*, Legislative Council, 2 November 2017, 5626–5631. It was noted that a timeframe of six months has been operating well in jurisdictions in the United States of America and appropriately limits eligibility for access to voluntary assisted dying to someone who is close to death: Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3433 (C McLeish); and 3433 (N Angus). A number of members of parliament expressed concerns that a 12-month timeframe is too long, given that prognostication is an inexact science. Some members of parliament expressed concerns that prognostication may be less reliable the further away a person is from death: see, eg, Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3433 (McLeish); 3435 (Ryall); 3439 (Thompson); 3440 (Clark). However, the Minister for Health noted that there is no evidence of increased accuracy at 12 or six months and that clinicians tend to overestimate, rather than underestimate, life expectancy: Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3436 (J Hennessey, Minister for Health).

95 Victoria, *Parliamentary Debates*, Legislative Council, 16 November 2017, 6097–8, 21 November 2017, 6216 (G Jennings, Special Minister of State).

96 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health). See also Western Australia, *Parliamentary Debates*, Legislative Council, 26 November 2019, 9196 (S Dawson, Minister for Environment, Disability Services, Electoral Affairs).

97 B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 434.

98 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 6(1)(c), 10(1)(e).

99 Although one of the eligibility criteria was that the person must be suffering intolerably with a 'relevant medical condition', which was defined to mean a 'disease, illness or injury, or medical condition' that is 'advanced, incurable and irreversible and is expected to cause the death of the person': End of Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) cll 5, 9(e) (as introduced).

that 'there is no necessity to stipulate a time frame if the legislation makes it clear the law is only for people at the end of their life'. It also explained that, while a timeframe to expected death 'is referenced extensively in palliative care in Australia':[100]

> there may be good arguments not to include a time frame, especially for people with degenerative chronic or neurological conditions. Often the progression of these diseases are unpredictable — decline can happen swiftly and with devastating consequences even in those patients whose death was not predicted for many months. Sometimes, too, the suffering of an incurable and irreversible disease is greatest in those who are not immediately dying: rather, they are condemned to even greater suffering over a longer period.
>
> For example, a person with advanced [multiple sclerosis] or with motor neurone disease may face many years of extreme pain, loss of autonomy, indignity, and mental anguish. People with terminal and debilitating chronic illnesses make up around 10% of suicides each year in Australia, as indicated by evidence to the Victorian, [Western Australian] and Queensland inquiries.

7.105 However, an amendment was moved during debate in the upper house to include a specific timeframe of six months, or 12 months for a neurodegenerative disease, within which the person's death must be expected.[101] The main reason given was that it is 'very strongly' in line with the expectations of the community and the medical profession that voluntary assisted dying should only be an option for those who are actively dying; it is not a choice between life and death for those who are otherwise not dying.[102] It was therefore considered that 'the default position should be that the person is facing death' in the near future.[103]

7.106 The member who introduced the Bill responded that a specific timeframe may prolong a person's suffering and mean that they 'have to wait until they have six months to go' before they can start the process. He noted that in overseas jurisdictions that do not include a specific timeframe, 'most people… still end their life within the last two to three weeks of their death'. He also noted that the Victorian Panel recommended a single timeframe of 12 months.[104]

7.107 There was a particular concern that some doctors may be hesitant to assess a person as having six months to live until the person is clearly much closer to death, thus delaying access to voluntary assisted dying in circumstances where the person is suffering and, in some cases, until it becomes too late.[105]

7.108 Another member noted that, although it is impossible to predict exactly when someone will die, doctors frequently undertake these types of prognostic assessments in circumstances where someone is being treated for a condition that will cause death:[106]

> When you have had a diagnosis of a condition that is terminal, that is incurable, that is likely to cause significant suffering, then obviously your doctor would have spoken to you about all the implications associated with that — what the normal course of events

100 Go Gentle Australia, *A Guide to the Debate on Voluntary Assisted Dying in Australia* (2nd ed, August 2020) 19. See further Queensland Parliamentary Committee Report No 34 (2020) [5.3.5], Table 1.

101 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 54 ff (R Forrest, Independent member for Murchison and Chair of Committees), 81. An amendment was also made to enable a person to apply to the Voluntary Assisted Dying Commission (the oversight body established under the Bill) for an exemption from this requirement, if the Commission is satisfied that the prognosis of the person's relevant medical condition is such that it should not apply to the person: see further Tasmania, *Parliamentary Debates*, Legislative Council, 27 October 2020, 190 (R Forrest, Independent member for Murchison and Chair of Committees). See End of Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) s 6(1)(c), (3)–(5) (Reprint of Bill as amended by the Legislative Council).

102 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 54–6 (R Forrest, Independent member for Murchison and Chair of Committees).

103 Ibid, 61 (J Palmer, Member for Rosevears).

104 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 57–60 (M Gaffney, Independent member for Mersey). See further Tasmania, *Parliamentary Debates*, Legislative Council, 22 September 2020, 84, 86, 88–91 (M Gaffney, Independent member for Mersey). As introduced, the Victorian Bill included a single timeframe of 12 months.

105 See Tasmania, *Parliamentary Debates*, Legislative Council, 22 September 2020, 84, 86 (M Gaffney, Independent member for Mersey).

106 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 55 (R Forrest, Independent member for Murchison and Chair of Committees).

> are, and what options for treatment are, what the effects of those treatments are likely to be, how they might affect you.

Other jurisdictions

7.109 In Belgium, Luxembourg, the Netherlands, and Canada, there is no requirement that the person be diagnosed with a life-limiting condition or that the person's death be expected within a specific timeframe. However, in some jurisdictions the legislation includes additional safeguards that apply if the person is not expected to die soon.[107]

7.110 The data from those jurisdictions show that people usually access voluntary assisted dying when they are near to death. In the Netherlands, although the legislation 'does not rule out granting a request for [voluntary assisted dying] from a [person] who might have many years to live',[108] it has been reported that:[109]

> … the majority of patients who receive euthanasia or physician-assisted suicide have a short-estimated life expectancy: a week or less for 36%, 2–4 weeks for another 36%, 1–6 months for 19% and more than 6 months for 8%.

7.111 In contrast, overseas jurisdictions that limit eligibility to a person who is diagnosed with a terminal disease or illness also include a requirement that death must be expected within six months (for example, New Zealand and state legislation in the United States).

7.112 Some jurisdictions have sought to introduce legislation that limits eligibility to people who have been diagnosed with a disease, illness or medical condition that will cause death without the inclusion of a specific timeframe within which death must be expected. However, legislation in such terms has not successfully passed through any Australian parliament,[110] with the exception of the *Rights of the Terminally Ill Act 1995* (NT) (which was overturned by the Commonwealth Parliament in 1997).[111] That Act was in force for nine months between July 1996 and March 1997. Seven people applied and four people died under the Act. All had cancer and most were in advanced stages.[112]

Parliamentary Committee and the White and Willmott Model

7.113 The Parliamentary Committee recommended that eligibility for access to voluntary assisted dying should be limited to a person who is diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death. However, the Committee considered that specific timeframes for the eligibility period should be avoided because of the 'practical difficulties in obtaining a prognosis and timeframe of progression of some medical conditions, such as motor neurone disease'.[113] It recommended that:[114]

> any voluntary assisted dying scheme in Queensland should not propose precise

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107 In Belgium, this includes requirements for additional consultations with specialists or psychiatrists and the extension of the applicable waiting periods between the person's written request and the provision of voluntary assisted dying: *Belgian Euthanasia Act 2002*, art 3, § 3. In Canada, if the person's natural death is not reasonably foreseeable, additional safeguards apply, including a minimum 90 day assessment period, a requirement for a second eligibility assessment by a practitioner with expertise in the condition that is causing the person's suffering and two clarifications of informed consent: *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3.1).

108 Regional Euthanasia Review Committees (Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) 9.

109 B Onwuteaka-Philipsen, L Willmott and B White, 'Regulating voluntary assisted dying in Australia: some insights from the Netherlands' (2019) 211 (10) *Medical Journal of Australia* 438. In Belgium it has been reported that 'in the vast majority of cases (85.4%), the physician estimated that patient deaths were predictable in the near future'. It was further noted that 'patients whose death is clearly not expected in the short term' suffered mostly from polypathologies (a combination of several conditions): N Francis, *Belgian euthanasia report for 2018 released*, Dying for Choice.com.

110 Eg, Death with Dignity Bill 2016 (SA) (negatived on 17 November 2016).

111 This Act provided that a person could request assistance to voluntarily terminate their life if the person was, 'in the course of a terminal illness experiencing pain, suffering and/or distress to an extent unacceptable to the [person]'.'Terminal illness' was defined to mean 'an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient': *Rights of the Terminally Ill Act 1995* (NT) s 3 (definition of 'terminal illness'), 4, 7. This Act was passed but no longer has any effect, following the passing of federal legislation: *Northern Territory (Self-Government) Act 1978* (NT) s 50A, as inserted by the *Euthanasia Laws Act 1997* (Cth) s 3, sch 1.

112 D W Kissane MD, A Street and P Nitschke, 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' (1998) 9134(352) *The Lancet* 1097.

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

114 Ibid Rec 5.

> 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.

7.114 Like Victoria, the eligibility criteria in the White and Willmott Model include a requirement that the person be diagnosed with a medical condition that is 'incurable' and is 'advanced, progressive and will cause death'.[115] However, unlike Victoria, Western Australia, and Tasmania, the model does not include a specific timeframe within which a person's death must be expected.

7.115 The explanatory notes state that:[116]

> We adopt this approach because a time limit is arbitrary. While a secondary consideration, not imposing a time limit avoids a registered medical practitioner from having to engage in the difficult task of determining prognosis and timing of death.

7.116 In an earlier article, the authors also explained their reasons for not including a specific timeframe. In their view:[117]

> First, the balancing of values exercise undertaken above[118] does not point to the need for a specified period of time. Secondly, it is difficult to predict with any certainty when a person is likely to die, making the eligibility certification a challenging if not impossible task for the doctor. Thirdly, a practical harm that can occur when temporal limits are imposed is that people who have a relevant medical condition that will cause their death but are outside the relevant time period may choose to starve themselves until they are close enough to death that the time condition is satisfied. (note added)

Submissions

7.117 Our Consultation Paper asked whether the eligibility criteria for a person to access voluntary assisted dying should require that the person be diagnosed with a disease, illness or medical condition that is expected to cause death within a specific timeframe and, if so, what that timeframe should be.[119]

7.118 As noted above, some respondents submitted that eligibility for access to the scheme should not be limited to a person who is diagnosed with a life-limiting disease, illness or medical condition. Those respondents also submitted that there should be no requirement for the person's death to be expected within a specific timeframe.[120]

7.119 Among respondents who submitted that eligibility should be limited to a person who is diagnosed with a particular disease, illness or medical condition that is advanced, progressive and will cause death, views differed as to whether the eligibility criteria should also include a specific timeframe within which death is expected.

7.120 Some respondents did not support the inclusion of a specific timeframe. They variously submitted that a specific timeframe would be arbitrary, that prognostication is an inexact science, and life expectancy too difficult to predict, and that a timeframe would be a barrier to access and might prolong a person's suffering until the person can meet this criterion.[121] For example, a registered nurse submitted that predicting remaining life

115 White and Willmott Model cl 9(e).

116 Explanatory Notes, White and Willmott Model, 3-4.

117 L Willmott and B White, 'Assisted Dying in Australia: A Values based Model for Reform' in I Freckelton and K Petersen (eds) *Tensions and Traumas in Health Law* (The Federation Press, 2017) 503–4.

118 The authors balanced the value of life with the values of autonomy and reducing suffering and concluded that this balancing exercise favours an approach that limits eligibility for access to voluntary assisted dying to a person who is diagnosed with a disease, illness or medical condition that will cause death.

119 QLRC Consultation Paper No 79 (2020) Q-7, Q-8. The Commission also asked whether there should be a specific timeframe that applies if a person is diagnosed with a disease, illness or medical condition that is neurodegenerative. For example, should the relevant timeframe be within six months, or within 12 months in the cases or a disease, illness or medical condition that is neurodegenerative (as in Victoria and Western Australia).

120 A number of these respondents submitted that the key criteria for the person's disease, illness or medical condition should be the person's level of suffering and the seriousness of their condition (which need not be terminal), consistent with the approach in overseas jurisdictions that do not limit eligibility for access to voluntary assisted dying to a person with a terminal illness, or whose death is expected within a specific timeframe until death. A few respondents considered that it should be the person's choice to access voluntary assisted dying.

121 A few respondents noted that some medical practitioners may be reluctant to give a prognosis until a person is close to death.

expectancy is inexact and may be inaccurate, and that the inclusion of a timeframe is arbitrary as different diseases, illnesses or medical conditions will have different trajectories, and 'there is always individual variance'. This respondent also observed that 'some terminal medical conditions present severely distressing symptoms a long time prior to the person's eventual death', and that the inclusion of a specific timeframe 'would in some cases, only result in prolonging suffering and possibly lead some people to commit violent suicides'.

7.121 Christians Supporting Choice for Voluntary Assisted Dying submitted that a specific timeframe should not be included in the eligibility criteria, noting that:

> It is very difficult to accurately predict a time frame to death, unless the person is reaching the terminal phase of their illness.
>
> The degree of suffering being experienced by the person who meets the other eligibility requirements should be [the] overriding criteria for access. If the aim of the [Voluntary Assisted Dying] Act is to give the option to avoid futile enduring untreatable suffering, then it is not rational to have a time limit, as with some degenerative illness the severe suffering can be longer than any arbitrary time eg of 12 months.

7.122 Dying with Dignity Victoria submitted that:

> Removing the time restrictions on prognosis will allow patients to begin the voluntary assisted dying process when they are not at the end stage of their illness. This will not result in anyone dying prematurely, it will just allow those who want to have this option to do so without the unnecessary pressure of very limited time.

7.123 Some respondents, including some voluntary assisted dying advocacy groups, expressed support for the approach in the White and Willmott Model. It limits eligibility to a person who has been diagnosed with a medical condition that is incurable and is advanced, progressive and will cause death, but does not include a specific timeframe until death. Instead, it includes a higher threshold for the person's level of suffering.

7.124 The Clem Jones Group submitted that:

> Medical practitioners recognise that it is difficult to set with precision any time periods covering the rate of deterioration in the condition of a person suffering a terminal illness or progressive illness that will ultimately lead to their death.
>
> It is not uncommon for some terminally ill patients to live far longer than an initial prognosis and doctors rightly caution against accepting such time frames as being absolute.
>
> Therefore we consider arbitrary time frames in any voluntary assisted dying law in Queensland would represent an unfair impost on medical practitioners as well as being a potential barrier to those seeking access to [voluntary assisted dying].
>
> …
>
> There will always be those who are caught by such arbitrary time frames and may end up suffering more if they deteriorate to a state in which they cannot proactively seek access to [voluntary assisted dying].
>
> We believe the unrelievable suffering by a person — either terminally ill or suffering a neurodegenerative condition — as determined by that person should be the measure on which the timing of access to voluntary assisted dying should be based.

7.125 A few respondents, including a nursing and midwifery union and a hospital and health service, submitted that the eligibility criteria should not include a specific timeframe, but that death must be 'reasonably foreseeable' as a consequence of an advanced and progressive terminal, chronic or neurodegenerative disease, illness or medical condition. A member of the public submitted that the legislation should not include a specific

timeframe until death, where the person's death is also required to be 'imminent'.[122]

7.126 In contrast, other respondents—including AMA Queensland, Palliative Care Social Work Australia, the Australian Psychological Society, a medical practitioner, and members of the public—submitted that the eligibility criteria should require that the person has been diagnosed with a disease, illness or medical condition that will cause death and that is expected to cause death within a specific timeframe. Their main reasons for the inclusion of a specific timeframe in the eligibility criteria were that it provides clarity and guidance regarding eligibility, ensures consistency in interpretation and application, and appropriately limits access to the end of life.

7.127 Avant Mutual Group Limited submitted that:

> On balance, we believe that Queensland's legislation should follow the time frames in the Victorian and Western Australian legislation in this regard.
>
> 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.

7.128 MIGA similarly 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.

7.129 Palliative Care Social Work Australia submitted that:

> Whilst there are challenges relating to time frames (eg, requires a physician to be definitive in their prognosis), time frames are commonly understood and used in clinical practice and provide some level of clarity regarding eligibility.

7.130 Similarly, a medical practitioner noted that 'the argument against stipulation of a time is that estimation of prognosis is not easy' but submitted that timeframes are commonly used in clinical practice.

7.131 Go Gentle Australia submitted that the inclusion of a specific timeframe 'is essential for two reasons':[123]

> 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. The laws in VIC and WA which allow for 6 months for those

122 This respondent observed that the relevant policy documents and explanatory materials could include a definition of 'imminent' for the purposes of access to voluntary assisted dying.

123 Note that this differs from the position previously stated by Go Gentle Australia in a document to accompany debate on the Tasmanian debate.

> diagnosed with an incurable disease, illness or medical condition that is advanced and progressive and will cause death are designed to help those people.
>
> The additional reach of the laws — 12 months for those with a neurodegenerative disease, such as motor neurone disease, multiple sclerosis, or Parkinson's disease — helps the next largest category of those who seek access to [voluntary assisted dying].
>
> Many people with [motor neurone disease] are over-represented in Australia's (and Western Australia's) suicide statistics.
>
> The experience in Victoria shows that on average 25 per cent of applicants have progressed between their first and last request within 11 days and 50 per cent within 19 days.

7.132 The Lutheran Church of Australia Queensland District submitted that the inclusion of a specific timeframe in the eligibility criteria:

> is important to maintain the distinction between this being a choice about the manner and timing of a person's death rather than a choice between life and death.

7.133 A member of the public similarly submitted that the inclusion of a specific timeframe until death ensures that voluntary assisted dying is an end of life option for people who are dying, not an option for people who may have many years to live.

7.134 Some respondents also submitted that a timeframe until death should be included in the eligibility criteria for consistency with the legislation in Victoria and Western Australia.

7.135 Views differed among respondents who supported a timeframe until death about what it should be.

7.136 The Lutheran Church of Australia Queensland District submitted that the eligibility criteria should specify a timeframe of four months. It considered that this would make it clear that voluntary assisted dying is an option to 'avoid excruciating deaths' and not about giving people who are otherwise not dying a 'right to die'.

7.137 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld jointly submitted that the timeframe 'should not exceed 6 months', as '[t]his is an important safeguard … to ensure that only people at the end of life have access to voluntary assisted dying'.

7.138 Some respondents—including AMA Queensland, Dying with Dignity NSW, a medical practitioner, and a member of the public—submitted that, if a timeframe is included in the eligibility criteria, it should be six months, or 12 months for neurodegenerative conditions, consistent with the legislation in Victoria and Western Australia.

7.139 Other respondents submitted that if a timeframe is included in the eligibility criteria, there should be a single timeframe of 12 months (as opposed to different timeframes for different diseases, illnesses and medical conditions, as in Victoria and Western Australia).

7.140 An academic, Ms Jodhi Rutherford, reported the findings of a study of medical practitioners' general knowledge and perspectives of the Victorian Act. She submitted that:[124]

> To address the barrier to access that many participants perceive in the life expectancy criteria, some take the view that 12 months is more appropriate. It is noted that this was the initial life expectancy timeframe endorsed by the drafters of the Victorian legislation before that timeframe was constrained during the Parliamentary Debates. By specifying a six-month timeframe, the primary [voluntary assisted dying] patient population is understood by participants to be people dying from cancer …
>
> A six-month timeframe has potentially discriminatory access implications for other patient populations whose disease or illness might follow a different trajectory.

124 See also J Rutherford, 'Doctors and the *Voluntary Assisted Dying Act 2017* (Vic): Knowledge and General Perspectives' (2020) 27(4) *Journal of Law and Medicine* 952.

7.141 Go Gentle Australia submitted that:

> 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.

7.142 That respondent also noted that the Western Australian Panel recommended a 12 month timeframe because that is consistent with end of life policy documents and existing practice.

7.143 A member of the public submitted that a single timeframe of 12 months is equitable.

7.144 Gold Coast Retirees Inc submitted that if a timeframe is specified, it could be extended to 12 months, or 24 months for neurodegenerative conditions.

The Commission's view

7.145 The eligibility criteria in the draft Bill should include a requirement that the person has been diagnosed with a disease, illness or medical condition that is expected to cause death within 12 months.

7.146 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 and manner of their death. A specific timeframe gives clear guidance to the community and the health profession about who is eligible.

7.147 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. While a timeframe of six months may be more consistent with an end of life clinical trajectory for most advanced cancers, 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.

7.148 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.

7.149 This Commission agrees 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. The draft Bill limits eligibility to people who:

- are at the end of life,
- have been diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death,
- are suffering and dying,
- have decision-making capacity for access to voluntary assisted dying, and
- meet the other eligibility criteria.

7.150 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.

7.151 The Commission notes 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. It will enable people 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.

7.152 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 may well 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.

7.153 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.

7.154 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.

Level of suffering

Victoria, Western Australia, and Tasmania

7.155 In Victoria and Western Australia, one of the eligibility criteria is that the person must have an eligible disease, illness or medical condition that 'is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'.[125] This criterion was recommended by the Victorian Panel and the Western Australian Panel.[126] The Victorian Panel explained that the legislation should require two things: the person must be approaching death (as in state legislation in the United States), and suffering (as in the legislation in Belgium, Luxembourg, and the Netherlands). It wrote, 'these dual requirements represent strong safeguards'.[127]

7.156 The extent to which the person's suffering may be relieved or is tolerable is a subjective assessment to be determined by the person.[128] This recognises individual autonomy and is consistent with a person-centred approach to care.[129] It also recognises that 'a person's experience of the nature and intensity of their suffering is entirely subjective'.[130]

7.157 In Victoria, guidance for health practitioners explains that:[131]

> Suffering is a subjective experience of the individual and the medical practitioner must allow the patient to assess whether they are experiencing suffering they cannot

125 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iv); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c)(iii).
126 Vic Ministerial Advisory Panel Final Report (2017) 74, Rec 2; WA Ministerial Expert Panel Final Report (2019) 35, Rec 2.
127 Vic Ministerial Advisory Panel Final Report (2017) 76.
128 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (J Hennessy, Minister for Health); Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5.
129 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health); Vic Ministerial Advisory Panel Final Report (2017) 78–9; WA Ministerial Expert Panel Final Report (2019) 34–5, Rec 8.
130 Vic Ministerial Advisory Panel Final Report (2017) 76. See also WA Ministerial Expert Panel Final Report (2019) 34–5, Rec 8.
131 Vic Guidance for Health Practitioners (2019) 39.

> tolerate. If the suffering is linked to the medical condition, then this eligibility criterion is met.

7.158 The Victorian and Western Australian panels considered that the eligibility criteria should not incorporate a higher threshold for the level of suffering by requiring, for example, that the suffering is 'enduring and unbearable', or 'grievous and irremediable'.

7.159 The Victorian Panel considered that the word 'suffering', on its own, denotes a sufficiently high threshold for eligibility and that an additional requirement that the suffering is 'enduring and unbearable' would require people to suffer unbearably for too long before they become eligible.[132] It also considered that suffering should always be judged by the person concerned, and that the addition of a further description such as 'enduring':[133]

> may mean others would apply their own meaning to these words and it would therefore cease to be an assessment made by the person themselves. If a medical practitioner could find that a person's suffering was not sufficient for eligibility to access voluntary assisted dying, this would no longer be a subjective test and would instead become a medical judgment.

7.160 The Western Australian Panel also considered that suffering should always be subjectively assessed (that is, from the person's point of view),[134] and observed that the addition of terms such as 'grievous and irremediable' could 'potentially compromise the compassionate intention of the legislation and lead to a possible interpretation that there should be an objective determination of the nature of the suffering'.[135] The Panel concluded that:[136]

> It is sufficient that there be suffering related to the eligible condition (from the person's point of view) and that this suffering cannot be relieved in a manner acceptable to the person.

7.161 One of the eligibility criteria in the Tasmanian Act is that the person must be 'suffering intolerably from a relevant medical condition'.[137]

Meaning of 'suffering'

7.162 'Suffering' is not defined in the legislation in Victoria or Western Australia. However, the Victorian Panel explained that 'suffering' in this context is not limited to the physical symptoms of a person's condition, such as pain. It can also include 'non-physical aspects such as loss of function, control and enjoyment of life', and suffering caused by the treatment of the person's condition.[138] The Western Australian Panel explained that suffering is 'an intensely personal experience and can take a variety of forms', including 'physical, mental, emotional, social, spiritual or existential'.[139]

7.163 The Victorian guidance explains that:[140]

> [s]uffering can be defined as a state of distress associated with events that threaten the intactness of the individual. While it often occurs in the presence of pain, shortness of breath or other bodily symptoms, suffering extends beyond the physical.

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132 Vic Ministerial Advisory Panel Final Report (2017) 79.
133 Ibid 79.
134 WA Ministerial Expert Panel Final Report (2019) 34.
135 Ibid 35.
136 Ibid.
137 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 10(1)(e).
138 Vic Ministerial Advisory Panel Final Report (2017) 76.
139 WA Ministerial Expert Panel Final Report (2019) 34. See further Western Australia, *Parliamentary Debates*, Legislative Assembly, 4 September 2019, 6401 (RH Cook, Minister for Health), explaining that:

> suffering is not defined because it is entirely subjective… The Joint Select Committee on End of Life Choices and the ministerial expert panel formed the view that a patient's suffering was an intensely personal experience and may take a variety of forms, such as physical, mental, emotional, social, spiritual or existential

See further Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6580, 6584 (M McGowan, Premier).
140 Vic Guidance for Health Practitioners (2019) 39. See also Vic Ministerial Advisory Panel Final Report (2017) 77.

> A patient's request for voluntary assisted dying is 'usually motivated by multiple, interactive factors in relation to progressive, serious illness, including both physical and psychological suffering, a desire to control the circumstances of one's death and to relieve distress over the loss of autonomy'. (notes omitted)

7.164 The Victorian Voluntary Assisted Dying Review Board reported that:[141]

> Loss of autonomy was frequently cited by applicants as a reason for requesting voluntary assisted dying.
>
> …
>
> Other reasons for accessing voluntary assisted dying which were commonly reported included being less able to engage in activities that make life enjoyable, losing control of body functions, and loss of dignity.

7.165 In Oregon, data on the reasons people request voluntary assisted dying have been collected since 1998. Over that time, 90.6 per cent of people who accessed voluntary assisted dying cited concerns about losing autonomy, 89.9 per cent cited decreased ability to engage in activities that make life enjoyable, and 73.6 per cent cited loss of dignity. Other end of life concerns included being a burden on family, friends, or caregivers (47.5 per cent), losing control of bodily functions (43.1 per cent), inadequate pain control or concern about inadequate pain control (27.4 per cent), and financial implications of treatment (4.5 per cent).[142]

7.166 However, it has been noted that, while these reflect the many concerns a person may have at the end of life, it is not true to say that these are the sole reasons that the person has chosen, and has been given, legal access to voluntary assisted dying. To be eligible to access voluntary assisted dying in those jurisdictions, the person must be diagnosed with a disease, illness or medical condition that will cause death.[143] The person's suffering must be 'causally linked to their disease, illness or medical condition'.[144]

7.167 The Tasmanian Act defines when a person is 'suffering intolerably in relation to a relevant medical condition'.[145] Section 14 provides:

> **14. When person is suffering intolerably in relation to a relevant medical condition**
>
> For the purposes of this Act, a person is suffering intolerably in relation to a relevant medical condition if —
>
> (a) the person has a relevant medical condition; and
>
> (b) persistent suffering that is, in the opinion of the person, intolerable is being caused to the person by any one or more of the following:
>
> (i) the relevant medical condition or the relevant medical condition together with the person's other medical conditions;
>
> (ii) anticipation of the suffering, or expectation, based on medical advice, of the suffering, that may arise from the relevant medical condition or from the relevant medical condition together with the person's other medical conditions;
>
> (iii) the treatment that the person has received or the combination of that treatment with the treatment of other medical conditions of the person;
>
> (iv) anticipation of the suffering, or expectation, based on medical advice,

141 Voluntary Assisted Dying Review Board Report of Operations: January–June 2020 (2020) 9.

142 The categories are not mutually exclusive; people could elect as many reasons for choosing voluntary assisted dying as applicable: Oregon Health Authority, Public Health Division, Center for Health Statistics, *Oregon Death with Dignity Act 2020 Data Summary* (Report, 2020) 12, 13 Table 1.

143 Go Gentle Australia, *A Guide to the Debate on Voluntary Assisted Dying in Australia* (August 2020) 18.

144 Vic Ministerial Advisory Panel Final Report (2017) 77.

145 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 10(1)(e).

of the suffering, that may arise from the treatment that the person may receive in relation to the relevant medical condition or the combination of that treatment with the treatment of the person's other medical conditions;

(v) the complications of a medical kind arising from, or related to, the treatment of the relevant medical condition or the combination of that treatment with the treatment of the person's other medical conditions;

(vi) anticipation of the suffering, or expectation, based on medical advice, of the suffering, that may arise from the complications of a medical kind arising from, or related to, the treatment of the relevant medical condition or the combination of that treatment with the treatment of the person's other medical conditions; and

(c) there is no reasonably available treatment that, having regard to both the treatment and the consequences, including side effects of the treatment, is reasonably likely to –

(i) improve the person's relevant medical condition, or overall health and wellbeing, in a manner, to an extent, and in a period of time, that is acceptable to the person; and

(ii) in the opinion of the person, lessen the person's suffering to an extent that is acceptable to the person.

7.168 This is substantially the same approach as in the Victorian and Western Australian Acts.

Parliamentary Committee and the White and Willmott Model

7.169 In Queensland, the Parliamentary Committee recommended that, to be eligible, a person must be diagnosed with a medical condition 'that cannot be alleviated in a manner acceptable to the person'.[146]

7.170 Under the White and Willmott Model, the person must be diagnosed with a medical condition that 'is causing intolerable and enduring suffering'.[147] It also states that, for the purposes of that provision:[148]

(a) whether suffering is intolerable is to be determined by the person requesting access to voluntary assisted dying;

(b) suffering caused by a person's medical condition includes suffering caused by treatment provided for that medical condition; and

(c) suffering includes physical, psychological and existential suffering.

7.171 The explanatory notes state that the requirement for the medical condition to be causing 'intolerable and enduring suffering' is:[149]

> a higher threshold than under the Victorian Act but is consistent with some international approaches.

7.172 The authors explained in an earlier article that:[150]

> the degree of suffering must be sufficiently high and of an enduring nature for the values of autonomy and reducing suffering to trump the value of life. Suffering that is fleeting and not sustained would be insufficient. Similarly, suffering that is not significant, as judged by the individual … would not qualify.

146 Qld Parliamentary Committee Report No 34 (2020) 120, Rec 4.
147 White and Willmott Model cl 9(e)(iii).
148 Ibid cl 10(2).
149 White and Willmott Model, Explanatory Notes 4. In relation to overseas jurisdictions, see [4.29]–[4.31] above.
150 L Willmott and B White, 'Assisted Dying in Australia: A Values based Model for Reform' in I Freckelton and K Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 505.

Submissions

7.173 Our Consultation Paper asked whether the eligibility criteria should require that the person be diagnosed with a disease, illness or medical condition that is 'causing suffering to the person that cannot be relieved in a manner that the person considers tolerable' (as in Victoria and Western Australia).[151]

7.174 Most respondents submitted that the eligibility criteria should include a requirement in those terms. Its inclusion would maintain the person's autonomy and reflects a person-centred approach to care. Some of those respondents submitted that this form of wording allows the person's level of suffering, and the extent to which it is tolerable, to be self-assessed by the person.

7.175 An academic, Ms Jodhi Rutherford, submitted that this eligibility criterion is operating well in Victoria and was strongly supported by medical practitioners who participated in a study examining their knowledge and perspectives of the Victorian Act.[152]

7.176 Several respondents—including Professors White and Willmott, a voluntary assisted dying advocacy group, and the Queensland Law Society—supported provisions in the same or similar terms as the White and Willmott Model, as outlined above.

7.177 Dying with Dignity Victoria submitted that this implies that 'the suffering cannot be relieved in a manner the person considers acceptable'.

7.178 The Lutheran Church of Australia Queensland District submitted that this approach should be adopted because it 'sets a higher bar' than in Victoria and Western Australia, by requiring the person's suffering to be both enduring and intolerable.

7.179 However, two members of the public jointly submitted that 'enduring' should not be included in this eligibility criteria. They wrote:

> The threshold requirement for suffering to be enduring is an unnecessary criterion. This was noted by both Victoria and Western Australia in their respective drafting process. In the interest of consistency, a requirement for enduring suffering should not be included in Queensland. Furthermore, including such a requirement would devalue the person's subjective assessment of their suffering and their autonomous choice to access the scheme.

7.180 Queensland Nurses & Midwives' Union and Australian Lawyers Alliance each submitted that the legislation should provide that the person must be experiencing 'grievous and irremediable' suffering related to their disease, illness or medical condition 'that cannot be relieved in a manner acceptable to the person'.

7.181 Several respondents submitted that a person's level of suffering, including the extent to which it can be relieved or alleviated, should be determined by that person.

7.182 A member of the public observed that it is the person concerned who is most qualified to know how much suffering is tolerable. Another member of the public similarly considered that 'suffering is an individual's experience'.

7.183 MIGA submitted that:

> it is difficult to see how inclusion of an objective element into the element of suffering can be done in a way which is both meaningful and appropriate. Attempting to objectively assess degree of suffering to determine whether it reaches a certain, accepted level would be an extremely difficult process medico legally. **Terminology such as '*enduring and unbearable*' or '*grievous and irremediable*' are inherently open to a range of interpretations.** The approach of '*intolerable and enduring suffering*' determined by the person themselves does not necessarily cause the same problems. (emphasis added)

151 QLRC Consultation Paper No 79 (2020) Q-9.

152 See J Rutherford, 'Doctors and the *Voluntary Assisted Dying Act 2017* (Vic): Knowledge and General Perspectives' (2020) 27(4) *Journal of Law and Medicine* 952.

7.184 Go Gentle Australia submitted that:

> no doctor can measure suffering, but they can determine what suffering is claimed and relate that to the state of the illness…

7.185 It also observed that in Victoria the other eligibility criteria about the diagnosis and prognosis of the person's condition are clinical determinations, and that '[t]his objectivity can ensure that trivial claims to suffering are screened'.

7.186 Several respondents, including Dying with Dignity Queensland and AMA Queensland, submitted that 'suffering' is not limited to physical pain or suffering caused by the symptoms of the person's condition. VALE Group noted that suffering may include that caused by the side effects of the treatments administered, or other health challenges as a result of a compromised immune system. Other respondents variously observed that suffering can include psychological suffering, or other non-physical aspects such as loss of function, control, and enjoyment of life, or loss of dignity.

7.187 Some respondents, including two voluntary assisted dying advocacy groups, supported the inclusion of the White and Willmott Model provision, which states that 'suffering' is not limited to physical suffering.

7.188 A few respondents, however, submitted that 'suffering' should be defined to be limited to physical pain for the purposes of eligibility for access to voluntary assisted dying. One respondent submitted that a person should not be eligible because of non-medical factors such as 'hopelessness, feeling [like] a burden, loss of interest or pleasure and loneliness'. Palliative Care Social Work Australia submitted that '"suffering" invites a broad interpretation'. It considered that emotional and psychological suffering caused by the disease should be distinguished from physical pain for the purposes of establishing eligibility for access to voluntary assisted dying.

7.189 Some respondents noted the importance of access to quality palliative care and other services, like counselling, for people at the end of life.

7.190 A few respondents considered that the legislation should specifically refer to suffering that cannot be palliated. A medical practitioner submitted that it should provide that the person must be diagnosed with a condition that is causing suffering that 'the person feels cannot be relieved through access to current medical and psychological treatments'.

7.191 By contrast, an academic submitted that the person's level of suffering should not be one of the eligibility criteria.

The Commission's view

7.192 In addition to requiring the person to be diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death, and that is expected to cause death within 12 months, the eligibility criteria should require that the condition is causing intolerable suffering. This reflects the intention that voluntary assisted dying should be an option only for people at the end of life who are suffering and dying. The dual requirements for the person to be both suffering and dying are a crucial control over who is eligible to access voluntary assisted dying.

7.193 Whether the person's suffering is intolerable is a subjective assessment, to be determined by the person requesting access to the scheme. To make this clear, the draft Bill provides that the person must be diagnosed with a disease, illness or medical condition that 'is causing suffering that the person considers to be intolerable'.

7.194 The person's suffering must be causally linked to the disease, illness or medical condition that makes them eligible. Unrelated and pre-existing conditions like loneliness do not qualify. However, suffering is not limited to the physical pain or symptoms caused by their condition. To make this clear, the draft Bill states that suffering includes physical or mental suffering, and suffering caused by the treatment of that condition.

7.195 This approach recognises that suffering is a personal experience best determined by the sufferer and that it may take various forms. It respects personal autonomy and reflects a person-centred approach to care.

7.196 We acknowledge that a person should not be able to access voluntary assisted dying for trivial or temporary suffering, or because the person is lonely or feels they are a burden on others. The draft Bill does not provide access in such cases. The Bill must be considered in totality.

7.197 Eligibility for access to voluntary assisted dying is limited to a person at the end of life who is suffering and dying. To access voluntary assisted dying, the person must make three requests at separate intervals, and must be independently assessed as eligible by two medical practitioners. To satisfy the eligibility criteria, the person must be 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 the person suffering that the person considers to be intolerable. Whether the person satisfies the first two criteria is a clinical determination. Whether the condition is causing intolerable suffering is a subjective determination by the person concerned.

7.198 In those circumstances, we consider that the eligibility criteria should not include an additional requirement that the person's level of suffering be 'enduring' or constant. This would be inconsistent with the compassionate purpose of the draft Bill and may prolong the person's suffering over an uncertain and longer period before they can meet the test. The addition of 'enduring' potentially introduces an objective determination of the nature of the person's suffering. For the reasons outlined, the person's level of suffering is best determined by the person.

7.199 Also, such a requirement is unnecessary to address concerns about suffering that is temporary. To access voluntary assisted dying, the person must complete the requirements of the request and assessment process. This demonstrates that the person's request is enduring and indirectly ensures that the intolerable suffering that prompts the person's separate requests is not temporary.

7.200 We consider that our recommended combination of criteria, which limits eligibility for voluntary assisted dying to people at the end of life who are experiencing intolerable suffering and dying, strikes the right balance between the fundamental value of human life, on the one hand, and the values of individual autonomy and reduced suffering on the other.

7.201 Several respondents emphasised the importance of access to quality palliative care and other services to reduce a person's suffering at the end of life. We reiterate that voluntary assisted dying is distinct from palliative care and does not diminish a person's right to access high-quality palliative care and other services to reduce their suffering. As the terms of reference state, 'the provision of compassionate, high-quality and accessible palliative care for persons at their end of life is a fundamental right for the Queensland community'.[153]

153 Terms of Reference, para 3.

RECOMMENDATIONS

7-1 The eligibility criteria should require that the person has been diagnosed with a disease, illness or medical condition that:

(a) is advanced, progressive and will cause death; and

(b) is expected to cause death within 12 months; and

(c) is causing suffering that the person considers to be intolerable.

7-2 To avoid doubt, the draft Bill provides that:

(a) A person is not eligible for access to voluntary assisted dying only because the person—

(i) has a disability as defined in section 11 of the *Disability Services Act 2006*; or

(ii) has a mental illness as defined in section 10 of the *Mental Health Act 2016*.

(b) However, a person who has a disability or who has a mental illness may be eligible for access to voluntary assisted dying if they meet all the eligibility criteria.

7-3 The draft Bill clarifies that suffering caused by the person's disease, illness or medical condition includes physical or mental suffering, and suffering caused by the treatment provided for that condition.

CRITERION TWO: DECISION-MAKING CAPACITY

7.202 In each jurisdiction that permits voluntary assisted dying, the eligibility requirements generally include that a person must have capacity to make a decision about voluntary assisted dying.

7.203 A capacity requirement has been emphasised in Australian jurisdictions. The Victorian Panel stated that a requirement that a person has decision-making capacity creates a 'clear and enforceable line' regarding who can access voluntary assisted dying.[154] It also explained the importance of this safeguard:[155]

> the existence of decision-making capacity is such a fundamental safeguard to the protection of individual autonomy and the voluntary assisted dying process that it must be included in the eligibility criteria. Voluntary assisted dying must be 'voluntary'—that is, a person must have decision-making capacity to make an autonomous choice—at all stages of the process. Failure to have this safeguard could 'put very vulnerable people at great risk of manipulation and abuse'.

7.204 Similarly, the Western Australian Panel explained that there must be a requirement for a person to have decision-making capacity at 'all stages' of the voluntary assisted dying process 'in order to provide fundamental safeguards, protect individual autonomy and maintain the integrity of the … process'.[156]

Overview of legislative approaches

7.205 In Victoria, Western Australia, and Tasmania, one of the eligibility criteria is that the person has 'decision-making capacity for voluntary assisted dying'.[157]

7.206 The legislation provides that a person is presumed to have decision-making capacity unless there is evidence to show that they do not have that capacity.[158] The definition of 'decision-making capacity' is similar in each jurisdiction. A person has decision-making capacity if the person has the capacity to:[159]

Victoria	Western Australia[160]	Tasmania
understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision; and	understand any information or advice about a voluntary assisted dying decision that is required under [the] Act to be provided to the patient; and	understand the information or advice that is reasonably required in order to be able to make the decision; and
retain that information to the extent necessary to make the decision; and	understand the matters involved in a voluntary assisted dying decision; and	remember such information or advice to the extent necessary to make the decision; and
use or weigh that information as part of the process of making the decision; and	understand the effect of a voluntary assisted dying decision; and	use or evaluate the information or advice for the purposes of making the decision; and

154 Vic Ministerial Advisory Panel Final Report (2017) 62. See also, Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2948, 2951 (J Hennessey, Minister for Health), in which it was stated that 'having decision-making capacity throughout the entire process is an important safeguard in ensuring that a person's decision is voluntary, informed and enduring'.

155 Vic Ministerial Advisory Panel Final Report (2017) 63, citing The Commission on Assisted Dying (England and Wales), *The current legal status of assisted dying is inadequate and incoherent*, Report (Demos, 2011) 310, available at <https://demos.co.uk/project/the-commission-on-assisted-dying/>.

156 WA Ministerial Expert Panel Final Report (2019) 105, see also 25. See generally Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137-5138 (RH Cook, Minister for Health).

157 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(c); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(d); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 10(1)(c). This eligibility requirement is also reflected in other provisions of the legislation. In Tasmania, this criterion is expressed more broadly as a requirement that 'the person has decision-making capacity'. However, the definition of decision-making capacity specifically requires that the person must have capacity at the time of making the decision: s 12(1).

158 *Voluntary Assisted Dying Act 2017* (Vic) s 4(2); *Voluntary Assisted Dying Act 2019* (WA) s 6(3); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 12(2)(a).

159 *Voluntary Assisted Dying Act 2017* (Vic) s 4(1); *Voluntary Assisted Dying Act 2019* (WA) s 6(2); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 12(1). As to communication using means such as electronic or visual aids see *Voluntary Assisted Dying Act 2017* (Vic) s 4(3); *Voluntary Assisted Dying Act 2019* (WA) s 158(3).

160 In Western Australia, the term 'voluntary assisted dying decision' is defined to mean a request for access to voluntary assisted dying or a decision to access voluntary assisted dying: *Voluntary Assisted Dying Act 2019* (WA) s 6(1).

Victoria	Western Australia[160]	Tasmania
communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.	weigh up the factors referred to in [the preceding three points] for the purposes of making a voluntary assisted dying decision; and	communicate the decision, and the person's opinions in relation to the decision, whether by speech, in writing, by gesture or by other means.
	communicate a voluntary assisted dying decision in some way.	

7.207 In Victoria, persons are taken to understand information relevant to the decision if they understand an explanation given in a way appropriate to their circumstances (for example, through modified language or visual aids).[161] In Tasmania, persons are taken to understand if it 'reasonably appears' that they understand an explanation of the consequences of making the decision.[162]

7.208 The legislation in Victoria and Tasmania also provides that, in determining whether a person has decision-making capacity, regard must be had to the following:[163]

- a person may have decision-making capacity for some decisions but not others;
- a lack of decision-making capacity may be temporary;
- a person should not be assumed to lack decision-making capacity based on appearance or because others think the decision unwise.

7.209 In Victoria, a person has decision-making capacity if it is possible for that person to make decisions with 'practicable and appropriate support'. This includes: using information or formats tailored to a person's needs; communicating the person's decision or assisting them to communicate it; giving a person additional time; discussing the decision with the person; and, where a person has a disability, using technology that can alleviate its effects.

7.210 In Victoria, the person who is assessing decision-making capacity 'must take reasonable steps to conduct the assessment at a time and in an environment in which the person's decision-making capacity can be most accurately assessed'.[164]

7.211 Guidance for health practitioners in Victoria explains that, when assessing a person's decision-making capacity about voluntary assisted dying, a medical practitioner should give the patient relevant information about their diagnosis, prognosis, and the options available and then 'check' their capacity. Checking may involve asking the patient to paraphrase their understanding of the information, explain their thoughts or views, and give reasons for their chosen option.[165]

7.212 Generally, the definition of 'decision-making capacity' in Victoria, Western Australia, and Tasmania draws on other legislation in those jurisdictions relating to medical treatment, guardianship and administration, and mental health.[166]

7.213 In Victoria, the definition of 'decision-making capacity', including the additional factors to which there must be regard when determining capacity, mirrors the definition of

161 *Voluntary Assisted Dying Act 2017* (Vic) s 4(3).
162 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 12(2)(b).
163 *Voluntary Assisted Dying Act 2017* (Vic) s 4(4); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 12(3).
164 *Voluntary Assisted Dying Act 2017* (Vic) s 4(5).
165 Vic Guidance for Health Practitioners (2019) [2.2], Table 4. It is observed that '[m]edical practitioners frequently assess their patients' understanding of treatment options as part of normal clinical practice'. The guidance notes that a 'capacity and consent tool' may be useful in guiding the assessment discussion.

An assessment should occur at the most suitable time and in the most suitable environment, taking into account the patient's symptom control, medication and support. See also *Voluntary Assisted Dying Act 2017* (Vic) s 4(5).
166 In Tasmania, there are similarities with the definition of 'decision-making capacity' in the *Mental Health Act 2013* (Tas) s 7(1).

that term in the *Medical Treatment Planning and Decisions Act 2016* (Vic).[167] The Victorian Panel explained that this test 'is contemporary … and is generally regarded as appropriate to test decision-making capacity for a wide range of medical treatment decisions', and that utilising this test 'is likely to achieve consistent application by medical practitioners'.[168]

7.214 In Western Australia, the definition of 'decision-making capacity' mirrors the definition in the *Mental Health Act 2014* (WA),[169] and was described as 'consistent with other decision-making capacity frameworks [used] in the health system, including the mental health system'. It has also been observed that '[m]edical practitioners are already comfortable with the definition of decision-making capacity' in the *Mental Health Act 2014* (WA) and that the definition is 'widely understood by the medical community'.[170]

7.215 The *Mental Health Act 2014* (WA) also provides—in the same section as the definition of decision-making capacity—that, for the purposes of the Act, 'a decision made by a person about a matter relating to himself or herself must be made freely and voluntarily'.[171] It was explained, during parliamentary debate, that this is not included in the definition of decision-making capacity in the Western Australian Act because 'voluntariness is already built into the [legislation] as an eligibility criterion' and 'it is not necessary to include it twice'.[172]

7.216 A person is required to have decision-making capacity for voluntary assisted dying at each stage of the process.[173] In Western Australia and Tasmania, the waiting periods

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167 *Medical Treatment Planning and Decisions Act 2016* (Vic) s 4. This definition, the presumption of capacity, the additional factors to which there must be regard and the other relevant matters are also included, in the same terms, in the more recent *Guardianship and Administration Act 2019* (Vic) ss 5, 6.

The *Medical Treatment Planning and Decisions Act 2016* (Vic) provides for, among other things, the making of an advance directive about future medical treatment and the making of medical treatment decisions on behalf of a person who does not have decision-making capacity: s 1. The *Guardianship and Administration Act 2019* (Vic) relates to guardianship and administration orders for people who do not have decision-making capacity.

With some differences, the definition also mirrors the definition of the term in the *Powers of Attorney Act 2014* (Vic) ss 4, 5. A similar definition is included in the *Mental Health Act 2014* (Vic) s 68. Those Acts also include a presumption of capacity.

168 Vic Ministerial Advisory Panel Final Report (2017) 60, Rec 3. See also, generally, Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3423 (J Hennessey, Minister for Health); Victoria, *Parliamentary Debates*, Legislative Council, 14 November 2017, 5862–63 (G Jennings, Special Minister of State).

169 *Mental Health Act 2014* (WA) s 15(1). This Act also includes a presumption of capacity: s 13(1). See also, in relation to the capacity to make a particular decision about treatment and in largely identical terms to s 15(1), the meaning of 'capacity to make a treatment decision': s 18(1).

170 Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 211, 214–15 (RH Cook, Minister for Health); Western Australia, *Parliamentary Debates*, Legislative Council, 20 November 2019, 9048-9050 (S Dawson, Minister for Environment, Disability Services, Electoral Affairs). It was also stated, in similar terms, that the *Voluntary Assisted Dying Act 2019* (WA) is 'using the Western Australian framework [for decision-making capacity], which is consistent across the medical field in Western Australia, including in the Mental Health Act': 211 (RH Cook, Minister for Health).

It was explained more specifically that the approach in Western Australia does not include a requirement that the person retain the information, as in Victoria, because the requirements to understand the information, the matters involved and the effect of a decision 'provide a framework for retention' that make it unnecessary to expressly include that requirement: 211, 214 (RH Cook, Minister for Health). Amendments to including a requirement of retention were opposed, including on the basis that to do so would cause a 'legislative inconsistency' with the *Mental Health Act 2014* (WA): Western Australia, *Parliamentary Debates*, Legislative Council, 20 November 2019, 9050, 9064-9065 (S Dawson, Minister for Environment, Disability Services, Electoral Affairs).

See also, generally, WA Ministerial Expert Panel Final Report (2019) 22–5. In consultation, the Western Australian Ministerial Expert Panel 'found that, by and large, most were satisfied with the presumption of capacity in the absence of evidence otherwise and with the existing structure of determining capacity as outlined in the *Mental Health Act 2014*': 23.

171 *Mental Health Act 2014* (WA) s 15(2).

172 Western Australia, *Parliamentary Debates*, Legislative Council, 20 November 2019, 9050 (S Dawson, Minister for Environment, Disability Services, Electoral Affairs).

173 *Voluntary Assisted Dying Act 2017* (Vic) ss 16, 20(1)(a), 25, 29(1)(a), 34, 41(1), 46(c)(ii), (v), sch 1, Form 5; *Voluntary Assisted Dying Act 2019* (WA) ss 24(1)–(2), 28(1)(a), (2), 35(1)–(2), 39(1)(a), (2), 42, 51(1), (3)(f)(i), 59(5)(a); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 10(1)(c), 12, 15(4)(a), 27(1)(b), 34(1)(b), 48(1)(b), 56(1)(b), 78.

Specifically, in Western Australia, the coordinating practitioner must complete a final review form, which includes a statement certifying whether or not the practitioner is satisfied that the person has decision-making capacity for voluntary assisted dying. Provision to similar general effect is made in the Victorian legislation, which requires the coordinating practitioner to certify whether 'the request and assessment process' has been completed as required by the Act.

If the coordinating practitioner or consulting practitioner is unable to determine whether the person has decision-making capacity for voluntary assisted dying, they must refer the person to another health practitioner who has appropriate skills and training (such as a psychiatrist in the case of mental illness) and may adopt that practitioner's determination on the matter: *Voluntary Assisted Dying Act 2017* (Vic) ss 18(1), (3), 27(1),(3); *Voluntary Assisted Dying Act 2019* (WA) ss 26(1)(b), (2), (4)–(5), 37(1)(b), (2), (4)–(5); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 12(4), (5).

The person or other eligible applicant may apply to VCAT (in Victoria), the State Administrative Tribunal (in Western Australia) or the Voluntary Assisted Dying Commission (in Tasmania) for review of a coordinating practitioner's or consulting practitioner's decision that the person does or does not have decision-making capacity for voluntary assisted dying: *Voluntary Assisted Dying Act 2017* (Vic) ss 68(1)(a)(iii), (b)(iii), (c)–(d); *Voluntary Assisted Dying Act 2019* (WA) s 84(1)(a)(ii), (b)(ii), (c)(i); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 95(1)(b).

that are usually required between a person's requests for access may be reduced or waived if it is likely that the person will lose decision-making capacity within that period.[174]

7.217 Generally, overseas jurisdictions also require that a person is 'competent' or has 'capacity'. Some of those jurisdictions, including New Zealand, define that term in a similar way to the Australian jurisdictions.[175]

Queensland

7.218 The Parliamentary Committee recommended that a voluntary assisted dying scheme in Queensland should limit eligibility to people with decision-making capacity.[176] The White and Willmott Model's eligibility criteria include that 'the person must have decision-making capacity in relation to voluntary assisted dying'. The model provides that a person is presumed to have decision-making capacity and defines the term in the same way as the legislation in Victoria.[177]

7.219 The White and Willmott Model notes that definitions of 'capacity' or 'decision-making capacity' vary between jurisdictions and that the approach may need to be adjusted to reflect those differences. For example, the test for capacity in the *Guardianship and Administration Act 2000* (Qld) includes a requirement that a person is able to decide 'freely and voluntarily', but in the White and Willmott Model, this is a separate eligibility criterion.[178]

Queensland's guardianship legislation

7.220 Our Consultation Paper explained that Queensland has other specific laws about decision-making capacity, including the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*, (collectively known as 'Queensland's guardianship legislation').[179]

7.221 Both Acts define the term 'capacity',[180] which is generally applied as a threshold test to determine whether an adult has the capacity to make a decision about a particular matter,[181] including matters related to the adult's health care.[182] They establish a scheme by which:[183]

- an adult may give directions for their future health care which are effective if the adult later does not have decision-making capacity; and
- another person may be appointed to make decisions for an adult who has 'impaired capacity' (meaning that they do not have capacity), either by the adult at an earlier

174 *Voluntary Assisted Dying Act 2019* (WA) s 48(3); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 30(2)(b), 53(2)(b),108(4). In each jurisdiction, the waiting periods can also be reduced or waived if it is likely that the person will die within that period of time.

175 See further QLRC Consultation Paper No 79 (2020) [4.131] ff.

176 Qld Parliamentary Committee Report No 34 (2020) 127, Rec 6. The Parliamentary Committee also recommended that any scheme 'requires further research, consultation and examination to be undertaken with respect to improving end of life options for people who do not have decision-making capacity, particularly for ensuring Advance Health Directives are fit for purpose and effective: Rec 7.

177 White and Willmott Model cll 7, 9(c). The definition mirrors s 4(1) of the *Voluntary Assisted Dying Act 2017* (Vic) but does not include the content (such as the additional factors to which there must be regard) of s 4(3)–(5) of that Act.

178 White and Willmott Model, Explanatory Notes 7. This is consistent with the approach in Victoria, Western Australia and Tasmania.

179 The Consultation Paper also discussed the *Mental Health Act 2016* (Qld): QLRC Consultation Paper No 79 (2020) [4.111] ff.

180 *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of 'capacity'); *Powers of Attorney Act 1998* (Qld) sch 3 (definition of 'capacity').

181 See also QLRC Consultation Paper No 79 (2020) [4.130]. As to the term 'matters', see QLRC Consultation Paper No 79 (2020) [4.121], n 154.

182 An adult's 'health care' includes the diagnosis, maintenance or treatment of a physical or mental condition, and the withholding or withdrawal of a life-sustaining measure if commencing or continuing that measure would be inconsistent with good medical practice: *Guardianship and Administration Act 2000* (Qld) sch 2 items 2(g), 4, 5; *Powers of Attorney Act 1998* (Qld) sch 2 items 2(h), 4, 5. See also, as to the terms 'life-sustaining measure' and 'good medical practice': *Guardianship and Administration Act 2000* (Qld) sch 2 items 5A, 5B; *Powers of Attorney Act 1998* (Qld) sch 2 items 5A, 5B; QLRC Consultation Paper No 79 (2020) [4.121], nn 156, 157.

183 *Guardianship and Administration Act 2000* (Qld) ss 3, 6–9, sch 4 (definition of 'impaired capacity'); *Powers of Attorney Act 1998* (Qld) ss 3, 5, 6A, sch 3 (definition of 'impaired capacity'). See further QLRC Consultation Paper No 79 (2020) [4.120] ff.

The Acts are to be read in conjunction, but the *Guardianship and Administration Act 2000* (Qld) prevails in the event of any inconsistency between them: *Guardianship and Administration Act 2000* (Qld) s 8(2); *Powers of Attorney Act 1998* (Qld) s 6A.

time when they had capacity or by QCAT if there is a need for a decision.

7.222 Under Queensland's guardianship legislation, an adult is presumed to have capacity[184] and the term 'capacity' is defined as follows:[185]

> capacity, for a person for a matter, means the person is capable of—
>
> (a) understanding the nature and effect of decisions about the matter; and
>
> (b) freely and voluntarily making decisions about the matter; and
>
> (c) communicating the decisions in some way.

7.223 The Qld Capacity Assessment Guidelines (2020) were introduced to help assess an adult's capacity to make a particular decision, according to Queensland's guardianship legislation. The guidelines include principles and practical guidance to be applied in making an assessment.[186] They apply broadly to persons carrying out a capacity assessment for various matters—for example, deciding if an adult can consent to medical treatment or requires more support for decision-making, or whether a decision-maker should be appointed on an adult's behalf.[187]

Principles and acknowledgements

7.224 The *Guardianship and Administration Act 2000* acknowledges the rights and decision-making capacity of adults. Specifically, the Act acknowledges that:[188]

- an adult's right to make decisions is fundamental to their inherent dignity, should be restricted and interfered with to the least possible extent, and includes the right to make decisions with which other people may not agree;
- an adult's capacity to make decisions may differ according to the type of decision to be made (including its complexity) and the support that can be provided by the adult's existing support network;[189] and
- an adult with impaired capacity has a right to 'adequate and appropriate support for decision-making'.

7.225 Queensland's guardianship legislation also contains principles[190] that require adults to receive support and access to information that is necessary for them to make, or

184 See *Guardianship and Administration Act 2000* (Qld) ss 7(a), 11, 11B, item 1, 34; *Powers of Attorney Act 1998* (Qld) s 6C, item 1, 111A. The presumption of capacity 'is not affected by any personal characteristics such as disability, mental illness or age (if the person is over 18 years of age)': Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 5.

185 *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of 'capacity'); *Powers of Attorney Act 1998* (Qld) s 3 sch 3 (definition of 'capacity'). Cf *Mental Health Act 2016* (Qld) s 14(1)–(3) (meaning of 'capacity to consent to be treated').

There are also separate references to a person's 'capacity' to make an enduring power of attorney or an advance health directive, which require that the person understands the nature and effect of the document (including understanding the specific matters listed in the Act) and is capable of making the document freely and voluntarily: *Powers of Attorney Act 1998* (Qld) ss 41, 42; Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) s 6.

186 *Guardianship and Administration Act 2000* (Qld) s 250; Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020). It was explained that the guidelines are intended to 'act as a complementary educative tool for individuals or entities that have to make a determination about an adult's capacity, [for example] an attorney or administrator or a witness to an enduring document': Explanatory Notes, Guardianship and Administration and Other Legislation Amendment Bill 2018 (Qld), 19.

187 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 6–7. These guidelines also include a detailed capacity assessment checklist, which can be used as a guide by a person who is conducting an assessment of capacity: s 5.

See also, in relation to recommendations for guidelines about capacity previously made by this Commission, QLRC Consultation Paper No 79 (2020) [4.115].

188 *Guardianship and Administration Act 2000* (Qld) s 5. It is also noted in the Queensland Capacity Assessment Guidelines that an adult's capacity may fluctuate: Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 6.

189 An adult's capacity can depend on the time that a decision is made: Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 6.

190 *Guardianship and Administration Act 2000* (Qld) ss 11B, 11C; *Powers of Attorney Act 1998* (Qld) ss 6C, 6D. Broadly, the Acts include general principles and health care principles that must be applied by a person or entity that performs a function or exercises a power under these Acts or under an enduring document, and by a person making a decision for an adult on an informal basis. Further, the community is encouraged to apply and promote the general principles. See also *Mental Health Act 2016* (Qld) ss 5, 14(2)–(3).

participate in making, decisions and to communicate their decisions.[191] The principles also require that others act in a way that promotes and safeguards, and is least restrictive of, an adult's rights, interests and opportunities.

7.226 The Qld Capacity Assessment Guidelines (2020) also set out five principles to apply when assessing an adult's capacity. Broadly, these principles, which overlap with the principles and acknowledgements in those Acts, are:[192]

- *Always presume an adult has capacity*: An adult should not be assumed to lack capacity because of their age, appearance, conduct and personal habits, beliefs, language and communication skills, or any impairment (for example, an intellectual disability or a physical impairment).
- *Capacity is decision-specific and time-specific*: An adult may lack capacity for some decisions but not others (for example, an adult may be able to make simple decisions about their personal care but not complex decisions about their medical treatment). An adult might also have capacity at some times of the day but not others, or on some days but not others (for example, an adult might take a medication with a sedative effect at a set time each day).
- *Provide the adult with the support and information they need to make and communicate decisions*: An adult should be supported to express their views and wishes in any way (for example, through their conduct). An adult's capacity can depend on the support and information available to them, and they cannot be treated as unable to make a decision unless 'all practicable steps' have been taken to give them the necessary information and support.
- *Assess the adult's decision-making ability rather than the decision they make*: The focus of a capacity assessment must be on the adult's ability 'to exercise the decision-making process', noting that a person's right to make decisions includes the right to 'take risks' and to 'make "bad" decisions'.
- *Respect the adult's dignity and privacy*: An assessment of an adult's capacity should occur in a suitable place, that preserves the privacy and dignity of the adult and limits possible distractions. The adult should be informed that their capacity to make a specific decision is being assessed, and the possible consequences of the assessment should be explained. The information provided by the adult during the assessment must be protected.

The definition of capacity

7.227 In summary, the definition of 'capacity' in Queensland's guardianship legislation has three limbs. The Qld Capacity Assessment Guidelines give further information about how to assess an adult's capacity against each of those limbs.

LIMB (A): UNDERSTANDING THE NATURE AND EFFECT OF DECISIONS

7.228 The first limb requires that an adult can understand the nature and effect of their decisions about the relevant matter.

7.229 The Capacity Guidelines explain that the adult needs to be able to understand the information that is relevant to the decision, including the options and their consequences. It is sufficient for the adult to have a 'basic understanding of the key features' of that information, but for this criterion to be met, more complex decisions require more understanding.[193]

191 'An adult's capacity can improve depending upon the support available to them' and states that '[f]or this reason, an adult can't be found to lack capacity until all practical steps have been taken to provide the support and information needed to make the decision': Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 6.

192 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 9–14.

193 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 16.

7.230 The adult must also be able to retain the relevant information. This may only be for a short period, provided the period is long enough for the adult to make a decision.[194] Also, the adult must have the ability to broadly identify the advantages and disadvantages of the available options and to understand the consequences of those options, then weigh those consequences and reach a decision.[195]

7.231 Giving the adult the information they need to make a decision might involve using the adult's usual methods of communication, or providing information in a way that is accessible to them; for example, by engaging an interpreter, having a support worker present, using assistive technologies, or providing simple explanations aided by diagrams. Other factors include ensuring that the assessment occurs at the best time for the adult and in an appropriate location, giving the adult enough time to consider information, and having a support person present.[196]

LIMB (B): FREELY AND VOLUNTARILY MAKING DECISIONS

7.232 The second limb of 'capacity' requires that an adult is capable of freely and voluntarily making decisions about the relevant matter.

7.233 The Capacity Guidelines explain that '[i]t must be clear that the adult is making the decision and is not being pressured or coerced into making the decision'. Risk factors that might indicate pressure or coercion, or affect an adult's ability to make a decision freely and voluntarily, include:[197]

- family conflict, especially if one family member has isolated the adult from other family members or their usual support networks;
- the history or presence of threats or perceived threats and abuse;
- threats to withdraw care and support;
- sudden decisions to make significant changes to their arrangements (like large gifts of money or property) that are out of character and would disadvantage the adult.

7.234 The Capacity Guidelines note that the test in this limb of the definition should not be applied 'too broadly'. They state that a person may seek advice from others before reaching a decision and that this does not mean that a decision was not made freely and voluntarily. The guidelines explain that 'the focus is on whether the adult can make a decision free of intimidation, pressure or influence'.[198]

7.235 If it is suspected that an adult is being abused or pressured into making decisions, 'the priority must be to ensure the adult's health, safety and well-being'. The adult's immediate safety should be prioritised, and they should be put in touch with appropriate support services.[199]

7.236 In a previous review, the Commission concluded that this limb of the definition of capacity is 'an important legislative safeguard' in that an adult's ability to make a decision independently is 'arguably a useful indicator of the [adult's] capacity to exercise decision-making power in his or her own interests'.[200]

LIMB (C): COMMUNICATING DECISIONS

7.237 The final limb of 'capacity' requires that an adult is capable of communicating their decisions in some way.

194 Ibid. The Queensland capacity assessment guidelines note that '[t]his is an important consideration for people with conditions such as dementia'.
195 Ibid 17.
196 Ibid 14, 31–2. See also the discussion of 'Communicating the decision' below.
197 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 17.
198 Ibid 18.
199 Ibid 26. Further, consideration should be given to whether an assessment of the adult's capacity can be done at another time and when the adult has appropriate support.
200 QLRC, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) vol 1, [7.208]–[7.212].

7.238 The definition of capacity notes that the *Guardianship and Administration Act 2000* elsewhere states that:[201]

> In deciding whether an individual is capable of communicating decisions in some way, the tribunal must investigate the use of all reasonable ways of facilitating communication, including, for example, symbol boards or signing.

7.239 This is noted in the definition of capacity 'to emphasise that all reasonable means should be used to facilitate communication before a person is treated as unable to communicate'.[202]

7.240 A person who is assessing an adult's capacity must make sure that the adult is provided with support to facilitate communication of their decision (this is in addition to providing information to the adult). Types of support that might be given include the use of an interpreter, symbol boards for people with limited verbal language, or permitting another person (such as a support worker or a speech therapist) to be present and to assist with communication.[203]

Submissions

7.241 In our Consultation Paper we proposed that the draft Bill in Queensland should provide that, for a person to be eligible for access to voluntary assisted dying, the person must have decision-making capacity.

7.242 Respondents who addressed this proposal agreed. However, some also considered that access should be provided, in some circumstances, to people who lack decision-making capacity, such as when a person had decision-making capacity when they gave an advance directive but later lost it. That issue is considered in a later separate section.

7.243 The primary reason that respondents gave for supporting a requirement that a person has decision-making capacity is that it would ensure the act of accessing voluntary assisted dying is voluntary. Some respondents submitted that capacity until death is essential because it provides a safeguard against the risk of pressure or coercion, noting that people without capacity are vulnerable to manipulation.

7.244 A requirement to have decision-making capacity and to be acting voluntarily at all stages of the voluntary assisted dying process was also said to be consistent with the requirements for capacity to consent in other end of life care settings.

7.245 Some respondents raised other concerns that they considered related to decision-making capacity. Many of these also relate to other areas of the report. Broadly, they included:

- A delay between approval to access voluntary assisted dying and administration of the substance could mean a person loses capacity in the interim, creating opportunities for coercion or for administration of the substance without a reasoned decision.
- Other safeguards in the voluntary assisted dying scheme might also operate to ensure that people have decision-making capacity; but those safeguards might still be insufficient protection for some people.
- There are challenges for medical practitioners in assessing a person's capacity. These include conducting an assessment in circumstances where the practitioner does not have an established relationship with the person or access to appropriate specialist practitioners for assistance.
- Consideration should be given to the decision-making capacity of people who have a mental illness or severe disability. Appropriate safeguards, including access to specialist services, are needed, as well as proper treatment for these people.

201 *Guardianship and Administration Act 2000* (Qld) s 146(3); sch 4 (definition of 'capacity', note).
202 Explanatory Notes, Guardianship and Administration and Other Legislation Amendment Bill 2018 (Qld), 32.
203 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 18–19.

How should 'decision-making capacity' be defined?

7.246 Our Consultation Paper asked whether decision-making capacity should be defined in the same terms as the Queensland guardianship legislation, or in similar terms to the definition in the voluntary assisted dying legislation in Victoria and Western Australia.

7.247 Some respondents supported adopting the definition of 'capacity' in Queensland's guardianship legislation. Their reasons included:

- This definition of capacity is well-established in Queensland law.
- The definition includes a requirement that the decision is made 'freely and voluntarily', which is important as it goes to issues of coercion and reinforces the importance of an element of voluntariness.
- Consistency across Queensland's guardianship legislation and voluntary assisted dying legislation is important because there is likely to be overlap in their application to the same person. Also, voluntary assisted dying legislation should not cause confusion by introducing a different definition of capacity.
- This definition is essentially consistent with the approach taken in Victoria and Western Australia.

7.248 Other respondents supported defining 'decision-making capacity' in similar terms to the voluntary assisted dying legislation in Victoria and Western Australia. Their reasons included:

- The definition is straightforward, clear, and in plain English. It can be easily understood and applied by anyone involved.
- Consistency with Victoria and Western Australia is important, including for training purposes.
- A test to determine a person's understanding of the information and the implications of accessing a voluntary assisted dying scheme is essential to obtaining free and informed consent. The White and Willmott Model (which is consistent with Victoria) sets a higher bar for determining capacity in the context of voluntary assisted dying than the definition in Queensland's guardianship legislation.

7.249 Some respondents also made other suggestions about the meaning of 'decision-making capacity'. These included relying on the current law about decision-making capacity as it applies in other end of life scenarios or adopting the test of capacity to make a will.

7.250 Some respondents favoured including statements about decision-making capacity, consistent with the approach in the Victorian Act and the Queensland *Guardianship and Administration Act 2000*. Such statements could be:

- A presumption of capacity (although others criticised this presumption or suggested that it should be a presumption of *incapacity*).
- A person may have capacity for some decisions but not others.
- Capacity may fluctuate, or a lack of capacity may be temporary. Also, decisions can change and change over time. This should not be confused with ambivalence or used to undermine capacity.
- A person should not be assumed to lack capacity because of their appearance or because others consider their decision unwise. The focus must be on whether a person can apply their understanding to the decision, not on whether the decision is sensible or 'right'.
- A person has capacity if they can make a decision with practicable and appropriate support, and they have a right to that support.

7.251 Some respondents also commented on the importance of training for practitioners, and of providing guidelines about capacity assessment.

7.252 Several respondents noted the intersections between QCAT and capacity assessments, including that QCAT already undertakes assessments of capacity and that there might be scope for QCAT to provide a formal declaration of capacity in some circumstances.

The Commission's view

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

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

7.255 A decision-making capacity requirement is consistent with the legislation in other Australian and overseas jurisdictions and is generally consistent with the requirements about capacity to consent to or refuse medical treatment.

7.256 Therefore, the draft Bill provides that to be eligible for access to the voluntary assisted dying scheme, the person must have decision-making capacity for voluntary assisted dying.

The definition of decision-making capacity

7.257 We recommend that the term 'decision-making capacity' should be defined consistently with the definition of 'capacity' in Queensland's guardianship legislation.

7.258 Consistency of the draft Bill with other relevant Queensland legislation should be a priority.[204] Any legislation about voluntary assisted dying will operate closely with other health care decisions, which often link to Queensland's guardianship legislation. For example, Queensland Health guidelines about end of life care apply the definition of 'capacity' within the *Guardianship and Administration Act 2000* and more generally incorporate the operation of Queensland's guardianship legislation in circumstances where a person does not have capacity. The legislative framework for the withdrawal or withholding of life-sustaining measures is triggered by the question of whether an adult has capacity, within the meaning of Queensland's guardianship legislation, to make decisions about health matters.[205]

7.259 Registered medical practitioners in Queensland have experience in applying the definition of capacity in Queensland's guardianship legislation. QCAT also has experience in applying it and, under the draft Bill, will have jurisdiction to review decisions made about a person's decision-making capacity for voluntary assisted dying.[206] Adopting the Queensland guardianship legislation definition uses this experience. It also avoids any confusion that might result from having a different definition of decision-making capacity for voluntary assisted dying.

7.260 Finally, there is not a significant practical difference between the definition of 'capacity' in Queensland's guardianship legislation and the definitions of 'decision making capacity' in voluntary assisted dying legislation in other Australian jurisdictions. Particularly when read in conjunction with the Qld Capacity Guidelines 2020, these definitions all contemplate that similar requirements must be met for a person to have capacity to make a particular decision.

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204 Prioritising the consistency of voluntary assisted dying legislation with other relevant legislation was also the approach taken by the Victorian Ministerial Advisory Panel, which mirrored the definition of decision-making capacity used in Victorian legislation about medical treatment, and the Western Australian government, which mirrored the definition of decision-making capacity used in mental health legislation.

205 Queensland Health, Clinical Excellence Division, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*, Document No QH-GDL-462:2019 (January 2018) [1.4], [1.4.2]–[1.4.3]. See also Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.2], [1.7]. See further QLRC Consultation Paper No 79 (2020) [4.130].

206 Utilising a consistent definition also means that QCAT and others will be able to refer to previous QCAT decisions about the meaning of the term 'capacity'.

7.261 Therefore, the draft Bill provides that a person has decision-making capacity for voluntary assisted dying if the person is capable of:

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

7.262 We do not consider it necessary to define or explain the phrase 'decisions about access to voluntary assisted dying'. This is a broad phrase that encompasses a decision by a person to make a request for access to voluntary assisted dying and any subsequent decisions, if required, such as requesting administration by a practitioner.

7.263 The express requirement for a person to be capable of freely and voluntarily making decisions about voluntary assisted dying is not included in the definition of decision-making capacity in other jurisdictions. However, it gives a useful, additional aspect for assessment of a person's decision-making capacity and therefore an additional layer of protection.[207] It also reinforces that a person's decision to access voluntary assisted dying must be their own and must be voluntary. The importance of voluntariness in this context cannot be overstated.

7.264 We also recommend a separate eligibility criterion that a person must be acting voluntarily and without coercion. We acknowledge that there may be some overlap between the definition of decision-making capacity and this criterion; however, the requirement that, to have decision-making capacity, a person must be capable of freely and voluntarily making a decision is expressed in terms of the person's capacity to make decisions freely and voluntarily. The separate eligibility criterion specifically requires that, in making decisions about accessing the scheme, the person is acting voluntarily and without coercion. These requirements, operating together, are important safeguards.

7.265 The *Guardianship and Administration Act 2000* provides that when QCAT is deciding whether a person is capable of communicating their decisions in some way, it must investigate the use of all reasonable ways of facilitating communication, such as symbol boards or signing. The draft Bill provides that, when accessing the voluntary assisted dying scheme, a person may communicate their requests and have discussions about the process verbally or by some other means, such as gestures, and it enables a person to obtain assistance from an interpreter or a speech pathologist. We consider that means of communication other than spoken English are adequately addressed in the draft Bill.

7.266 We have recommended elsewhere that, as part of the implementation of a voluntary assisted dying scheme in Queensland, comprehensive guidelines for registered health practitioners should be developed. Such guidelines would give registered medical practitioners comprehensive guidance about assessing a person's decision-making capacity. Given that the definition of decision-making capacity in the draft Bill mirrors the one in the *Guardianship and Administration Act 2000*, any guidelines about voluntary assisted dying should draw on the Capacity Guidelines.

A presumption of capacity

7.267 The draft Bill provides that a person is presumed to have decision-making capacity for voluntary assisted dying unless shown not to have that capacity.

7.268 The starting point should be a presumption that the person making the request has the necessary capacity. This approach is consistent with the law about consent, the presumption of capacity operating in Queensland's guardianship legislation, and voluntary assisted dying legislation in other Australian jurisdictions.

207 In connection with Queensland's guardianship legislation, this limb of the definition of capacity has been described as a 'useful indicator' of an adult's capacity to make decisions in their own interests.

7.269 Importantly, although the draft Bill includes a presumption that a person has decision-making capacity for voluntary assisted dying, the registered medical practitioner determining the person's eligibility must be satisfied that this is so.

Factors to be considered when determining decision-making capacity

7.270 In addition to defining decision making capacity, the draft Bill should state some of the factors of particular relevance in determining whether a person has decision-making capacity. The list will not be exhaustive, but it will be helpful.

7.271 This approach is consistent with similar legislation in Victoria and Tasmania. It is also generally consistent with Queensland's *Guardianship and Administration Act 2000* and the associated Capacity Guidelines. The guidelines include acknowledgements about an adult's decision-making rights and set out principles relevant to capacity and the assessment of capacity.

7.272 These additional factors will not be expressed in the same terms as the *Guardianship and Administration Act 2000*, an Act that relies, in part, on more general principles and acknowledgements about the rights of adults, some of which have greater relevance to guardianship than to a scheme for voluntary assisted dying. However, the factors listed in the voluntary assisted dying legislation in Victoria and Tasmania and some of the principles and acknowledgements in the *Guardianship and Administration Act 2000* and the Capacity Guidelines are similar.[208] These are:

Voluntary assisted dying legislation in Victoria and Tasmania[209]	*Guardianship and Administration Act 2000* **(Qld) and the Qld Capacity Assessment Guidelines (2020)[210]**
• a person may have decision-making capacity to make some decisions but not others	• an adult's capacity to make decisions may differ according to the type of decision, including, for example, its complexity • capacity is decision-specific, and a person may have capacity to make some types of decisions but not others
• if a person does not have decision-making capacity, that may be temporary and not permanent	• capacity can change or fluctuate
• it should not be assumed that a person does not have decision-making capacity based on their appearance or because they make a decision that others consider unwise	• the right to make decisions includes the right to make decisions with which other people may not agree • a capacity assessment does not focus on whether the adult's decision is 'good' or 'bad', but on the adult's ability to exercise the decision-making process • it is wrong to assume incapacity because of age, appearance, dress, beliefs, language skills, personal habits, an impairment (such as an intellectual disability or hearing impairment) or any other characteristic

208 *Guardianship and Administration Act 2000* (Qld) ss 5, 11B; Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020).

209 *Voluntary Assisted Dying Act 2017* (Vic) s 4(4); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 12(3).

210 See, in particular, *Guardianship and Administration Act 2000* (Qld) ss 5(b), (c), (e), 11B, principles 8(2)–(3), (6), 10(2)(b); Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 5, 6, 10–13.

Voluntary assisted dying legislation in Victoria and Tasmania[209]	*Guardianship and Administration Act 2000* (Qld) and the Qld Capacity Assessment Guidelines (2020)[210]
• a person has decision-making capacity if it is possible for the person to make decisions with practicable and appropriate support (Victoria only)	• an adult's capacity to make decisions may differ according to the support available from members of their existing support network, and can depend on the support and information that is available to them • an adult with impaired capacity has a right to adequate and appropriate support for decision-making • an adult must be given the support and access to information necessary to enable them to make or participate in decisions, and to communicate their decisions • an adult cannot be treated as unable to make a decision until all practicable steps have been taken to provide the support and access to information necessary for the adult to make and communicate a decision

7.273 The listed factors are particularly important in determining whether a person has decision making capacity for voluntary assisted dying. They express some of the important principles underlying voluntary assisted dying, such as recognition of the rights of people with decision-making capacity to have their autonomy respected and to have access to support in making informed decisions about end of life choices.

7.274 Given the importance of these factors in determining whether a person has decision-making capacity, we conclude that it is appropriate for them to be stated in the draft Bill. Consistent with the approach to defining decision-making capacity, these factors should be drafted in a form that is consistent with the *Guardianship and Administration Act 2000*.

7.275 Drawing on the combined factors set out above, the draft Bill provides that, in determining whether a person has decision-making capacity, regard must be had to the following:

- 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, or the fact that the person has an illness or disability; or
  - because the person makes a decision that others think unwise;
- a person is capable of doing one of the three things required to have decision-making capacity if the person is capable of doing the thing with adequate and appropriate support.

7.276 In Victoria, the voluntary assisted dying legislation also provides examples of 'practicable and appropriate support'. Examples include:[211]

(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.

7.277 These examples are a useful addition to the legislation, and similar examples are included in the draft Bill. Although these examples are general in nature, they make

211 *Voluntary Assisted Dying Act 2017* (Vic) s 4(4)(d), examples.

clear that support is broadly interpreted and can extend from simple supports, such as offering a person more time to consider things, through to assistive technologies that require the involvement of a speech therapist.

7.278 Many varied examples of support are contained in the Qld Capacity Assessment Guidelines (2020) and in Victoria, Guidance for Health Practitioners (2019). In addition to certain examples being included in the draft Bill, associated guidelines should give more specific guidance about, and examples of, 'adequate and appropriate support'.

7.279 The laws in Victoria and Tasmania also include two additional matters that are relevant to decision-making capacity. First, the Victoria law requires a person who is assessing decision making capacity to take 'reasonable steps to conduct that assessment at a time and in an environment in which the person's decision-making capacity can be most accurately assessed'.[212] This is consistent with the Capacity Guidelines[213] and would seem to be consistent with good medical practice. Such a requirement ensures that a person's decision-making capacity is assessed in circumstances that are supportive, and that the person is given the opportunity to demonstrate their capacity. However, like the Capacity Guidelines, these matters can be adequately dealt with in guidelines for registered health practitioners. The guidelines could explain what will be required to establish an appropriate and supportive environment for an assessment of decision-making capacity for voluntary assisted dying.

7.280 Second, linked with the requirement to understand the information or advice relevant to the decision, the legislation in Victoria and Tasmania states that a person will be 'taken to understand' that information or advice if they can understand an appropriate explanation of it (in Victoria), or if it reasonably appears that they can understand an explanation of the consequences of making the decision (in Tasmania).[214]

7.281 This is generally consistent with the approach taken in the *Guardianship and Administration Act 2000* and the associated Capacity Guidelines. The guidelines state, for example, that information must be provided in an 'accessible' format, which can include giving the person information and describing their options using simple language, with pictures or diagrams to assist, and by avoiding unnecessary detail. An adult must be able to understand the 'key features' of the relevant information (although greater understanding is required for more complex decisions) and show a 'general understanding' of the consequences of the options available to them.[215]

7.282 A legislative provision of the type used in Victoria and Tasmania is not, however, easily incorporated into the draft Bill. This is because the proposed definition of 'decision making capacity' refers to understanding the nature and effect of a decision about access, rather than the information relevant to a decision. The matter of when a person can be considered to have understood information that will inform understanding of the nature and effect of a decision is best addressed in guidelines. These will give guidance, in a similar way to the Capacity Guidelines, about the ways in which information can be explained and the type of understanding that might be required or sufficient in particular circumstances.

7.283 As noted, the Victorian guidelines explain that a medical practitioner should give a patients relevant information about their diagnosis, prognosis, and the options available and then 'check' their capacity, which 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.

212 *Voluntary Assisted Dying Act 2017* (Vic) s 4(5).
213 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) 14, 31–2.
214 *Voluntary Assisted Dying Act 2017* (Vic) s 4(3); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 12(2)(b).
215 Department of Justice and Attorney-General, *Queensland Capacity Assessment Guidelines 2020* (version 1, 30 November 2020) (2020) 16–17, 32.

RECOMMENDATIONS

7-4 The eligibility criteria should also require the person to have decision-making capacity for voluntary assisted dying.

7-5 The draft Bill provides that a person has decision-making capacity for voluntary assisted dying if the person is capable of:

(a) understanding the nature and effect of decisions about access to voluntary assisted dying; and

(b) freely and voluntarily making decisions about access to voluntary assisted dying; and

(c) communicating decisions about access to voluntary assisted dying in some way.

7-6 The draft Bill provides that a person is presumed to have decision-making capacity for voluntary assisted dying unless the person is shown not to have that capacity.

7-7 The draft Bill provides that, in determining whether a person has decision-making capacity, regard must be had to the following:

(a) a person may have decision-making capacity to make some decisions but not others;

(b) capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it;

(c) it should not be presumed that a person does not have decision-making capacity:

(i) because of a personal characteristic such as age, appearance or language skills, or the fact that the person has an illness or disability; or

(ii) because the person makes a decision that others think unwise;

(d) a person is capable of doing one of the three things required to have decision-making capacity (see Recommendation 7-5) if the person is capable of doing the thing with adequate and appropriate support.

Such support could include:

(i) giving information or formats tailored to the needs of a person;

(ii) communicating or assisting a person to communicate the person's decision;

(iii) giving a person additional time and discussing the matter with the person;

(iv) using technology that alleviates the effects of a person's disability.

Adults who lack or lose decision-making capacity

7.284 The eligibility criteria in the draft Bill require that a person must have decision making capacity for voluntary assisted dying at each stage of the process.[216] They therefore render ineligible persons who lack decision-making capacity because of some condition, or who, having decision-making capacity at the start of the process, subsequently lose it and do not regain it.

7.285 Decision making capacity for voluntary assisted dying is a fundamental safeguard that protects individual autonomy and helps ensure that a person is acting voluntarily. It also protects people who might be vulnerable. It is consistent with the approach taken to voluntary assisted dying in most other jurisdictions, including other Australian jurisdictions, and the requirements about capacity to consent to or refuse medical treatment, including life-sustaining treatment.

7.286 A complex issue is whether a person who had at a certain stage decision-making capacity for voluntary assisted dying but who then lost it before the process could be completed should be allowed to access it 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.

7.287 In Western Australia, the Ministerial Expert Panel recommended that to access voluntary assisted dying a person must have decision-making capacity. However, it noted that a significant theme in its consultation was the issue of access by people who have dementia. On this topic, the Panel stated that:[217]

> in order to provide fundamental safeguards, protect individual autonomy and maintain the integrity of the voluntary assisted dying process, a person must have decision-making capacity at all stages in the process. The person must have decision-making capacity in order to make a choice or request to administer or be administered the lethal dose of medication.
>
> For people who have lost decision-making capacity, it is not possible to validly confirm that they want to proceed with administering the lethal dose of medication. These decisions would require the subjective judgement of a third party, thus negating the voluntary nature of the decision and over-riding a fundamental safeguard.

7.288 The Western Australian Panel also noted that a significant related theme in its consultation was the ability of a person to express their wishes about voluntary assisted dying in an 'advance health directive'. The Panel stated that there are many issues associated with this topic, including:[218]

> The person would need to identify the precise point at which they would wish to die in advance of reaching that point – this may be highly unreliable as the person may identify a situation that their future self does not indeed find intolerable and may actively refuse. A third party would be required to interpret the patient's current state of health and suffering and anticipate their wishes to proceed or not with assisted dying; this would potentially place a significant burden on that third party.

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

217 WA Ministerial Expert Panel Final Report (2019) 104–5. The Panel also noted that the inability of a person with dementia to withdraw an earlier decision to access voluntary assisted dying is another complicating factor.

218 Ibid 106. The panel also noted questions about whether voluntary assisted dying would be a 'treatment' for the purposes of advance health directives and the *Guardianship and Administration Act 1990* (WA). See also, as to the term 'treatment': Western Australian Ministerial Expert Panel on Advance Health Directives, *Final Report of the Ministerial Expert Panel on Advance Health Directives* (Final Report, Government of Western Australia, August 2019) 50–2.

7.289 The Victorian Ministerial Advisory Panel stated that 'having decision-making capacity throughout the voluntary assisted dying process is a fundamental safeguard'.[219] It explained that there is a fundamental difference between the advance refusal of life-sustaining medical treatment and an advance request for voluntary assisted dying. This is because:[220]

> while a person may appreciate the nature and effect of different medical treatments in advance, and consent to or refuse these, it is not possible for them to accurately identify in advance a point in time at which they would want to die.

7.290 The Victorian Panel concluded that 'excluding people who do not have decision-making capacity from accessing voluntary assisted dying creates a clear and enforceable line'.[221] Similar to Western Australia, the Panel noted particular concerns related to people with dementia but continued to hold the view that a requirement for decision-making capacity is a necessary safeguard.[222]

7.291 In Belgium, Luxembourg, and the Netherlands, a person is permitted to access assisted dying if they had, at an earlier time when they were capable or competent, made an advance directive.[223] In Belgium and Luxembourg, a physician may provide euthanasia in accordance with an advance directive if the patient is suffering from a serious or severe and incurable disorder that is caused by an illness or accident, is unconscious, and their condition or situation is irreversible given the current state of medical science.[224]

7.292 In the Netherlands, a person who is 16 years or older and 'deemed capable of making a reasonable appraisal of [their] own interests' may make a written declaration requesting that their life be terminated. If the patient is no longer capable of expressing their will, a physician may comply with the request.[225] It has been stated that such declarations may not be followed in the Netherlands due to concerns by medical practitioners that they will be 'accused of not following due process' or, in cases involving people with advanced dementia, because being unable to communicate with the person makes it difficult to determine the existence of the other required criteria.[226]

7.293 In Canada, further consideration has been given to whether the law about medical assistance in dying (MAiD) should be amended to allow for advance requests, or to accommodate people who have been found eligible for assistance to die but may lose

219 Vic Ministerial Advisory Panel Final Report (2017) 13, 58–9.

220 Ibid 61. See also: The Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) 38–9.

The Victorian Ministerial Advisory Panel also noted that an advance care directive enables a person to consent to or refuse medical treatment in advance. Voluntary assisted dying would not be a treatment offered by a practitioner, creating complications around the commencement and timing of the assessment process for voluntary assisted dying. See also, as to discussion of voluntary assisted dying as a treatment decision: Western Australian Ministerial Expert Panel on Advance Health Directives, *Final Report of the Ministerial Expert Panel on Advance Health Directives* (Final Report, Government of Western Australia, August 2019) 50–2.

221 Vic Ministerial Advisory Panel Final Report (2017) 62.

222 Ibid 61–2. In connection with people who have dementia, the Panel noted that where a person does not have decision-making capacity it is not possible to confirm that they still want to proceed with voluntary assisted dying and at what point they wish to do so.

223 QLRC Consultation Paper No 79 (2020) [4.134]–[4.136].

224 *Belgian Euthanasia Act 2002* art 4; *Luxembourg Law on Euthanasia and Suicide 2009* art 4. The description and terminology used in this text is generally based on the legislation in Belgium, but the legislation in Luxembourg is largely similar. See further: Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, The *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) 110–12.

225 The physician must apply the same 'due care criteria' that operate for a request from a person who can express their will, to the greatest extent possible in the particular situation: *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(2); Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) [4.1].

226 Eg, Evidence to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, Brisbane, 10 September 2019, 12–13 (C Cartwright); Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, The *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) 78, 107–9, 122–24, 127 ff; P Mevis et al, 'Advance directives requesting euthanasia in the Netherlands: do they enable euthanasia for patients who lack mental capacity?' (2016) 4(2) *Journal of Medical Law and Ethics* 127.

their capacity.[227] The Canadian Parliament has recently passed legislation requiring that that there be a 'comprehensive review' of the Criminal Code provisions related to medical assistance in dying and their application, including issues related to 'advance requests'.[228]

7.294 The law was also amended to provide for a waiver of the requirement that a person must expressly consent to receiving medical assistance to die immediately before it is administered, in circumstances where a person's natural death is foreseeable. This applies if the person has lost the capacity to consent but, before that occurred, met the eligibility requirements and satisfied the other safeguards, entered into an arrangement for administration of an assisted dying substance on a specific day, and consented to administration on or before that day (if they lost capacity before that day).[229] However, this will be invalid if the person demonstrates refusal or resistance to administration.[230]

7.295 It was explained that:[231]

> while recognizing the inherent risks and complexity of permitting medical assistance in dying for persons who are unable to provide consent at the time of the procedure, Parliament considers it appropriate to permit dying persons who have been found eligible to receive medical assistance in dying and are awaiting its provision to obtain medical assistance in dying even if they lose the capacity to provide final consent, except if they demonstrate signs of resistance to or refusal of the procedure.

7.296 In Queensland, the Parliamentary Committee recommended that a voluntary assisted dying scheme should limit eligibility to people with decision making capacity. It also observed that the issue of advance decision making for voluntary assisted dying requires further consideration, with any outcome balancing the wishes of individuals and the need to protect both vulnerable individuals and the medical practitioners who are providing voluntary assisted dying services. It recommended that any voluntary assisted dying scheme:[232]

> requires further research, consultation and examination to be undertaken with respect to improving end of life options for people who do not have decision making capacity, particularly in relation to ensuring Advance Health Directives are fit for purpose and effective.

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227 See, eg, *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(1)(b); *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016, c 3, s 9.1; Canada, *Parliamentary Debates*, House of Commons, 22 April 2016, 2580 (J Wilson-Raybould, Minister of Justice and Attorney General); Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, The *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018); Bill C-7 (2020), cl 7.

228 *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, s 5. The review is to be undertaken by a Joint Committee of both Houses of Parliament and commence within 30 days of the Act receiving royal assent (which took place on 17 March 2021), and the Committee is required to submit a report no later than one year after commencement of the review.

During the passing of this legislation, it was proposed to make other amendments to the law that would have permitted advance requests for medical assistance in dying. Those amendments did not pass: See, eg, Canada, *Parliamentary Debates*, House of Commons, 11 March 2021, Journal No 71, 638–46; J Bryden, 'Senate passes Bill C-7 to expand access to medical assistance in dying' CBC News (online, 17 March 2021) <https://www.cbc.ca/news/politics/senate-passes-medical-assistance-dying-billc7-1.5954281>.

229 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3.2). There is also provision for a person to enter into an agreement with a practitioner to the effect that, if the person self-administers an assisted dying substance but does not die within a specified period and loses capacity to consent to receiving medical assistance in dying, then the practitioner may administer a second substance to cause the person's death: s 241.2(3.5). *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 82(3)(d), 88.

230 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3.2)(c), (3.4). Refusal to have the assisted dying substance administered, or resistance to its administration, may be demonstrated by words, sounds or gestures. However, the Act provides that '[f]or greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance': s 241.2(3.3).

231 *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, preamble.

232 Qld Parliamentary Committee Report No 34 (2020) 127, Recs 6, 7. See also 122-127, summarising submissions received by the Parliamentary Committee on this topic.

7.297 The *Powers of Attorney Act 1998* (Qld) creates a scheme whereby a person can make an advance health directive to give directions about future health care should the person lose decision-making capacity.[233] This can include a direction requiring that a life sustaining measure is withheld or withdrawn in specified circumstances, although the circumstances in which such a direction can operate are limited by the Act.[234]

7.298 The directions that can be validly given in an advance health directive are limited to those relating to 'health matters'[235] and 'special health matters'.[236] Those terms are not defined in a way that would permit a person to make an advance health directive about voluntary assisted dying.

Submissions

7.299 Our Consultation Paper asked what the position should be if a person who has started the process of accessing voluntary assisted dying loses, or is at risk of losing, their decision-making capacity before they complete the process.[237]

7.300 Many respondents addressed this topic. Respondents who supported the general proposition that a person must have decision making capacity for voluntary assisted dying had mixed views about whether the draft Bill should extend in some circumstances to people who no longer have decision-making capacity.

7.301 Many of these respondents expressed the view that a person who loses decision making capacity should not necessarily be ineligible to access voluntary assisted dying. Some respondents suggested that in some circumstances access to the scheme could still be offered to a person who had partly or wholly completed the assessment process and had been found eligible for access. Numerous respondents, including the Australian and New Zealand College of Anaesthetists & Faculty of Pain Medicine, legal academics, health practitioners, and members of the public, suggested that there should be provision for a person to make an advance decision about voluntary assisted dying that could be applied at a later date if the person lost decision-making capacity; for example, by enabling voluntary assisted dying to be a matter that a person could include in an advance health directive or by creating another similar mechanism that would allow a person to make and record an advance decision. Generally, respondents considered that these approaches would promote autonomy and respect an individual's wishes.

7.302 Other respondents said that a person who has lost decision making capacity should not be permitted to access voluntary assisted dying, and many of them also submitted that advance decision-making about voluntary assisted dying should not be permitted.

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233 *Powers of Attorney Act 1998* (Qld) ch 3, pt 3.

234 Generally, a direction to withhold or withdraw a life-sustaining measure can only operate if the person making the directive has no reasonable prospect of regaining capacity, and: has a terminal illness, or an incurable or irreversible condition, and is expected to die within one year; is in a persistent vegetative state; is permanently unconscious; or has such a severe illness or injury that there is no reasonable prospect they could recover to the extent that their life could be sustained without the continued application of life-sustaining measures. For a direction to withhold or withdraw artificial nutrition or artificial hydration, it is also required that the commencement or continuation of the measure would be inconsistent with good medical practice. There are also general grounds on which a health practitioner would not be liable for failing to follow an advance health directive, including if a direction is inconsistent with good medical practice: *Powers of Attorney Act 1998* (Qld) ss 35(1)(a), (2)(b), 36(2), 103(1)–(2); QLRC Consultation Paper No 79 (2020) [4.121]–[4.123].

235 A 'health matter' is a matter relating to health care, other than special health care, of the person making the advanced care directive. The term 'health care' is defined as care or treatment of, or a service or a procedure for, the person to diagnose, maintain, or treat the person's physical or mental condition, which is carried out by, or under the direction or supervision of, a health provider. Health care also includes the withholding or withdrawal of a life-sustaining measure if the commencement or continuation of that measure would be inconsistent with good medical practice. It does not include first aid treatment, a non-intrusive examination for diagnostic purposes, the appropriate administration of non-prescription drugs or psychosurgery: *Powers of Attorney Act 1998* (Qld) sch 2 items 4, 5.

236 A 'special health matter' is a matter relating to special health care of the person. The term 'special health care' is defined to include health care of the following types: tissue donation whilst the adult is alive; sterilisation; termination of pregnancy; participation in special medical research or experimental health care; electroconvulsive therapy or a non-ablative neurosurgical procedure; or another prescribed special health care: *Powers of Attorney Act 1998* (Qld) sch 2 items 6, 7.

237 QLRC Consultation Paper No 79 (2020) Q-13. The Commission also included three examples with this question, which asked:

(a) Should a person who loses their decision-making capacity become ineligible to access voluntary assisted dying?

(b) Should there be any provisions to deal with the circumstance where a person is at risk of losing their decision-making capacity, other than allowing for a reduction of any waiting periods? If so, what should they be?

…

(c) Should a person be able, at the time of their first request, to give an advance directive as to specific circumstances in which their request should be acted on by a practitioner administering a voluntary assisted dying substance, despite the person having lost capacity in the meantime?

These respondents submitted that requirements for a person to have capacity and be acting voluntarily throughout the process are necessary safeguards to protect vulnerable people. They observed that there is a possibility that a person's decision will change over time. They also observed that, if advance decision-making were permitted, this could create complexities and place pressure on medical practitioners.

7.303 Some respondents suggested that a voluntary assisted dying scheme might accommodate people at risk of losing decision-making capacity in other ways; for example, by lengthening or removing the requirement that a person is likely to die within a particular period or by permitting reduced waiting periods in those circumstances.[238]

7.304 Several respondents, including the Clem Jones Group, submitted that advance decision making about voluntary assisted dying should be the subject of further research. They supported the suggestion of the Parliamentary Committee to conduct further research into end of life options for people who do not have decision-making capacity.[239] Other respondents, including the Queensland Law Society and STEP Queensland, suggested that a voluntary assisted dying scheme in Queensland should apply only to people with decision-making capacity, and issues of advance decision making or loss of capacity can be revisited when the law is reviewed.[240]

7.305 Several respondents raised concerns about people who have been diagnosed with dementia, because their condition will mean that they will lose decision-making capacity and so be unable to access voluntary assisted dying. These respondents noted the increasing prevalence of dementia, and the fears or concerns that many individuals have about losing capacity and not having their health care decisions respected. They submitted that, to accommodate access by people with dementia, there should be provision for advance decision making or implementation of other legislative mechanisms (such as broader eligibility criteria).[241]

7.306 The eligibility or otherwise of persons with dementia to access voluntary assisted dying under five different frameworks was considered in a recent article.[242] The authors concluded that access on the basis of Alzheimer's disease (the most common form of dementia) is very unlikely under the laws in Victoria, Western Australian, and Oregon. They explained:[243]

> The requirements to have decision-making capacity, and at the same time have a condition which is advanced and expected to cause death within a certain time period, will exclude access to [voluntary assisted dying] under these frameworks. The same result will follow under the [White and Willmott] Model, despite a lack of timeframe until death being required, as the person is similarly very unlikely to have decision-making capacity once Alzheimer's is at an advanced stage.

The Commission's view

7.307 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

238 One respondent suggested that waiting periods should not be reduces because this decreases that safeguards associated with the scheme. Another respondent submitted that, given the many scenarios in which possible or actual loss of capacity could arise, it would be difficult to address this by providing for a reduction in waiting periods.

239 Another respondent, a member of the public, explicitly opposed the recommendation made by the Parliamentary Committee. This respondent expressed the view that it should always be a requirement that a person has decision-making capacity, and that to conduct such research is 'dangerous' and a 'slippery slope'.

240 Also, suggesting a review as an option if the inclusion of people without decision making capacity is not addressed at this time.

241 Access to voluntary assisted dying by people with a diagnosis of dementia was also explored by the Parliamentary Committee: Qld Parliamentary Committee Report No 34 (2020) 123–27.

242 B 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).

243 Ibid.

assisted dying should be limited to people who are assessed to have decision making capacity at all stages throughout the voluntary assisted dying process.[244]

7.308 The focus of any voluntary assisted dying scheme in Queensland will be on people who have decision-making capacity and who can make an autonomous and voluntary decision to access the scheme. Some of the key safeguards embedded in the draft Bill are that a person must have decision-making capacity at different stages of the process and must be acting voluntarily and without coercion. The scheme also makes it clear that a person who has applied or been approved for access to voluntary assisted dying can change their mind at any time.

7.309 There is a strong argument that permitting a person to make an advance decision about voluntary assisted dying, and to have a voluntary assisted dying substance administered at a time when they no longer have capacity, would be inconsistent with these safeguards. A person in that position would not have capacity at the time of administration to request it. Yet if the advance authority to administer was binding, they could not change their mind and halt the process at that point. This raises the issue of voluntariness.

7.310 We acknowledge that autonomy might reasonably be said to be protected if a person is permitted to make an advance decision where they clearly set out the choices they want to have respected and implemented in the future. However, it is necessary to balance this against the need to protect the vulnerable, including people who do not have decision-making capacity. There may be circumstances where the vulnerability of a person who does not have decision-making capacity is increased because they have made an advance decision about voluntary assisted dying.[245] In our view, the protection of the vulnerable requires a person to have decision-making capacity at each stage of the process. This should remain the position until the complexities of making an advance directive about voluntary assisted dying are addressed and carefully considered.

7.311 We are aware that this will have the effect of excluding some people from access to voluntary assisted dying, either because they are not eligible or did not want to access voluntary assisted dying at an earlier time when they might have had capacity, or because their capacity declines unexpectedly and affects their ability to access the scheme. We note concerns that some people may access voluntary assisted dying earlier than they otherwise would because of fears that they will lose capacity and not be eligible. We consider, however, that this can be mitigated to some extent by the other factors such as the requirement that a person's disease, illness or medical condition is expected to cause death within 12 months.

7.312 There are significant difficulties in framing a scheme that would permit advance decision-making about voluntary assisted dying, either as part of the proposed scheme or as part of existing Queensland laws about decision-making capacity. These difficulties include:

- *the time at which a person could be permitted to make an advance decision, and the way this could occur*

  Under other Queensland laws about decision making capacity, a person can make an advance health directive at any time and with the approval of a single medical practitioner. In the case of voluntary assisted dying, it might be necessary to narrow the time within which a person can make an advance decision—for example, to the period after diagnosis with an illness that might make a person eligible or at the

244 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.

245 In Canada, it is also noted that permitting advance decisions might relieve distress that may be caused by the fear of losing capacity before a person can access medical assistance in dying or relieve suffering by giving people a sense of control. There are also suggestions that allowing access to voluntary assisted dying by people with impaired capacity might increase stigma or devalue the lives of people with impaired capacity, or that it would lead to assisted dying being viewed as an acceptable alternative to caring for those without capacity: Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, The *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) 55–6, 138–41, 145–48.

point of being found eligible for access to voluntary assisted dying. It might also be necessary to include additional requirements around the making of the advance decision about voluntary assisted dying.

- *the application of a person's advance decision about voluntary assisted dying*

  The onus would be on a medical practitioner to decide when a person should be administered a voluntary assisted dying substance. That would be a significant burden. It also raises difficult issues, such as what the position should be if a person makes an advance decision about voluntary assisted dying but, at the time when the criteria for administration are met, does not appear to be experiencing intolerable suffering or objects to the administration. These issues might be particularly relevant to people who have a diagnosis of dementia.

- *the criteria for activating an advance request for voluntary assisted dying*

  It would be difficult for a medical practitioner to apply any subjective criterion, such as a person's level of suffering. On the other hand, if legislation included narrower criteria, such as in Belgium where the person must be unconscious, then this is likely not to satisfy the desire of many people to be allowed to make an advance decision for conditions such as dementia.

- *the need for any further safeguards around advance decision-making for voluntary assisted dying, and what they should be*

  Examples of suggested safeguards are: limited and well-defined criteria for providing voluntary assisted dying in accordance with an advance decision, additional review and assessment requirements, time limits on the validity of advance directives, counselling for people who wish to make an advance directive, and additional training and support services for health practitioners.[246]

- *current difficulties associated with the operation of the Powers of Attorney Act*

  These relate to the limitations that the legislation 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 Parliamentary Committee that considered the issue of voluntary assisted dying.[247] They are overdue for attention.

7.313 Given the need to prioritise adequate protection for vulnerable people and the difficulties associated with the framing of any scheme, we are not persuaded that the voluntary assisted dying scheme we propose could adequately provide for advance decision-making. Further consideration needs to be given to how the scheme could include safeguards that would adequately protect a person who does not have decision making capacity and to whom it is proposed to administer a voluntary assisted dying substance.

7.314 Legislation permitting advance decision-making for voluntary assisted dying has been considered or enacted in three European jurisdictions, albeit sometimes in limited ways, and this topic is the subject of ongoing research and consideration. We agree with the conclusion reached in Canada that there are 'significant knowledge gaps' related to advance decision-making for voluntary assisted dying, and that more generally it is important to conduct 'additional research on the experiences of those living with a loss of decision-making capacity, their families and caregivers, and their interactions with

246 See, in particular, Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, The *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) 150 ff, 173–75; Council of Canadian Academies, *State of Knowledge on Medical Assistance in Dying for Mature Minors, Advance Requests, and Where a Mental Disorder Is the Sole Underlying Medical Condition: Summary of Reports* (2018) 23–4. Generally, in this Canadian report, opinions differed about which safeguards would be necessary and if any combination of safeguards could sufficiently reduce the risk of permitting advance decision making about assisted dying to a level that is acceptable.

247 See further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (Qld), *Aged care, end of life, and palliative care*, Report No 33 (March 2020) [21.4.1], 410, 421–2, Rec 76; QLRC, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) vol 2, Rec 11-3, and see generally ch 11. See also QLRC Consultation Paper No 79 (2020) [4.120]–[4.127].

the health care system'.[248] There is more work to be done in this area, including within a specific Queensland context.

7.315 The draft Bill, if enacted, will establish a new legislative framework for access to voluntary assisted dying by adults who have decision-making capacity. Our view is that it would be best for any new legislation to be enacted for this group of people, and for the legislation 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.

7.316 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.
- 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.

7.317 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 to request it at different times as part of the process.

7.318 The draft Bill, however, includes a provision requiring a review of the operation of the legislation, including a review of eligibility requirements for accessing the scheme. This review would inform the scope and operation of the scheme in Queensland, including any future consideration of the conditions on which access to the scheme might be permitted to people who lose their decision-making capacity after making an advanced health directive or similar instruction about voluntary assisted dying.

CRITERION THREE: VOLUNTARY AND WITHOUT COERCION

7.319 Voluntary assisted dying legislation requires that a person is acting voluntarily and is not being coerced or pressured.

Overview of legislative approaches

7.320 In Western Australia and Tasmania, one of the eligibility criteria to access voluntary assisted dying relates to voluntariness.

7.321 In Western Australia, the criteria include that 'the person is acting voluntarily and without coercion'.[249] This reflects a fundamental concept that participation in voluntary assisted dying must be completely voluntary in all respects'.[250]

7.322 In Tasmania, a person must be 'acting voluntarily' and, for the purposes of the legislation:[251]

> a person is acting voluntarily if the person is not acting under duress, coercion or because of a threat of punishment or unfavourable treatment, or a promise to give a reward or benefit, to the person or another person.

7.323 In Victoria, the voluntariness of the person's request is not one of the eligibility criteria. However, when assessing whether the person is eligible, the coordinating practitioner

248 Council of Canadian Academies, The Expert Panel Working Group on Advance Requests for MAID, The *State of Knowledge on Advance Requests for Medical Assistance in Dying* (2018) 150 ff, 175–76.

249 *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(e). This eligibility requirement is reflected in other provisions of the Act, including ss 42(3)(a)(i), 51(3)(f)(ii), 55(b)(ii), 59(5)(b), 61(2)(b)(ii). The person or other eligible applicant may apply to the State Administrative Tribunal for review of a coordinating or consulting medical practitioner's decision that the person is or is not acting voluntarily and without coercion: s 84(1)(a)(iii), (b)(iii), (c)(ii).

250 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5. See also Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5138 (RH Cook, Minister for Health).

251 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 10(1)(d), 13.

and the consulting practitioner must each be satisfied that the person meets the eligibility criteria and 'is acting voluntarily and without coercion'.[252]

7.324 The Victorian guidance for health practitioners explains that assessing whether a person is acting voluntarily and without coercion 'should firstly involve talking with the patient on their own' and then, if appropriate and with the person's consent, having a discussion with the family. Health practitioners are advised to allow enough time to discuss and understand the person's reasons for making the request, as well as observing family dynamics and talking with other members of the person's treating team.[253]

7.325 The requirement for a person to be acting voluntarily and without coercion is one that applies generally throughout the voluntary assisted dying process.[254] It is also protected by other requirements in the legislation. For example, the requirement that a request for voluntary assisted dying must be made by the person 'personally' (in Victoria) or 'in person' (in Western Australia)[255] reflects that a request to access the scheme must be the person's own choice.[256]

7.326 As already discussed, a separate eligibility requirement in each jurisdiction is that a person has decision-making capacity. The requirement for decision-making capacity, along with the multi staged process of assessing a person's request and eligibility, is an 'important safeguard' to ensure that the process remains voluntary and to protect people from coercion or abuse.[257] The Victorian Panel stated, for example, that the requirement for a person to have decision-making capacity 'is fundamental to ensuring a person's decision to access voluntary assisted dying is their own, is voluntary, and is not the product of undue influence or coercion'.[258]

7.327 Similar overseas legislation also includes, in various forms, requirements about voluntariness. For example, it may require that a person's request is made voluntarily or that it is not the result of external pressure.[259]

Queensland

7.328 The White and Willmott Model stipulates that a person's decision must be 'made voluntarily and without coercion'.[260]

7.329 The Parliamentary Committee did not make any recommendation about this requirement. However, it noted in general terms the importance of a 'staged process' of ongoing assessment of a person's request and their decision-making capacity,[261] which may also be relevant to ensuring that a person's decision is voluntary and free of coercion.

7.330 As discussed above, in Queensland's guardianship legislation, one of the requirements is that the person is capable of 'freely and voluntarily making decisions about the matter'.

252 *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(a), (c), 29(1)(a), (c). Other provisions of the Act also have the effect of ensuring that the person is 'acting voluntarily and without coercion', including ss 34(2)(a)(i), 46(c)(iii), 66(1)(c).

253 Vic Guidance for Health Practitioners (2019) [2.4].

254 *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(c), 29(1)(c), 34(2)(a)(i), 41(1), 46(c)(iii), (v), sch 1 form 5; *Voluntary Assisted Dying Act 2019* (WA) ss 24(2), 28, 35(2), 39, 42(3)(a)(i), 51(3)(f)(ii), 59(5)(b); *End of Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 10(1)(d), 13, 15(4)(d), 78. See also Vic Guidance for Health Practitioners (2019) [2.4]. Specifically, in Western Australia, the coordinating practitioner must complete a final review form, which includes a statement certifying whether or not the practitioner is satisfied that, in making a request to access voluntary assisted dying, the person is acting voluntarily and without coercion. Provision to similar general effect is made in the Victorian legislation, which requires the coordinating practitioner to certify whether 'the request and assessment process' has been completed as required by the Act.

255 *Voluntary Assisted Dying Act 2017* (Vic) s 11(2)(b); *Voluntary Assisted Dying Act 2019* (WA) s 18(1), (2)(c). In Western Australia, if it is 'not practicable' for the person to make the request in person, they may do so 'using audio visual communication': ss 18(2)(c), 158(2)(a).

256 See further QLRC Consultation Paper No 79 (2020) [4.86]–[4.87].

257 See Vic Ministerial Advisory Panel Final Report (2017) 58, 87–9; WA Ministerial Expert Panel Final Report (2019) 25, 56, 105. See also Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (J Hennessey, Minister for Health).

258 Vic Ministerial Advisory Panel Final Report (2017) 58.

259 See further QLRC Consultation Paper No 79 (2020) [4.94]–[4.95].

260 White and Willmott Model cl 9(d)(ii). This is consistent with the drafting approach in Western Australia.

261 Qld Parliamentary Committee Report No 34 (2020) [8.2.4], [9].

Submissions

7.331 Our Consultation Paper proposed that the draft Bill should provide that, to be eligible for access to voluntary assisted dying, the person must be acting voluntarily and without coercion.

7.332 Respondents who addressed this proposal agreed. Their reasons included:

- It is an important safeguard to protect people who may be vulnerable to pressure, coercion, or undue influence.
- The elderly, people with a disability, or those who feel they are a burden on others, may be vulnerable and need protection. An express requirement of this nature acts as an additional safeguard.
- It is consistent with voluntary assisted dying legislation in Australia and overseas, and with requirements for capacity in other end of life settings.

7.333 Some respondents observed that other aspects of a voluntary assisted dying scheme would also protect against coercion or undue influence. For example, an assessment should be carried out with the person alone, with express consideration of voluntariness (supported by training for practitioners) and with specialist assistance where appropriate. The process should require the person to raise the topic of voluntary assisted dying, confirm their decision on multiple occasions, have capacity throughout the process, and self-administer the substance.

7.334 A few respondents suggested that terms such as 'voluntary' and 'coercion' should be defined, or that voluntariness should be an express element of the definition of decision-making capacity.

7.335 Some respondents supported prohibitions or offences related to coercing or inducing a person to access voluntary assisted dying.

7.336 Some respondents expressed concern that there would be difficulties in protecting people, particularly those who were vulnerable such as the elderly, from coercion. They observed that coercion is often subtle and difficult to detect and suggested that the proposed safeguards would be insufficient. Others suggested that coercion, or more generally an involuntary decision, might be relevant where people cannot access adequate support or end of life care and feel 'forced' into accessing voluntary assisted dying.

The Commission's view

7.337 Access to voluntary assisted dying should be available only in circumstances where the person seeking access is acting voluntarily 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.

7.338 A requirement of this nature is a fundamental safeguard. In conjunction with the other safeguards in the draft Bill (particularly the requirement for a person to have decision-making capacity), it will protect individual autonomy and help ensure that access to the scheme is properly regulated.

7.339 This requirement is consistent with other relevant legislation in Queensland. In particular, Queensland's guardianship legislation recognises that, to have capacity, the person must be capable of freely and voluntarily making decisions.

7.340 We have considered whether a requirement for a person to be acting voluntarily and without coercion should be included as part of the eligibility criteria for access to voluntary assisted dying (as in Western Australia and Tasmania), or be left as a matter for the assessing medical practitioners. On balance, we prefer to include this requirement as an eligibility criterion. This has the effect of making clear, at a single

point in the draft Bill, all the requirements that a person must satisfy to be eligible. Also, as already noted, a close connection exists between the concepts of decision-making capacity and voluntariness, and so it is preferable that those concepts appear together in the draft Bill.

7.341 Therefore, the draft Bill provides that to be eligible for access to voluntary assisted dying the person must be acting voluntarily and without coercion. This 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, 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 a key safeguard in the draft Bill.

Should the terms 'voluntarily' and 'without coercion' be defined?

7.342 Except in Tasmania, where the legislation describes the circumstances in which a person is 'acting voluntarily', legislation about voluntary assisted dying in other Australian states does not define the terms 'voluntary' and 'coercion'.

7.343 The term 'voluntary' ordinarily refers to something that is done 'of one's own accord or by free choice',[262] and in a general legal sense, 'voluntariness' refers to '[t]he state or condition of being voluntary, free, or unconstrained; absolute freedom or liberty in respect of choice, determination, or action'.[263] It has a particular meaning in certain legal contexts.[264] The term 'coerce' ordinarily refers to forcing or compelling a person to do something,[265] and in a general legal sense, 'coercion' refers to '[c]ommanding and controlling the actions of others by means of power or force rather than persuasion'.[266]

7.344 As a general approach, words or phrases in legislation should be given their ordinary, plain English meaning and should not be defined unless it is necessary to do so.[267]

7.345 The addition of the words 'and without coercion' to the word 'voluntarily' suggests an additional element beyond free choice. It also raises the question of whether 'coercion' in this context extends beyond actions that place coercive pressure, such as a threat, to other forms of improper influence that compel or force a decision.

7.346 The concept of coercion is used in Queensland legislation in various contexts. For example, section 218 of the Criminal Code (Qld) creates an offence of procuring sexual acts by coercion, and this includes threats or intimidation of any kind. Section 8 of the *Domestic and Family Violence Protection Act 2012* (Qld) defines 'domestic violence' as meaning behaviour by a person towards another person that is, among other things, coercive. In that section, 'coerce a person means compel or force a person to do, or refrain from doing, something'. The *Industrial Relations Act 2016* (Qld) includes numerous references to coercion.[268]

7.347 Without a statutory definition or context that would alter the word's ordinary meaning, the word 'coercion' in voluntary assisted dying legislation would be taken to mean words or actions that force or compel a decision. It would not necessarily extend to conduct that involves improper use of a position of trust or influence. The issue is whether the word 'coercion' in this context should be given this extended meaning.

7.348 The requirement of 'voluntarily and without coercion' would exclude conduct that induces a person to act against their will or deprives them of a free choice, as well as

262 *Macquarie Dictionary* (online at 23 December 2020) 'voluntary'.
263 *Australian Law Dictionary* (Oxford University Press, 3rd ed, 2018, online) 'voluntariness'.
264 For example, a confession will not be voluntary if the will of the accused was so overborne that the confession was not made in the exercise of a free choice to speak or remain silent: *McDermott v R* (1948) 76 CLR 501, 511-512. In that context a confession will not be voluntary if it results from a threat or promise held out by a person in authority.
265 *Macquarie Dictionary* (online at 23 December 2020) 'coerce'.
266 *Australian Law Dictionary* (Oxford University Press, 3rd ed, 2018, online) 'coercion'.
267 See generally Office of the Queensland Parliamentary Counsel, 'Clear meaning' in *Principles of good legislation: OQPC guide to FLPs*, (14 February 2014) [6].
268 See, eg, *Industrial Relations Act 2016* (Qld) ss 195, 244, 268, 280, 287, 292, 300, 307.

threats, promises, or acts of intimidation that force or compel a decision. The ordinary meaning of the words 'voluntarily' and 'without coercion' may not exclude improper use of a position of trust or influence that falls short of 'coercion'.

7.349 Because of the uncertain meaning of 'without coercion' in this context, we consider that the word 'coercion' should be clarified and defined to include 'threats, promises, or intimidation of any kind, including by improper use of a position of trust or influence'. We prefer the words 'improper use of a position of trust or influence' to the term 'undue influence', which has a technical meaning in the law of contract, equity, and succession.

7.350 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.

7.351 Therefore, 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'.

Other matters

7.352 The guidelines given to registered health practitioners should explain concepts such as *voluntariness* and *coercion.* They could describe how a medical practitioner might assess this criterion and give examples or indicators of coercion.

7.353 Other features of the draft Bill that help safeguard against coercion and protect vulnerable individuals from exploitation are:

- limitations on the circumstances in which a discussion about voluntary assisted dying may be initiated;
- requirements about the qualifications of medical practitioners and the assessments that must be undertaken before access to voluntary assisted dying is permitted;
- a request and assessment process that includes multiple stages and requires that all stages are thoroughly documented and reported; and
- specific provisions that persons requesting access to the scheme must be told that they may change their mind at any time.[269]

RECOMMENDATIONS

7-8 The eligibility criteria should also require that the person is acting voluntarily and without coercion.

7-9 The draft Bill defines the term 'coercion' to include threats, promises or intimidation of any kind, including by improper use of a position of trust or influence.

269 See also, in similar terms, Qld Parliamentary Committee Report No 34 (2020) [9.1.1], Recs 8, 9; Vic Ministerial Advisory Panel Final Report (2017) 87–9.

CRITERION FOUR: AGED AT LEAST 18 YEARS

7.354 In Victoria, Western Australia, and Tasmania, and in most overseas jurisdictions, one of the eligibility criteria for access to voluntary assisted dying is that a person must be at least 18 years of age.[270] In Australia, this is generally the age at which a person is regarded, in law, as an adult.[271]

7.355 This age criterion was also recommended by the Parliamentary Committee and adopted in the White and Willmott Model. The Parliamentary Committee explained that such an approach is consistent with the legislation in Victoria and Western Australia.[272]

7.356 Many of the reasons for limiting access to voluntary assisted dying to people who are at least 18 years of age are provided in the context of considering whether children should have access to voluntary assisted dying. In Victoria and Western Australia, the reasons for the age limitation included:[273]

- Eighteen years is the age at which a person is considered to have attained full age and capacity and is given other rights and responsibilities (such as voting or making a will), and voluntary assisted dying legislation should be consistent;
- Adults are presumed to have capacity to consent to (or refuse) medical treatment; and
- The age limit is consistent with the expectation of autonomy for adults, and with the approach in most other jurisdictions.

Submissions

7.357 In our Consultation Paper, we proposed that the draft legislation should provide that a person must be aged at least 18 years to be eligible for access to voluntary assisted dying.[274]

7.358 About one-third of the respondents addressed this proposal, or otherwise referred to the age at which a person should be eligible for access to the scheme.

7.359 Some respondents—including the Clem Jones Group, Dying with Dignity Queensland, Dying with Dignity NSW, and Go Gentle Australia—supported limiting eligibility for voluntary assisted dying to people aged at least 18 years. Many of these respondents observed that this approach is consistent with the legislation in Victoria and Western Australia, and the age at which a person is generally regarded, in law, as an adult.

7.360 One respondent disagreed with this proposal on the basis that 18 years of age is 'too young' to access the scheme and submitted that a person should be aged at least 25 years.[275]

7.361 Exit International submitted that, if an age criterion is included, it could be similar to

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270 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(a); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(a); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 10(1)(a); *End of Life Choice Act 2019* (NZ) s 5(1)(a); *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(1)(b); *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.1(a), 443.2(a); *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25 48-102(1), 25 48 103(1); *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7-661.01(13), 7-661-02(a); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L-1 (definition of 'adult'), 327L-2; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.2(A), 2140.4; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann C.26:16 3 (definition of 'adult'), C.26:16 4(a); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.1.01(1), 127.805.2.01(1); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann §§ 5281(8), 5283; *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(1), 70.245.020(1). As a result of this age limitation, a child—a person who is under 18 years—is not eligible for voluntary assisted dying in those jurisdictions. In contrast, access to voluntary assisted dying by children is sometimes permitted in Belgium and the Netherlands, and is currently the subject of further review in Canada: See further QLRC Consultation Paper No 79 (2020) [4.58]–[4.59].

271 *Age of Majority Act 1974* (ACT) s 5; *Minors (Property and Contracts) Act 1970* (NSW) s 9; *Age of Majority Act* (NT) s 4; *Law Reform Act 1995* (Qld) s 17; *Age of Majority (Reduction) Act 1971* (SA) s 3; *Age of Majority Act 1973* (Tas) s 3; *Age of Majority Act 1977* (Vic) s 3; *Age of Majority Act 1972* (WA) s 5.

272 Qld Parliamentary Committee Report No 34 (2020) 117, Rec 2; White and Willmott Model cl 9(a).

273 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2947–8 (J Hennessey, Minister for Health); Vic Ministerial Advisory Panel Final Report (2017) 53–4, 211–12; Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6580, 6586 (M McGowan, Premier, Minister for Public Sector Management; State Development, Jobs and Trade; Federal-State Relations); WA Ministerial Expert Panel Final Report (2019) 20; WA Joint Select Committee on End of Life Choices Report (2018) [7.48]. See also B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 434.

274 QLRC Consultation Paper No 79 (2020) P-1.

275 This respondent also noted that having a lower age for access to voluntary assisted dying could worsen matters such as youth suicide.

legislation proposed in an overseas jurisdiction to the effect that people over the age of 70 who are 'tired of life' should be able to access professional assistance to end their life.[276]

7.362 The Clem Jones Group submitted that an 'upper age limit' is not necessary if legislation contains appropriate criteria to determine the eligibility and competence of people requesting access to voluntary assisted dying.

The Commission's view

7.363 Access to voluntary assisted dying should be limited to adults; that is, people who are at least 18 years of age.[277]

7.364 Limiting access to adults is consistent with other relevant laws in Queensland. Generally, 18 years is the age at which a person is regarded in law as an adult and is given legal rights and responsibilities. Further, the law relating to consent to medical treatment provides that an adult with capacity can make decisions about their own health care, including consenting to or refusing medical treatment, or requesting that treatment be withdrawn (even if this will cause the person to die or make their death happen sooner).[278]

7.365 This approach is also consistent with the legislation in most other jurisdictions that permit voluntary assisted dying, including Victoria, Western Australia, and Tasmania.

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

7.367 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 access to 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.

7.368 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.

7.369 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.

7.370 Therefore, the scheme we propose relates to adults who have, and are shown to have, decision-making capacity to request voluntary assisted dying and to request it on separate occasions as part of a process.

RECOMMENDATION

7-10 The eligibility criteria should also require that the person is at least 18 years of age.

276 This respondent noted that there could be argument about whether the age should be higher or lower than 70 years, but that '[t]he important fact is that the permanence of death needs to be understood and appreciated'.

277 This is consistent with the Commission's preliminary view, as expressed in the Consultation Paper, that 'the draft legislation should provide that one of the eligibility criteria that must be satisfied for a person to access voluntary assisted dying is that the person must be aged 18 years or more': QLRC Consultation Paper No 79 (2020) [4.67]–[4.72].

278 See further, as to consent to medical treatment, QLRC Consultation Paper No 79 (2020) [4.128]–[4.130].

Voluntary assisted dying and children

7.371 While the Parliamentary Committee recommended an age limit of at least 18 years because it is consistent with the legislation in Victoria and Western Australia,[279] one committee member also observed that the capacity of children to make significant medical decisions is recognised in law and by Queensland Health. This member expressed the view that the Parliamentary Committee's report:[280]

> should have included an additional recommendation … that any voluntary assisted dying scheme in Queensland requires further research, consultation and examination to be undertaken with respect to improving end of life options for terminally ill patients who have not yet reached majority, with a particular focus on existing criteria and guidelines for determining Gillick competence in relation to other health related decision-making.

7.372 In some circumstances, a child can give consent to medical treatment if the child has the capacity to do so. A child is capable of giving informed consent to medical treatment when the child 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.[281] A child who meets this standard is commonly referred to as 'Gillick competent'.

7.373 The issue of access to voluntary assisted dying by children is complex, and there are differing views on the topic. Other jurisdictions have identified the main reasons for not permitting children to access voluntary assisted dying, and there are other matters that inform consideration of the issue.

7.374 The issue of access to voluntary assisted dying by children was raised by some of the respondents to this review. Some respondents supported a scheme that does not permit children to access the scheme. Their reasons included that children may not have the capacity to consent and that this approach is consistent with the current law about children and end of life decision-making. It also protects vulnerable people.

7.375 Other respondents, while supporting a voluntary assisted dying scheme being limited to adults for the present, contended that the scheme should be monitored, and further consideration given in the future to children being included. Some of these respondents observed that the assessment of a child's capacity is complex and difficult. This approach was said to provide an opportunity to understand the 'nuances' of capacity for adults before considering the application of the scheme to children.

7.376 Still other respondents submitted that the draft Bill should allow children to access voluntary assisted dying. They argued that refusing access to a child who otherwise meets the eligibility criteria may be 'arbitrary' or 'discriminatory' and inconsistent with the law about consent to medical treatment by children (including the concept of Gillick competence). The result would be that children 'must continue to suffer' while adults

279 Qld Parliamentary Committee Report No 34 (2020) 117, Rec 2. This approach was also taken in the White and Willmott Model: cl 9(a)

280 Ibid 199–200 (Statement of Reservation by Michael Berkman).

In Tasmania, the End of Life Choices (Voluntary Assisted Dying) Bill 2020 cl 142(3) provided for a panel to conduct a review and 'obtain information' about whether people under 18 in other jurisdictions could access processes similar to the voluntary assisted dying process in that Bill. It was emphasised that this constituted only a review, with no guarantee of future actions or outcomes, and that it is important to gather information and understanding about the issue. However, the clause was opposed due to a lack of community support, including concern that this provision would prevent the passing of the Bill. It also was considered unnecessary for research to be included as a legislative requirement. There was more general opposition to further considering or permitting access to voluntary assisted dying by children. The provision was not included in the Bill as passed: Tasmania, *Parliamentary Debates*, Legislative Council, 15 September 2020, 70–2 (M Gaffney), 106-107 (Palmer); 22 September 2020, 75 (M Gaffney); 27 October 2020, 164 (Forrest), 159–162 (M Gaffney), 167–73.

Further studies about access to voluntary assisted dying by children are currently being undertaken in Canada. Recently, the Canadian Parliament passed legislation which requires that that there be a 'comprehensive review' of the Criminal Code provisions related to medical assistance in dying and their application, including issues related to 'mature minors'. The review is to be undertaken by a Joint Committee of both Houses of Parliament and commence within 30 days of the Act receiving royal assent (which took place on 17 March 2021), and the Committee is required to submit a report no later than one year after commencement of the review: *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 (2nd Sess), c 2, s 5; QLRC Consultation Paper No 79 (2020) [4.59].

281 *Department of Health and Community Services v JWB and SMB ('Marion's Case')* (1992) 175 CLR 218, 237, quoting *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 189. See also LexisNexis Australia, *Halsbury's Laws of Australia* [205–2130] (9 January 2020). See further QLRC Consultation Paper No 79 (2020) [4.62]–[4.66].

could 'request that their suffering be ended'.[282]

7.377 Suggestions for permitting children to access the scheme were varied. Some respondents suggested that children who meet all the other eligibility criteria should be permitted to access voluntary assisted dying in circumstances where they are Gillick competent, or where they are 16 or 17 years of age. There was also support for additional safeguards around access by children; for example, requirements for an additional assessment of the child's decision-making capacity, the involvement or agreement of the child's parents, or that access be approved by a court or tribunal.[283]

7.378 Strong views are held by respondents, and others, about this issue. We acknowledge that voluntary assisted dying legislation in a few overseas jurisdictions applies to children in some circumstances.[284]

7.379 Limiting eligibility to people aged at least 18 years has the effect of treating children differently from adults when children and adults have much in common. Children and adults are both entitled to respect for their autonomy and to have access to lawful medical treatments. Both can become ill and experience significant suffering.[285]

7.380 Only some children will be 'Gillick competent' and able to make or participate in significant medical decisions. However, due to their youth, children (including those who are Gillick competent) also have greater vulnerabilities and consequently a greater need for protection.

7.381 The concept of Gillick competence applies generally to consent to medical treatment by children.[286] The application and operation of this concept can often be complex, particularly in connection with a significant medical procedure or a medical treatment that carries significant risk. Any law permitting a child to consent to, or in some way access, voluntary assisted dying would link to these broader issues about the operation of Gillick competence and the law governing consent to medical treatment by children, which are outside the scope of this reference.

7.382 Although the concept of Gillick competence may be relied on by way of analogy to justify allowing a child who has 'a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'[287] to access the voluntary assisted dying scheme, care is required to not equate different kinds of capacities. There is an analogy between capacity to consent to medical treatment and capacity to direct that life-saving treatments be withheld. Even then, the Supreme Court has a jurisdiction to authorise medical treatment for a 'mature minor' who is capable of understanding and withholding consent for a specific form of treatment.[288]

7.383 The capacity to fully understand and consent to the withholding or withdrawal of treatment, when doing so is likely to result in death, may be likened to the capacity to choose voluntary assisted dying. However, a 'mature minor' does not necessarily have the right to end their life by insisting that treatment be withheld. The similarities and differences between the

282 R Syme, 'A Response to White and Willmott' (2020) 8(1) *Griffith Journal of Law and Human Dignity* 1, 6. Another respondent expressed the view that a person should be aged 18 years or more to be eligible for access to voluntary assisted dying, but did note that doing so might conflict with the rights of people under 18 years to enjoy their human rights without discrimination.

Some respondents observed that access to voluntary assisted dying by children is permitted in some overseas jurisdictions, but has been used by only a small number of children; R Syme, 'A Response to White and Willmott' (2020) 8(1) *Griffith Journal of Law and Human Dignity* 1, 10.

283 Some respondents more simply expressed support for permitting children who meet the eligibility criteria to access voluntary assisted dying, with various suggestions for additional regulation or safeguards.

284 See further QLRC Consultation Paper No 79 (2020) [4.58].

285 In forming its 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. See further the discussion of this topic in QLRC Consultation Paper No 79 (2020) [4.56] ff.

286 See QLRC Consultation Paper No 79 (2020) [4.62]–[4.66].

287 *Department of Health and Community Services v JWB and SMB ('Marion's Case')* (1992) 175 CLR 218, 237, quoting *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 189. See also LexisNexis Australia, *Halsbury's Laws of Australia* [205–2130] (9 January 2020). See further QLRC Consultation Paper No 79 (2020) [4.62]–[4.66].

288 *X v The Sydney Children's Hospital Network* (2013) 85 NSWLR 294; [2013] 85 NSWLR 294.

withdrawal of treatment and the active ending of life should be considered in assessing whether the same legal regime that applies to withdrawal of life-saving treatment for children should apply to children who wish to access voluntary assisted dying.

7.384 Different legal regimes apply for the withholding or withdrawal of treatment and access to voluntary assisted dying. The law does not equate these measures for adults. It is not apparent that it should be so for children.

7.385 As explained in our Consultation Paper,[289] there is a need to explore further the application of any voluntary assisted dying scheme, with modifications, to children. At present, there are gaps in the scientific, evidence-based research available to inform the development of policy in this area. For example, there would be benefit in future consultations being undertaken with children, child health and other experts, and medical practitioners practising in the field of paediatrics, particularly in the area of end of life care and the withdrawal or withholding of life sustaining measures.

7.386 In light of these issues and considering that the draft Bill, if implemented, will establish a new legal framework for access to voluntary assisted dying by eligible adults in Queensland, we have concluded that the appropriate course is for any new legislation to be properly reviewed and evaluated before considering any extension of it.

7.387 The draft Bill includes a provision requiring a review of the operation of the legislation, including a review of eligibility requirements for access to voluntary assisted dying. This review would inform consideration of the scope and operation of the voluntary assisted dying scheme in Queensland, including any future consideration of the conditions on which access to the scheme might be permitted for minors with 'Gillick competence'.

CRITERION FIVE: RESIDENCY

7.388 An issue is whether the eligibility criteria should include a residency requirement and, if so, what it should be.

7.389 Submissions were divided on these questions. Many favoured a residency requirement as a way to prevent non-residents from travelling to Queensland purely to access voluntary assisted dying. Others strongly opposed such a requirement as being wrong in principle because it prevents a person who is dying from doing so at a place of their choosing, possibly in the company of close family in Queensland.

7.390 This section outlines the recommendations of the Parliamentary Committee, and the White and Willmott Model it supported, before turning to the provisions in other jurisdictions. It then turns to the submissions we received on the residency issue and the possible justifications for a residency requirement.

7.391 Submissions and experience in Victoria identify certain practical problems in health practitioners assessing residency requirements, and the apparently unintended consequences of the Victorian residency requirement. For example, it may be interpreted to exclude someone who has resided in that State for decades but who is a New Zealand citizen and not a 'permanent resident of Australia'. Issues arise as to how an assessing health practitioner decides the potentially complex issue of whether someone satisfies the residency requirement in a difficult case, including the evidence required to prove that someone is 'ordinarily resident' in a certain place. The first part of this section will consider those practical issues.

Queensland Parliamentary Committee

7.392 The Parliamentary Committee recommended that any scheme in Queensland should limit eligibility to Australian citizens or permanent residents who are ordinarily resident in Queensland. It did not include a minimum period in its recommendations.[290] This is

289 QLRC Consultation Paper No 79 (2020) [4.71].
290 Qld Parliamentary Committee Report No 34 (2020) 118, Rec 3.

consistent with the approach in the White and Willmott Model, which requires only that a person must be ordinarily resident in the jurisdiction:[291]

> as this is sufficient to achieve the policy goal of preventing non-residents having access to voluntary assisted dying in [the] State. The additional time-based requirement … creates a further hurdle to access voluntary assisted dying for otherwise eligible persons and is unnecessary to prevent cross-border requests.

7.393 The Committee did, however, comment that the residency requirement should be 'similar to the restrictions that apply in the Victorian and Western Australian schemes'.[292]

Victoria

7.394 In Victoria, the eligibility criteria include a residency requirement. This is to prevent a person who is a non-resident from travelling to that jurisdiction for the purpose of accessing voluntary assisted dying.[293]

7.395 To satisfy the requirement, the person must:[294]

(i) be an Australian citizen or permanent resident;

(ii) be ordinarily resident in Victoria; and

(iii) at the time of making the first request, have been ordinarily resident in Victoria for at least 12 months.[295]

7.396 The Victorian Panel did not recommend a minimum time that a person must be ordinarily resident in Victoria, noting that there is no minimum period of residency required by the legislation in most other jurisdictions and that such a requirement would be administratively burdensome and onerous for the dying and suffering person.[296]

7.397 Accordingly, as originally introduced, the Victorian Bill did not require that a person be ordinarily resident in Victoria for at least 12 months at the time of making the request. However, the Bill was amended in the Legislative Council to include a time-based requirement. This was in response to uncertainty about the meaning of 'ordinarily resident' and concerns about non-residents travelling to Victoria to access voluntary assisted dying.[297]

7.398 In 2020, VCAT considered the 'ordinarily resident' requirement of the Victorian Act and held that whether a person is 'ordinarily resident' in Victoria is a matter of fact and degree.[298] The Tribunal explained that:[299]

> The person may be resident without always being physically present. The requirement that a person be 'ordinarily resident' requires something more than the mere fact of residing in a place. It requires a finding of where a person regularly or customarily lives as opposed to being temporarily resident for holiday, business or educational purposes ... A person's subjective opinion or intentions as to where or how they view themselves as 'ordinarily resident' are relevant.

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291 White and Willmott Model cl 9(b); White and Willmott Model, Explanatory Notes 3.

292 Qld Parliamentary Committee Report No 34 (2020) 118.

293 Victoria, *Parliamentary Debates*, Legislative Council, 14 November 2017, 5818 (G Jennings, Special Minister of State).

294 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(b).

295 Section 68 of the *Voluntary Assisted Dying Act 2017* (Vic) provides that a person or other eligible applicant (for example, a patient) may apply to VCAT for review of particular decisions of the coordinating practitioner or consulting practitioner, including a decision that the person is or is not ordinarily resident in Victoria, or was or was not ordinarily resident in Victoria for 12 months at the time of making a first request: s 68(1)(a)(i)–(ii), (b)(i)–(ii).

296 Vic Ministerial Advisory Panel Final Report (2017) 52, 57, Rec 2.

297 The amendments were passed in Committee. See Victoria, *Parliamentary Debates*, Legislative Council, 14 November 2017, 5818 (G Jennings, Special Minister of State); Victoria, *Parliamentary Debates*, Legislative Council, 16 November 2017, 6097 (G Jennings, Special Minister of State).

298 *NTJ v NTJ (Human Rights)* [2020] VCAT 547. The Tribunal held that the person, who was retired and had spent time travelling outside Victoria in the 12 months prior to making a first request for voluntary assisted dying, satisfied the eligibility requirement of being ordinarily resident in Victoria for 12 months at the time of making the request given that he had a Victorian address, a Victorian driver's license and other licensing and registration activity in Victoria, a family who live in Victoria and had regularly returned to and lived in Victoria: [83], [91](a).

299 Ibid [83]–[88].

Western Australia

7.399 The Western Australian Act also includes a residency requirement. It provides that the person must:[300]

- be an Australian citizen or permanent resident; and
- at the time of making a first request, have been ordinarily resident in Western Australia for at least 12 months.

7.400 The Western Australian Panel considered that the need to have been ordinarily resident in Western Australia for at least 12 months before the first request would set clear parameters for the assessing practitioner to ensure that access is limited to those ordinarily resident in Western Australia and would be consistent with the approach taken in Victoria.[301]

Tasmania

7.401 The Tasmanian Act provides that a person meets the residency requirements under the Act if:[302]

> (a) the person —
>
> (i) is an Australian citizen; or
>
> (ii) is a permanent resident of Australia; or
>
> (iii) has been resident in Australia for at least 3 continuous years immediately before the person makes the relevant first request; and
>
> (b) the person has been ordinarily resident in Tasmania for at least 12 continuous months immediately before the person makes the relevant first request.

7.402 Like the Victorian and Western Australian legislation and the White and Willmott Model, the Tasmanian Act requires a person to have Australian citizenship or permanent residency to be eligible to access the scheme, but it provides an alternative. It allows a person to have been resident in Australia for at least three continuous years immediately before making the first request.[303] This appears to contemplate persons who may have been living in Australia for many years on particular visas but have never become Australian citizens or 'permanent residents' as that term is used in immigration law.

7.403 The need for the person to have been ordinarily resident in Tasmania for at least 12 continuous months immediately before making the first request resembles the requirements in Western Australia and Victoria but adds the requirement that the residency must be 'continuous'.[304]

7.404 Unlike the laws in Victoria and Western Australia, the Tasmanian Act describes how 'ordinarily resident' may be demonstrated. Evidence of residency may include possessing a driver licence, entry on the electoral roll, or holding a lease for residential premises.[305]

300 *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(b). Section 84(1) allows an eligible applicant (eg, a patient) to apply to the State Administrative Tribunal for review of a decision by the coordinating practitioner or the consulting practitioner (as the case may be) that a patient has or has not been ordinarily resident in Western Australia for a period of at least 12 months.

301 WA Ministerial Expert Panel Final Report (2019) 20–21, Rec 3. The Panel noted that assessing practitioners and people seeking access to voluntary assisted dying would benefit from having clear and objective legislative guidance on residency.

302 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 10 and 11.

303 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 11(1)(a)(iii).

304 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(b); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(b).

305 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 11(5).

Overseas jurisdictions

New Zealand

7.405 The New Zealand Act provides to be eligible that the person must:[306]

- have New Zealand citizenship as provided in the *Citizenship Act 1977* (NZ); or
- be a permanent resident as defined in section 4 of the *Immigration Act 2009* (NZ).[307]

Canada

7.406 The Canadian legislation provides that a person seeking to access assisted dying must be eligible for health services funded by a government in Canada (or would be eligible after any applicable minimum period of residence or waiting period).[308]

United States of America

7.407 Assisted dying legislation in various states of the United States requires the person to be a resident of the state in which the person is seeking assisted dying, but does not set any minimum period for being a resident of the relevant state.[309] Most state legislation or rules stipulate the evidence needed to prove residency, such as possession of a driver licence in that state.[310]

Europe

7.408 Voluntary assisted dying legislation in Europe does not impose residency requirements. However, the laws appear to have in mind a person that has a long-term connection with the particular jurisdiction in which the person seeks to access the scheme.

7.409 For example, the Netherlands Act requires the treating physician to be satisfied that the patient's request is 'well-considered' and that the patient's suffering is unbearable with no prospect of improvement. The physician, together with the patient, must conclude that there is no reasonable alternative. Several conversations with the physician might be necessary to meet these requirements. The Netherlands Government website notes that the assessment is complex, and it is up to the physician to decide 'whether this is possible in case of a request done by a person who does not reside in the Netherlands and has only recently arrived here'.[311]

Submissions

7.410 Based on the residency requirements in Victoria and Western Australia, our Consultation Paper asked whether the eligibility criteria for a person to access voluntary assisted dying in Queensland should be that the person is:

- an Australian citizen or permanent resident; and

306 *End of Life Choice Act 2019* (NZ) s 5(1)(b).

307 A 'permanent resident' is a person who holds a NZ permanent residency visa: *Immigration Act 2009* (NZ) s 4.

308 *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* SC 2016, c3 s 241.2(1)(a). This provision is an attempt to ensure that medical assistance in dying in Canada occurs in the context of a patient-physician relationship and that Canada did not become a voluntary assisted dying destination: Special Joint Committee on Physician Assisted Dying, Parliament of Canada, Medical Assistance In Dying: A Patient-Centred Approach (Report, February 2016) 24, rec 8. Recent amendments to the Canadian legislation do not affect this eligibility requirement.

309 *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.1(o), 443.2(3); *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-102 (13)–(14); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L–1 (definition of 'qualified patient'), 327L–13; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140.15; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019* § 26:16-4; *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800 1.01 (11), 127.860 3.10; Vermont Patient Choice and Control at End of Life Act 2013, 18 VT Stat Ann § 5283(5); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(11), 70.245.130. See also *District of Columbia Death with Dignity Act 2016* DC Code §§ 7-661.4, 7-661.7.

310 See, eg, Oregon legislation which sets out various methods by which a person may demonstrate their residency in Oregon such as (but not limited to) possession of an Oregon driver licence, being registered to vote in Oregon, evidence of owning or renting property in Oregon, or filing an Oregon tax return for the most recent tax year. *Oregon Death with Dignity Act 1997* Or Rev Stat § 127.860 3.10(1)(4). Similar provision for proving residency is made in the legislation in other US states and the evidence required is set out in the legislation or administrative rules for each place.

311 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1); Government of the Netherlands, Topics – Euthanasia <https://www.government.nl/topics/euthanasia/is-euthanasia-allowed>. Similarly, the Luxembourg Act requires that the physician must ensure the persistence of the patient's physical or mental suffering by holding several interviews at reasonable intervals, having regard to the evolution of the patient's condition. This appears to envisage the person having lived in or visited Luxembourg for a reasonable period.

- ordinarily resident in Queensland.

7.411 We then asked: if the person is required to be ordinarily resident in Queensland, should there be a minimum period and, if so, what would that period be?

Inclusion of a residency requirement

7.412 About a quarter of respondents addressed whether residency should be a criterion of eligibility for a person to access voluntary assisted dying. Of those, most agreed that there should be some type of residency requirement, whether it be Australian citizenship or permanent residency, ordinarily resident in Queensland, or both. Many favoured a residency requirement to prevent non-residents from travelling to Queensland solely to access the scheme.

7.413 However, some respondents were opposed to any residency requirement. They saw it as preventing persons from dying where they choose, possibly near to family in Queensland. Others believed that it undermined the 'human rights basis' of the proposed legislation. For example, two academics jointly submitted that:

> Citizenship and residency status are largely legal issues, separate from the more pertinent issue of human rights. Some people who may wish to access [voluntary assisted dying] may have been living in Australia for a significant period of time, but may be waiting for finalisation of immigration matters. Others may have come to Australia to seek treatment, or to join family in Australia, or in Queensland, for their final days, perhaps in order to ensure they have the support of their family through their illness.
>
> Exclusion of people on the basis that they are not citizens or permanent residents of Australia, or ordinarily resident in Queensland, ignores the strong human rights basis of the proposed [voluntary assisted dying] laws.

7.414 The Queensland Department of Local Government, Racing and Multicultural Affairs submitted:

> Through the *Queensland Multicultural Policy*, the Queensland Government has committed to support all the people of Queensland to participate and feel they belong, no matter how people came here or where they came from. There are cohorts of people who have been living long-term or indefinitely in Queensland but are regarded as temporary, such as New Zealand citizens on non-protected Special Category Visas and people seeking asylum on temporary protection visas.

7.415 Other respondents opposed to a residency requirement regarded the issue as one of equity and availability of treatment. For example, one respondent submitted:

> Vulnerable people should always be welcome to travel to wherever they can get the best treatment available. Patients opposed to [voluntary assisted dying] should certainly be allowed to travel to places that don't provide it. Patients who do want it should be allowed to travel to places that do provide it.

7.416 Palliative Care Social Work Australia submitted that the issue should be the impact of access to voluntary assisted dying on public health funding:

> It is understood that opening access to non-Australian citizens or permanent residents; and those who do not ordinarily reside in Queensland would have funding and resource implications. However, if a person is eligible for Medicare or from a country with a reciprocal Medicare arrangement, could this be considered? It is suggested the issue of residency be approached through a social justice lens …

Australian citizen or permanent resident and ordinarily resident in Queensland

7.417 Most respondents who supported a residency requirement agreed that Australian citizenship or permanent residency plus Queensland residency should be required. A common theme was the need to avoid having people move to Queensland from

another state or territory merely to access voluntary assisted dying—so-called 'death tourism' or 'voluntary assisted dying tourism'. For example, the Australian Lawyers Alliance submitted:

> To avoid [voluntary assisted dying] 'tourism', there should be a requirement that persons accessing [voluntary assisted dying] are either Australian citizens or permanent residents … These requirements would be consistent with the [voluntary assisted dying] schemes in Victoria and Western Australia and the draft legislation annexed to the [voluntary assisted dying] report. In addition, persons should be ordinarily resident in Queensland and at the time of initiating their request, have been resident in Queensland for at least 12 months. This requirement is consistent with the [voluntary assisted dying] schemes in Victoria and Western Australia…

7.418 Go Gentle Australia agreed that it should be necessary to satisfy both the Australian citizenship or permanent residency requirement and to be ordinarily resident in Queensland 'to discourage/prevent [voluntary assisted dying] tourism'. It also suggested a modified approach based on the Tasmanian Bill, including the alternative of having been resident in Australia for at least three continuous years immediately before making the first request. Go Gentle Australia submitted that this approach would deal with people such as those on:

> a range of Working and Skilled Visas which allow a person to stay in Australia permanently, … people from NZ, and British citizens who made Australia their home before current visa requirements were implemented in 1984 …

7.419 Other respondents submitted that requiring both Australian citizenship or permanent residency and being ordinarily resident in Queensland was consistent with voluntary assisted dying legislation in other Australian jurisdictions.

7.420 Some respondents also suggested that there should be clarity around the definition of 'ordinarily resident'.[312]

Australian citizen or permanent resident of Australia only

7.421 Some respondents who supported a residency requirement submitted that it should be enough to be an Australian citizen or permanent resident without the additional need to be ordinarily resident in Queensland. For example, Christians Supporting Choice for Voluntary Assisted Dying submitted:

> I submit that [an Australian citizen or permanent resident] should apply. I hope that [ordinarily resident in Queensland] should not be necessary as I hope that within the next few years all residents in Australian states and territories will have equal access to [voluntary assisted dying], making [ordinarily resident in Queensland] irrelevant.
>
> …
>
> We could also have the occasional example where a young member of a Queensland family goes to, eg, NSW to study longer term. While doing so they rent a house in NSW and use a NSW driver licence. That person is very unfortunate and diagnosed with a terminal illness and wishes to die in their family surroundings. Not having (b) would permit this to happen.

Ordinarily resident in Queensland only

7.422 Some respondents considered that Australian citizenship or permanent residency should not be a requirement, provided the person is ordinarily resident in Queensland.

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312 This respondent referred to 'ordinary' as explained in the *Family Law Act 1975* (Cth). Section 4 of the *Family Law Act 1975* (Cth) provides that 'ordinarily resident' includes 'habitually resident' but provides no further definition. In *LK v Director-General, Department of Community Services* (2009) 237 CLR 582 the High Court discussed 'habitually resident' in the context of the Family Law (Child Abduction Convention) Regulations 1986 (Cth). It held that the term allowed consideration of a wide variety of circumstances which also takes account of a person's intentions. However, a person's intentions are not necessarily decisive and are considered along with other factors. This approach bears some similarity to that taken by VCAT in *NTJ v NTJ (Human Rights)* [2020] VCAT 547 in considering the meaning of 'ordinarily resident'.

7.423 One respondent, a retired medical practitioner with decades of experience in end of life ethics and practice, noted:

> There are a considerable number of people living in Australia for some years who have not become Australian citizens or permanent residents. I know of at least 5 instances in Victoria where such people who met all the other requirements for [voluntary assisted dying] were denied assistance on this ground. The basic reason for this provision is to prevent so-called 'suicide tourism', which is reasonable, but this can be dealt with by rigorous proof of State residency requirements for 1–2 years (as considered appropriate) …

7.424 Dying with Dignity Victoria submitted:

> lest the services [in] Queensland be overloaded with travellers the limit to 'ordinarily resident in Queensland' is reasonable. The requirement for (a) seems unnecessary if (b) applies.

Period for being ordinarily resident in Queensland

7.425 Most respondents addressing the residency requirement focused on the length of time a person must be ordinarily resident in Queensland before making the first request to access voluntary assisted dying.

7.426 Professors White and Willmott submitted that:[313]

> Unfortunately, there is not a body of published literature reporting on the early practical experience of [voluntary assisted dying] in Victoria. However, there is at least anecdotal evidence that there have been some practical difficulties in providing documentation in relation to both citizenship/permanent residence and also proof of ordinary residence for 12 months prior to the first request.

7.427 Some respondents suggested various minimum periods before making a relevant first request. Most suggested a minimum timeframe of 12 months, with AMA Queensland submitting that its members supported a 12-month requirement.

7.428 Some respondents wanted a short timeframe if it were necessary to have a minimum residency period.[314] For instance, Dying with Dignity Queensland supported a six month minimum residency requirement.[315] On the other hand, one respondent proposed a three year minimum timeframe to avoid the risk of persons coming to Queensland solely to access voluntary assisted dying.

7.429 One respondent, said that while there should be no time limit, there should be a requirement for 'habitual' residency.[316]

Other matters

7.430 As noted, some respondents submitted that legislation should clarify concepts such as 'ordinarily resident'.

7.431 One respondent submitted that doctors should not be expected to verify a patient's compliance with a residency requirement because of the difficulties in assessing whether a person was 'ordinarily resident' in Queensland and that this role should be left to the oversight body.

313 White and Willmott Model, Explanatory Notes 3: 'the additional time-based requirement … creates a further hurdle to access voluntary assisted dying for otherwise eligible persons and is unnecessary to prevent cross-border requests'.

314 A minimum of six months was also supported by the Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld.

315 This respondent stated that 'however, if a minimum of time as a Queensland resident must be legislated – I propose that this be no more than two weeks, so as not to exclude some newly arrived Queenslanders who are dying and suffering'.

316 See also, *LK v Director-General, Department of Community Services* (2009) 237 CLR 582 in which the High Court discussed the phrase.

The Commission's view

7.432 The submissions raise issues of principle and more pragmatic questions. They raise the justification for any residency requirement that precludes persons travelling from overseas or interstate to access a scheme for voluntary assisted dying.

7.433 Difficult issues include the consequences of preventing people with a close connection to Queensland (for example, a resident of Tweed Heads whose family and treating practitioners are in Queensland, who moves to Queensland for treatment and palliative care) from accessing the option of voluntary assisted dying at that final stage because they do not satisfy a residency requirement.

Possible justifications for a residency requirement

7.434 Residency requirements in Australian legislation impose two cumulative elements. The first concerns Australian citizenship or permanent residence. The second concerns residency of the legislating state.

7.435 Both requirements prevent non-residents from travelling to that jurisdiction simply to access a scheme that is not available where they normally live. In some articles and submissions, this is referred to as 'suicide tourism'. This phenomenon is associated with a place such as Switzerland where voluntary assisted dying is available to non-residents.

7.436 The Victorian Act's residency requirement was justified on the grounds of it being 'Victorian legislation that is intended to apply to Victorian residents'.[317]

7.437 A more persuasive justification concerns the priority that residents of the legislating jurisdiction should expect to have in a system that depends on limited resources and a finite number of qualified persons to assess eligibility and to administer medication.

7.438 Particularly at the early stage of implementing a voluntary assisted dying scheme (when there may be few qualified practitioners), allowing persons from other countries and interstate to access the scheme could deny residents access. It could also place excessive demands on palliative care places in Queensland.

7.439 One argument against a residency requirement is that a person who is dying should be able to access, as a matter of right, voluntary assisted dying in Queensland as they might access any other medical assistance in Queensland. However, that argument cannot be taken too far. The analogy with other medical services breaks down because voluntary assisted dying is unlike a surgical or other medical procedure that is available both in Queensland and the person's home state. It is unlike someone who might undergo elective surgery or a medical procedure in their home state but who prefers to come to Queensland for that lawful procedure. For example, voluntary assisted dying is not available to a person in New South Wales. A doctor who assisted the person to die in New South Wales would be committing an offence.

7.440 Many submissions that oppose a residency requirement engage the argument that voluntary assisted dying is a right, and that if people wish to travel to Queensland to be near family or friends in their final days, or simply to die in the sun, they should be able to do so. As one person wrote: 'If I was living in Victoria, I might like to live my last months in a warm place and die with the sun on my face'.

7.441 These arguments about the right of a person to die at a place of their choosing have considerable force. Rights are not ordinarily limited to the citizens or residents of a place.

7.442 In addition, the argument that the resident of another state should be able to travel to Queensland and access a service available to Queenslanders, without being subject to discrimination as an out-of-state resident, draws some support from section 117 of the *Commonwealth Constitution*.

317 Vic Ministerial Advisory Panel Final Report (2017) 56.

7.443 Section 117 provides:

> A subject of the Queen, resident in any State, shall not be subject in any other State to any disability or discrimination which would not be equally applicable to him if he were a subject of the Queen resident in such other State.

7.444 The section's scope and the extent to which its guarantee is qualified by laws that can be justified as having some legitimate and non-discriminatory operation is a complex matter. In *Street v Queensland Bar Association* ('Street's case'), Mason CJ said that section 117 'renders a disability or discrimination invalid if the notional fact of residence within the legislating State would effectively remove the disability or discrimination or substantially deprive it of its onerous nature'.[318] Despite its presence in the Constitution for more than 120 years, a question remains whether section 117 has a rights-based vision or a purpose of enhancing national unity in a federal system.[319] In any event, the court in Street's case appeared to acknowledge that the protection given by section 117 is not absolute.

7.445 The court noted that there must be some limit on the ambit of section 117, especially when considering that it is not primarily a restriction on legislative power. The section is intended to prohibit, within certain limits, the imposition of a disability or discrimination based on residence, but does not specify what limits, if any, there may be to its operation.

7.446 Mason CJ noted that a justification for a residence-based discrimination would be where:[320]

> the State were able to demonstrate that the interests of the State in maintaining its autonomy, over and above such interest it might have in giving an advantage to its residents over non-residents, required such action to be taken. Obviously, there will be circumstances in which need for regulation of activity, including professional activity, in order to protect the public in a State, requires that conditions be prescribed which may have a greater impact on out-of-State residents than residents of the legislating State.

7.447 Brennan J stated that:[321]

> if there is a rational and proportionate connection between the condition and some objective other than the subjecting of protected persons to different treatment because they are an out-of-State resident, s. 117 does not apply.

7.448 A requirement to be ordinarily resident in Queensland as a condition of eligibility for access to voluntary assisted dying may be said to give an advantage to the residents of Queensland and subject non-residents from other states to discrimination, contrary to section 117. However, any such discrimination might be justified by the need to maintain the integrity of the State's health system and to ensure the availability of voluntary assisted dying services for Queensland residents.

7.449 During a controversy over access to Queensland's hospitals during the COVID-19 epidemic, Professor George Williams wrote about section 117:[322]

> The idea of universal access to services is written into the text of the Constitution. Section 117 says that people cannot be subject to 'any disability or discrimination' because they reside in a different state. Jobs in Tasmania cannot be reserved for Tasmanians, nor should healthcare in Queensland be denied to people from northern NSW.

7.450 The extent of protection afforded by section 117 of the Constitution is uncertain and beyond the scope of this report to resolve. It is sufficient to observe that views differ

318 (1989) 168 CLR 461, 489.
319 A Simpson, 'The (Limited) Significance of the Individual in Section 117 State Residence Discrimination' (2008) 32(2) *Melbourne University Law Review* 639, <http://www5.austlii.edu.au/au/journals/MelbULawRw/2008/19.html>.
320 *Street v Queensland Bar Association* (1989) 168 CLR 461, 493.
321 *Street v Queensland Bar Association* (1989) 168 CLR 461, 511.
322 G Williams, 'High Court may loosen the Premiers' rules around state border closures', *The Australian* (online), 7 September 2020.

about the section's purpose and scope. Its possible application to a state-based residency requirement would depend on the justification for the requirement, including the availability of State resources and their funding under federal-state arrangements. The possible application of section 117 should be noted. Irrespective of its possible application, a point of principle arises.

7.451 There is an argument that, as a matter of principle, a person should be allowed to die at a place of their choosing, and that persons who reside in a state like New South Wales, which does not allow voluntary assisted dying, or in a state like Victoria, which does, should therefore be able to access lawful voluntary assisted dying in Queensland. However, this argument gives rise to an issue of access by Queenslanders to a scheme enacted for their benefit. It also calls into question the quality of the scheme and the quality of end of life care and treatment, including palliative care, if services are burdened by many people travelling from other states and territories for the sole purpose of gaining access to voluntary assisted dying.

7.452 Not having a residency requirement risks denying access by Queenslanders who qualify for voluntary assisted dying and who are enduring great suffering. Queensland has a legitimate interest, as a sovereign state, in ensuring that the health systems it operates or regulates function properly. The State has a responsibility to ensure that any voluntary assisted dying scheme here and the health system in Queensland are not unduly burdened by demands placed on them by people who travel to Queensland simply to access the scheme.

7.453 The individual rights of Queensland residents to access high-quality, end of life care, including palliative care and the option of voluntary assisted dying, might be compromised by open access to voluntary assisted dying in Queensland.

7.454 The State has a legitimate interest in ensuring that the scheme is not burdened by demand from people arriving from overseas and interstate who have no substantive connection with Queensland and who come here simply to access the scheme.

7.455 Therefore, a residency requirement can be justified by the need to ration finite resources to ensure access to high-quality care to Queenslanders, for whose benefit the scheme is principally enacted and supported by the State government. Without such a requirement, the right of a Queensland resident to access the scheme and the quality of end of life care and treatment might be compromised by excessive demand.

The consequences of an inflexible residency requirement

7.456 A residency requirement for the person to be 'ordinarily resident in Queensland' can be justified in the interests of best accommodating the rights of persons, some of whom have no connection to Queensland, and others who are long-term residents of Queensland and who have a higher claim on finite resources funded by the State government. It is, however, important to recognise that an 'ordinarily resident in Queensland' or similar requirement may have harsh, and possibly unintended, consequences for individuals who have a substantial connection with Queensland and who might be thought to be deserving of access to the scheme.

7.457 An example is a long-term resident of Tweed Heads, or some other place close to the Queensland border, who has worked most of his life in Queensland, contributing to its economy and community, and whose family live in Queensland. Such a person may have treating doctors in Queensland and rely on Queensland hospitals for his care. In the final weeks of his life, he might wish to take up residence with his family, or in a palliative care facility near his family. However, such temporary residence probably would not qualify him as 'ordinarily resident in Queensland'.

7.458 Other deserving cases can be readily imagined. Suppose a young person goes to study and work in London for some years with plans to return to Queensland (where her family lives) at some ill-defined point. She may not be 'ordinarily resident in Queensland'

since her absence is prolonged. If she suddenly develops a terminal illness and wishes to return to Queensland for treatment and care, and to be close to family support, she might not be eligible for voluntary assisted dying. It seems harsh to deny such a person, with a substantial connection to Queensland but who is not 'ordinarily resident' in Queensland, the opportunity to access voluntary assisted dying in the final stages of her suffering, close to her family, if she so chooses.

7.459 Such harsh outcomes may be an unfortunate, but inevitable, consequence of adopting a residency requirement that operates, overall, for the greater good. They may, however, justify the conferral of a discretionary power on an official to exempt the person from the residency requirement, if the official is satisfied of circumstances that demonstrate a substantial connection to Queensland and justify the granting of an exemption on compassionate grounds.

The first element: Australian citizenship or residency

7.460 Australian jurisdictions favour a residency requirement with two cumulative elements. The first concerns Australian citizenship or residence. The second concerns residence of the legislating State.

7.461 It might be said that the first element is unnecessary to stop 'suicide tourism' by anyone wishing to travel from overseas to Queensland to access the scheme, since the requirement to be ordinarily resident in Queensland would not be satisfied by them, particularly if it additionally required residence in Queensland for a substantial period.

7.462 The first element may also be said to unfairly exclude long-term residents of Australia who are not Australian citizens and who do not qualify for immigration purposes as 'permanent residents'.

7.463 The apparent purpose of the first element is to prevent access to voluntary assisted dying by persons who travel to Australia simply to access the scheme. A requirement that a person be ordinarily resident in the legislating jurisdiction would not necessarily preclude such an international traveller from accessing the scheme. It would simply require them to live in the legislating jurisdiction for long enough to qualify as 'ordinarily resident'.

7.464 The first element may be justified by the need to ration finite resources to ensure access to high-quality care to Queenslanders, for whose benefit the scheme is principally enacted and supported by the State government. If the first element were to be cast in terms of being 'an Australian citizen or a permanent resident of Australia', then it might have unintended consequences if the words 'permanent resident' are interpreted (as in Victoria) as having the technical meaning they have in immigration law. As one respondent submitted, the requirement to be a 'permanent resident' may not be satisfied by certain persons who have been long-term residents of Queensland, 'but are regarded as temporary, such as New Zealand citizens on non-protected Special Category Visas and people seeking asylum on temporary protection visas'. One respondent reported at least five instances in Victoria where people who met all the other requirements for voluntary assisted dying and who had lived in Australia for some years were denied assistance because they were not Australian citizens or 'permanent residents'.

7.465 These are valid concerns. However, they are likely to be accommodated by the type of provision contained in the Tasmanian Act, which offers a third option to satisfy the first element. It provides that a person meets the residency requirements if the person:[323]

> (i) is an Australian citizen; or
>
> (ii) is a permanent resident of Australia; or
>
> (iii) **has been resident in Australia for at least 3 continuous years immediately before the person makes the relevant first request.** (emphasis added)

323 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 11(1)(a).

7.466 Such a provision may be said to prevent access to voluntary assisted dying by people who travel to Australia simply for this purpose, and it does so in a more effective way than a requirement that the person be ordinarily resident in the legislating State (with or without an additional requirement of having been ordinarily resident in that State for at least a period of months at the time of making the first request).

7.467 Therefore, we favour a residency requirement with two cumulative elements. The first concerns Australian citizenship or residence; the second concerns residence of the legislating State.

7.468 The first element should be that the person:

- is an Australian citizen; or
- is a permanent resident of Australia; or
- has been ordinarily resident in Australia for at least three years immediately before the person makes the relevant first request.

7.469 The third alternative, unlike the Tasmanian provision, does not include the word 'continuous'. It also includes the word 'ordinarily'. The inclusion of the word 'continuous' seems unnecessary and potentially confusing. It might suggest to those wishing to access the scheme or those required to administer its eligibility requirements that a person would not have been resident in Australia for at least three 'continuous' years if they went overseas during that period and briefly resided in another place for business, educational, or recreational purposes. This is not the intent of the provision. Its intent is to give an alternative to someone who is not an Australian citizen or a 'permanent resident' of Australia, as that term is understood in the context of immigration law, but who is a long-term resident of Australia. It would apply to someone who is ordinarily resident in Australia but who has departed on occasions from Australia and returned to it during the relevant period. The person would still have to prove they have been ordinarily resident in Australia for at least three years before the first request.

The second element: Residency in Queensland

7.470 The residency requirement in the draft Bill should include that the person be 'ordinarily resident' in Queensland. This requirement is consistent with the legitimate purpose of a residency requirement, the approach adopted in other Australian States, and the White and Willmott Model.

7.471 It also accords with the Parliamentary Committee's conclusion that such a requirement will ensure that people do not move to Queensland 'purely to access [voluntary assisted dying]'.[324]

Should there be a minimum period to be 'ordinarily resident' in Queensland?

7.472 The Parliamentary Committee did not recommend a minimum period. It noted the 12 month period in legislation in Victoria and Western Australia.

7.473 Some submissions recommended a shorter qualifying period of three months and cautioned against a longer minimum period. A submission by Dying with Dignity Queensland to the Parliamentary Committee noted:[325]

> Longer periods may unfairly exclude those with rapidly progressive disease following diagnosis which was unknown at the time of taking up residency.

7.474 In its submission, Dying with Dignity Queensland recommended that the minimum period the person must be ordinarily resident in Queensland be six months before making the first request.

324 Qld Parliamentary Committee Report No 34 (2020) 118 [8.2.2].
325 Ibid 117 [8.2.2], citing Dying with Dignity Queensland, Submission 1215 to Qld Parliamentary Committee Report No 34 (2020) 9.

7.475 Most submissions that addressed this question favoured a minimum period.

7.476 Those who did not favour a minimum period argued that an additional time-based requirement: [326]

- creates 'a further hurdle to access voluntary assisted dying for otherwise eligible persons and is unnecessary to prevent cross-border requests'; or
- creates practical problems in providing documentation to prove ordinary residence for the required period.

7.477 Professors White and Willmott adopted these positions.

7.478 We are not persuaded that a time requirement is unnecessary. If the requirement were simply that the person be 'ordinarily resident in Queensland', then that would be satisfied in the case of a person who took up residence in Queensland as that person's 'settled and usual place of abode'.[327] It would apply if the person moved to Queensland with the intention of permanently residing there and did so for a 'sufficiently prolonged' period that it was not a temporary absence from their usual residence. It would apply to a person who moved to Queensland and had their sole place of residence in Queensland, making it their chosen place to live in their final weeks or months of life simply to access the voluntary assisted dying scheme. Such a person may be 'ordinarily resident' in Queensland for a fairly short time, even a matter of weeks.

7.479 A minimum period therefore has utility in achieving the purpose of a residency requirement. Without it, the right of a Queensland resident to access the scheme and the safe operation of that system might be compromised by excessive demand from persons who relocate to Queensland to access voluntary assisted dying and who can establish after a short time that they are 'ordinarily resident' in Queensland.

7.480 Therefore, we favour the adoption of a minimum period that the person has been ordinarily resident in Queensland.

7.481 Any practical problems in providing documentation or other evidence to prove ordinary residence for the required period are best addressed by provisions about facilitating proof of residence and the period of residence. They do not justify having no minimum period.

What should the minimum period be?

7.482 Any minimum period should be sufficiently long to achieve the provision's purpose to:

- ensure access to high-quality care to Queenslanders, for whose benefit the scheme is principally enacted and supported by the State government; and
- not compromise the right of a Queensland resident to access the scheme and the quality of end of life care in the Queensland health system as a result of excessive demand on it.

7.483 These legitimate goals are advanced by not providing automatic access to someone who becomes 'ordinarily resident' in Queensland for a short time before seeking access to the voluntary assisted dying scheme and who becomes a Queensland resident simply to access the scheme.

7.484 Any minimum period should not be so long as to preclude access to the scheme by someone who is ordinarily a Queensland resident and who deserves access to it. An example is the one given in the Dying with Dignity Queensland submission of a person with a rapidly progressive disease following diagnosis who was not aware of the disease at the time of taking up residency in Queensland.

326 White and Willmott Model, Explanatory Notes 3.

327 *Re Vassis; Ex parte Leung* (1986) 9 FCR 518; *Compton v Ramsay Health Care Australia Pty Ltd* (2017) 256 FCR 345, [65]–[66]; *NTJ v NTJ (Human Rights)* [2020] VCAT 547, [75]–[79].

7.485 Any residency requirement, particularly one with a lengthy minimum period, has the potential to disentitle such a deserving case or the example given earlier of a long-term resident of a border area who has close connections to Queensland by way of family and medical treatment. Another example is the young person with a rapidly progressive disease, who returns from overseas or interstate to spend the last few weeks or months of life with her family in Queensland.

7.486 These exceptional and deserving cases are not a reason for not adopting a residency requirement, including one of a certain duration. Instead, they may justify the inclusion of a provision that allows an official or body a discretion to exempt the person from the residency requirement in such exceptional circumstances.

7.487 Other Australian jurisdictions have adopted a 12 month period, which represents a balance between competing considerations.

7.488 Having regard to the need to have a substantial minimum period to achieve the residency requirement's purpose, we consider that the minimum period should be 12 months.

7.489 We, therefore, recommend that the second element of the residency requirement be that, at the time of making the first request, the person must have been ordinarily resident in Queensland for at least 12 months.

Should there be provision for exceptional cases?

7.490 A residency requirement may have harsh and unwarranted consequences for individuals who have a close connection to Queensland and who might be thought to be deserving of access to a system of voluntary assisted dying in Queensland. Some examples have just been given.

7.491 Therefore, we favour the conferral of a discretionary power to exempt a person from the residency requirement if the decision-maker is satisfied of circumstances that demonstrate a substantial connection to Queensland and justify the granting of an exemption on compassionate grounds.

7.492 The nature of the power to exempt is such that it is best conferred on an official, such as the Director-General of Health or the Director-General's delegate, rather than a review body such as the Voluntary Assisted Dying Review Board or QCAT. The application for an exemption is one best made to an official rather than a tribunal.

7.493 A person who is in Queensland and is eligible to access voluntary assisted dying, save for a residency requirement, is likely to have a connection with a health service in Queensland, such as a hospital. Such a person's circumstances are likely to be known to the health service, making it sensible for the application for the exemption to be processed through that service and approved by a delegate of the Director-General of Health, such as the Chief Executive of the relevant service or a delegate of that Chief Executive.

7.494 The discretion to exempt a person from the residency requirement should arise if the decision-maker is satisfied that the person has a substantial connection to Queensland and that the circumstances justify the granting of the exemption on compassionate grounds. The intended operation of the exemption power might be illustrated in the statute, the Explanatory Notes to it, or in other extrinsic material with the kinds of examples discussed in this section.

A review of the necessity for a residency requirement

7.495 We have recommended a residency requirement out of a concern that, without it, the right of a Queensland resident to access the scheme and the safe operation of that scheme might be compromised by excessive demand.

7.496 This might be seen by some as an excessively cautious approach and one that runs counter to the principle that:

- a person who is dying should be able to access, as a matter of right, voluntary assisted dying in Queensland as they might access any other medical assistance in Queensland;
- rights are not ordinarily limited to the citizens or residents of a place.

7.497 Our concern about excessive demand being placed on palliative care services and any voluntary assisted dying scheme in Queensland, particularly in its early stages, is not based on any modelling of demand or prediction of the number of qualified persons available to assess cases and meet that demand. The potential demand from persons moving from other states to access the system in Queensland is something that would be hard to model. Any assumption about how many people from New South Wales and other states would be inclined to make such a move cannot be based on the experience of a similar movement from one Australian state to another. Therefore, our concern about demand is precautionary rather than based on hard evidence.

7.498 Future developments, including the introduction of voluntary assisted dying schemes in other Australian jurisdictions and the operation of the scheme in Queensland may call into question the need to have a residency requirement at all. Therefore, we recommend that the inclusion of a residency requirement in any legislation be reviewed as part of a future review of the legislation's operation.

The meaning of 'ordinarily resident'

7.499 VCAT distilled the following principles about the meaning of 'ordinarily resident':[328]

a. 'resident' and 'ordinarily resident' are not technical terms and have their ordinary English meaning;

b. whether a person is 'ordinarily resident' is a question of fact and degree;

c. to say a person is 'ordinarily resident' must mean something more than being 'resident' with the word 'ordinarily' connoting a comparison, a measure of degree;

d. it is a settled and usual place of abode, the place where a person regularly or customarily lives;

e. there must be some element of permanence, to be contrasted with a place where a person stays only casually or intermittently;

f. a person may have two places of residence, may regularly live in each, and cannot be physically present in both at the same time, but may be resident (or ordinarily resident) in each at the same time; and

g. a temporary absence from the relevant jurisdiction may not prevent a person from being 'ordinarily resident' in that jurisdiction. It is a question of fact and degree at which point a temporary absence might 'if sufficiently prolonged' prevent it being proper to continue to regard the person as ordinarily resident in that jurisdiction. Whether the person intends to return to the jurisdiction after the temporary absence is relevant to determining whether they are 'ordinarily resident' during the absence.

7.500 Resolving the question of whether someone is 'ordinarily resident' in a certain state may be difficult in some cases, but this is no reason to abandon the concept of 'ordinarily resident' in favour of a statutory definition of that or a similar term. The established concept should be capable of application if it is properly understood.

328 *NTJ v NTJ (Human Rights)* [2020] VCAT 547, [77].

The meaning of 'permanent resident of Australia'

7.501 Legislation in Victoria and Western Australia includes in the first element of its residency requirements that the person is 'an Australian citizen or permanent resident'. This has unfortunate, and seemingly unintended, consequences for some people who have resided in Australia for decades but have not become Australian citizens[329] or permanent residents[330] of Australia.[331] We have addressed this by including, as a third alternative, that the person 'has been ordinarily resident in Australia' for at least three years immediately before the person makes the relevant first request. This applies the notion of 'ordinarily resident' just discussed.

7.502 It remains useful to clarify for the purpose of the second alternative the meaning of 'permanent resident of Australia'. The *Migration Act 1958* (Cth) does not define the term 'Australian permanent resident' in one place. Instead, it provides in different places that the term has the meaning of that phrase in the regulations. The Act makes provision for kinds of visas, some of which are known as a 'permanent visa', while others are known as a 'temporary visa'.[332] There is also a class of temporary visa known as a special category visa for a person who is a New Zealand citizen.[333]

7.503 The term 'permanent resident' is used in many Queensland Acts.[334] A typical definition appears in the *Land Tax Act 2010* (Qld) Schedule 4:

> **permanent resident means —**
>
> the holder of a permanent visa under the *Migration Act 1958* (Cwlth), section 30(1); or
>
> a New Zealand citizen who is the holder of a special category visa under the *Migration Act 1958* (Cwlth), section 32.

7.504 We recommend that the same definition be used for the first element of the residency requirement.

The issue of proof

7.505 The vast majority of individuals seeking to access to voluntary assisted dying are unlikely to give rise to any issues about whether a residency requirement of the kind we propose is satisfied. Usually, the individual will be well known to the coordinating practitioner, who will know of the individual's long-term residence in Australia and in Queensland. Otherwise, the residency requirement should be capable of proof from accessible documents, such as a passport, driver licence, electoral roll, or documents relating to a place of residence, such as a residential tenancy agreement. Proof might also be had by a simple form of statutory declaration to be signed by the individual, by their neighbour, or another person who can verify through personal knowledge that the individual was ordinarily resident at a certain place at a particular time or during a particular period.

7.506 In some cases, the place at which the person was 'ordinarily resident' may be less clear. However, as the Victorian case of *NTJ v NTJ (Human Rights)*[335] illustrates, a person may have more than one residency, and adopt a lifestyle in retirement of travelling around Australia, without ceasing to be 'ordinarily resident' in the place to which they return.

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329 The term 'Australian citizen' in not defined in the Victorian or Western Australian legislation, and so might derive its meaning from the definition in the *Australian Citizenship Act 2007* (Cth) s 4.

330 The term 'Australian…permanent resident' in not defined in the Victorian or Western Australian legislation but is taken to have the meaning that it has in immigration law.

331 Voluntary Assisted Dying Review Board Report of Operations January-June 2020 (2020) 6 <https://www.bettersafercare.vic.gov.au/site/default/files/202008/VADRB_Report%20of%20operations%20August%202020%20FINAL_0.pdf>

332 *Migration Act 1958* (Cth) s 30.

333 *Migration Act 1958* (Cth) s 32.

334 For example, *Bail Act 1980* (Qld), *Building Boost Grant Act 2011* (Qld), Duties Act 2001 (Qld), *Education (Queensland College of Teachers) Act 2005* (Qld), *First Home Owner Grants and Other Home Owner Grant Act 2000* (Qld), *Land Tax Act 2010* (Qld), *Youth Justice Act 1992* (Qld).

335 *NTJ v NTJ (Human Rights)* [2020] VCAT 547.

7.507 The burden on an assessing practitioner to verify a residency requirement should not be made greater than it needs to be. Guidance should be given to participants in any scheme about the established meaning of 'ordinarily resident' and the types of documents and other evidence that may prove that a person was ordinarily resident in Queensland at a certain time. The Tasmanian Act lists the type of evidence that may prove a person was ordinarily resident at a certain time. We doubt whether such details need to be included in Queensland's legislation. However, they may be helpful in guidelines that explain the meaning of 'ordinarily resident' and the types of documents and other evidence that may prove that fact.

7.508 The process for establishing residence should recognise that some persons who are close to death may have disposed of documents in anticipation of dying or have difficulty in accessing them. Many elderly people no longer have a current driver licence and are required to dispose of their expired ones, so a current driver licence or vehicle registration may not be available in those cases.

7.509 We recommend that regulations and guidelines be developed to facilitate proof of residency.[336] The regulation could provide a form of sworn declaration that would help an applicant support a claim of residence and an assessing practitioner to be satisfied with it.[337] The declaration might be supported by one or more documents that tend to prove residency, such as a passport, driver licence, rates notice, or tenancy agreement. Other evidence, such as enrolment as an elector for federal or state elections, might prove residency. The fact that a person has been resident at a place at a certain time, or over a certain period, might be verified by a person with personal knowledge of that fact, such as a neighbour, in the form of a simple statutory declaration. The form of declaration to be completed by the applicant and by any supporting declarant should be easily accessible.

7.510 In most cases, the coordinating practitioner's personal knowledge of the applicant or the declarations and supporting documents are likely to prove that the person satisfies the residency requirements.

7.511 In some other cases it will be clear that a person does not satisfy the residency requirements and is therefore ineligible to access voluntary assisted dying in Queensland unless granted an exemption.

7.512 In rare cases where the assessing practitioner remains uncertain about whether the person meets the residency requirements, the person will not have established their eligibility. A decision by an assessing practitioner that the person (without an exemption from the residency requirement) has not satisfied the residency requirement, and is therefore ineligible to access voluntary assisted dying in Queensland, will be subject to review by QCAT under the review provisions discussed in Chapter 16.

336 For example, the Victorian authorities provide guidance to health practitioners for determining citizenship and/or residency, including the documents that will prove it: Department of Health & Human Services (Vic), 'Health practitioner information' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information>.

337 The types of evidence that a person is or is not ordinarily resident in Tasmania include any of the following: a driver licence, a lease for residential premises, or a statutory declaration from the person as to where, at a particular time, the person is or was ordinarily resident: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 11(5).

RECOMMENDATIONS

7-11 The eligibility criteria should also 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'.

7-12 The draft Bill provides that the Director-General 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.

7-13 The inclusion of a residency requirement in any legislation should be reviewed as part of a future review of the legislation's operation.

7-14 Regulations, guidelines and forms should be developed to facilitate proof-of-residency requirements.

A FURTHER CONSIDERATION: ENDURING REQUEST

7.513 Our Consultation Paper asked whether the eligibility criteria should require that the person's request for voluntary assisted dying be enduring—that is, the person has made the request more than once over time.[338]

7.514 Voluntary assisted dying legislation in Australian and overseas jurisdictions differs in its approach to ensuring that the request to access voluntary assisted dying is 'enduring'. Some laws provide that the request be enduring as a defined eligibility criterion or condition for access. Some require the overseeing medical practitioners to be satisfied of the enduring nature of the request. Others do not use the word 'enduring', yet the process to access voluntary assisted dying may demonstrate a request that endures.

7.515 The Western Australian Act and the White and Willmott Model have an eligibility criterion that the person's request to access voluntary assisted dying must be enduring.[339] The Victorian Act requires, at various stages throughout the process, that the relevant medical practitioner be satisfied that the person's request is enduring;[340] the witness to the administration request and administration of the voluntary assisted dying substance must certify the same.[341]

7.516 In other jurisdictions, the procedural requirements embedded in the process tend to demonstrate that a person's request is enduring. Other safeguards, such as encouraging the person to discuss their wish with others[342] or ensuring that the request is well-considered,[343] also confirm the enduring nature of the request.

Overview of legislative approaches

Enduring nature of the request as an eligibility criterion

7.517 The Western Australian Act and the White and Willmott Model provide as part of the eligibility criteria that the person's request or decision must be enduring.[344]

7.518 Under these frameworks, the assessing medical practitioners[345] must be satisfied that the person meets all eligibility criteria, which include that the person's request[346] to access voluntary assisted dying endures throughout the process from the first request to the taking of the substance.

7.519 In Western Australia, the relevant medical practitioner must be satisfied that the person's request for accessing voluntary assisted dying was enduring at the first assessment,[347] consulting assessment,[348] final review[349] and administration (where the substance is to be administered by the practitioner).[350] The administering practitioner must also certify that, at the time of administering the substance, the patient's request for access to voluntary assisted dying was enduring.[351] The witness to the administration of the substance to the patient must certify that the patient's request for access to voluntary assisted dying appeared to be enduring.[352]

338 QLRC Consultation Paper No 79 (2020) Q-14.
339 *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(f); White and Willmott Model cl 9(d)(i).
340 *Voluntary Assisted Dying Act 2017* (Vic) ss 47(3)(b), 48(3)(c)), 64(1)(c)), 66(1)(d).
341 *Voluntary Assisted Dying Act 2017* (Vic) s 65(2)(a)(iii).
342 As provided for in the *End of Life Choice Act 2019* (NZ) s 11(2).
343 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(a).
344 *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(f); White and Willmott Model cl 9(d)(i).
345 Referred to as the 'first medical practitioner' and 'second medical practitioner' in the White and Willmott Model and the 'coordinating practitioner' and 'consulting practitioner' in the Western Australian Act.
346 Or 'decision' as in the White and Willmott Model.
347 *Voluntary Assisted Dying Act 2019* (WA) ss 24, 28
348 *Voluntary Assisted Dying Act 2019* (WA) ss 35, 39.
349 *Voluntary Assisted Dying Act 2019* (WA) ss 51(3)(f)(iii).
350 *Voluntary Assisted Dying Act 2019* (WA) s 59(5).
351 *Voluntary Assisted Dying Act 2019* (WA) s 61(2)(b)(iii).
352 *Voluntary Assisted Dying Act 2019* (WA) s 62(3)(a).

7.520 In the White and Willmott Model, the relevant medical practitioner must be satisfied that the person's request to access voluntary assisted dying was enduring at the first assessment,[353] second assessment,[354] and final request.[355] The witness to the making of the final request is also required to certify that the person's request appeared to be enduring.[356]

Medical practitioner to be satisfied of enduring nature of the request

7.521 In Victoria, the enduring nature of the request forms part of the assessment process[357] rather than being listed as an eligibility criterion. However, in practice it has the same effect as the Western Australian Act. The relevant medical practitioners, at various stages of the process, must be satisfied that the request is enduring.

7.522 The Victorian Act provides that the coordinating medical practitioner must be satisfied that the person's request for access is enduring at the outcome of the first assessment, when applying for a self-administration or practitioner administration permit, and when accepting the administration request. After administering the substance, the coordinating medical practitioner must also certify that the person's request for access was enduring.[358] As part of the consulting assessment, the consulting medical practitioner must be satisfied that the person's request was enduring.[359]

7.523 The requirement for the request to be enduring is also a condition to the coordinating medical practitioner possessing, using, and administering the voluntary assisted dying substance.[360] The person who witnesses the administration request and administration of the substance must also certify that the person's request to access voluntary assisted dying appeared to be enduring.[361]

7.524 In Queensland, the Parliamentary Committee did not make any specific comment or recommendation about the enduring nature of a person's request as part of the eligibility criteria or the assessment process. However, it recommended that the White and Willmott Model be used as the basis for any legislative scheme in Queensland about voluntary assisted dying.

7.525 In making an enduring request a part of the process, the Victorian Panel noted that the Victorian Parliamentary Committee recognised the need to guard against impulsive decisions by people experiencing extreme physical and emotional pain to ensure they were not accessing the scheme without proper consideration.[362] It stated that:[363]

> the request and assessment process recommended by the Panel will ensure the person's request for voluntary assisted dying is their autonomous choice, and is voluntary, informed and enduring.

7.526 The Victorian Panel also noted that:[364]

> the primary medical practitioner is best placed to judge the enduring nature of the patient's request in the context of the trajectory of their condition. The independent secondary medical practitioner is best placed to act as a safeguard to ensure the judgement of the primary medical practitioner is reasonable. The Parliamentary Committee was of the view that these assessments, combined with the requirement that a patient be 'at the end of life', provide the necessary protection to ensure

353 White and Willmott Model cl 16.
354 White and Willmott Model cl 21.
355 White and Willmott Model cl 30(d).
356 White and Willmott Model cl 32(2)(c).
357 *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(d)), 29(1)(d).
358 *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(d)), 47(3)(b), 48(3)(c)), 64(1)(c)), 66(1)(d).
359 *Voluntary Assisted Dying Act 2017* (Vic) s 29(1)(d).
360 *Voluntary Assisted Dying Act 2017* (Vic) s 46(c)(iv)).
361 *Voluntary Assisted Dying Act 2017* (Vic) s 65(2)(a)(iii).
362 Vic Ministerial Advisory Panel Final Report (2017) 123.
363 Vic Ministerial Advisory Panel Final Report (2017) 86.
364 Vic Ministerial Advisory Panel Final Report (2017) 123.

requests are properly considered, while also taking into account a patient's condition and likely deterioration.

Request and assessment process and other mechanisms

7.527 Where legislation does not express that the request must be 'enduring', most legislative models contain a mechanism to ensure that the request is 'well-considered',[365] made 'repeatedly',[366] or 'unchanged'.[367] In some jurisdictions, a requirement for a request to be enduring is achieved through making multiple requests, having intervals or waiting periods between requests, written declarations, regular communication between the practitioner and patient, and other safeguards.

7.528 Neither the Tasmanian Act nor the New Zealand Act stipulate as an eligibility criterion that the request must be enduring. The Tasmanian Act requires the patient to go through a request and assessment process. The New Zealand Act provides that the attending medical practitioner must personally communicate with the person about the wish for assisted dying at intervals determined by the progress of the person's terminal illness.[368]

7.529 Similarly, in Quebec, the physician must verify that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals, depending on the progress of the patient's condition.[369]

7.530 Under the Belgian Act, the physician must ensure that the patient's request is voluntary, well-considered, and repeated. The physician also must be certain of the durable nature of the patient's request and is required to have several conversations with the patient over a reasonable period, taking into consideration the progress of the patient's condition.[370]

7.531 Similarly, the Luxembourg Act requires the request to be made 'voluntarily, after reflection and, if necessary, repeated'. In addition, the doctor must 'ensure the persistence of the patient's physical or mental suffering and their recently expressed or reiterated wish. To that end, they must hold several interviews with the patient, at reasonable intervals, having regard to the evolution of the patient's condition'.[371]

7.532 In the Netherlands, the physician must be satisfied that the patient's request is voluntary and well considered.[372]

7.533 The Canadian eligibility criteria does not expressly include that the request of the person seeking to die must be 'enduring'. However, the safeguards and mechanisms surrounding the provision of medical assistance in dying help ensure that the request is enduring in nature. These include a waiting period (where the person's natural death is not reasonably foreseeable), an opportunity to withdraw the request immediately before administration, and the requirement for the person to again (just before administration) express consent to medical assistance in dying.[373]

7.534 Likewise, while the voluntary assisted dying legislation in the United States does not state an enduring request as an eligibility criterion, the legislation requires the patient place three separate requests with a built-in waiting period.

365 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.*
366 *Belgian Euthanasia Act 2002* art 3(1) and 3(2)(2).
367 Quebec Act respecting end-of-life care, RSQ, c S-32.0001.
368 *End of Life Choice Act 2019* (NZ) s 11(2)(b).
369 Quebec Act respecting end-of-life care, RSQ, c S-32.0001, s 28(c).
370 *Belgian Euthanasia Act 2002*, art 3(1) and 3(2)(2).
371 Ministry of Health and Ministry of Social Security (Luxembourg), *Euthanasia and Assisted Suicide, Law of 16 March 2009: 25 questions, 25 answers* (June 2010) (English translation) art 2(1)(2) and 2(2)
372 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* art 2(1)(a).
373 *Canada Criminal Code*, RSC 1985, c C-46, ss 241.2(3)(h), 241.2(3.1)(i), (k).

Definitions

7.535 The *Macquarie Dictionary* defines 'enduring' as 'lasting' or 'permanent'. The Victorian Panel noted that '[a]n enduring request, by its very nature, requires an ongoing and sustained interest over time'.[374]

7.536 The term 'enduring' is not defined in current voluntary assisted dying jurisdictions. Nor are the similar terms 'well-considered' and 'repeated' defined in the legislation that adopts such terminology.

7.537 The Victorian guidance for health practitioners states that '[a]s part of ongoing care, the coordinating medical practitioner should have ongoing conversations with the patient about their end of life preferences and their decision to access voluntary assisted dying'.[375]

7.538 It also provides that in declaring their satisfaction that a patient's decision is voluntary and enduring, 'sufficient time should always be taken to discuss and understand the reasons why a patient is requesting voluntary assisted dying'.[376]

7.539 In the Netherlands, the Regional Euthanasia Review Committees' Review Procedures in Practice state that the requirement for the request to be 'well considered' means that:

> the patient has given the matter careful consideration on the basis of adequate information and a clear understanding of his illness. The request must not have been made on impulse. Caution is also required in cases where the patient expresses doubt by repeatedly making and withdrawing requests over a given period of time. That a patient hesitates or has doubts regarding such a profound step as euthanasia is understandable and not necessarily a contraindication. The important thing is that the request should be consistent, taking account of all the patient's circumstances and utterances. A repeated request can be a sign that the patient is consistent in his desire for euthanasia.[377]

7.540 The same document notes that:

> [t]he patient may make his request known well before euthanasia is performed, but if the patient's condition is deteriorating rapidly, there may be only a (very) short period of time between the request and the performing of euthanasia. In other words, a request need not necessarily have persisted for a long period of time in order to be granted. It is not unusual for patients to be hesitant about euthanasia, but ultimately the physician must be satisfied that the request is unequivocal and consistent.[378]

No obligation to continue after making the first request

7.541 In Victoria and Western Australia, one of the features of the voluntary assisted dying process is that the person must participate at each stage and may decide not to continue the process at any time.[379] A similar provision is made in the Tasmanian and New Zealand Acts.[380]

7.542 If a person withdraws their request to access voluntary assisted dying, the person is required to make a new request and start the process again.[381]

7.543 The White and Willmott Model provides that '[a] person requesting access to voluntary assisted dying may decide at any time not to take any further step in relation to access

374 Vic Ministerial Advisory Panel Final Report (2017) 123.
375 Vic Guidance for Health Practitioners (2019) 24.
376 Ibid 40.
377 Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) 20.
378 Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) 19.
379 *Voluntary Assisted Dying Act 2017* (Vic): No obligation to continue after making first request (s 12), no obligation for person to continue after certification of request and assessment process on final review (s 44). *Voluntary Assisted Dying Act 2019* (WA): No obligation to continue after making first request (s 19), No obligation for patient to continue after completion of request and assessment process (s 53).
380 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 16; *End of Life Choice Act 2019* (NZ) s 23.
381 *Voluntary Assisted Dying Act 2017* (Vic) s 12(3); *Voluntary Assisted Dying Act 2019* (WA) s 19(3); *End of Life Choice Act 2019* (NZ) s 23(3); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 16(3).

to voluntary assisted dying' and this decision may be expressed verbally or by gestures or other means of communication available to the person.[382]

Submissions

7.544 Most submissions that addressed this issue favoured that requests for access to voluntary assisted dying be enduring. The reasons included that it would 'ensure that the person's request is well-considered', not 'a passing response to suffering' and 'more than a short-term reaction to their condition'.

7.545 Some respondents supported the White and Willmott Model. For example, the Queensland Law Society stated its support for:

> the drafting of clauses 7, 9(d)(i), 11, 27 and 30, that the eligibility criteria should require the request to be 'enduring' and that decision-making capacity should be demonstrated at the time of each request.

7.546 Respondents considered it was important to ensure the process was voluntary; it would act as a 'safeguard to the clinician as well as to the family that this is a well-considered request' and would 'avoid issues associated with elder abuse and protection of the vulnerable more generally.' In addition, one respondent noted that it would also ensure consistency with the Victorian and Western Australian legislation.

7.547 In considering whether the requirement for 'enduring' should form a distinct eligibility criterion or whether it is embedded in the process, two legal academics jointly submitted:

> It is not clear what benefit the requirement for the request to be 'enduring' adds, noting that under the proposed laws, the request, eligibility assessment, and access are separated across an extended period of time. In the event the patient changed their mind, there should be adequate safeguards in place to reassure them that they are not obligated to proceed with any stage of the process, and can change their mind at any point up to the time at which the medication is administered. It is difficult to imagine anyone seeking to access voluntary assisted dying on some sort of a whim. Any participation is more likely to be based on genuine uncertainty, which is probably more effectively addressed through access to professional advice and counselling provided during the assessment process, rather than instrumentally addressed by a requirement that the request be enduring, however defined.

7.548 One respondent proposed that the assessment process provide for the enduring nature of the request, rather than form part of the eligibility criteria.

7.549 Some respondents supported the use of a waiting period. Another preferred a system adopted in other Australian jurisdictions, whereby a practitioner certifies the voluntariness and the enduring nature of requests for voluntary assisted dying at multiple stages. Several respondents favoured the process of requiring repeated requests while ensuring that if a three-stage process were adopted, it would not drag on unnecessarily.

7.550 One respondent supported that the request be enduring but noted that 'this must be documented and measured in a more objective way than a physician deciding that the patient's request is 'well-considered' and that a 'workable test should be defined in the law'.

7.551 However, a few respondents thought that any safeguard would be ineffectual.

7.552 In addition, while advocating for the request to be enduring, some submissions noted that this should be subject to the individual being able to rescind his or her decision. Some respondents raised concerns that a person can change their mind about living or dying and, for this reason, cautioned against a requirement for the request to be enduring.

382 White and Willmott Model cl 36.

The Commission's view

7.553 The principles of dignity and autonomy, on the one hand, and protection and safeguarding, on the other, are not mutually inconsistent. Safeguards act to support and promote the autonomy of vulnerable people.[383]

7.554 According to Professors Willmott and White:[384]

> Autonomy is advanced where requests for assistance to die are settled and non-ambivalent. A model which acted on a fleeting or ambivalent request would also not uphold the values of life and protecting the vulnerable.

7.555 Mechanisms to ensure that a request is enduring provide an additional safeguard to protect vulnerable persons from coercion and exploitation. The draft Bill provides that a person may decide not to continue the process, and they should be told this more than once. This upholds the principle of respect for an individual's autonomy.

7.556 Ultimately, although the legislative framework in voluntary assisted dying jurisdictions may take a different approach in ensuring a request is 'enduring', 'repeated' or 'well-considered', the policy goal across all jurisdictions is the same: to ensure persons requesting access to voluntary assisted dying have, over time, discussed it with their health practitioner and have made many requests of the same nature.

7.557 In ensuring that a person's request to access voluntary assisted dying is enduring, we do not see any great practical difference between requiring an enduring request as an eligibility criterion or building a level of durability into the request and assessment process.

7.558 Adopting 'enduring' as an eligibility criterion encounters some problems—for example, the seemingly incongruous requirement that a 'first request' is enduring, and leaving either the word 'enduring' undefined or defined in a way that may be confusing, such as 'well-considered' when what is intended is 'lasting' or 'repeated'.

7.559 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 if it is embedded as part of the process.

7.560 The request and assessment process, which includes a waiting period, ensures the request is not a fleeting one. If the person has been assessed as eligible, they must also be informed of various matters, including that they can decide not to continue with the process at any time. In addition, they must demonstrate at different stages of the process that they have decision-making capacity.

7.561 The operation of the legislative scheme should be considered as a whole. The processes we propose ensure the enduring nature of the person's request. That enduring nature is evidenced at various points, including:

> the requirement for the person to make three separate requests during the request and assessment process, one of which is in writing, coupled with a minimum waiting period;
>
> the assessment of decision-making capacity, which forms part of the coordinating assessment and the consulting assessment, includes an assessment of whether the person understands the nature and effect of their decision to access voluntary assisted dying; and to have that capacity, the person must be able to communicate their decisions about voluntary assisted dying;
>
> the requirement for the coordinating practitioner and the consulting practitioner, if

383 See Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, Report No 131 (2017) 20, in the context of older people.

384 L Willmott and B White, 'Assisted Dying in Australia: A Values-based Model for Reform' in I Freckelton and K Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 507.

they are satisfied that the person is eligible, to each inform the person that they can decide not to continue the request and assessment process or not to access voluntary assisted dying at any time;

the making of an administration decision by an eligible person; and

in the case of practitioner administration, the requirement for the administering practitioner to be satisfied that, at the time of administering the substance, the person had decision-making capacity.

7.562 In summary, 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 can decide not to continue with the process. 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.

7.563 A requirement that the request is enduring is firmly embedded in the draft Bill. Therefore, it is unnecessary to make it an additional eligibility criterion.

RECOMMENDATION

7-15 It is unnecessary for the eligibility criteria to require that the person's request be enduring. This requirement is embedded in the detailed processes and safeguards contained in the draft Bill.

ELIGIBILITY CRITERIA IN PRACTICE

7.564 This section of the report has undertaken 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 already 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.

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

7.566 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.

7.567 Of the people who have been issued an administration permit in Victoria and have since died:[385]

- 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).

7.568 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.

385 Voluntary Assisted Dying Review Board Report of Operations July-December 2020 (2021) 11 <https://www.bettersafercare.vic.gov.au/sites/default/files/202102/VADRB_Report%20of%20operations%20Feb%2021_FINAL.pdf>.

7.569 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*.[386] 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 next article analysed whether each of the nine selected medical conditions could give an individual with the condition access to voluntary assisted dying.

7.570 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.

7.571 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.

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

7.573 The reasons why the five conditions just noted were thought by the authors to be very unlikely to make a person with any one of the them eligible under the Australian frameworks are explained in detail in the article. In 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 capacity for decision-making.
- ***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.

7.574 The authors raised for consideration the need to avoid an uncritical acceptance of the Victorian Act in developing frameworks in other Australian states. 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.

386 B White et al, 'Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks', *University of New South Wales Law Journal* (forthcoming)

7.575 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. This includes the question of whether a requirement for a time until death is appropriate.

7.576 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 the decision-making capacity for voluntary assisted dying is very unlikely to be retained by the time the condition reaches an advanced stage.

7.577 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. 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. 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.

7.578 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 have also explained why we prefer a 12 month timeframe.

7.579 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 in 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 to complete it.

7.580 Therefore, we have recommended a timeframe of 12 months, rather than six months, as a compassionate and balanced measure.

ELIGIBILITY CRITERIA IN COMBINATION

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

- 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

7.582 Each element within a criterion must be satisfied.

7.583 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.

7.584 The person must satisfy each of these elements. 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 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.

7.585 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.

7.586 As Professors White and Willmott and their co-authors have recently observed:[387]

> 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 VAD regulation. While it may be politically attractive to add numerous safeguards to VAD 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 VAD legislation safe, when aggregated, can in fact make access to VAD cumbersome or even unworkable**. (emphasis added)

7.587 We accept that some will regard our recommendations about eligibility criteria and other matters as being overly conservative and that they place 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.

7.588 The critical point is that the recommendations on eligibility and other matters, such as the process of assessment, operate as a whole.

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

387 BP White et al, 'Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks', *University of New South Wales Law Journal* (forthcoming).

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

7.591 Some will say that we should have been less conservative and extended our eligibility recommendations:

- to people with stable but devastating conditions that render their suffering intolerable;
- to mature minors who have enough understanding to give informed consent to voluntary assisted dying;
- to people who come from overseas or interstate to access voluntary assisted dying in Queensland; or
- to people who lack or lose decision-making capacity for voluntary assisted dying but have given an advance directive about accessing it.

7.592 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.

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

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

CHAPTER 8

The request and assessment process

Chapter 8: The request and assessment process

CHAPTER SUMMARY

We have to recommend 'the process for access to voluntary assisted dying to be initiated, granted or denied'.[1] 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.

This chapter 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, a referral to an expert in the field of that disease about that matter would be made. 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 choose to make a 'second request'. It is a formal declaration, signed in the presence of 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 must 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:

1 Terms of reference, para 3.

- 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.

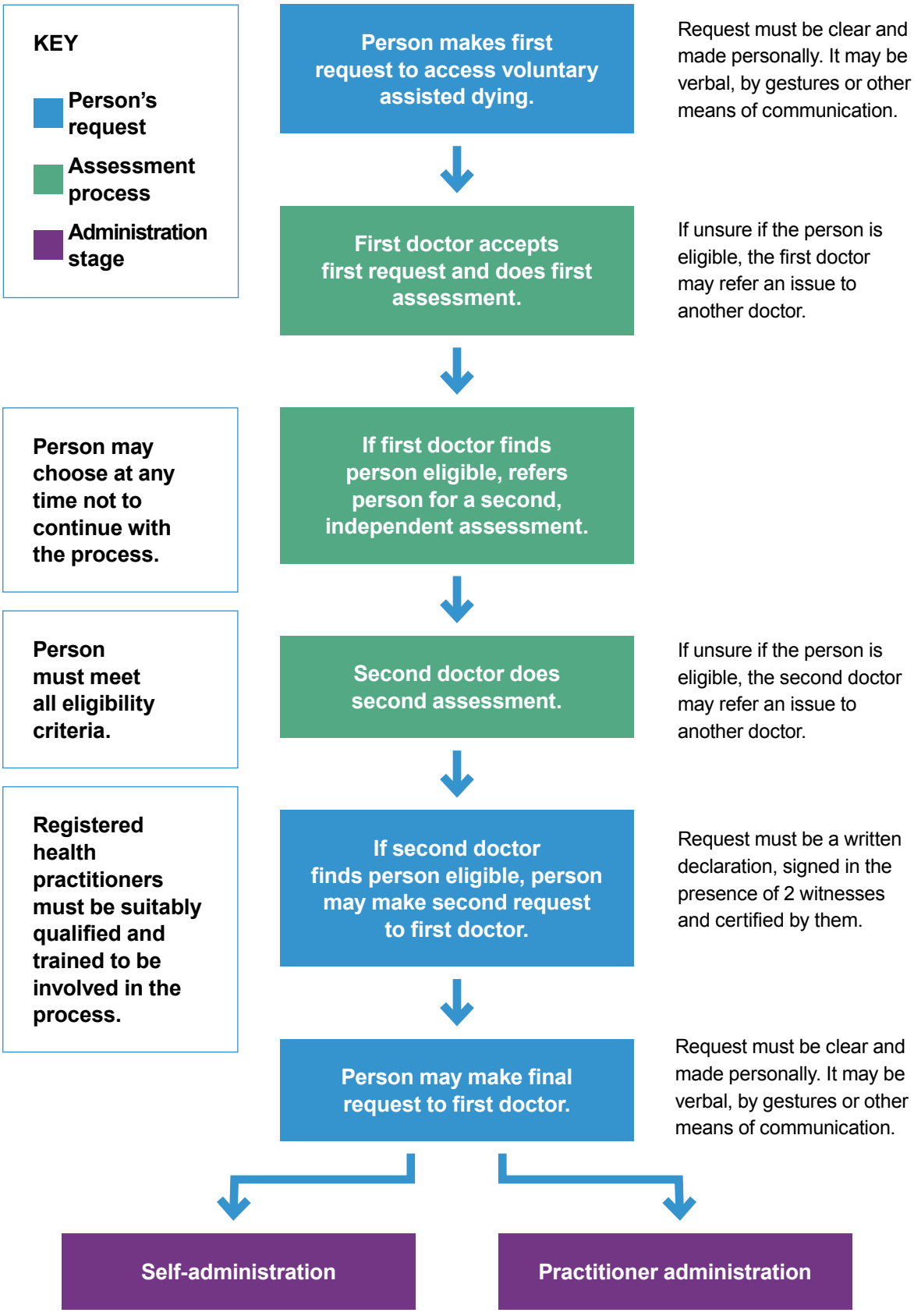
In some circumstances a period of nine days may be too long. The waiting period should be able to be reduced if the person is likely to die or lose decision-making capacity for voluntary assisted dying within that period (for instance because their condition deteriorates and pain treatment for it will 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.

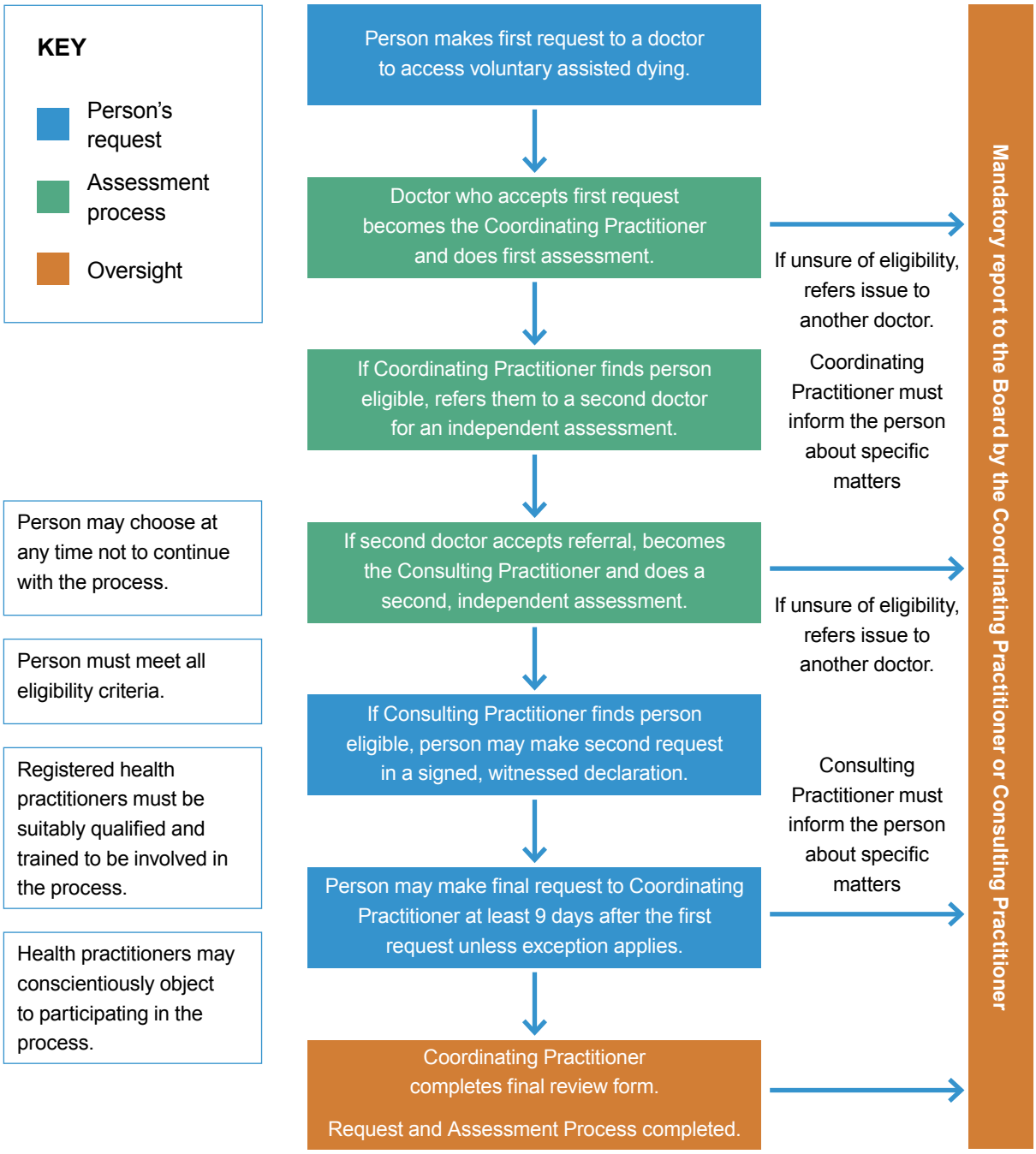
The proposed Request and Assessment Process appears in the following diagrams.

The proposed process



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

The proposed request and assessment process in detail



ACCESS TO VOLUNTARY ASSISTED DYING

8.1 Generally, the legislation in each Australian jurisdiction requires that a person make multiple requests for access and undergo multiple assessments to determine their eligibility for access.

8.2 In contrast, some other jurisdictions require only a single request for access or do not establish a particular process that must be followed.

Victoria and Western Australia

8.3 In Victoria and Western Australia, the voluntary assisted dying process has many safeguards to protect the vulnerable and ensure that the person's decision to access it is voluntary and enduring. In particular, the legislation establishes a staged 'request and assessment process'.

8.4 The term 'request and assessment process' is defined to mean, in respect of the person, 'the making or conducting of … a first request, a first assessment, a consulting assessment, a written declaration, a final request and a final review'.[2] The request and assessment process includes requirements for:

- the person to make three requests for access, the first and third of which may be made verbally, and the second of which must be in the form of a written declaration signed in the presence of two witnesses, and for a waiting period between the first and final (third) request;
- two medical practitioners to independently assess the person's eligibility for access, and to give the person particular information to ensure the person's decision is fully informed, before the person may make their second request; and
- participating medical practitioners to report to an independent board that monitors the process at various stages.

8.5 A staged process of three requests and two eligibility assessments was recommended by the Victorian Panel and the Western Australian Panel.[3] The Victorian Panel explained that:[4]

> To access voluntary assisted dying a person will need to make three requests and be assessed by two independent medical practitioners. The three request process creates a clear structure for assessments by the two medical practitioners to ensure the person meets all of the eligibility criteria for voluntary assisted dying. The process also ensures that a person's request is voluntary, considered and enduring and provides multiple opportunities for this to be reassessed.

8.6 The Victorian Panel considered that a staged request process is not overly burdensome, as it is an important safeguard to ensure voluntary decisions and is 'consistent with other medical practices where significant risk must be managed'. The Panel noted, for example, that the standard process for accessing elective surgery also requires repeated consultations with multiple medical practitioners and repeated provision of information.[5]

8.7 The Victorian and Western Australian Acts also clearly establish the roles and responsibilities of the two medical practitioners, known as the 'coordinating practitioner' and the 'consulting practitioner', who are responsible for assessing the person's eligibility for access. The coordinating practitioner is responsible for coordinating all the

2 *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of 'request and assessment process'); *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'request and assessment process'). In Victoria, it also includes the making of a contact person appointment.

3 Vic Ministerial Advisory Panel Final Report (2017) 112–14, Recs 19, 20; WA Ministerial Expert Panel Final Report (2019) 67, Rec 18.

4 Vic Ministerial Advisory Panel Final Report (2017) 114.

5 Ibid 112. At the same time, the Panel stated that the process 'should not create undue burden or anxiety, and should be undertaken in the spirit of person-centred care'.

clinical and legal processes and ensuring that all the legal requirements are met. In particular, the coordinating practitioner is responsible for conducting the first eligibility assessment, making the referral to the consulting practitioner, and ensuring that all the required documentation is completed and provided to the Board. The consulting practitioner is responsible for conducting the second independent eligibility assessment and reporting the outcome of that assessment to the Board.[6]

White and Willmott Model

8.8 Like Victoria and Western Australia, the White and Willmott Model also requires the person to make three requests for access, the second of which must be a written declaration that the person may make if two medical practitioners have each independently assessed the person as eligible and provided the person with particular information.

8.9 The requirements for making the first and second request are substantially similar to the requirements in the Victorian Act. However, unlike Victoria and Western Australia, the final request occurs at the time of the administration of the substance. Accordingly, there are additional requirements that apply to the final (third) request.

Tasmania

8.10 Like Victoria and Western Australia, the Tasmanian Act also sets out a staged request and assessment process, which requires the person to make three requests for access and be independently assessed as eligible by two medical practitioners, before the substance may be prescribed and administered.

8.11 However, there are differences in the detail and order of the request and assessment process in Tasmania, compared to Victoria and Western Australia (and the White and Willmott Model). In particular, the Tasmanian Act provides that:

- the person must make three requests (the first may be oral or in writing and may be made only if the person has been given the relevant facts for access; the second and third must be in writing and signed);
- the person's 'primary medical practitioner' (whose role is equivalent to the coordinating practitioner in Victoria and Western Australia) must determine the person's eligibility following each of those three requests;[7]
- the second request may be made after the first determination of eligibility, which requires the primary medical practitioner to give 'relevant information in relation to eligibility';
- the primary medical practitioner does not refer the person to another medical practitioner to independently determine the person's eligibility until the second request is made.

8.12 The Tasmanian Panel considered the impact of the more onerous request and assessment process proposed in the then Tasmanian Bill:[8]

> The Tasmanian … Bill requires that three formal requests be made by the patient for [voluntary assisted dying] and four assessments be undertaken of a patient's eligibility for [voluntary assisted dying] before a person can finally self-administer a [voluntary assisted dying] substance or have it administered to them by an [administering health

6 Ibid 101.

7 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 26, 33, 55. For each request the primary medical practitioner must be satisfied the person is eligible under s 10 of the Act, that is, that the person has attained the age of 18 years, meets the residency requirements, has decision-making capacity, is acting voluntarily, and is suffering intolerably in relation to a relevant medical condition. The practitioner must not make the determination for a request until they have met the person in person or by audio-visual link: ss 27, 34, 56.

The practitioner's determination must be in writing and 'contain the relevant information about eligibility in relation to the person'. As soon as reasonably practicable and within seven days of determining the request, the practitioner must notify the person of the outcome, place the determination or a copy of it on the person's medical records, and give a copy to the Commission: ss 7, 28–29, 35–36, 57–58.

8 Tas Review Panel Report (2021) [6.4.9].

> practitioner]. While this extended request and assessment process will have impacts on persons requesting [voluntary assisted dying] who are very ill and seeking a timely response, there will also be impacts on medical practitioners. The number of requests required is greater than that in comparable jurisdictions with two required in each of Victoria, Western Australia and in the [South Australian] Bill. The number of assessments required in the [Tasmanian] Bill is double the number required in Victoria, Western Australia, New Zealand, and also in the South Australian … Bill. The view among medical practitioners at the Review Workshop, was that the additional requirements of the Tasmanian [voluntary assisted dying] regime would be a disincentive to medical practitioners to participate in [voluntary assisted dying] processes. There was also significant concern that the length of time needed for the additional assessments may lead to distress among patients who were very ill and suffering and may be unable to complete the process and access [voluntary assisted dying] prior to their death.

Overseas jurisdictions

8.13 The three-request process is consistent with the approach in state legislation in the United States.[9]

8.14 In contrast, the New Zealand Act does not establish a staged request and assessment process that requires the person to make three requests; the person is required to make only one written request for access.[10] Similarly, the federal legislation in Canada requires only that the person provide a written request for voluntary assisted dying.[11]

8.15 The legislation in Belgium, Luxembourg and the Netherlands does not establish a particular request and assessment process, or require the person to make a written request. However, there are various requirements for the person's request to be 'well considered' or made 'after reflection'.[12]

Submissions

8.16 Although it was not the subject of a specific consultation question,[13] some respondents, including Professors White and Willmott, the Queensland Law Society, some voluntary assisted dying advocacy groups, a registered nurse and members of the public, submitted that there should be a staged request process requiring the person to make multiple requests for access, one of which must be in writing and signed in the presence of witnesses.[14]

8.17 Professors White and Willmott continued to support the approach in the White and Willmott Model. They submitted that a requirement for:

> three requests (first one may be oral, second in writing and third may be oral) represents an appropriate approach to safeguard that it is the person's own decision to seek [voluntary assisted dying].

8.18 The Queensland Law Society submitted that:

> the process set out in the [White and Willmott] Model which requires an applicant

9 Eg, *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.840.3.06, 127.850.3.08.

10 *End of Life Choice Act 2019* (NZ) s 11. However, the person must confirm their request in an approved form and, at the time of administration, the person must be asked if they choose to receive the substance at that time or at a later time, or if they choose to rescind their request: ss 12, 20.

11 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3)(b)–(c). However, the person must be given an opportunity to withdraw their request and must give their express consent to receive medical assistance in dying at the time it is provided: s 241.2(3)(d), (g), (h).

12 *Belgian Euthanasia Act 2002* art 3(1); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(1)(2); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(a). The explanatory material in the Netherlands explains that the person must make a request themselves, and that their request must be well-informed, consistent, and not on impulse. It also states that the consistence of the person's request is apparent from the person's repeated request or other utterances. The request may be verbal: Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) [3.2].

13 The Consultation Paper asked about selected issues connected with the request and assessment process, some of which were based on the staged request and assessment process in Victoria and Western Australia. It also asked whether there were any other issues relating to procedural matters that respondents wished to comment on: QLRC Consultation Paper No 79 (2020) Q-20–Q-22, Q-34.

14 Most respondents supported a three-stage request process.

> to make a series of requests, and the condition for an applicant to obtain separate assessments of their eligibility by two independent medical practitioners, [is] appropriate.

8.19 Two members of the public jointly submitted that the person's request should be made 'at least twice', but also supported 'the [three] phase approach for consistency in Australian jurisdictions as long as this [three] phase process is not able to drag on unnecessarily'. The Queensland Nurses and Midwives' Union submitted that it should be the case that the person '[m]ust make two requests, either oral or written to their doctor', and '[m]ust reconfirm their request once all conditions have been met'.

8.20 Dying with Dignity Queensland, Christians Supporting Choice for Voluntary Assisted Dying and a registered nurse submitted that a requirement for the person to make repeated requests at separate intervals demonstrates that the person's request is enduring. Some respondents also submitted that a staged request process enables the person to demonstrate their decision-making capacity at each stage.[15]

8.21 Dying with Dignity Queensland submitted that the person should be able to make their first request to either a medical practitioner or registered nurse, and that it should be a legal requirement that a written record of the request is retained.

8.22 Instead of a staged request and assessment process, the Lutheran Church of Australia Queensland District submitted that a new stand-alone government agency should be created. It submitted that all requests for voluntary assisted dying should be referred to the agency for approval, following an assessment by two state-appointed independent medical practitioners no earlier than 21 days after the request is referred.

The Commission's view

8.23 Access to voluntary assisted dying in Queensland should be governed by a staged request and assessment process, similar to the process that is followed in Victoria and Western Australia.

8.24 A staged request and assessment process will operate as a key safeguard in the proposed voluntary assisted dying scheme. Among other things, the requirement for a person to make multiple requests and to undergo multiple eligibility assessments will assist in ensuring that access is available only to people who have decision-making capacity for voluntary assisted dying and are acting voluntarily and without coercion. Compliance with the request and assessment process will also demonstrate that the person has consistently maintained their decision to request access.

8.25 In practice, the requirement for a person to comply with a staged request and assessment process will not be overly burdensome. The requirements placed upon the person at each stage are not intended to be complex. However, their combined operation will assist in ensuring that there is a robust process for determining a person's eligibility and identifying any people who may be vulnerable or ineligible for access.

8.26 A staged request and assessment process will also put into place a clear structure that can be followed by a medical practitioner who is assisting a person to navigate the voluntary assisted dying scheme. This will ensure that each step of the process is followed, and that a medical practitioner is aware of the requirements associated with assessing a person's eligibility for access.

8.27 The request and assessment process under the draft Bill consists of three requests (one of which must be in the form of a written declaration) and two independent assessments by registered medical practitioners of a person's eligibility to access voluntary assisted dying.

8.28 Accordingly, the draft Bill defines the term 'request and assessment process' to mean

15 Another respondent submitted that repeated requests for access to voluntary assisted dying 'should be required to be consistent to indicate the competence of the person making the request'.

the process consisting of the following steps:

- a first request;
- a first assessment;
- a consulting assessment;
- a second request;
- a final request; and
- a final review.

8.29 Each stage of the request and assessment process in the draft Bill is discussed separately in the remainder of this chapter.

THE FIRST REQUEST FOR ACCESS TO VOLUNTARY ASSISTED DYING

8.30 In each jurisdiction that has a staged request and assessment process, there are requirements for a person to make a 'first request' for access to voluntary assisted dying.

Victoria and Western Australia

8.31 In Victoria and Western Australia, the person may make a first request to a registered medical practitioner.[16]

8.32 It is recognised that in practice the person may have informal discussions, including with their medical practitioner or other health practitioners, seeking general information before deciding to request access. However, if a person wishes to access voluntary assisted dying, they will need to be assessed by a suitably qualified doctor who will determine in the first instance if the person is eligible for access, and who will be responsible for coordinating the clinical and legal processes for access.[17] The legislative process for requesting access to voluntary assisted dying therefore commences formally with an initial verbal request to a medical practitioner.[18] The Victorian Panel explained that:[19]

> Medical practitioners necessarily play a central role in voluntary assisted dying because they have a lead role in providing treatment and care as well as stewardship of the medications that are appropriate for voluntary assisted dying. The role of medical practitioners could either be that of a gatekeeper in assessing eligibility for voluntary assisted dying, or a more holistic role of ensuring people are provided with appropriate care and have genuine choice at the end of their life. The Panel is of the view that voluntary assisted dying should not occur as a fringe medical practice and that people who decide to request voluntary assisted dying should continue to be provided high quality treatment and care in accordance with expected standards.

8.33 The first request must be 'clear and unambiguous',[20] as it must be able to be distinguished from a request for information about voluntary assisted dying.[21]

16 *Voluntary Assisted Dying Act 2017* (Vic) s 11(1); *Voluntary Assisted Dying Act 2019* (WA) s 18(1). The request must be initiated by the person, as discussed in Chapter 6 above.

17 Vic Ministerial Advisory Panel Final Report (2017) 100; Department of Health & Human Services (Vic), 'Overview' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/vad-overview>.

18 Vic Ministerial Advisory Panel Final Report (2017) 113, noting that 'it needs to be clear that the process to access voluntary assisted dying commences formally with an initial verbal request'.

19 Ibid 99.

20 *Voluntary Assisted Dying Act 2017* (Vic) s 11(2)(a); *Voluntary Assisted Dying Act 2019* (WA) s 18(2)(a).

21 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 5; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 7. See also Vic Ministerial Advisory Panel Final Report (2017) 113.

8.34 The request must also be made to the medical practitioner by the person themselves.[22] It cannot, for example, be made by a family member or carer on the person's behalf. This is to ensure that the request is the person's own decision and that it is made voluntarily and without coercion.[23]

8.35 The request may be made verbally or by other means of communication, such as gestures.[24]

8.36 The medical practitioner to whom the first request is made must accept or refuse the request.[25] If the request is refused, the person can choose to make another request to a different medical practitioner. It is only when a person's first request is accepted that the assessment process will commence.[26]

8.37 In Victoria, the Board has recently explained that a 'first request' cannot be made to a medical practitioner who does not subsequently become the person's coordinating medical practitioner. It was stated that the Victorian Act requires that 'the coordinating medical practitioner must be the person who receives and accepts the first request'.[27]

8.38 When a medical practitioner accepts the person's first request, they become the 'coordinating practitioner' and will be responsible for conducting the first eligibility assessment (the 'coordinating assessment').[28] This is discussed in more detail below.

8.39 If the coordinating practitioner determines that the person is ineligible for access, the request and assessment process ends.[29] If the coordinating practitioner determines that the person is eligible, they must inform the person of the outcome and refer the person to another medical practitioner for a consulting assessment.[30]

8.40 The medical practitioner to whom a person is referred for a consulting assessment must accept or refuse the referral.[31] If the referral is refused, the coordinating practitioner can refer the person to a different medical practitioner. When a medical practitioner accepts the referral, they become the 'consulting practitioner' and will be responsible for conducting the second eligibility assessment (the 'consulting assessment').[32]

22 In Victoria, the Act states that the request 'must be made by the person personally'. In Western Australia, the request 'must be made during a medical consultation' and made in person or, if that is not practicable, by audiovisual communication: *Voluntary Assisted Dying Act 2017* (Vic) s 11(2)(b); *Voluntary Assisted Dying Act 2019* (WA) ss 18(2)(b)–(c), 158(2)(a).

23 Department of Health & Human Services (Vic), 'Overview' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/vad-overview>.

24 *Voluntary Assisted Dying Act 2017* (Vic) s 11(3); *Voluntary Assisted Dying Act 2019* (WA) s 18(3). The person may be assisted by a qualified interpreter or speech pathologist: *Voluntary Assisted Dying Act 2017* (Vic) s 115; *Voluntary Assisted Dying Act 2019* (WA) s 162.

25 *Voluntary Assisted Dying Act 2017* (Vic) s 13; *Voluntary Assisted Dying Act 2019* (WA) s 20. The acceptance or refusal of a first request for access is discussed below.

26 Eg, Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: Making the First Request' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Making-the-First-Request.pdf>.

27 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 14.

28 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'co-ordinating medical practitioner'), 13–16; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'coordinating practitioner'), 20–24.

Eligibility assessments are discussed below. The coordinating practitioner and the consulting practitioner must assess the person as eligible for access to voluntary assisted dying if the person meets all the eligibility criteria and understands the information that is required to be provided. In Victoria, each practitioner must also be satisfied that the person is acting voluntarily and without coercion and that their request for access is enduring: *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1), 29(1); *Voluntary Assisted Dying Act 2019* (WA) ss 28(1), 39(1).

29 *Voluntary Assisted Dying Act 2017* (Vic) s 20(2); *Voluntary Assisted Dying Act 2019* (WA) s 28(2).

30 *Voluntary Assisted Dying Act 2017* (Vic) ss 19–22; *Voluntary Assisted Dying Act 2019* (WA) ss 27–30. The coordinating practitioner must notify the person of the outcome of the first assessment and give a copy of the first assessment report form to the Board within seven days (in Victoria) or within two business days (in Western Australia) of completing the first assessment. In Western Australia, the coordinating practitioner must also give a copy of the first assessment report form to the person.

31 *Voluntary Assisted Dying Act 2017* (Vic) s 23; *Voluntary Assisted Dying Act 2019* (WA) s 31. The acceptance or refusal of a referral for a consulting assessment is discussed below.

32 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'consulting medical practitioner'), 24–25; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'consulting practitioner'), 32–35.

8.41 If the consulting practitioner determines that the person is eligible for access, the person may move on to the next stage of the process. If the consulting practitioner determines that the person is ineligible, the coordinating practitioner may refer the person to another medical practitioner for another consulting assessment.[33]

White and Willmott Model

8.42 Similar to Victoria and Western Australia, a person's first request must be clear and unambiguous, and made by the person personally to a registered medical practitioner. It may be made verbally or by gestures or other means of communication available to the person.[34]

8.43 Two medical practitioners—the 'first medical practitioner' and 'second medical practitioner'—must each independently assess whether the person is eligible for access.[35] Each practitioner must also give the person particular information.[36]

8.44 The first and second medical practitioner must undertake, respectively, a 'first assessment' and a 'second assessment', each of which requires an examination of the person and a review of their relevant medical records. If both practitioners are satisfied that the person is eligible, then the person may move on to the next stage of the process. If the second medical practitioner assesses the person as ineligible, the first practitioner can refer the person to another practitioner for another second assessment.[37]

Tasmania

8.45 Unlike Victoria and Western Australia, the Tasmanian Act provides that a person may make a first request only after receiving the 'relevant facts in relation to accessing voluntary assisted dying' in person from a medical practitioner.[38] These facts include information about the operation of the Act, how the person's eligibility will be determined, the functions and contact details of the Voluntary Assisted Dying Commission, what assistance to die the person may receive from a primary medical practitioner or administering health practitioner, and where advice about palliative care, other treatment or pain relief may be obtained.[39] This requirement encourages the person to consider all available options before making a request.[40]

8.46 A first request may be made orally (in person and 'not by way of audio-visual link') or in writing (signed by the person or, if the person is unable to sign, by another person designated to sign on their behalf).[41]

8.47 A medical practitioner who accepts a first request,[42] becomes the person's 'primary medical practitioner' and must give the person 'relevant information in relation to the person's first request'.[43] The practitioner must then determine whether the person is eligible.[44]

33 *Voluntary Assisted Dying Act 2017* (Vic) ss 29–31; *Voluntary Assisted Dying Act 2019* (WA) ss 39–41. The consulting practitioner must notify the person and the coordinating practitioner of the outcome of the consulting assessment (in Western Australia this must be done 'as soon as practicable' after the completion of the assessment). The consulting practitioner must also complete the consulting assessment report form and give a copy of it to the Board within seven days (in Victoria) or two business days (in Western Australia). In Western Australia, a copy of the report must also be provided to the person.

34 White and Willmott Model cl 11.

35 White and Willmott Model cll 12(1), 16, 21.

36 White and Willmott Model cll 18, 23.

37 White and Willmott Model cll 15–24.

38 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 18(2)–(3), (6). If a person attempts to make a first request without first having received the relevant facts, the practitioner must give them to the person: s 18(6).

39 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 8.

40 See Tasmania, *Parliamentary Debates*, Legislative Council, 15 September 2020, 63 (M Gaffney).

41 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 18(2), (3)(b), (4).

42 The medical practitioner must accept or refuse the person's first request. As to acceptance or refusal, see *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 19–23.

43 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 22, 24.

44 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 26, 27(3).

8.48 Unlike in Victoria and Western Australia, it is not until after the person is determined as eligible on a second request that they will be referred for another assessment by a consulting medical practitioner.[45]

New Zealand

8.49 In New Zealand, a person who wishes to exercise the option of receiving assisted dying must inform their medical practitioner (the 'attending medical practitioner') of their wish. The attending medical practitioner must give the person particular information, and ensure that the person knows or understands other matters.[46]

8.50 There are no specific requirements for the person to make further requests, but the attending medical practitioner is required to 'personally communicate by any means … with the person about the person's wish at intervals determined by the progress of the person's terminal illness'.[47]

8.51 If the person wishes to proceed with their request, the attending medical practitioner must give the person the approved form to sign and date, confirming their request.[48] The attending medical practitioner must then reach an opinion about the person's eligibility to access assisted dying.[49]

8.52 If an attending medical practitioner either assesses a person as eligible, or as someone who would be eligible if they were assessed as competent to make a decision about voluntary assisted dying, the medical practitioner must request that an 'independent medical practitioner' provide a second opinion about the person's eligibility.[50] The attending medical practitioner must request the details of the independent medical practitioner from a statutory body, the 'Support and Consultation for End of Life in New Zealand Group' ('SCENZ').[51]

8.53 If the person is assessed as eligible for access by both the attending medical practitioner and the independent medical practitioner, the attending medical practitioner must inform the person of this fact and arrangements must be made for the administration of the medication.[52] There is no requirement for the person to make a second or third request.

The Commission's view

8.54 In accordance with the adoption of a staged request and assessment process that is similar to the approach taken in Victoria and Western Australia, the request and assessment process should commence with a first request.

8.55 As in those jurisdictions, it is important that the first request is clear and unambiguous so that it can be distinguished from any more general request for information about voluntary assisted dying or about a person's end of life options.

8.56 The request must also be made by the person personally, and not by any other person on their behalf. This will assist in demonstrating, among other things, that it is the person's own decision to make the request and that the request is made voluntarily and without coercion. It also reflects the position that no one except for the person themselves can make a decision about whether they access voluntary assisted dying.

45 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 37(1).
46 *End of Life Choice Act 2019* (NZ) s 11.
47 *End of Life Choice Act 2019* (NZ) s 11(2)(b). Examples of 'means of communication' include communication by telephone or electronic communication.
48 *End of Life Choice Act 2019* (NZ) ss 11–12. The attending medical practitioner must send the completed form to the Registrar (assisted dying), established under the Act. The Registrar (assisted dying) is a nominated employee of the Ministry of Health: s 27(1).
49 *End of Life Choice Act 2019* (NZ) ss 12-13. The attending medical practitioner must complete an approved form recording their opinion and send the completed form to the Registrar (assisted dying): s 13(3).
50 *End of Life Choice Act 2019* (NZ) s 14. The independent medical practitioner must complete an approved form recording their opinion and send the completed form the Registrar (assisted dying). They must also send the completed form to the attending medical practitioner: s 14(4).
51 *End of Life Choice Act 2019* (NZ) ss 4 (definitions of 'SCENZ' and 'SCENZ Group'), 14(2)(a), 25.
52 *End of Life Choice Act 2019* (NZ) s 17. As to administration, see Chapter 10 below.

8.57 The person is not required to communicate their request in any particular way. They may make the request verbally, using gestures or using another method of communication that is available to them. There are separate provisions in the draft Bill which provide for the use of an interpreter, if required.

8.58 Accordingly, the draft Bill provides that a person may make a request (a 'first request') to a medical practitioner for access to voluntary assisted dying, and that the request must be:

- clear and unambiguous; and
- made by a person personally and not by another person on their behalf.

8.59 The draft Bill also makes it clear that the person can make the request verbally or by gestures or another means of communication available to the person.

The coordinating practitioner

8.60 The draft Bill provides that when a person makes a first request to a medical practitioner, the medical practitioner must decide whether to accept or refuse that request. If the medical practitioner refuses the person's request, then the person may make another first request to a different medical practitioner.

8.61 If the medical practitioner accepts the request, the draft Bill provides that the medical practitioner becomes the person's coordinating practitioner. It is at this point, when the first request is accepted, that the request and assessment process will commence.

8.62 Under the draft Bill, the coordinating practitioner will be required to conduct a 'first assessment', to assess whether the person is eligible for access and give the person particular information. Each of these matters is discussed separately below.

8.63 If the coordinating practitioner decides that the person does not meet the requirements of a first assessment, the request and assessment process will end. However, the person should not be precluded from making a new first request to a different medical practitioner (or to the same medical practitioner at a different time) and commencing a new request and assessment process. This is consistent with the general ability of a person to obtain a second medical opinion about a matter, and with the fact that a person's eligibility may change over time. For example, the person's prognosis may change.

8.64 If the coordinating practitioner assesses the person as having met the requirements of the first assessment, then the draft Bill requires that the practitioner refer the person to another medical practitioner for a second assessment, referred to as the 'consulting assessment'. A requirement to undergo two assessments by two different medical practitioners is an important safeguard. This provides an additional opportunity for a person's eligibility to be assessed and for the person to be given relevant information, and to identify if the person is vulnerable.

8.65 The coordinating practitioner must inform the person of the outcome of the first assessment as soon as practicable after its completion, and must complete the approved form (the 'first assessment record form') and give a copy of it to the Board within two business days after completing the assessment.

The consulting practitioner

8.66 The draft Bill provides, in similar terms to provisions applying to the coordinating practitioner, that when a medical practitioner receives a referral for a consulting assessment, the practitioner must decide whether to accept or refuse the referral. If the practitioner refuses the referral, then the person can be referred to a different medical practitioner.

8.67 If the medical practitioner accepts the referral, the practitioner becomes the person's consulting practitioner and must conduct a 'consulting assessment'. This is similar to the assessment conducted by the coordinating practitioner, and is discussed separately below.

8.68 The draft Bill provides that, if the consulting practitioner assesses the person as not meeting the requirements of a consulting assessment, the coordinating practitioner may refer the person to another medical practitioner for a further consulting assessment. There is no limit on how many times this may occur.[53]

8.69 As explained for a first request, a person is generally entitled to seek multiple medical opinions and there may be circumstances that cause a person's eligibility to change. As such, the number of requests or assessments that may be made is not restricted by the draft Bill.

8.70 The consulting practitioner must inform the person and the coordinating practitioner of the outcome of the consulting assessment as soon as practicable after its completion, and must notify the Board in the approved form (the 'consulting assessment record form') within two business days after completing the consulting assessment.

8.71 If the person is assessed by both practitioners as meeting the requirements for access, the person may move on to the next stage of the process.

ACCEPTANCE OR REFUSAL OF A FIRST REQUEST OR REFERRAL

8.72 In other jurisdictions, legislation provides how and when a registered medical practitioner should accept or refuse a first request or a referral for a consulting assessment.[54]

Victoria

8.73 In Victoria, a registered medical practitioner to whom a first request is made, or to whom the person is referred for a consulting assessment, must inform the person within seven days of their acceptance or refusal of the request or referral.[55]

8.74 A practitioner must refuse a request or referral if they do not meet the minimum qualification and experience requirements in the Act. In addition, a practitioner may refuse a request or referral if they:[56]

- have a conscientious objection to voluntary assisted dying; or
- believe that they will not be able to perform the duties of a coordinating practitioner or consulting practitioner due to unavailability.

8.75 If a practitioner refuses a request or referral, they are required to inform the person (and in the case of a referral, the coordinating practitioner) of their reason for refusing the request or referral.[57]

8.76 If a practitioner accepts a first request, they are required to record the first request and their acceptance of the request in the person's medical record.[58] If a person's first request is refused, the person will need to make another request to a different medical practitioner.

53 The provisions in the draft Bill about referral for a consulting assessment apply equally to a referral for a further consulting assessment.

54 The New Zealand Act provides that a health practitioner is not under any obligation to assist a person wishing to exercise the option of receiving assisted dying if that practitioner has a conscientious objection, and requires that in those circumstances the practitioner must tell the person of their objection and provide them with information. However, the Act does not otherwise address the acceptance or refusal of a request to exercise the option of assisted dying: *End of Life Choice Act 2019* (NZ) ss 8–9. As to conscientious objection, see Chapter 14 below.

55 *Voluntary Assisted Dying Act 2017* (Vic) ss 13, 23.

56 *Voluntary Assisted Dying Act 2017* (Vic) ss 13(1)(b), (2), 23(1)(b), (2)–(6). See further the discussion of minimum qualification and experience requirements of coordinating practitioners and consulting practitioners in Chapter 13 below.

57 *Voluntary Assisted Dying Act 2017* (Vic) ss 13(1)(b), 23(1)(b).

58 *Voluntary Assisted Dying Act 2017* (Vic) s 14.

Western Australia

8.77 In Western Australia, there is a similar requirement for a registered medical practitioner who receives a first request or a referral for a consulting assessment to accept or refuse the request or referral.[59]

8.78 The reasons for which a request or referral can be refused are that the practitioner:[60]

- has a conscientious objection to voluntary assisted dying, or is otherwise unwilling to perform the duties of a coordinating practitioner or consulting practitioner;
- is unable to perform the duties of a coordinating practitioner or consulting practitioner due to unavailability or some other reason; or
- is required to refuse the request or referral because they are not eligible to act as a coordinating practitioner or consulting practitioner.

8.79 A practitioner to whom a request or referral is made must inform the person (and in the case of a referral, the coordinating practitioner) of their acceptance or refusal within two business days. However, if a practitioner's refusal is because they have a conscientious objection, then they must immediately inform the person (and, if applicable, the coordinating practitioner) of their refusal.[61] It was explained that this is consistent with a practitioner's professional obligation not to unduly delay a person's access to voluntary assisted dying. It was also explained that a practitioner who has a conscientious objection will refuse as a matter of course, so does not require a length of time to consider a request. Other medical practitioners may need some time to consider their availability or whether they wish to complete the mandatory training before giving their decision to the person.[62]

8.80 At the time of accepting or refusing a request, the medical practitioner is required to give the person 'the information approved by the CEO'.[63] This will be information about the voluntary assisted dying process and 'will help the person access the relevant resources and supports they need to participate in the process'.[64] It was explained that a practitioner who refuses a request should provide a person with general information about voluntary assisted dying because they are 'a patient to whom a duty is owed' and it is important that people have access to information.[65]

8.81 A medical practitioner who receives a request or a referral must record certain information in the person's medical record, including: the request or referral, the practitioner's decision to accept or refuse it, the reason for any refusal and, in the case of a first request, whether the practitioner has given the patient the required information.[66] A practitioner must also notify the Board about similar information.[67]

59 *Voluntary Assisted Dying Act 2019* (WA) ss 20(1), 31(1).
60 *Voluntary Assisted Dying Act 2019* (WA) ss 20(2)–(3), 31(2)–(3).
61 *Voluntary Assisted Dying Act 2019* (WA) ss 20(4)(a), (5)(a), 31(4)–(5).
62 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 8, 11–12; WA Ministerial Expert Panel Final Report (2019) 54, Rec 14.
63 *Voluntary Assisted Dying Act 2019* (WA) s 20(4)(b), (5)(b).
64 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 8. See also Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health).
65 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health); WA Ministerial Expert Panel Final Report (2019) 52–3, Rec 13. The issue of providing information is discussed in greater detail in the context of conscientious objection, in Chapter 14 below.
66 *Voluntary Assisted Dying Act 2019* (WA) ss 21, 32.
67 *Voluntary Assisted Dying Act 2019* (WA) ss 22, 33.

Tasmania

8.82 The Tasmanian Act provides that a medical practitioner to whom a first request is made, or to whom a person is referred for a second opinion, must accept or refuse the request or referral within 48 hours. A practitioner must refuse if they are not eligible to act as the person's primary medical practitioner or consulting medical practitioner, and may refuse for any reason, including that the practitioner has a conscientious objection to providing assistance to die.[68]

8.83 The medical practitioner is not required to give the person reasons for accepting or refusing the request or referral, although they may do so.[69]

8.84 Where a medical practitioner accepts or refuses a first request, they must notify the person and the Commission 'as soon as reasonably practicable', but in any case within seven days, of initially accepting or refusing the request, and must also note the request and their acceptance or refusal on the person's medical records.[70]

Submissions

8.85 The issue of a medical practitioner's acceptance or refusal of a first request or a referral for a consulting assessment was not specifically raised in the Consultation Paper. Many respondents made submissions about the participation of practitioners in voluntary assisted dying, usually in the context of conscientious objection. The issue of conscientious objection is more fully addressed in Chapter 14.

8.86 The Cancer Council Queensland submitted that legislation should not frame the position of health practitioners who do not want to participate in voluntary assisted dying as a matter of 'conscientious objection':

> While the concept of 'conscientious objection' may cover some health practitioners' wish not to participate in assisted dying—for example, because of religious or other ethical objections—it is unlikely to cover the circumstances of all health practitioners … who wish not to participate in assisted dying. … Some practitioners will not want to participate in assisted dying for reasons that are better understood in terms of the nature of their medical practice than questions of conscience. **Some practitioners will have concerns about the ways in which the availability of assisted dying will impact on their therapeutic relationship with their patients, and will prefer not to have it as part of their practice.** It may not always be clear whether health practitioners wish not to participate as a matter of principle, as compared to feeling that they do not have the knowledge or confidence to provide the information and make the decisions and judgments that the legislation will require.
>
> Attempting to force all of these different circumstances into the concept of 'conscientious objection' is likely to create unnecessary difficulties at a number of levels: for health practitioners making decisions about whether they participate in assisted dying, and working through the reasons for their decision; in communication between health practitioners and patients about whether practitioners offer assisted dying and why or why not; and in assumptions by others about the choices made by individual health practitioners to participate or not to participate. … (emphasis added)

8.87 Cancer Council Queensland went on to submit that all registered health practitioners should provide information about voluntary assisted dying, and that those that choose not to otherwise participate should be required to provide referrals to alternative services.

68 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 19, 20(1)–(2), 39, 40.
69 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 21, 41.
70 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 20(3), 23.

8.88 Go Gentle Australia observed that a practitioner 'has an absolute right not to participate' in voluntary assisted dying and should be able to 'opt out' for any reason; for example, due to religious beliefs, because they do not want to participate in an unfamiliar process or because they view it as against the Hippocratic oath.

8.89 The United Workers Union submitted that a person must be able to refuse to participate for any reason, including conscientious objection or another ground. Other respondents, including the Queensland Nurses and Midwives' Union, Australian Lawyers Alliance and a medical defence insurer and professional indemnity insurer, submitted that a person should be able to exercise a conscientious objection and should not be compelled to participate in voluntary assisted dying. A few other respondents referred to health practitioners or people having a right 'to determine whether to participate' or 'not to be involved at any stage', or to health practitioners not being required to participate in voluntary assisted dying.[71]

8.90 The acceptance or refusal of a request or referral by a medical practitioner overlaps closely with the more specific topic of conscientious objection. Respondents who addressed that topic were generally of the view that a practitioner who has a conscientious objection to voluntary assisted dying should be able to refuse to participate in the process.

8.91 Some respondents submitted that a practitioner should be required to disclose their conscientious objection, including because to do so is consistent with good medical practice, while others submitted that practitioners have a right to privacy or should not be required to provide an explanation.

8.92 Views about the time within which a practitioner should inform the person of their conscientious objection (and, if relevant, refer the person elsewhere or transfer their care) were varied, ranging between 'early in the care relationship' or 'immediately' or soon after a request is made, to avoid any delays adding to a patient's suffering, through to seven days after a request.

8.93 Some respondents supported a requirement that a practitioner who has a conscientious objection should refer a person elsewhere or transfer their care, including because this appropriately balances the rights of practitioners and individuals, assists in ensuring that individuals can access voluntary assisted dying and is consistent with good medical practice. There was support for referral to another practitioner or facility that will give the person information about or assistance to access voluntary assisted dying, referral to an information source such as the care navigator service, or a combination of these options.

8.94 Other respondents opposed any requirement for an objecting practitioner to refer, arguing that referral is a form of participation that affects the right to object or undermines freedom of conscience and belief, and that the matter is adequately addressed by ethical guidelines. Some submissions suggested instead that there should be a central information source to assist patient access.

The Commission's view

8.95 The draft Bill includes provisions about the acceptance or refusal of a first request or a referral for a consulting assessment by a medical practitioner.

8.96 This provision will provide certainty and clarity about the outcome of a first request made in accordance with the Act.

8.97 Including provisions about these matters, particularly as they relate to the acceptance or refusal of a first request, ensures the person is given a clear answer from a medial practitioner about whether they will assist the person. In addition, these provisions

71 More generally, the Lutheran Church of Australia Queensland District submitted that a practitioner should be required to 'opt-in' to a voluntary assisted dying scheme by nominating themselves to participate, rather than being required to 'opt-out' on the grounds of conscientious objection.

ensure that the process of seeking access is not unduly delayed by a medical practitioner's refusal to accept a request or referral.

8.98 Accordingly, the draft Bill provides that if a first request for voluntary assisted dying is made to a medical practitioner, or if a patient is referred to a medical practitioner for a consulting assessment, the medical practitioner must accept or refuse the first request or referral.

8.99 It is useful for the draft Bill to set out, in similar terms to the Western Australian Act, the reasons for which a medical practitioner can refuse a first request or a referral. This makes clear that a practitioner's participation must also be voluntary, and that a practitioner can refuse to participate for multiple reasons. It also offers guidance to medical practitioners, particularly those who are faced with a request in circumstances where they are unfamiliar with the voluntary assisted dying process.

8.100 First, the draft Bill makes it clear that a medical practitioner must refuse a first request or a referral if that practitioner is not eligible to act as a coordinating practitioner or consulting practitioner. This is simply a consequence of the requirement that a coordinating practitioner or consulting practitioner must have particular qualifications.

8.101 Second, the draft Bill states that a practitioner may choose to refuse a first request or a referral if the practitioner has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a coordinating practitioner or consulting practitioner. Including a broader reference to 'unwilling' recognises that some practitioners may not want to participate for personal reasons not necessarily amounting to a conscientious objection; for example, because they consider that participation would disrupt their therapeutic relationship with their patient.

8.102 Finally, the draft Bill states that a practitioner may choose to refuse a first request or a referral if the practitioner is unavailable or otherwise unable to perform the duties of a coordinating practitioner or consulting practitioner. This recognises that a practitioner may sometimes lack the time to act as a coordinating practitioner or consulting practitioner. There may also be other practical or professional reasons for refusing; for example, that the person's location is not easily accessible by the practitioner.

8.103 In summary, the draft Bill provides that a medical practitioner:

- must accept or refuse a first request for access to voluntary assisted dying, or a referral for a consulting assessment;
- is required to refuse a first request or referral if they are not eligible to act as a coordinating practitioner or consulting practitioner; and
- may refuse a first request or referral if the practitioner:
  - has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a coordinating practitioner or consulting practitioner; or
  - is unavailable or otherwise unable to perform the duties of a coordinating practitioner or consulting practitioner.

Informing the person of the acceptance or refusal

8.104 Where a first request is made to a medical practitioner, that practitioner must inform the person whether they accept or refuse the request. In the case of a referral for a consulting assessment, the practitioner must inform both the person and the coordinating practitioner of their acceptance or refusal.

8.105 We have considered whether a practitioner who refuses should be required to give a reason for their refusal. It is arguable that it may be enough for a practitioner to make clear that the request is refused, particularly if, in the case of a first request, a refusal is combined with the provision of information (as discussed below). That may be sufficient to make a person aware that they might be able to access voluntary assisted dying elsewhere.

8.106 On the other hand, there is value in a practitioner providing a reason for their refusal. Where a practitioner is responding to a first request, a requirement to explain to the person that they are refusing the request for a particular reason, such as a conscientious objection or their unavailability, makes clear to the person that the refusal is not because voluntary assisted dying is unlawful or because they are ineligible for access. It is for a reason particular to that medical practitioner. Without an explanation, there is a risk that a person will incorrectly assume voluntary assisted dying is not accessible to them.[72]

8.107 More generally, codes of conduct and ethics for medical practitioners require that a practitioner who has a conscientious objection to a treatment of procedure inform their employer, colleagues and patients of their objection. Similarly, the *Termination of Pregnancy Act 2018* requires a practitioner who has a conscientious objection to termination of pregnancy to disclose their conscientious objection.[73] These codes and provisions are discussed in Chapter 14.

8.108 On balance, it is reasonable to require a practitioner who refuses a first request or a referral for a consulting assessment to give a reason for their refusal. This should not require any detailed explanation; for example, a practitioner could simply state that they are refusing the request because they are presently unavailable.

8.109 It is also necessary for provisions about the acceptance or refusal of a first request or referral to include specific timeframes. As explained previously, one function of these provisions will be to ensure that a person's access to voluntary assisted dying is not unduly delayed.

8.110 Providing a practitioner with a period of seven days to accept or refuse a request or referral is unnecessarily lengthy. In some circumstances, it is likely that a practitioner will know immediately whether they will accept a request or referral. Accordingly, the draft Bill adopts the same timeframes as Western Australia.

8.111 As observed in Western Australia, a practitioner who has a conscientious objection to voluntary assisted dying will not usually require a period of time to consider their response to a request or referral, because they will refuse it as a matter of course. As such, where a practitioner refuses a request or referral because they have a conscientious objection, they should be required to immediately inform the person (and, if required, the coordinating practitioner) of their refusal.

8.112 There may be some circumstances where a practitioner requires time to consider whether they are willing to participate in all or part of the process. For example, some practitioners may wish to consider their willingness to be involved in a case that might require practitioner administration of the substance. In those circumstances, a practitioner may not be able to immediately respond because they would need to consider whether they were, in that particular case, 'otherwise unwilling' to perform the duties of a coordinating practitioner or consulting practitioner.

8.113 In other circumstances, it is reasonable that a practitioner has a period of two business days within which to consider and respond to a request. A practitioner may, for example, need to familiarise themselves with the qualifications required to be a coordinating or consulting practitioner, consider if they wish to undergo the mandatory training or review their availability.

8.114 Accordingly, the draft Bill provides that a medical practitioner to whom a first request is made, or to whom a person is referred for a consulting assessment, must inform the person (and, in the case of a referral, the coordinating practitioner) of their acceptance or refusal within two business days. However, if a practitioner refuses a request or referral because the practitioner has a conscientious objection, then they should

72 See also Vic Ministerial Advisory Panel Final Report (2017) 111.
73 *Termination of Pregnancy Act 2018* (Qld) s 8(2).

immediately inform the person (and practitioner) of their refusal. The practitioner should give a reason for any refusal at the same time.

8.115 It would be good medical practice for a practitioner to inform the person (and the coordinating practitioner, as relevant) of their acceptance or refusal and any reason at the earliest possible opportunity. For example, if a practitioner is aware at the time of a request that they do not hold the required qualifications to be a coordinating practitioner or consulting practitioner (and does not intended to obtain them), it would be appropriate that they immediately refuse the request.

Providing a person with relevant information

8.116 It is appropriate to require a practitioner who accepts or refuses a first request to give the person relevant information and resources.

8.117 When the first request is accepted, giving the person further information and access to resources may assist or support the person to navigate the process.

8.118 The draft Bill follows the Western Australian Act and requires that the practitioner give the person the information approved by the chief executive of the Department (the 'approved information'). The approved information must be published on the Department's website.

8.119 This approach enables the information to be settled during the implementation period, and to be changed over time if required. Publication on the relevant website ensures that the information can be easily located by practitioners and others who might want to obtain it.

8.120 The approved information might include:

- details of an official voluntary assisted dying care navigator service that can give the person information, including the name and contact details of medical practitioners or health service providers who may be able to assist;
- details of a Government website giving information about voluntary assisted dying in Queensland; and
- fact sheets or other information about voluntary assisted dying in Queensland.

8.121 Giving information may be more complex if the practitioner refuses the request. The rights and interests of different participants must be balanced. Participation must be entirely voluntary, including for medical practitioners. The right of a practitioner not to participate must be recognised, including because of a conscientious objection. A person must also be able to access information about their end of life choices and take steps to access lawful options, including voluntary assisted dying.

8.122 Requiring a medical practitioner who refuses a first request to give the person certain information appropriately balances these different rights and interests.

8.123 This requirement is consistent with the Western Australian Act. It is also consistent with the MBA Code of Conduct and the AMA Position Statement on conscientious objection. Those standards provide that a medical practitioner who has a conscientious objection must not impede a patient's access to a lawful treatment and should ensure the patient has sufficient information to exercise their right to see a different medical practitioner.[74]

8.124 The requirement is less onerous than the conscientious objection provision in the *Termination of Pregnancy Act 2018*, which requires an objecting practitioner to refer a woman to another practitioner or health service provider.[75]

8.125 In the early stages of the Act's operation, there may be only a small number of practitioners who are willing and able to provide voluntary assisted dying services This

74 See Chapter 14 below.
75 *Termination of Pregnancy Act 2018* (Qld) s 8(3), discussed in Chapter 14 below.

may make referral to another practitioner or health service difficult. However, it is useful for the person to be given information and resources to help commence and navigate the process. It will help the person seek access elsewhere if they wish.

8.126 The information to be given when a first request is refused should be stated in the legislation.

8.127 Where a medical practitioner refuses a first request, it is important that the person understands that a different medical practitioner may be able to help them with their request. The person should also be given information about another person or service that may be able to help them.

8.128 Accordingly, the draft Bill provides that a medical practitioner who refuses a first request must, when informing the person of their refusal:

- inform the person that other registered health practitioners, health service providers or services may be able to assist with their request; and
- give the person:
  - information about a registered health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person; or
  - details of an official voluntary assisted dying care navigator service that can give the person information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist.

8.129 This requirement does not necessarily require a refusing practitioner to give the person information about another health practitioner or health provider. The second part of the requirement is presented in the alternative, and therefore offers flexibility. In some circumstances, the practitioner may give the person information about another practitioner or service; for example, where they are aware of another practitioner who is qualified to be a coordinating practitioner. In other circumstances, the requirement will be satisfied by giving the person details of an official voluntary assisted dying navigator service.

8.130 It is not necessary for a practitioner who accepts or refuses a referral for a consulting assessment to give the person similar information. In those circumstances, the person is already in contact with their coordinating practitioner, who can provide relevant information and, if necessary, help find an alternative practitioner for the consulting assessment.

Medical records and advice to the Board

8.131 The draft Bill also includes requirements for the recording of this information, to ensure accurate record-keeping. Accordingly, a medical practitioner must record in the person's medical record the first request or referral for a consulting assessment, their decision to accept or refuse it, the reason for any refusal and, for a first request, the giving of information to the person.

8.132 In addition, within two business days after deciding to accept or refuse a referral for a consulting assessment, the medical practitioner must complete a record of the acceptance or refusal of the referral in the approved form and give a copy of the form to the Board.[76]

76 See further [8.528], [8.533] below.

ELIGIBILITY ASSESSMENTS

8.133 In Victoria, Western Australia and Tasmania, two medical practitioners must each independently assess whether the person is eligible for access to voluntary assisted dying. The White and Willmott Model makes similar provision.

8.134 The legislation in overseas jurisdictions also requires two independent assessments of the person's eligibility.[77]

Requirement for two independent eligibility assessments

8.135 In Victoria, Western Australia and Tasmania, the coordinating practitioner and the consulting practitioner must each independently assess whether the person is eligible.[78]

8.136 The requirement for two medical practitioners to independently assess the person's eligibility was recommended by the Victorian Panel and the Western Australian Panel, and is considered to be a 'fundamental safeguard'.[79]

8.137 The consulting assessment must be done, independently of the coordinating assessment, against the eligibility criteria.[80] The coordinating practitioner and the consulting practitioner are expected to assess each of the eligibility criteria and satisfy themselves that the person has fulfilled all the requirements.[81]

8.138 The Victorian Act provides that the coordinating practitioner and the consulting practitioner must each 'assess whether the person requesting access to voluntary assisted dying meets the eligibility criteria'.[82] The guidance for health practitioners explains that:[83]

> The consulting medical practitioner must undertake an independent consulting assessment of the patient's eligibility for voluntary assisted dying using the same criteria as the coordinating practitioner.
>
> The consulting medical practitioner may have access to clinical and other records connected with the first assessment but must undertake their own assessment of the patient's eligibility for access to voluntary assisted dying.

8.139 The Western Australian Act provides that the coordinating practitioner and the consulting practitioner must each 'assess whether the patient is eligible for access to voluntary assisted dying' and that, for the purposes of those provisions, they must each 'make a decision in respect of each of the eligibility criteria'.[84] It further provides that, for the purposes of the consulting assessment 'the consulting practitioner must independently from the coordinating practitioner form their own opinions on the matters to be decided'.[85]

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77 See, eg, *Belgian Euthanasia Act 2002* art 3(1), (2)(3); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(3); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(e); *End of Life Choice Act 2019* (NZ) ss 13–14; *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3)(e). State legislation in the United States requires the person's diagnosis and prognosis to be 'medically confirmed' by a second physician: See, eg, the definitions of 'consulting physician' and 'medically confirmed' in *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.800.1.01(4), (8). The person's eligibility must be assessed by two medical practitioners, except for the federal legislation in Canada, which provides that a medical practitioner or nurse practitioner may assess the person's eligibility.

78 *Voluntary Assisted Dying Act 2017* (Vic) ss 16, 20(1), 25, 29(1); *Voluntary Assisted Dying Act 2019* (WA) ss 16, 24, 28, 35, 39; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 10, 26, 33, 47, 55.

79 See, eg, Vic Ministerial Advisory Panel Final Report (2017) 100, 119, Recs 12, 22; WA Ministerial Expert Panel Final Report (2019) 56, 65 (agreeing with the recommendation in the WA Joint Select Committee on End of Life Choices Report (2018)). See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 8.

80 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 8; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 11.

81 *Voluntary Assisted Dying Act 2017* (Vic) ss 6(b), 9, 16, 20(1), 25, 29(1); *Voluntary Assisted Dying Act 2019* (WA) ss 15(b), 16, 24, 28, 35, 39(1).

82 *Voluntary Assisted Dying Act 2017* (Vic) ss 16, 25, with a legislative note referring to ss 20(1)(a), 29(1)(a). A legislative note is included to make it clear that, in order to assess the person as eligible, the coordinating practitioner and the consulting practitioner must each be satisfied that 'the person meets all the eligibility criteria to be assessed as eligible for access to voluntary assisted dying'.

83 Vic Guidance for Health Practitioners (2019) [2.8].

84 *Voluntary Assisted Dying Act 2019* (WA) ss 24(1)–(2), 35(1)–(2).

85 *Voluntary Assisted Dying Act 2019* (WA) s 35(3).

8.140 The Western Australian Act also states that nothing in these provisions prevents the coordinating practitioner or the consulting practitioner 'from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner'.[86]

8.141 The Tasmanian Act similarly requires two medical practitioners (the 'primary medical practitioner' and the 'consulting medical practitioner') to each determine whether the person is eligible.[87] The consulting medical practitioner must not determine the person's eligibility unless they have met the person (in person or 'by way of audio-visual link').[88] To make a determination, the consulting medical practitioner may examine the person and access 'medical reports' and 'other information in relation to the person' from the primary medical practitioner.[89]

8.142 The White and Willmott Model requires two medical practitioners to each independently assess the person's eligibility.[90] It states that, in undertaking those assessments, the first medical practitioner and the second medical practitioner must each 'assess whether the person requesting access to voluntary assisted dying meets the eligibility criteria'. It further states that each assessment 'requires an examination of the person and a review of their relevant medical records'.[91]

Independence of the coordinating practitioner and the consulting practitioner from each other

8.143 Unlike Victoria and Western Australia, the White and Willmott Model also provides that the two medical practitioners who undertake the assessments 'must be independent of each other', and that they will not be independent of each other if:[92]

(a) they are family members; or

(b) one medical practitioner is employed by or working under the supervision of the other medical practitioner.

8.144 The Tasmanian Act provides that the primary medical practitioner must not refer the person to a consulting medical practitioner who is:[93]

(a) a member of the family of the [primary medical practitioner]; or

(b) employed by, contracted directly or indirectly by, or working under the supervision of, the [primary medical practitioner]; or

(c) a person who is the employer of, has a direct or indirect contract with, or is a supervisor of, the [primary medical practitioner].

8.145 Those provisions were not included in the Bill as first introduced, but were the subject of amendments in Parliament 'to ensure greater safeguards against potential abuse of the legislation'.[94]

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86 *Voluntary Assisted Dying Act 2019* (WA) ss 24(3), 35(4).

87 The primary medical practitioner must determine each request by determining whether the person is eligible for access to voluntary assisted dying, and the consulting medical practitioner must also determine whether the person is eligible for access to voluntary assisted dying. A person is eligible for access to voluntary assisted dying if they meet the eligibility criteria: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 5 (definition of 'eligible to access voluntary assisted dying'), 10, 26, 33, 47, 55.

88 *End-of-Life-Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 48(1)(a).

89 *End-of-Life-Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 43–44.

90 White and Willmott Model cll 12(1), 15(1), 20(1).

91 White and Willmott Model cll 15, 20.

92 White and Willmott Model cl 12(2).

A similar provision is included in the *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(6).

In some other jurisdictions, the legislation provides that the consulting practitioner must be independent of the coordinating practitioner: *End of Life Choice Act 2019* (NZ) s 4; *Belgian Euthanasia Act 2002* art 3(2); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(2)(3).

The New Zealand Act specifically requires the attending medical practitioner to request the details of the independent medical practitioner from a legislative body, the 'Support and Consultation for End of Life in New Zealand Group' ('SCENZ'): *End of Life Choice Act 2019* (NZ) s 14(2).

93 *End-of-Life-Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 37(2).

94 Tas Review Panel Report (2021) 43, referring to Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 431. See also End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) cl 35 (as introduced).

8.146 The Western Australian Panel observed that, during its consultation, 'points were raised in relation to the independence of the assessing practitioners' from each other. It observed that:[95]

> Whilst not explicitly precluded, if the assessing practitioners are from the same practice (for example) it may be difficult to determine that each practitioner is truly independent of the other. There is a risk that a consulting practitioner may feel implicit pressure to concur with the first assessment findings. The Panel particularly notes that in assuring independence it is important that neither practitioner is in a supervisory or employing role in relation to the other. Each practitioner is responsible for arriving at their own conclusion and must provide an independent assessment.
>
> …
>
> The Panel agrees with the Joint Select Committee that at least two independent practitioners must assess the person and be satisfied that the person meets the eligibility criteria.

8.147 During the parliamentary debate, these concerns were discussed. The government explained that the approach in the legislation requires that the assessments must be independent from each other, and that each assessing practitioner must form their own opinions about each of the eligibility criteria (rather than requiring that the assessing practitioners be independent from each other). It was noted that additional requirements for the assessing medical practitioners to be independent from each other 'may cause accessibility issues in rural, regional and remote areas'.[96]

8.148 Medical practitioners are subject to professional obligations and must comply with professional standards, including codes of ethics, codes of conduct, policies and guidelines.[97] Good medical practice involves recognising and resolving conflicts of interest in the best interests of the patient:[98]

> Patients rely on the independence and trustworthiness of doctors for any advice or treatment. A conflict of interest in medical practice arises when a doctor, entrusted with acting in the interests of a patient, also has financial, professional or personal interests, or relationships with third parties, which may affect their care of the patient. Multiple interests are common. They require identification, careful consideration, appropriate disclosure and accountability. When these interests compromise, or might reasonably be perceived by an independent observer to compromise, the doctor's primary duty to the patient, doctors must recognise and resolve this conflict in the best interests of the patient.

Outcome of assessments

8.149 The legislation in Victoria, Western Australia and Tasmania clearly sets out the roles and responsibilities of assessing medical practitioners to remove any doubt about their respective responsibilities under the legislation.[99]

8.150 The legislation provides that the coordinating practitioner and the consulting practitioner must each assess the person as eligible if they are satisfied that:[100]

95 WA Ministerial Expert Panel Final Report (2019) 65.

96 Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6613–14 (RH Cook, Minister for Health) observing, for example, that a requirement that the two assessing practitioners must not work in the same practice could cause issues in rural, regional and remote places where there may be only one practice.

97 Health Practitioner Regulation National Law (Queensland) pt 5 div 3. Non-compliance may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional, and may result in disciplinary action: Health Practitioner Regulation National Law (Queensland) s 5 (definitions of 'unsatisfactory professional performance', 'unprofessional conduct' and 'professional misconduct') pt 8 divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107.

98 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [10.12].

99 Vic Ministerial Advisory Panel Final Report (2017) 100.

100 *Voluntary Assisted Dying Act 2017* (Vic) ss 9, 20, 29; *Voluntary Assisted Dying Act 2019* (WA) ss 16, 28, 39.

- the person meets all the eligibility criteria for access to voluntary assisted dying (and, in Victoria, the person is acting voluntarily and without coercion, and the person's request is enduring);[101] and
- the person understands the information that the practitioner is required to give to the person if they are assessed as eligible.

8.151 The Victorian Panel explained that:[102]

> [t]he two assessments are important in ensuring that only those who are eligible gain access to voluntary assisted dying, but it ensures also that a person is given accurate information to make their decision about voluntary assisted dying. The two assessments also provide an important opportunity to assess voluntariness.
>
> …
>
> The two eligibility assessments should be regarded as important therapeutic encounters, not only as a matter of ensuring compliance with legislation. In this respect, it will be expected that these assessments take the form of interactive communication. The assessing medical practitioners must be satisfied of all of these elements before the person is eligible to access voluntary assisted dying.

8.152 If the coordinating practitioner determines that the person is ineligible for access, the request and assessment process ends.[103]

8.153 If the consulting practitioner assesses the person as ineligible, the coordinating practitioner may refer the person to another medical practitioner for a further consulting assessment.[104]

8.154 The Victorian Panel explained that:[105]

> If either the coordinating or consulting medical practitioner assesses the person as ineligible, they will not be able to access voluntary assisted dying. The Panel notes, however, that obtaining second opinions is a standard part of medical practice and if a person disagrees with either medical practitioner's assessment, they may seek a second assessment. If a coordinating medical practitioner finds a person ineligible, they would need to recommence the process with a different medical practitioner. If the consulting medical practitioner finds the person ineligible, the coordinating medical practitioner may refer the person to another practitioner if they still believe the person is eligible. Some people may attempt to visit multiple medical practitioners to obtain a favourable assessment, but the Panel does not consider this creates a danger of misuse. The eligibility criteria are clear and the Voluntary Assisted Dying Review Board will review each assessment, regardless of the outcome. This means if a person is deemed ineligible by multiple medical practitioners, but one medical practitioner assesses the person as eligible, it will be clear to the Board that further investigation is required.

8.155 The White and Willmott Model similarly provides that the person is eligible if the first medical practitioner and the second medical practitioner are satisfied that the person meets the eligibility criteria, and understands the information required to be provided to the person. It also provides that, if the first medical practitioner assesses a person as eligible for access but a second medical practitioner assess that person as not

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101 In Western Australia, the requirements that the person is acting voluntarily and without coercion, and that the person's request for access is enduring, are included in the eligibility criteria. In contrast, in Victoria, these are not included in the eligibility criteria. However, the coordinating practitioner and the consulting practitioner must each be satisfied that the person is acting voluntarily and without coercion and that their request is enduring, in order to assess the person as eligible for access. See the discussion of eligibility criteria in Chapter 7 above.

102 Vic Ministerial Advisory Panel Final Report (2017) 121-22.

103 *Voluntary Assisted Dying Act 2017* (Vic) s 20(2); *Voluntary Assisted Dying Act 2019* (WA) s 28(2).

104 *Voluntary Assisted Dying Act 2017* (Vic) s 31; *Voluntary Assisted Dying Act 2019* (WA) s 41.

105 Vic Ministerial Advisory Panel Final Report (2017) 121. See further at 122, stating that:

> [a]s the Voluntary Assisted Dying Review Board will be required to review each assessment for voluntary assisted dying, the Board will be able to identify unexplained patterns of 'doctor shopping' and refer medical practitioners who do not act in accordance with the law to the Australian Health Practitioner Regulation Agency or Victorian Police.

eligible, the first medical practitioner may refer the person to another registered medical practitioner for a further second assessment.[106]

8.156 In contrast, the Tasmanian Act prohibits the primary medical practitioner from referring a person to another consulting practitioner if two consulting medical practitioners have already determined that the person is ineligible.[107] In such an event the voluntary assisted dying process ends,[108] and the primary medical practitioner is prohibited from accepting another first request from the person for 12 months.[109] It was explained that:[110]

> In order to prevent undue pressure on doctors and misplaced optimism on the part of the person, if two [consulting medical practitioners] determine the person is not eligible, the process ends…Although this does not preclude the person from commencing the [voluntary assisted dying] process again and making a new request, the former [primary medical practitioner] may not accept a first request for 12 months so you cannot go back to the same doctor and say – 'I want to go again' because you were found ineligible in the first place.

Submissions

8.157 The Consultation Paper asked whether the draft legislation should provide that the coordinating practitioner and the consulting practitioner must each assess whether the person is eligible for access to voluntary assisted dying and that:[111]

(a) the consulting assessment must be independent from the coordinating assessment (as in Victoria and Western Australia); and

(b) the coordinating practitioner and the consulting practitioner who conduct the assessment must be independent of each other.

8.158 Most respondents submitted that there should be a requirement for two independent eligibility assessments.

8.159 Dying with Dignity Victoria submitted that '[i]ndependence is addressed if the two people who assess [the person's eligibility] make their assessments independently'.

8.160 The Clem Jones Group similarly submitted that the coordinating practitioner and the consulting practitioner should each be required to '[i]ndependently form their own opinions on matters to be decided in relation to a patient's application for and access to voluntary assisted dying'.

8.161 Many respondents submitted that the draft legislation should provide both that the consulting assessment must be independent from the coordinating assessment and that the coordinating practitioner and the consulting practitioner who conduct the assessments must be independent of each other.

8.162 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld submitted that:[112]

> [t]hese are fundamental safeguards for ensuring the independence of the assessment process and the protection of vulnerable people from any form of coercion.

8.163 Professors White and Willmott continued to support the approach in the White and Willmott Model, which provides that two medical practitioners must each independently assess the person's eligibility, and that those medical practitioners must be independent from each other, meaning that they must not be family members, and one medical practitioner must not be employed by, or working under the supervision of, the other.

106 White and Willmott Model cl 24.
107 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 38.
108 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 51.
109 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 52.
110 Tasmania, *Parliamentary Debates*, Legislative Council, 15 September 2020, 65 (M Gaffney).
111 QLRC Consultation Paper No 79 (2020) Q-22.
112 Palliative Care Nurses Australia submitted that this 'supports transparency of the process' and is an important safeguard.

8.164 Go Gentle Australia, Dying with Dignity Queensland, and a medical defence organisation and professional indemnity insurer submitted that the draft legislation should include a requirement for two independent eligibility assessments, and provide that the two medical practitioners must not be family members, and one must not be employed by, or under the supervision of, the other.

8.165 A registered nurse submitted that:

> The person requesting [voluntary assisted dying] should have two separate and completely independent assessments conducted by the coordinating practitioner and the consulting practitioner. One of these practitioners should not be employed by the other, or be a relative of the other.

8.166 Palliative Care Social Work Australia submitted that eligibility assessments 'should be undertaken independently' and that '[n]one of the involved practitioners should be junior to the other (eg, registrar and consultant) as this creates a power dynamic that will reduce the independence requirement'.

8.167 However, some respondents who supported a requirement that the assessing practitioners must be independent of each other also submitted that there may be some practical difficulties with such a requirement, depending on what 'independent' is understood to mean, or how it is defined.

8.168 AMA Queensland submitted that the draft legislation should ensure that 'both doctors come to their own conclusion and make independent decisions', and that the meaning of 'independent' should 'be made clear to avoid ambiguity'.

8.169 Cancer Council Queensland noted that, while they supported a requirement that the practitioners should be independent of each other in principle, there may be 'some practical challenges'. This respondent observed that 'Queensland's specialist health professionals are generally collegiate and known to each other, so their capacity to act truly independently may be queried'.

8.170 Several respondents had concerns about how a requirement for the assessing practitioners to be independent of each other may impact accessibility, particularly in rural, regional and remote areas.

8.171 Some of those respondents submitted that telehealth could be a way to address those concerns and maintain the independence of practitioners. Two academics jointly submitted that:

> in remote and regional areas, it may be appropriate for some of this work to be undertaken via telehealth, as it may not be possible to physically access multiple trained and eligible practitioners who are independent of one another to a sufficient degree to satisfy the legislation …

8.172 A member of the public submitted that, while it is desirable for the assessing practitioners to be independent of each other 'this requirement may be difficult to meet in a timely manner in small or rural towns', and that perhaps an exception could be provided in those circumstances.

8.173 A few respondents submitted that, while the coordinating practitioner and the consulting practitioner should be independent of each other, they should not have to be from different medical practices, as this may 'place unacceptable hardship and suffering on people living in remote communities where there may not be another medical practice for hundreds of kilometres'.

8.174 A member of the public submitted that a requirement for the assessments to be independent from each other (rather than requiring the practitioners to be independent from each other) 'is a reasonable compromise', given that requiring the assessing practitioners to be independent from each other could cause accessibility issues, particularly in rural, regional and remote areas.

8.175 Some respondents proposed institutional safeguards to ensure the independence of medical practitioners and address concerns about accessibility.

8.176 Christians Supporting Choice for Voluntary Assisted Dying suggested that the body overseeing the voluntary assisted dying scheme could allocate a consulting practitioner from a register upon receipt of a first request to ensure independence.

8.177 Go Gentle Australia similarly submitted that:

> the establishment of an independent referral service for practitioners would provide an additional safeguard to ensure practitioners are independent of each other. It would also greatly assist the process of finding a second practitioner and ensure equitable access.

8.178 A few respondents also submitted that the consulting practitioner should not have access to the first assessment report. A medical practitioner submitted that 'it is essential that all assessments are made "blind" to other assessments'.

8.179 Other respondents submitted that the assessing practitioners should be able to refer to relevant documentation or medical records. Go Gentle Australia submitted that:

> While the assessment must be made independently, both practitioners will still be able to rely on existing medical records, which should be made available on request.

8.180 A member of the public submitted that there should not be a requirement for two independent eligibility assessments.

The Commission's view

8.181 The draft Bill requires two suitably qualified and trained medical practitioners to each independently assess the person's eligibility.[113] This requirement is a fundamental safeguard, and is a feature of all voluntary assisted dying schemes in Australia and overseas.

8.182 As explained above, the draft Bill provides that the coordinating practitioner is responsible for conducting a 'first assessment', during which the practitioner must assess whether the person is eligible for access to voluntary assisted dying.

8.183 If the coordinating practitioner is satisfied that the person is eligible and understands the information the coordinating practitioner is required to give to them under the draft Bill (discussed below), then the coordinating practitioner must assess the person as meeting the requirements of the first assessment.

8.184 If the coordinating practitioner assesses the person as meeting the requirements of the first assessment, the practitioner must refer the person to another medical practitioner (the 'consulting practitioner') for a consulting assessment, to also assess the person's eligibility against the eligibility criteria.

8.185 The draft Bill states that the consulting practitioner must independently of the coordinating practitioner form their own opinions on the matters to be decided. If the consulting practitioner is satisfied that the person is eligible and understands the information the coordinating practitioner is required to give to them under the draft Bill (discussed below), then the consulting practitioner must assess the person as meeting the requirements of the consulting assessment.

8.186 In conducting the first assessment or consulting assessment, the coordinating practitioner and the consulting practitioner may have regard to any relevant information about the person that has been prepared by, or at the instigation of, another health practitioner. This is consistent with standard medical practice. The draft Bill makes it clear, however, that the assessments of the coordinating practitioner and the consulting

113 It is a requirement that the coordinating practitioner and the consulting practitioner each complete the approved training before they begin the first assessment or consulting assessment: See also, as to approved training, Chapter 13 below.

practitioner must be independent. In particular, it provides that the consulting practitioner must form their own opinions on each of the matters to be decided, independently of the coordinating practitioner.

8.187 It is not necessary to include an additional requirement that the coordinating practitioner and the consulting practitioner must be independent of each other, in the sense that they must not be family members, or that one must not be employed by, or under the supervision of, the other. The draft Bill makes it clear that the coordinating practitioner and the consulting practitioner must each independently assess whether the person is eligible, and independently form their own opinions. Medical practitioners are subject to professional obligations, including to recognise and resolve conflicts of interest, and breaches of those obligations may result in disciplinary action, including the suspension or cancellation of the practitioner's registration. The coordinating practitioner and the consulting practitioner must each report the outcome of, respectively, the first assessment and the consulting assessment, to the Board. This approach is consistent with the Victorian and Western Australian Acts.

8.188 A requirement for the coordinating practitioner and the consulting practitioner not to be in a supervisory relationship with each other may cause accessibility issues, particularly in rural, regional and remote areas, where access to practitioners may be limited. Such a requirement may also raise some uncertainty about the meaning of 'supervision' in this context, as workplace structures often mean that practitioners are considered to be in supervisory relationships, for example within clinical departments in public hospitals.

8.189 The coordinating practitioner and the consulting practitioner must each meet the eligibility requirements to act in these roles, including the minimum qualification and experience requirements. They must also have completed the approved training.

Requirements for referral of certain matters

Victoria and Western Australia

8.190 The Victorian and Western Australian Acts make it clear that, if either the coordinating practitioner or the consulting practitioner is not able to determine certain eligibility matters, they must refer the person to someone with appropriate skills and training to make that determination.

8.191 The coordinating practitioner or the consulting practitioner may adopt the determination of the other practitioner or person to whom the matter was referred.[114]

8.192 It was explained that:[115]

> This ability to refer is consistent with current Australian medical practice and ensures that the patient has access to the highest standard of assessment in the voluntary assisted dying process. This is yet another safeguard in the process, without placing undue strain on a specialist to undertake the role of a coordinating or consulting practitioner.

Referrals about the person's decision-making capacity

8.193 If the coordinating practitioner or consulting practitioner is not able to determine whether the person has the required decision-making capacity, they must refer the person to a registered health practitioner with appropriate skills and training to determine the matter. For example, if the person has a mental illness, the referral might be to a psychiatrist.[116]

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114 *Voluntary Assisted Dying Act 2017* (Vic) ss 18(3), 27(3); *Voluntary Assisted Dying Act 2019* (WA) ss 26(4), 37(4). See further Vic Guidance for Health Practitioners (2019) [2.3], noting that:

> medical practitioners should be aware that not relying on specialist referral reports may expose them to liability and any deviation from specialist recommendations ought to be clinically justified and documented, on the basis of the medical practitioner's assessment of the patient, acting within their scope of expertise or experience.

115 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 10, 13.

116 *Voluntary Assisted Dying Act 2017* (Vic) ss 18(1), 27(1); *Voluntary Assisted Dying Act 2019* (WA) ss 26(1)(b), (2), 37(1)(b), (2). See Vic Guidance for Health Practitioners (2019) 37, noting that '[d]epending on the patient's medical condition and/or any comorbid mental illness, suitable health practitioners may include a psychologist, neuro-psychologist, geriatrician or psychiatrist'.

8.194 The Victorian Panel explained that this referral provision:[117]

> ensure[s] that when a person's decision-making capacity in relation to voluntary assisted dying is in doubt it is assessed by the most appropriate expert so that assessing medical practitioners can be confident in finding a person has adequate decision-making capacity to access voluntary assisted dying.

8.195 The Panel explained that a psychiatrist would be the most appropriate expert for referral in cases of doubt about a person's decision-making capacity due to the presence, or suspected presence, of a mental illness. However, other experts or specialists may be more appropriate for referral in other cases:[118]

> Geriatricians, psycho-geriatricians, neurologists, neuropsychologists, psychooncologists, psychologists and palliative care specialists were all identified as specialists who could potentially make assessments about a person's decision-making capacity depending on the nature of the concern giving rise to the doubt about a person's capacity. For example, when an assessing medical practitioner suspects an elderly person may have a degree of cognitive impairment that may be impacting on their decision-making capacity in relation to voluntary assisted dying the assessing medical practitioner may refer them to a geriatrician for assessment. Where an assessing medical practitioner suspects a person's brain tumour or previous cerebrovascular accident may be impacting on their decision-making capacity they may refer them to a neuropsychologist for assessment.

Referrals about the person's disease, illness or medical condition

8.196 If the coordinating practitioner or consulting practitioner is unable to determine whether the person has a disease, illness or medical condition that meets the eligibility criteria (for example, if they cannot determine the person's diagnosis or prognosis), they must refer the person to:[119]

- in Victoria—a specialist medical practitioner who has appropriate skills and training in that disease, illness or medical condition; or
- in Western Australia—a registered health practitioner with appropriate skills and training to make a determination in relation to the matter.

8.197 The Victorian Panel noted that medical practitioners already have professional obligations to act within their scope of practice:[120]

> Medical practitioners assess whether they have the necessary skills to assist or treat patients and, if they do not, they refer them to an appropriate specialist. This is part of standard medical practice, and a medical practitioner risks breaching their professional obligations if they act outside the scope of their practice.

8.198 However, it considered that:[121]

> Given that voluntary assisted dying will be a new practice, the Panel recognises the importance of ensuring that only appropriately qualified medical practitioners are involved.

Referrals about whether the person is acting voluntarily

8.199 In Western Australia, if the coordinating practitioner or consulting practitioner is unable to determine if the person is acting voluntarily and without coercion, they must refer the person to 'another person who has appropriate skills and training to make

117 Vic Ministerial Panel Final Report (2017) 65, Rec 4.
118 Ibid 64.
119 *Voluntary Assisted Dying Act 2017* (Vic) ss 18(2), 27(2); *Voluntary Assisted Dying Act 2019* (WA) ss 26(1)(a), (2), 37(1)(b), (2).
120 Vic Ministerial Panel Final Report (2017) 103.
121 Ibid. For this reason, the Panel recommended that both the coordinating medical practitioner and consulting medical practitioner must be qualified as Fellows of a College (or vocationally registered) and at least one of the medical practitioners must have five years post-fellowship experience, and at least one of them must have expertise in the person's disease, illness or medical condition: Rec 14.

a determination in relation to the matter'.[122] This may include experienced registered health practitioners, health care workers, social workers and police officers with the 'skills and training' to determine if a person is acting voluntarily and without coercion.[123]

Other referral requirements

8.200 The Victorian Act requires the coordinating practitioner to make a referral if the person has a neurodegenerative disease, illness or medical condition that is expected to cause death within six to 12 months. The person must be referred to a specialist medical practitioner with appropriate skills and training in the person's particular neurodegenerative disease, illness or medical condition to determine the prognosis. The coordinating practitioner must adopt the specialist's determination.[124] There is no equivalent requirement for consulting practitioners.

8.201 This additional requirement was not recommended by the Victorian Panel or included in the Bill when introduced into Parliament. However, it was added by amendment during the parliamentary debates.[125] Guidelines explain that '[t]he additional assessment is required due to the increased difficulty in determining a patient's prognosis when it may be beyond six months'.[126]

White and Willmott Model

8.202 The White and Willmott Model includes a provision that, if either the coordinating practitioner or the consulting practitioner is unable to determine whether the person meets one or more of the eligibility criteria, they must refer the person 'to a registered health practitioner or health practitioners with appropriate skills and training', and may adopt that other practitioner's determination.[127]

Tasmanian Act

8.203 The Tasmanian Act provides that the primary medical practitioner may, for the purpose of determining each request, do any one or more of the following:[128]

(a) refer the person to another medical practitioner for examination;

(b) request the person to provide to the [primary medical practitioner] all information that the [primary medical practitioner] reasonably requires in order to make the determination;

(c) request a medical practitioner to provide to the [primary medical practitioner] copies of the medical records of the person that are in the possession of the medical practitioner and that the [primary medical practitioner] reasonably requires in order for the [primary medical practitioner] to make the determination;

(d) request a person to provide to the [primary medical practitioner] copies of medical records in relation to the person, that are held or stored by the medical record holder and that the [primary medical practitioner] requires in order to make the determination;

(e) request a psychiatrist, psychologist, registered health practitioner, or any other person whom the [primary medical practitioner] thinks fit, to provide to the [primary medical practitioner] the information that the [primary medical practitioner] reasonably requires in order to make the determination.

122 *Voluntary Assisted Dying Act 2019* (WA) ss 26(3), 37(3).
123 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 10.
124 *Voluntary Assisted Dying Act 2017* (Vic) s 18(4)–(6).
125 Victoria, *Parliamentary Debates*, Legislative Council, 21 November 2017, 6274–75 (G Jennings, Special Minister for State), 6277–78.
126 Vic Guidance for Health Practitioners (2019) 31. See also Chapter 7 above.
127 White and Willmott Model cll 17, 22.
128 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 25, 32, 54. The primary medical practitioner may also do any of these things at the request of the consulting medical practitioner, for the purpose of enabling the consulting medical practitioner to determine the request: s 46.

8.204 The consulting medical practitioner must not refer the person to a medical practitioner, other than the person's primary medical practitioner, for the purpose of obtaining information necessary to make a determination of the person's eligibility.[129] However, the consulting medical practitioner may ask the primary medical practitioner to make a referral or obtain a copy of any medical records or information on their behalf, so that the consulting medical practitioner has the information necessary to make the determination.[130]

Submissions

8.205 The Consultation Paper asked whether the draft legislation should provide that, if the coordinating practitioner or consulting practitioner:[131]

(a) is not able to determine if the person has decision-making capacity in relation to voluntary assisted dying—they must refer the person to a health practitioner with appropriate skills and training to make a determination in relation to the matter (as in Victoria and Western Australia);

(b) is not able to determine if the person has a disease, illness or medical condition that meets the eligibility criteria—they must refer the person to:

(i) a specialist medical practitioner with appropriate skills and training in that disease, illness or medical condition (as in Victoria); or

(ii) a health practitioner with appropriate skills and training (as in Western Australia);

(c) is not able to determine if the person is acting voluntarily and without coercion—they must refer the person to another person who has appropriate skills and training to make a determination in relation to the matter (as in Western Australia)?

8.206 Many respondents submitted that the draft legislation should provide that, if the coordinating practitioner or consulting practitioner is unable to determine if the person has the required decision-making capacity, they must refer the person to a health practitioner with 'appropriate skills and training' to determine the matter.

8.207 Respondents variously submitted that practitioners with 'appropriate skills and training' may include psychiatrists, practitioners with expertise in decision-making capacity assessment, geriatricians, nurse practitioners, or psychologists.

8.208 A few respondents emphasised that a referral to a psychiatrist should not be mandatory, and should be required only if, for example, there is evidence of a psychiatric illness.

8.209 Some respondents supported improved training and resources for practitioners on the basis that capacity assessment is a complex field requiring multifaceted care.

8.210 Several respondents submitted that the draft legislation should provide that, if the coordinating practitioner or consulting practitioner is not able to determine if the person has a disease, illness or medical condition that meets the eligibility criteria, they must refer the person to a 'health practitioner with appropriate skills and training' (as in Western Australia).

8.211 Many of those respondents submitted that a requirement for a referral to a specialist in the person's disease, illness or medical condition could unduly delay or limit patient access, particularly for people in rural, regional and remote areas.[132]

129 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 46(3).

130 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 45, 46(1). The primary medical practitioner is in any case required to provide the consulting medical practitioner with all medical reports and other information they may reasonably require within seven days of a person's referral being accepted: s 43.

131 QLRC Consultation Paper No 79 (2020) Q-23.

132 Some respondents submitted that telehealth should be an option for people in rural, regional and remote communities to access specialists.

8.212 Two respondents submitted that the wording in the Western Australian provision allows for more flexibility, depending on what is appropriate in each case.

8.213 VALE Group and a retired nurse submitted that the requirement for a 'specialist in the person's disease, illness or medical condition', fails to recognise that general practitioners can also be specialists.

8.214 However, some respondents submitted that the approach in Victoria, requiring a referral to 'a specialist medical practitioner with appropriate skills and training in that disease, illness or medical condition', should be adopted.

8.215 A medical defence organisation and professional indemnity insurer submitted that:

> The lesser Western Australian requirement, namely to refer to an appropriate practitioner (without any need for skills in the particular condition in question), would leave practitioners uncertain about what an appropriate referral would be.
>
> It would also leave open arguments that the Victorian approach effectively operates anyway, in that an appropriate practitioner would be one with skills and expertise in the particular illness, disease or medical condition.

8.216 Some respondents submitted that the draft legislation should provide that, if the coordinating practitioner or consulting practitioner is not able to determine if the person is acting voluntarily and without coercion, they must refer the person to 'another person who has appropriate skills and training to make a determination in relation to the matter' (as in Western Australia). Go Gentle Australia submitted 'while physicians routinely screen for signs of coercion, if there is doubt in the mind of a practitioner, this is an appropriate safeguard'.

8.217 The Australian College of Nurse Practitioners suggested nurse practitioners as appropriate to accept referrals to determine whether a person is acting voluntarily and without coercion. STEP Queensland and STEP Australia submitted that such referrals should be made to QCAT. The Australian Psychological Society observed that 'referral must be done in a timely manner'.

8.218 Dying with Dignity Queensland submitted that, if the coordinating practitioner or the consulting practitioner is unable to determine any of these matters, they should be required to refer the person to 'a registered health practitioner with appropriate skills and training'.

8.219 A medical practitioner similarly submitted that:

> In all instances (a), (b) and (c) a referral should be made to a health practitioner with appropriate skills and training. The precise nature of the training and skills should be defined, recognising that in many instances this person will hold a specialist qualification ...

8.220 Professors White and Willmott continued to support the approach in the White and Willmott Model, which provides that, if either the coordinating practitioner or the consulting practitioner is unable to determine whether the person meets one or more of the eligibility criteria, they must refer the person 'to a registered health practitioner or health practitioners with appropriate skills and training'.

8.221 The Clem Jones Group submitted that the legislation should provide for a referral to be made to either a 'specialist medical practitioner with appropriate skills and training' or 'a health practitioner with appropriate skills and training':

> We believe that in the circumstances as outlined in Q-23 (a), (b), and (c) provision should be made for the use of either a specialist medical practitioner with appropriate skills and training in a particular disease or a health practitioner with appropriate skills and training.

> We suggest this approach given that in a state as geographically large and diverse as ours there may be some delay in accessing a medical practitioner specialising in a particular condition or even accessing one at all.
>
> Such potential problems could be avoided if provision was made for the use of either a specialist or a practitioner with appropriate skills and training.

8.222 Some respondents made general comments in response to these questions.

8.223 Avant Mutual Group Limited submitted:

> Medical practitioners have an ethical duty to recognise and work within the limits of their competence and scope of practice. It is good medical practice that medical practitioners refer patients to others with appropriate skills and training if they are unable to determine an aspect of the patient's care themselves.

8.224 Palliative Care Nurses Australia Inc. commented that the inclusion of such referral provisions 'adds rigour to the process and ensures that the rights of the person seeking access to [voluntary assisted dying] are protected'.

8.225 The Office of the Health Ombudsman, Queensland submitted that such provisions:

> should provide some clarity and direction on these important issues. It should … encourage practitioners to ensure they comply with their professional obligations and act within their scope of practice. It is considered that this in turn may contribute to the delivery of higher standards of care.

The Commission's view

8.226 Consistently with other jurisdictions, the draft Bill requires that the coordinating practitioner or the consulting practitioner must refer some matters to another registered health practitioner (or, in some circumstances, another appropriate person) if they cannot reach a determination on a particular matter.

8.227 This is a necessary safeguard to ensure that any person who is assessed as eligible for access to voluntary assisted dying (or who goes on to access it) does in fact meet all the eligibility requirements.

8.228 A requirement to refer a person elsewhere in circumstances where a practitioner cannot determine a matter is also consistent with good medical practice. More generally, good medical practice would support referral in circumstances where a practitioner could not reach a decided view on a matter; for example, if a practitioner could not definitively diagnose a person's illness.

8.229 Of the eligibility criteria included in the draft Bill, a coordinating practitioner or a consulting practitioner should be required to refer a person elsewhere if they cannot reach a determination about the person's disease illness or medical condition, the person's decision-making capacity or whether the person is acting voluntarily and without coercion.

8.230 The remaining criteria are matters that require a factual determination.

8.231 Accordingly, the draft Bill provides that if the coordinating practitioner or the consulting practitioner is unable to determine whether:[133]

- the person has a disease, illness or medical condition that satisfies the eligibility criteria; or
- the person has the required decision-making capacity;

the practitioner must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter.

133 As to eligibility criteria, including a person's disease, illness or medical condition, decision-making capacity, and whether a person is acting voluntarily and without coercion, see Chapter 7 above.

8.232 The requirement to refer to 'a registered health practitioner who has appropriate skills and training to determine the matter' enables the referring practitioner to identify the registered health practitioner that may be most appropriate.

8.233 For example, the appropriate referee for a determination about a person's decision-making capacity may be a psychiatrist in some cases or a geriatrician in others.

8.234 The provision is also flexible enough to enable the referring practitioner to identify a range of appropriate practitioners when access might be limited, such as in rural, regional or remote areas.

8.235 The draft Bill also provides that if the coordinating practitioner or the consulting practitioner is unable to determine whether the person is acting voluntarily and without coercion, they must refer the person to another person who has appropriate skills and training to determine the matter.

8.236 This referral requirement will include a referral to another registered health practitioner, if appropriate. However, it might also include, for example, referral to a social worker or counsellor employed at a hospital or a police officer who has experience in relevant matters (such as offences involving elder abuse).

8.237 The draft Bill provides that if the coordinating practitioner or the consulting practitioner makes a referral about any of these matters, they may adopt the referee's determination.

8.238 This approach enables a practitioner to obtain a second opinion about a matter on which they could not reach a determination, and to adopt that determination in their assessment if they consider it appropriate.[134] If the practitioner does not agree with the determination made, they could withdraw from or transfer their role.

8.239 Finally, there is no need for the draft Bill to require that a person be referred for a third assessment in some or all circumstances, such as where the person has a neurodegenerative disease, illness or medical condition. The requirement for two assessments of the person's eligibility, by the coordinating practitioner and the consulting practitioner, is sufficient. Any uncertainty can be addressed by a referral to a third practitioner.

INFORMATION TO BE GIVEN TO A PERSON WHO MEETS THE ELIGIBILITY CRITERIA

8.240 In most jurisdictions, a person who meets the eligibility criteria must also be given and understand particular information before they can be assessed as eligible for access.

Victoria and Western Australia

8.241 In Victoria and Western Australia, if the coordinating practitioner is satisfied that the person meets all the eligibility criteria, the practitioner must inform the person of the following:[135]

- the person's diagnosis and prognosis;
- the treatment options available to the person, and the likely outcomes of that treatment;
- the palliative care and treatment options available to the person, and the likely outcomes of that care and treatment;
- the potential risks of taking a voluntary assisted dying substance that is likely to be prescribed for the purpose of causing their death;
- that the expected outcome of taking the substance is death;

134 See generally n 114 above.
135 *Voluntary Assisted Dying Act 2017* (Vic) s 19(1); *Voluntary Assisted Dying Act 2019* (WA) s 27(1).

- in Western Australia only, the method by which the substance is likely to be self-administered or administered, the request and assessment process (including the requirement for a written declaration), and that if the person chooses self-administration then they must appoint a contact person;
- that the person may decide not to proceed with requesting or accessing voluntary assisted dying at any time; and
- that if the person is receiving ongoing health services from a registered medical practitioner other than the coordinating practitioner, they are encouraged to inform that practitioner of their request.

8.242 In addition, the coordinating practitioner must, if the person consents, take all reasonable steps to fully explain to another person all the relevant clinical guidelines and a plan about the administration (or, in Victoria, the self-administration) of the substance.[136]

8.243 If the consulting practitioner is also satisfied that the person meets all the eligibility criteria, they must also inform the person of the matters listed at [8.241] above.[137] The requirement that both the coordinating practitioner and the consulting practitioner give the person this information ensures the person's decision is properly informed.[138]

8.244 These provisions do not affect any duty a registered medical practitioner has at common law or under another Act.[139] It was explained that these provisions are 'not intended to displace or limit the existing boundaries of informed consent, but [are] intended to operate as an extra safeguard alongside existing requirements'.[140]

8.245 The Victorian Panel explained that the aim is to give people genuine choice, and therefore it is critical people have the necessary information to make that choice. It also said that:[141]

> The Panel recognises that the requirements for medical practitioners to provide information are well established and notes that these continue to apply. Nonetheless, the Panel also acknowledges that as voluntary assisted dying will be a new practice, there should be explicit requirements about the minimum information that must be provided to a person to make clear the obligations of medical practitioners.

8.246 The Victorian Panel also explained that:[142]

> The person and the two assessing medical practitioners will discuss the required information during the two independent assessments. This may seem onerous, but the Panel is of the view that this will ensure the person receives all the information they need and will provide them with ample opportunity to ask questions and discuss the information. There may be occasions when the consulting medical practitioner is able to add new information because of their particular training or expertise. This will also allow assessing medical practitioners to ensure the person understands all the information they have been provided and have sought out themselves.

8.247 The coordinating practitioner and the consulting practitioner must assess the person as eligible if satisfied that the person meets all the eligibility criteria and understands the information that is required to be provided.[143]

136 *Voluntary Assisted Dying Act 2017* (Vic) s 19(2); *Voluntary Assisted Dying Act 2019* (WA) s 27(2). In Western Australia, the explanation must also be given to the person.

137 *Voluntary Assisted Dying Act 2017* (Vic) s 28(1); *Voluntary Assisted Dying Act 2019* (WA) s 38(1).

138 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2952 (J Hennessey, Minister for Health); Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 10.

139 *Voluntary Assisted Dying Act 2017* (Vic) ss 19(3), 28(2); *Voluntary Assisted Dying Act 2019* (WA) ss 27(3), 38(2).

140 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 7, 10; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 10, 13.

141 Vic Ministerial Advisory Panel Final Report (2017) 117.

142 Ibid 120–21.

143 *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1), 29(1); *Voluntary Assisted Dying Act 2019* (WA) ss 28(1), 39(1). In Victoria, they must also be satisfied that the person is acting voluntarily and without coercion and that the person's request for access is enduring.

White and Willmott Model

8.248 The White and Willmott Model has similar provisions to Victoria and Western Australia about the information to be provided to the person meeting the eligibility criteria. However, the White and Willmott Model includes a provision that the first medical practitioner must also encourage the person to inform their family of their request (not only other treating registered medical practitioners).[144]

8.249 Unlike the Victorian and Western Australian Acts, the White and Willmott Model does not require the first medical practitioner to take all reasonable steps, if the person consents, to fully explain to a family member (and, in Western Australia, the person) all relevant clinical guidelines and a plan in respect of the administration (or, in Victoria, the self-administration) of the substance.

8.250 The person will be eligible if the first and second medical practitioners are satisfied that the person meets the eligibility criteria and understands the information that is provided.[145]

Tasmania

8.251 The Tasmanian Act adopts a different approach to the content and timing of information given to the person.

8.252 If the person has made a first request, the primary medical practitioner must, before determining the request, give the person 'relevant information'. This includes:[146]

- the person's relevant medical condition and other medical conditions that may affect it, the treatment of those medical conditions and any possible complications of treatment;
- the person's prognosis;
- reasonably available treatment that may relieve the person's suffering or anticipated or expected suffering; and
- palliative care that may be available.

8.253 If the practitioner determines that the person is eligible and the person consents, the practitioner must give a family member 'relevant facts' and take all reasonable steps to explain to a family member 'the plan for the person to access voluntary assisted dying' including 'the arrangements to be made in relation to the body of the person' if the person intends to self-administer without an administering practitioner present.[147]

8.254 There is no requirement for the consulting medical practitioner to give the person the same 'relevant information' about eligibility. Unlike Victoria and Western Australia, the request is not referred to a consulting medical practitioner until the person is determined as eligible on a second request.[148]

New Zealand

8.255 In New Zealand, where a person who wishes to exercise the option of receiving assisted dying has informed the attending medical practitioner of their wish, the attending medical practitioner must then comply with particular requirements. These include:[149]

- giving the person information about their prognosis, and the irreversible nature and anticipated impacts of assisted dying;
- ensuring the person understands their other options for end of life care;

144 White and Willmott Model cll 18, 23. This Model does not include the matters identified as specific to Western Australia.
145 White and Willmott Model cl 24(1).
146 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 24.
147 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 27(4).
148 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 30, 33, 37.
149 *End of Life Choice Act 2019* (NZ) s 11. Other requirements are to communicate with the person at intervals about their request, do their best to ensure that the person expresses their wish free from pressure by conferring with other health practitioners and the person's family, and record their actions on the approved form.

- ensuring that the person knows they can decide at any time not to receive the assisted dying medication;
- encouraging the person to discuss their wish with others (for example, friends, family and counsellors);
- ensuring that the person knows they are not obliged to discuss their wish with anyone; and
- ensuring that the person has had the opportunity to discuss their wish with those people that they choose.

8.256 There is no requirement for similar information to be given by the second, independent medical practitioner.

Submissions

8.257 The Consultation Paper discussed the requirement for each medical practitioner to give the person the stated information and its role in ensuring that the person is properly informed when making a decision about voluntary assisted dying.[150] However, it was not the subject of a specific consultation question.[151]

8.258 Nevertheless, some respondents, including Professors White and Willmott, the Australian Lawyers Alliance, the Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine, Go Gentle Australia, the Royal Australasian College of Physicians and members of the public, provided their views about the need for people to be advised of all their end of life options, available treatments and what is involved in the voluntary assisted dying process.

8.259 Professors White and Willmott continued to support the approach taken in the White and Willmott Model. They submitted that having all the necessary information is an important safeguard against coercion.

8.260 Some respondents discussed the nature of the information that should be provided to a person. For example, the Australian Lawyers Alliance submitted that each practitioner should provide information about matters such as the person's diagnosis and prognosis, treatment and palliative care options, and the risks and expected outcomes of taking a voluntary assisted dying substance. This respondent stated that doing so would 'ensure that the person understands what all of their treatment options are and the consequences of participating in a [voluntary assisted dying] scheme'.[152]

8.261 Cancer Council Queensland, Palliative Care Queensland and some other respondents supported ensuring that persons seeking access are appropriately informed about palliative care. Cherish Life Queensland Inc submitted that discussion and investigation of whether the patient is aware of or has received palliative care should be mandatory.

8.262 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that the legislation should include guidelines on the information required to be provided but that the actual content should be prescribed by the specialist medical colleges. It proposed that the information should include discussions about:

- the difficulty of predicting likely time course, change in symptoms, response to treatments and what new treatment modalities may soon be available

150 QLRC Consultation Paper No 79 (2020), [2.18]–[2.22].

151 The Consultation Paper asked whether there should be a prohibition on a practitioner initiating a discussion about voluntary assisted dying with a person: QLRC Consultation Paper No 79 (2020) Q15, Q-16. That could be a conversation that would take place long before a person is assessed as eligible or not eligible for access. However, many responses to these questions focussed on the need for patients to be informed about all their end of life treatment options, of which voluntary assisted dying may be one. The Consultation Paper also asked if there were any other issues relating to procedural matters that respondents wished to comment on (Q34) to which some responses addressed an information provision.

152 This respondent also submitted that when dispensing medication, pharmacists should give information to persons about how the medication is to be stored safely, labelling requirements and what will happen if the medication is administered. Catholic Health Australia submitted that health care practitioners need to advise their patients about the likely benefits, burdens and risks of having or not having a particular treatment.

- palliative care options
- the consequences of taking an incomplete dose of the lethal medication.

8.263 That respondent also submitted:

> These resources should be disease-specific and evidence-based internet resources made accessible to the public. These would be accompanied by booklets and video presentations plus a 'hotline' to answer queries and redirect people to other helpful services. All resources must have multilingual options.

8.264 Some respondents observed that there is a need to ensure that the information is tailored to cultural, linguistic and educational backgrounds of patients and that efforts are made to ensure effective communication of the relevant information to those with particular disabilities and communication difficulties.

8.265 Go Gentle Australia submitted that:[153]

> It is important to have appropriate resources (such as interpreters and resources in community languages) to properly inform people about voluntary assisted dying. People from culturally and linguistically diverse communities, people with communication or cognitive impairments, people with disabilities and the Deaf community, will each require purpose-built resources.
>
> A person who does not speak English, or requires other types of communication assistance, should be able to seek assistance from an accredited interpreter, including an accredited Auslan interpreter, when accessing voluntary assisted dying.

8.266 Similarly, the Royal Australasian College of Physicians submitted that 'consideration must be given to enabling the exchange of information in formats accessible to the patient such as in the patient's preferred language, via sign language, interpreters, or orally'.

8.267 Dementia Australia highlighted the progressive and terminal nature of dementia and submitted that practitioners should, with the person's consent, include family members and carers in the voluntary assisted dying process.

8.268 Given the challenges around communicating with patients about voluntary assisted dying, particularly those from culturally diverse backgrounds or who face other communication barriers, some respondents emphasised the need for health practitioners to receive appropriate support and training. A medical defence organisation and professional indemnity insurer supported a mandatory training requirement.

The Commission's view

8.269 As is the case in most other jurisdictions, the draft Bill provides that a person seeking access to voluntary assisted dying must be given particular information.

8.270 Generally, the person must be given information about their disease, illness or medical condition, their options for treatment or palliative care, the operation of the voluntary assisted dying process and the administration of the substance. It is necessary for a person to have all this information so that they can reach an informed decision.

8.271 In many cases, a medical practitioner would be expected to give this type of information to a person as a matter of course, and as part of the general process of obtaining informed consent. However, given that voluntary assisted dying is an end of life option that was previously unavailable, and given the significant consequences of access, it is reasonable for legislation to explicitly set out the information that a person must be given. This approach also provides clear guidance to medical practitioners about what they must do to comply with the legislation.

153 Queenslanders with Disability Network noted that people with a disability have the right, at any time during treatment, to seek further information, cease treatment, seek second opinions, have access to all available treatment options and medications and give their own opinions.
In relation to people with communication difficulties, Speech Pathology Australia submitted that the communication aids used by people with communication issues typically lack the words necessary for someone who is nonverbal or has a communication problem to express a desire to access voluntary assisted dying.

8.272 Accordingly, the draft Bill provides that if the coordinating practitioner is satisfied that the person is eligible, they must inform the person about the following matters:

- the person's diagnosis and prognosis;
- the treatment options available to the person and the likely outcomes of that treatment;
- the palliative care and treatment options available to the person and the likely outcomes of that care and treatment;
- the potential risks of self-administering or being administered a substance likely to be prescribed under the legislation for the purposes of causing the person's death;
- that the expected outcome of self-administering or being administered a substance is death;
- the method by which a substance is likely to be self-administered or administered;
- the request and assessment process, including the requirement for a second request signed in the presence of two witnesses;
- that, if the person makes an administration decision, the person must appoint a contact person;
- that the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;
- that, if the person is receiving ongoing health services from another medical practitioner, the person may consider informing the other medical practitioner of the person's request for access.

8.273 For clarity, the draft Bill also defines the phrase 'palliative care and treatment' to mean care and treatment that:

- is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting; and
- is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering in order to improve their comfort and quality of life.

8.274 Palliative care can include steps taken to manage and relieve a person's symptoms, such as the provision of pain medication or oxygen therapy. It can also include the provision of medical treatment that is intended to manage a person's symptoms without curing their illness. For example, palliative treatment for cancer can include surgery to relieve discomfort caused by a tumour, or the use of drug or radiation therapy to relieve symptoms such as pain.[154]

8.275 In the circumstances, it is not necessary for the person to be encouraged to discuss their decision with their family. For some people, it may be a matter that they want to share with their family or friends. For others, it may be a matter that they want to keep private or share only with selected people. This decision is one that should be left to the discretion of the person, and not one that needs to be addressed by a practitioner.

8.276 It is also unnecessary for the coordinating practitioner, with the person's consent, to explain to another person relevant clinical guidelines and a plan about the administration of the substance. This would be premature, given that the person has not yet been assessed as eligible for access or made a final decision to proceed. This is a matter that the practitioner could appropriately address at a later stage, and if the person wants them to do so.

8.277 In addition, the person should be given similar information by the consulting practitioner. Although this has the effect that the person will be given the same type of information

154 Cancer Council Australia, *Understanding Palliative Care: A guide for people with cancer, their families and friends* (May 2019) 28–35; Cancer Council Victoria, 'Palliative treatment' <https://www.cancervic.org.au/cancer-information/treatments/treatments-types/palliative_care/palliative-care-treatment.html>.

on two occasions, that it is an important requirement to ensure that the person has all the necessary information and is offered multiple opportunities to discuss and develop their understanding of that information. Further, it is possible that one practitioner could offer additional or different information about some of these matters.

8.278 Accordingly, the draft Bill also provides that if the consulting practitioner is satisfied that the person is eligible for access, they must inform the person about the matters listed in [8.272].

8.279 The information listed in these provisions represents only the minimum information that must be provided to the person. Nothing would prevent a medical practitioner from providing a person with any additional information that is sought, or additional information that the practitioner has identified as being relevant to the person and their decision-making.

8.280 Further, it is not intended that these requirements would displace any other obligations on a practitioner to give a person what they consider to be relevant information, or any requirements relating to informed consent. Accordingly, the draft Bill provides that nothing in these provisions would affect any duty that a medical practitioner has at common law or under another Act.

8.281 Finally, the draft Bill provides separately for matters such as interpreters and communication by or with a person requesting access.[155]

8.282 As explained previously, each practitioner must assess the person as having met the requirements for the first assessment and the consulting assessment if the practitioner is satisfied that the person is eligible for access and understands the information that has been given under these provisions.

THE SECOND REQUEST FOR ACCESS TO VOLUNTARY ASSISTED DYING

8.283 As part of the staged request and assessment process, the legislation in Australian jurisdictions (as well as the White and Willmott Model) requires a person to make a second written request for access to voluntary assisted dying. In Victoria and Western Australia, this is often referred to as the 'written declaration'.

Victoria and Western Australia

8.284 If the coordinating practitioner and the consulting practitioner have each assessed the person as eligible, the person may make a second request for access.[156]

8.285 The second request must be a written declaration which states that the person requests access. It must be made in the approved form, and must specify that the person makes the declaration voluntarily and without coercion and understands the nature and effect of the declaration.[157]

8.286 The written declaration must be signed by the person in the presence of two witnesses (and, in Victoria, the coordinating practitioner).[158] If the person making the written declaration is unable to sign it, another person may sign it at the direction, and in the presence of, the person making the written declaration. The person signing on behalf of the person making the declaration must be aged at least 18 years and must not be

155 See Chapter 19 below.

156 *Voluntary Assisted Dying Act 2017* (Vic) s 34(1); *Voluntary Assisted Dying Act 2019* (WA) s 42(1). In Western Australia, the coordinating practitioner must record the date on which the written declaration was made and the date it was received by the coordinating practitioner in the patient's medical record. The coordinating practitioner must also give a copy of the written declaration to the Board within two business days of receiving it from the person. In Victoria, a copy of the written declaration is given with the final review form, following the final request for access to voluntary assisted dying: *Voluntary Assisted Dying Act 2017* (Vic) s 41(2); *Voluntary Assisted Dying Act 2019* (WA) ss 45, 46.

157 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'written declaration'), 34, sch 1, Form 3; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'written declaration'), 42.

158 *Voluntary Assisted Dying Act 2017* (Vic) s 34(2)(b); *Voluntary Assisted Dying Act 2019* (WA) s 42(3)(b).

a witness to the signing of the declaration (and, in Western Australia, must not be the coordinating practitioner or consulting practitioner).[159]

8.287 This implements the recommendations of the Victorian Panel and the Western Australian Panel, including that the written declaration should be completed to formalise the person's request after the person is fully informed and assessed as eligible, and before the final request.[160]

8.288 The purpose of the written declaration is to 'reflect the voluntary and enduring nature of the patient's request for access to voluntary assisted dying'.[161] In addition, the requirement for a written request 'has particular instrumental value as an aid to retrospective scrutiny of reported cases',[162] as it 'will be the lasting documentation of a person's decision to access voluntary assisted dying'.[163]

White and Willmott Model

8.289 If the first medical practitioner and the second medical practitioner have each assessed the person as eligible, the person may make a second request for access. The second request must be made as a written declaration in the approved form, stating that the person makes the declaration voluntarily and without coercion, and understands the nature and the effect of the request the person is making. It must be signed by the person in the presence of two witnesses and the first medical practitioner.[164]

Tasmania

8.290 If the primary medical practitioner determines that the person is eligible, the person may make a second request for access to their primary medical practitioner. This must be made at least 48 hours after their first request was made, unless the primary medical practitioner considers that they are likely to die within seven days or lose capacity within that 48 hour period.[165]

8.291 The second request must be in writing in the approved form, and witnessed by two adults or a commissioner for declarations. If the person is unable to sign the instrument, they may designate an adult to complete or sign it on their behalf, although this person cannot be their primary medical practitioner.[166]

8.292 If the person has made a second request, the primary medical practitioner must determine the second request, by determining the person's eligibility for access.[167] If at this point the primary medical practitioner determines that the person is eligible, the primary medical practitioner must refer the person to another independent medical practitioner to assess the person's eligibility.[168]

159 *Voluntary Assisted Dying Act 2017* (Vic) s 34(3)–(4); *Voluntary Assisted Dying Act 2019* (WA) s 42(4)–(5).
160 Vic Ministerial Advisory Panel Final Report (2017) 113–14, Rec 19; WA Ministerial Expert Panel Final Report (2019) 67, Rec 18.
161 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 15.
162 P Lewis and I Black, 'Adherence to the Request Criterion in Jurisdictions Where Assisted Dying Is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland' (2013) 41(4) *Journal of Law, Medicine & Ethics* 885, 894.
163 Vic Ministerial Advisory Panel Final Report (2017) 127.
164 White and Willmott Model cl 27. Like Victoria and Western Australia, there is provision for another person to sign the declaration at the direction of the person making the request, if the person making it is unable to sign.
165 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 30(1)–(2).
166 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 30(3)–(4).
167 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 33–35.
168 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 37.

8.293 If the second medical practitioner accepts the referral, they become the person's 'consulting medical practitioner'.[169] The consulting medical practitioner must determine whether the person is eligible for access.[170]

8.294 If the consulting medical practitioner determines that the person is eligible for access, then the person will be advised of the outcome and can move on to the next stage.[171] If two consulting medical practitioners determine that a person is not eligible, the voluntary assisted dying process will end for that person and, unless authorised to do so, the primary medical practitioner may not accept another first request from that person within 12 months.[172]

The Commission's view

8.295 In accordance with the decision that the draft Bill adopt a staged request and assessment process, the draft Bill provides that, after a person has been assessed as eligible for access to voluntary assisted dying and has met the requirements of both the first assessment and the consulting assessment, the person may make a second request for access.

8.296 It is appropriate for a person who has completed the eligibility assessments and continues to wish to access voluntary assisted dying to be required to make a second request. This request would be made after the person has been given the required information by the coordinating practitioner and the consulting practitioner, and after each practitioner has confirmed that the person has understood the information. Making a second request demonstrates that the person still wishes to proceed with accessing voluntary assisted dying.

8.297 As in Victoria and Western Australia, the draft Bill specifies that the second request must be in writing and in the approved form and must be given to the coordinating practitioner. The requirement for this request to be in writing is a suitable means of formalising the person's request for access. Also, it is appropriate that this formalised request is made after the person has been given the required information.

8.298 The second request must specify that the person is making the request voluntarily and without coercion, and that the person understands the nature and effect of the request. These should be explicitly addressed in the second request because it is critical that the person makes their request under these conditions, and therefore important that they are recorded in writing.

8.299 In making the second request, the person should also be required to provide practical information such as the name and contact details of the person, the coordinating practitioner and any interpreter that assisted the person.

8.300 The draft Bill requires that the second request be signed by the person in the presence of two eligible witnesses. If the person is unable to sign the request themselves, they may direct another person to sign it on their behalf. The person signing the request must do so in the presence of the person making the request and must be a person who is at least 18 years, is not a witness to the signing of the request, and is not the coordinating practitioner or the consulting practitioner.

169 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 42

170 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 47. The requirements for the determination of eligibility by the consulting medical practitioner are the same as for each determination by the primary medical practitioner. In particular, the consulting medical practitioner must be satisfied that the person is eligible under s 10 of the Act, and must not make the determination in relation to the referral until they have spoken to the person in person or by audio-visual link: ss 47, 48.
The determination of the consulting medical practitioner must be in writing and 'contain the relevant information about eligibility in relation to the person'. The consulting medical practitioner must notify the primary medical practitioner of the determination and must, as soon as reasonably practicable and within seven days of determining the request, place a copy of the determination on the person's medical records and give a copy to the Commission: ss 7, 47, 49, 50(1).
The primary medical practitioner who has been given notice of the consulting practitioner's determination must, as soon as reasonably practicable and within seven days, notify the person of the outcome, place the determination or a copy of the determination on the person's medical records, and give a copy of the determination to the Commission: s 50.

171 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 50.

172 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 51–52.

8.301 Finally, if the person is assisted by an interpreter in making their second request for access, then the interpreter must certify on the second request that they provided a true and correct translation of any material that was translated.

8.302 The draft Bill also provides that if a person gives a second request to the coordinating practitioner, the practitioner must record in the person's medical record the date on which the second request was made and the date on which it was received by the practitioner. The coordinating practitioner must also, within two business days of receipt, give a copy of the second request to the Board.

WITNESSING REQUIREMENTS

Requirement for a written request to be witnessed

8.303 As explained previously, legislation in other jurisdictions generally requires that a person's second request must be in the form of a written declaration and must be witnessed.

8.304 In Victoria, Western Australia and Tasmania, and in the White and Willmott Model, the written declaration must be signed in the presence of at least two witnesses.[173] These witnesses may be people who are chosen as witnesses by the person seeking access, but they must meet certain eligibility requirements (discussed separately below).

8.305 The requirement for the signing of the written declaration to be witnessed is a safeguard to protect the vulnerable and ensure that the person's request for access is made voluntarily.[174]

8.306 The Victorian and Western Australian Acts implement the recommendations of the Victorian Panel and the Western Australian Panel, respectively. The Victorian Panel noted that:[175]

> [a] person's written declaration of enduring request represents their enduring decision and witnessing requirements may help ensure requests are voluntary and properly informed… The requirement for two independent witnesses is an important safeguard to ensure requests are voluntary and free from abuse.

8.307 The Tasmanian Act provides that the written declaration must be witnessed, in the presence of the person, by at least two eligible adults or by a commissioner for declarations, who have observed the instrument being completed and signed.[176]

8.308 It is not uncommon for legislative frameworks to require written statements to be signed in the presence of one or two witnesses. For example, some documents made under the *Powers of Attorney Act 1998* are required to be made before an 'eligible witness'.[177] Similarly, under succession law, the requirement for written statements to be signed in front of witnesses acts a safeguard to mitigate against issues such as coercion, duress and undue influence.[178]

173 *Voluntary Assisted Dying Act 2017* (Vic) s 34(2)(b); *Voluntary Assisted Dying Act 2019* (WA) s 42(3)(b); White and Willmott Model cl 27(2)(c); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 30(3)(b).

174 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 12; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 15.

175 Vic Ministerial Advisory Panel Final Report (2017) 126–7.

176 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 30(3)(b). 'Commissioner for declarations' has the same meaning as in the *Oaths Act 2001* (Tas).

177 *Powers of Attorney Act 1998* (Qld) s 31. An eligible witness is a justice of the peace, commissioner for declarations, notary public or lawyer; not the person signing the document for the principal; not an attorney of the principal; not a relation of the principal or a relation of an attorney of the principal; if the document gives power for a personal matter—not a paid carer or health provider of the principal; and for an advance health directive—not a beneficiary under the principal's will.

178 *Succession Act 1981* (Qld) s 10.

8.309 Most overseas jurisdictions require a written request as part of the voluntary assisted dying process.[179] Like Victoria and Western Australia, state legislation in the United States provides that the written request must be signed in the presence of two witnesses.[180]

8.310 The federal legislation in Canada, previously required two independent witnesses. Following recent amendment, it now requires that a person's request for medical assistance in dying be signed and dated before one independent witness, who then also signs and dates the request.[181] It was explained that the requirement for two independent witnesses was 'difficult' or was 'an unbearable impediment' for some people, such as those living in long-term care facilities or remote areas or those who are older and without any remaining family.[182] This requirement was also described as 'a pro forma step', and it was explained that '[t]he purpose of the independent witness is simply to verify the identity of the person signing the request' and '[t]he witness is not involved in the assessment process'.[183]

8.311 In contrast, in New Zealand, the written request is required to be made and signed only in the presence of the attending medical practitioner,[184] and in Belgium and Luxembourg there are no requirements for a written request to be witnessed.[185]

Witnessing the request in the presence of coordinating practitioner

8.312 In addition to two witnesses, the Victorian Act and the White and Willmott Model requires the person's written declaration to be signed and witnessed in the presence of the coordinating practitioner.[186] The Victorian Panel considered that this requirement:[187]

> will mean that any questions the person or the witnesses may have can be explained by a medical practitioner who has undertaken the specific training about the obligations and requirements under the legislation.

8.313 In Victoria, guidance for health practitioners provides that:[188]

> In the presence of the witnesses, the coordinating medical practitioner should take the patient through a conversation about their decision, their understanding of the implications of their request to access voluntary assisted dying, and the potential risks and likely outcome of taking the voluntary assisted dying medication – noting that it will lead to their death.

179 See *Belgian Euthanasia Act 2002* art 3(4); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* arts 2(4), 4(1); Canada Criminal Code, RSC 1985, c C-46, s 241.2(3)(b)(i). In the United States, see, eg, *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.3; *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.810 2.02; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a)(4).
Cf: In the Netherlands there is no requirement for the request to be made in writing: *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*.

180 See, eg, *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.810.2.02.

181 Canada Criminal Code, RSC 1985, c C-46, s 241.2(3)(c), (3.1)(c). In Quebec, a form requesting medical assistance in dying must be signed in the presence of, and then countersigned by, a 'health or social services professional'. This may include the attending practitioner: *Quebec Act respecting end-of-life care*, RSQ, c S32.0001, s 26.

182 Canadian research has indicated that it can be difficult for some patients living in long-term care facilities to find two independent witnesses for their signature, including because contact with other people has narrowed or because the patient does not want to tell others of their decision to access medical assistance in dying. Among people who volunteered to act as a witness in such circumstances, there was a view that the requirement for an independent witness is unnecessary: Z Praslickova, M Kelly and E Wiebe, 'The experience of volunteer witnesses for Medical Assistance in Dying (MAiD) requests' (January 2020, online) *Death Studies*.

183 Canada, *Parliamentary Debates*, House of Commons, 26 February 2020, 1620, 1622 (D Lametti, Minister of Justice).

184 *End of Life Choice Act 2019* (NZ) s 12(3)(a), (5)(a)(i). If the person is not able to sign, another eligible person may sign and date the form on behalf of the person making the request, in the presence of the person making the request and the attending medical practitioner: s 12(3)(b), (4), 5(a)(ii).

185 *Belgian Euthanasia Act 2002* art 3(4); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* arts 2(4), 4(1)–(2). However, the legislation in Belgium provides that, if the person is not able to formulate the request in writing, the application must be recorded in writing in the presence of the physician. In Luxembourg the legislation provides that, if the person is unable to sign the document, another person may do so on their behalf. In those circumstances, the signing of the written request must be made in the presence of two witnesses, who attest that the person could not draft and sign the written request and that another person drafted and signed the written declaration on behalf of the person who is seeking access to assisted dying.

186 *Voluntary Assisted Dying Act 2017* (Vic) s 34(2)(b); White and Willmott Model cl 27(2)(c).

187 Vic Ministerial Advisory Panel Final Report (2017) 127, Rec 26.

188 Vic Guidance for Health Practitioners (2019) 47.

8.314 The legislation in Western Australia and Tasmania does not require the presence of the coordinating practitioner. The witnessing requirements in Western Australia implement the recommendations of the Western Australian Panel, which stated that:[189]

> In relation to witnessing provisions, the Panel noted advice from Victoria that their provisions were potentially complex in implementation and that Western Australia should aim to strike a balance between safeguards and practicality in this regard and wherever possible to base these provisions on an existing practice.

8.315 In particular, the Western Australian Panel recommended that it is not necessary for the coordinating practitioner to be present for the signing of the declaration in the presence of the witnesses, explaining that:[190]

> The Panel also gave consideration to how … the role of witnesses could be structured in a person-centred and time-sensitive way, given that many people seeking voluntary assisted dying would be very unwell by this stage.
>
> … the Panel determined that the two witnesses did not necessarily need to witness the declaration in the presence of the co-ordinating practitioner—this was not seen to add meaningful oversight and would likely add significant burden to the person.

Submissions

8.316 The Consultation Paper asked whether a model such as that in Western Australia (two witnesses) or Victoria (two witnesses and the coordinating practitioner) was the preferred option for witnessing arrangements.[191]

8.317 Respondents were divided as to whether Queensland should follow the approach in Victoria or Western Australia.

8.318 Those respondents in favour of the Western Australian approach highlighted concerns with requiring the coordinating practitioner's presence. Some noted that this may act as a barrier to access and create logistical obstacles to accessing voluntary assisted dying, particularly in rural, regional and remote Queensland where it may be difficult to ensure the presence of the coordinating practitioner.

8.319 Other respondents queried whether the requirement that the coordinating practitioner be present added any extra 'value or additional oversight', while some did not consider that the presence or absence of a doctor was a measurable safeguard and submitted that it serves no purpose other than to be 'red tape and bureaucracy'.

8.320 Further, some respondents considered signing a written declaration to be a legal intervention, not a medical one, and therefore that it does not necessitate the presence of the coordinating practitioner.

8.321 Some respondents raised concerns about the increased workload and burden that this additional requirement would place on the coordinating practitioner. It was observed that '[t]he administrative load on doctors is already high' and that the 'Victorian approach of effectively making the coordinating practitioner a further witness has the potential for new and uncertain obligations on them, such as assessing witness eligibility and/or potential for undue influence by the witnesses'.

8.322 Of those respondents supportive of the Victorian approach, several considered that the presence of the coordinating practitioner would operate as a strong safeguard and that such an approach offers the most safety.

8.323 AMA Queensland submitted that it is important that the coordinating practitioner is a witness to the declaration being signed, as it is the coordinating practitioner who makes the decision as to whether the patient meets the eligibility requirements.

189 WA Ministerial Expert Panel Final Report (2019) 67, Rec 18.
190 Ibid 67.
191 QLRC Consultation Paper No 79 (2020) Q-17.

8.324 Similarly, some respondents suggested that the coordinating practitioner could answer questions the witnesses may have to ensure they are comfortable witnessing the document, and to ensure that the person is not being coerced by the witness.

8.325 Go Gentle Australia referred to a statement by a general practitioner in Victoria:

> I make it very clear to the witness that your role is not just to witness the signature, it's to witness the person does have the mental capacity, that's their own free will. They know exactly what will happen when they take the medication and so on. And once they get the medication, they don't have to take it. So the witness needs to be reassured that all that's the case before they can sign.

8.326 Conversely, MIGA noted its concerns with the Victorian Panel's suggestion that practitioner's presence means that any questions the other witnesses have can be explained by them, and considered that the coordinating practitioner and the consulting practitioners' role in assessing eligibility should be confined to clinical or professional assessments.

8.327 An alternative suggestion made by one respondent was that due to difficulties in rural communities serviced by few practitioners, rather than having the coordinating practitioner present, a written declaration should be made in the presence of two witnesses and any health practitioner who is familiar with the process and able to answer questions (not necessarily the coordinating practitioner).

8.328 A further alternative considered by two other respondents was that the presence of the coordinating practitioner and only one other witness should be sufficient.

8.329 The Consultation Paper did not seek submissions about whether the draft legislation should provide that a justice of the peace may witness the written request for access, but some respondents offered suggestions similar to that proposed in Tasmania.

8.330 The Lutheran Church of Australia Queensland District suggested an approach in which 'two witnesses, one of whom is a commissioner for declarations, will be present when the applicant signs their voluntary assisted dying consent'. A member of the public observed that, '[a]s with many legal agreements, the witness should probably be a [justice of the peace]'.

The Commission's view

8.331 Consistently with the legislation in other jurisdictions, it is necessary that the second, written request be witnessed. A requirement of this nature will provide a safeguard to assist in ensuring that a person's request for access is made voluntarily, and to protect those people who may be vulnerable to abuse or coercion.

8.332 Accordingly, the draft Bill requires that the second request for access be signed by the person (or by another person on their behalf) in the presence of two people who are both eligible witnesses.

8.333 In order to adequately safeguard people, there must be two witnesses and they must be present at the same time. A requirement for anything less would potentially offer inadequate protection (for example, if the only witness was also attempting to influence the person making the request).

8.334 However, the requirements for a person to access voluntary assisted dying should not become unduly burdensome. For that reason, there should not also be a requirement for the coordinating practitioner to be present.

8.335 The requirement for two witnesses and the coordinating practitioner to be present while the person signs the second request may cause logistical difficulties. The professional obligations of the coordinating practitioner may significantly limit their availability, creating difficulties for both the person and the practitioner. In rural, regional or remote areas there may be practical barriers to having each person present at the same time.

Added requirements may significantly extend the time that it takes a person to comply with this stage of the request and assessment process.

8.336 The draft Bill does not permit the two eligible witnesses to be substituted with a single justice of the peace or a commissioner for declarations.[192] There is some argument that, due to their position, this may be a reasonable approach and that for some people it may simplify the witnessing requirements. However, we remain of the view that the requirement for a written request to be witnessed by two eligible people is a fundamental safeguard.[193]

Requirement for witnesses to the written declaration to certify certain matters

8.337 Legislation in each jurisdiction requires a witness to a written declaration to certify or attest to different matters. In the Victorian Act, and in the White and Willmott Model, the witness is required to certify more matters than in the Western Australian Act.

8.338 The Victorian and Western Australian Acts, and the White and Willmott Model, provide that the witness must:[194]

- certify in writing that, in their presence, the person making the declaration appeared to freely and voluntarily sign the declaration; and
- state that the witness is not knowingly an ineligible witness.

8.339 The Victorian Act and the White and Willmott Model additionally require the witness to certify that, in their presence, the person appeared at the time of signing the declaration:

- to have the required decision-making capacity; and
- to understand the nature and effect of making the declaration.

8.340 In contrast, the Tasmanian Act does not specify what matters the witnesses to the written declaration are required to certify (although this could later be specified in the approved form).[195]

8.341 Witnessing requirements are included in some state Acts in the United States. Most are similar. For example, in California the written request must be witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the person signing the request:[196]

- is personally known to them or has provided proof of identity;
- is acting voluntarily; and
- is of sound mind and not under duress, fraud or undue influence.

8.342 Legislation in other overseas jurisdictions does not specify what matters the witness must certify.[197]

192 In Queensland, justices of the peace and commissioners for declarations can witness and sign formal documents that require a qualified witness: Queensland Government, 'Services of a JP and Cdec' (16 February 2018) <https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/about-justice-of-the-peace/jps-services>. Justices of the peace and commissioners for declarations are appointed under the *Justices of the Peace and Commissioners for Declarations Act 1991* (Qld).

193 Nothing prevents a justice of the peace or a commissioner for declarations acting as a witness to a second request, provided that person otherwise satisfies the eligibility criteria.

194 *Voluntary Assisted Dying Act 2017* (Vic) s 36(1); *Voluntary Assisted Dying Act 2019* (WA) s 44(2); White and Willmott Model cl 29(1). In the case of witnessing the signing of a written declaration by another person on behalf of the person making the declaration, the witness must certify that the person appeared to freely and voluntarily direct the other person to sign the declaration and that the other person signed the declaration in the presence of the person and the witness: *Voluntary Assisted Dying Act 2017* (Vic) s 36(2); *Voluntary Assisted Dying Act 2019* (WA) s 44(3); White and Willmott Model cl 29(2).

195 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 30(3). The written declaration must be in the approved form.

196 *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.3.

197 The federal legislation in Canada simply requires that the practitioner must be satisfied the request was signed and dated by the person before an independent witness who then also signed and dated the request: Canada Criminal Code, RSC 1985, c C-46, s 241.2(3)(c), (3.1)(c).

8.343 The Victorian Panel noted that:[198]

> During the consultation process, stakeholders were generally more concerned with coercion or undue influence from families than from health practitioners. It is noted that the requirement for independent assessments by two medical practitioners also provides protection against undue influence from family members, as the assessing medical practitioners must be satisfied that the person is acting voluntarily.
>
> The Panel notes that in Oregon, 20 years of practice that requires two medical practitioners and two independent witnesses to certify that a person is acting voluntarily indicates that there is no evidence of coercion or undue influence of people who have proceeded with voluntary assisted dying. In Oregon there have been five cases out of 1,127 in which a person's written request was not properly witnessed. In each of these cases the medical practitioner was referred to the Oregon Medical Board. (notes omitted).

Submissions

8.344 The Consultation Paper did not ask what matters a witness should be required to certify when signing as witness to the written declaration.

8.345 However, one respondent noted that the requirement for the witness to certify that at the time of making the declaration the person appeared to have the required decision-making capacity and to understand the nature and effect of making the declaration 'imposes a significant burden on the witness to explore the patient's understanding of [voluntary assisted dying] in relation to their decision'.

8.346 In contrast, another respondent noted that the provisions of the White and Willmott model, which are similar to the Victorian Act, place 'no duty on the witness actually to be satisfied of anything more than the patient "appear(ed) to" act voluntarily, "appeared to act without coercion" …'.

The Commission's view

8.347 We consider that it is preferable for each witness to a person's second, written request to be required to certify certain matters, which are explicitly set out in the legislation.

8.348 Specifically, the draft Bill requires that each witness to the signing of the second request must certify in writing in the request that:

- in the presence of the witness, the person signed the written request; and
- the person appeared to sign the written request freely and voluntarily.

8.349 Each witness must also state in the request that they are not knowingly ineligible to witness the signing of the second request.

8.350 Certification of those matters operates as a safeguard and ensures that requests for access are made voluntarily. In providing such certification, a witness will be certifying that the person signed the document in their presence and that they appeared to do so freely and voluntarily. This will assist in demonstrating that the person chose to sign the request, and that they were not forced to do so by the other witness or by any other person who was present at the time.

8.351 It is not necessary for the witnesses to the second request to certify that, at the time the person signed the request, they appeared to have the required decision-making capacity. The purpose of requiring witnesses to the second request is to provide a safeguard to ensure that it is the person's own decision, and that it is made voluntarily and without coercion.

8.352 The person's capacity will, by this stage, have been independently assessed by two medical practitioners. In addition, the term 'decision-making capacity' has a particular

198 Vic Ministerial Advisory Panel Final Report (2017) 126. See also Lewis and Black, above n 162, 891-92.

meaning which may not be apparent to a person who is acting as a witness, and this may create difficulties.

8.353 It is also not necessary to require the witnesses to certify that the person appeared to understand the nature and effect of making the request. This is captured by the practitioners' assessment that the person has decision-making capacity and is acting voluntarily and without coercion.

8.354 In addition, the draft Bill contains similar witnessing requirements where the second request is signed by another person on the requesting person's behalf. The witness must certify in writing in the request that:

- in the presence of the witness, the person appeared to freely and voluntarily direct the other person to sign the request; and
- the other person signed the request in the presence of the person and the witness.

8.355 Again, each witness must also state in the request that they are not knowingly ineligible to witness the signing of the second request.

Witness eligibility requirements

8.356 In each jurisdiction, the legislation also provides that a witness to a written declaration must meet certain eligibility requirements. It has been explained that this provides an additional safeguard and is 'aimed at ensuring witnesses do not have a conflict of interest in witnessing the declaration'.[199]

8.357 In recommending provisions about witness eligibility, the Victorian Panel considered that:[200]

> The requirement for two independent witnesses is an important safeguard to ensure requests are voluntary and free from abuse. This would necessarily exclude people who are involved in the treatment or care of the person or who might benefit financially from the death of a person making the request. The Panel recognises that while such requirements may make it more difficult for a person to find [an] appropriate person to witness their written declaration of enduring request, the exclusions prevent conflicts of interest and provide further assurance of voluntariness.

8.358 The legislation in Victoria, Western Australia and Tasmania, and the White and Willmott Model, require that a witness to the written declaration must be aged at least 18 years. In addition, each jurisdiction has identified particular categories of people who are ineligible to witness a person's written declaration.[201]

8.359 The Victorian and Western Australian Acts, and the White and Willmott Model, provide that a person is ineligible to be a witness if the person:[202]

- knows or believes they are a beneficiary under a will of the person making the declaration, or may otherwise benefit financially or in any other material way from the death of the person making the declaration (Victoria, Western Australia, White and Willmott Model);

199 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 12; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 15.

200 Vic Ministerial Advisory Panel Final Report (2017) 127, Recs 26, 27. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 12; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 15.

201 *Voluntary Assisted Dying Act 2017* (Vic) s 35(1)(a)–(b); *Voluntary Assisted Dying Act 2019* (WA) s 43(1)(a)–(b); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 31(2), (3)(b); White and Willmott Model cl 28(1)(a)–(b).

202 *Voluntary Assisted Dying Act 2017* (Vic) s 35(2); *Voluntary Assisted Dying Act 2019* (WA) s 43(2); White and Willmott Model cl 28(2).

- is an owner of, or is responsible for the day-to-day operation of, any health facility at which the person making the declaration is being treated or resides (Victoria,[203] White and Willmott Model[204]);
- is directly involved in providing health services or professional care services to the person making the declaration (Victoria, White and Willmott Model[205]);
- is the coordinating practitioner or consulting practitioner for the person making the declaration (Western Australia).[206]

8.360 The Victorian Panel considered that 'people who are involved in the treatment or care of the person' should be ineligible to act as a witness.[207] However, the Victorian guidance for health practitioners states that:[208]

> Witnessing a patient's written declaration does not require prior knowledge of the patient or specialist knowledge but is based on the witness's observation of the patient at the time. Someone in an administrative role or other role who is not directly involved in the patient's care could be a witness.

8.361 In the Victorian Act, and in the White and Willmott Model, the term 'professional care services' is defined to mean any of the following services, when they are provided to another person under a contract of employment or a contract for services:[209]

- support or assistance;
- special or personal care (which includes assistance with matters such as hygiene, dressing, meals, mobility or medication, or the provision of 'substantial emotional support');
- a disability service within the meaning of, respectively, the *Disability Services Act 2006* (Vic) or the *Disability Act 2006* (Qld);[210]
- in Victoria, services provided by a registered NDIS provider within the meaning of the *National Disability Insurance Scheme Act 2013* (Cth).

8.362 In contrast, the Tasmanian Act states that one of the witnesses to the second request 'must not be any one or more of the following persons':[211]

> (a) a member of the family of the person;
>
> (b) a person who, at the time of witnessing the request, knows or believes that he or she is likely to, either directly or indirectly benefit from, or receive a financial benefit, directly or indirectly, as a result of, the death of the person, other than by receiving reasonable fees for the provision of services to the person to whom the request relates;

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203 In Victoria, a 'health facility' is defined by reference to the *Medical Treatment Planning and Decisions Act 2016* (Vic) which includes public and private hospitals, residential care services, the Victorian Institute of Forensic Mental Health and specialist disability accommodation, among others: *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definition of 'health facility').

204 Specifically, the White and Willmott Model includes a provision that a person is an ineligible witness if they are an owner of, or are responsible for the day-to-day operation of, any facility at which the person making the second request is receiving a health service, residential service or professional care service: cl 28(2)(b).
The term 'professional care service' is explained below. The White and Willmott model does not define the terms 'health service' or 'residential service'. Under the *Hospital and Health Boards Act 2011* (Qld), 'health service' is defined to mean a 'service for maintaining, improving, restoring or managing people's health and wellbeing': s 15.

205 Specifically, the White and Willmott Model includes a provision that a person is an ineligible witness if they are directly involved in providing a health service, residential service or professional care service to the person making the second request: cl 28(2)(c).

206 The Victorian Act and the White and Willmott Model do not expressly exclude the coordinating practitioner or the consulting practitioner. However, the exclusion of any person directly involved in providing health services or professional care services to the person making the declaration would arguably have the effect of excluding those practitioners.

207 Vic Ministerial Advisory Panel Final Report (2017) 127, Recs 26, 27.

208 Vic Guidance for Health Practitioners (2019) 47.

209 White and Willmott Model sch 1 (definitions of 'professional care services' and 'special or personal care'); *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definitions of 'professional care services' and 'special or personal care').

210 The *Disability Act 2006* (Vic) defines a disability service as 'a service specifically for the support of persons with a disability which is provided by a disability service provider'.
The *Disability Services Act 2006* (Qld) s 12 defines 'disability services', for people with disability, as one or more of the following: accommodation support services; respite services; community support services; community access; advocacy or information services or services that provide alternative forms of communication; research, training or development services; or another service prescribed by regulation. It does not include NDIS supports or services.

211 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 31(1).

(c) a person who is a residential care provider in relation to the person, or an employee or agent of a residential care provider in relation to the person;[212]

(d) a person who is a resident in the facility, owned or operated by a residential care provider in relation to the person, in which the person making the request resides. (note added)

8.363 In addition, the Tasmanian Act provides that a person's second request cannot be witnessed by the person's primary medical practitioner or consulting medical practitioner, or by another person who completes or signs the second request for and on behalf of the person making the second request.[213]

8.364 The legislation in other Australian jurisdictions deal with family members acting as witnesses. Western Australia prohibits a family member of the person making the declaration from acting as a witness.[214] In comparison, in Victoria and Tasmania, not more than one witness may be a family member of the person making the written declaration. The White and Willmott Model adopts a similar approach.[215]

8.365 In effect, the Victorian Act and White and Willmott Model therefore permit a family member who is not a beneficiary (or does not otherwise benefit financially or in a material way from the death of the person) to act as a witness to the written declaration.

8.366 In Victoria and Western Australia, a 'family member' of a person is defined to mean the person's spouse, domestic partner (in Victoria) or de facto partner (in Western Australia), parent, sibling, child or grandchild.[216] In the Tasmanian Act, 'member of the family' is defined to mean a person who is:[217]

- the father, mother, grandfather or grandmother of the person;
- the spouse of the person;
- a brother, sister, niece or nephew of the person;
- a person in a family relationship, within the meaning of the *Relationships Act 2003* (Tas), with the person;
- a person in a caring relationship, within the meaning of the *Relationships Act 2003* (Tas), with the person; or
- a child, or grandchild, of the person.

8.367 State legislation in the United States also requires a person's written declaration to be witnessed by two adults who are eligible to act as witnesses. Vermont requires that both witnesses meet the eligibility requirements. Other states require that only one of the two witnesses meet certain eligibility requirements.[218] The limitations on who is an eligible witness are generally similar to those in Australian jurisdictions.

8.368 The federal legislation in Canada includes similar independent witness limitations to those in the Australian jurisdictions. Following recent amendment, a person—other than a practitioner who will provide the person with medical assistance in dying or who has provided a specialist opinion—who provides health care services or

212 'Residential care provider' is defined, in relation to a person, to mean 'a person who owns or operates premises at which the first-mentioned person resides' and 'at which health services are, or may be, provided to the firstmentioned person by, or on behalf of, the person who owns or operates the premises': s 5.
The term 'health service' is defined (in s 5) by reference to the definition provided in the *Tasmanian Health Service Act 2018* (Tas). It includes, among other things, a hospital service, medical service, community health service or another service 'relating to the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in, or injury to, persons': *Tasmanian Health Service Act 2018* (Tas) s 3 (definition of 'health service').

213 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 31(2).

214 *Voluntary Assisted Dying Act 2019* (WA) s 43(2)(b).

215 *Voluntary Assisted Dying Act 2017* (Vic) s 35(3); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 31(1)(a); White and Willmott Model cl 28(3). In Tasmania, this would also have the effect that if the second request was witnessed by a commissioner for declarations, that commissioner also could not be a family member of the person.

216 *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definition of 'family member'); *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition 'family member').

217 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5 (definition of 'member of the family').

218 See, eg, *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.3; *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.805.2.02; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a)(4).

personal care as their primary occupation, and who is paid to provide that care to the person, may act as a witness.[219]

Submissions

8.369 The Consultation Paper asked several questions about what criteria should make a person ineligible to act as a witness for a written declaration. Each criterion is considered in detail below.[220]

8.370 Restrictions on who can act as a witness were considered necessary by some respondents to provide additional protection for the person and reduce the risk of coercion. In addition, the requirement for an independent witness was noted by one respondent as beneficial as it would 'alleviate any potential feelings of guilt from family or others who may feel obliged to sign for the person'.

8.371 Overall, respondents considered that a witness should not have any bias and be able to make a reasonable assessment, and should have no personal, financial or other conflicts of interest in the matter.

8.372 In addition to criteria that would make a person ineligible as a witness, one respondent noted that there should be requirements on the level of knowledge of the person making the declaration:

> witnesses should be required to know the person well enough to know if coercion is taking place, not simply strangers plucked from a hallway in order to checkmark a legal requirement.

8.373 However, respondents noted the need for balance between ensuring appropriate safeguards against coercion or bias through the requirement of a level of independence in the witness and accessibility of the voluntary assisted dying scheme, 'as such requirements may raise problems of access for people who are socially isolated or live remotely.'

8.374 As observed by Cancer Council Queensland:

> practical limitations mean that for many people, small circles of family or friends may be their entire support network. It can be very challenging for Queenslanders, particularly in regional and rural areas, to find people to witness any written declaration that are outside of this group.

8.375 Some respondents considered that telehealth options may overcome some of the limitations faced by Queensland's rural and remote population groups.

Age

8.376 All respondents that addressed the issue of the age of a witness were of the view that the witness should be over the age of 18 years.

A beneficiary or person who will benefit in some other way

8.377 The Consultation Paper asked whether a person who knows or believes that they are a beneficiary under a will of the person making the declaration, or a person who knows or believes that they may otherwise benefit financially or in any other material way from the death of the person making the declaration, should be ineligible to witness the written declaration.

219 Canada Criminal Code, RSC 1985, c C-46, s 241.2(3)(c), (3.1)(c), (5), (5.1)

220 QLRC Consultation Paper No 79 (2020) Q-18, Q-19. The Consultation Paper did not distinguish whether both witnesses, or only one of the witnesses, must meet each criterion.

8.378 Respondents generally submitted that that a person who knows or believes that they are a beneficiary under the person's will, or who knows or believes that they may otherwise benefit financially or in any other material way from the person's death, should not be eligible to act as a witness. For example, the Anglican Bishop of North Queensland submitted that 'none of the witnesses should be beneficiaries of the estate'.

8.379 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that:

> 'Subtle coercion' and the difficulty in identifying it are of concern. Family members or parties known to have an interest, including pecuniary interests, in whether the patient lives or dies should not be able to be witnesses to the request process.

8.380 However, two respondents considered that these criteria should not make a person ineligible to act as a witness.

8.381 Two academics jointly observed that, in respect of the making of wills, under section 11(3)(c) of the *Succession Act 1981*, even if a person is ineligible to act as a witness because they have an interest in the will, they may still be able to validly witness the will if the testator is aware of their interest.[221] These respondents also submitted:

> while there may be justifiable reasons for excluding those witnesses when the prospect of death is uncertain, these rationales might not apply when the person in question has, as per the [voluntary assisted dying] eligibility criteria, only weeks or at most months to live.

8.382 In addition, one respondent queried the value of such a requirement, submitting that 'while this is high-sounding in tone and intent, it will be readily circumvented by a beneficiary calling in aid a friend or acquaintance of the beneficiary to perform that task'.

Involved in the person's care or treatment

8.383 The Consultation Paper asked whether a person who is the owner of, or responsible for the day-to-day operation of, any health facility at which the person making the declaration is being treated or resides, should be ineligible to act as a witness, as is provided in the Victorian Act.

8.384 Many respondents considered that a person in this position should be ineligible to act as a witness. However, some other respondents considered that they should be eligible, and such a restriction was viewed as 'not really necessary' or as not presenting a conflict of interest.

8.385 Cancer Council Queensland submitted that '[p]eople involved in providing health services to the [person making the] declaration should not be able to witness any written declaration'.

8.386 On the other hand, two academics jointly noted that:

> …it is difficult to see how witnessing a declaration for [voluntary assisted dying] is likely to promote the interests of a health facility owner or manager, or a health services or professional care services provider in ways that could not similarly be achieved if they were not a witness…

8.387 In addition, these academics noted that if a person was found to have behaved unprofessionally in respect of witnessing a written declaration, they would risk losing their licence.

8.388 The Consultation Paper also asked whether a person who was directly involved in providing health services or professional care services to the person making the declaration should be ineligible to act as a witness as provided for in the Victorian Act.

221 Under the *Succession Act 1981* (Qld), a disposition will be void to the extent that it concerns the interested witness or a person claiming under the interested witness. However, that does not apply if the court is satisfied that the testator knew and approved of the disposition and it was made freely and voluntarily by the testator: s 11(2), (3)(c).

8.389 Most respondents who addressed this issue considered that such a person should not be a witness to the written declaration.

8.390 However, there were several respondents who were of the opinion that this category of persons should not always be ineligible to witness a written declaration. Some considered that one of the two witnesses should be able to be a person within this category, and one respondent explained that '[t]his would simplify things for the requesting person who is in a small facility or finds themselves admitted to a facility remote from friends and family'.

8.391 Two academics jointly observed that a care provider registered with AHPRA would be subject to disciplinary action if they acted inappropriately in witnessing a document.

The coordinating practitioner or consulting practitioner

8.392 The Consultation Paper also asked whether the coordinating practitioner or the consulting practitioner should be ineligible to act as a witness.

8.393 Many respondents submitted that the coordinating practitioner or the consulting practitioner should not be eligible to witness the person's written declaration. One respondent submitted:

> Access to coordinating practitioners can be difficult in regional areas, and consultations are increasingly undertaken using telehealth models. For that reason, there may be practical impediments that make it difficult for the coordinating practitioner to witness any written declaration.

8.394 Other respondents considered that the coordinating practitioner or the consulting practitioner should be able to witness the written declaration. One respondent submitted that the position should be that the coordinating practitioner or the consulting practitioner 'can be eligible as one of the two required witnesses'.

Family members

8.395 The Consultation Paper asked whether the draft legislation should provide that a family member of the person is ineligible to witness to a written declaration (as in Western Australia), or alternatively that not more than one witness may be a family member of the person making the declaration (as in Victoria, the White and Willmott Model and the Tasmanian Act).[222]

8.396 Most respondents did not support an approach that would result in a family member being entirely ineligible to act as a witness. Some respondents highlighted difficulties that might result from this approach; for example, for people in remote and regional areas. One respondent noted that family is often closely involved, and many patients will opt to discuss this within their family and may want family support. Another submitted:

> [F]or many people, small circles of family or friends may be their entire support network. It can be very challenging for Queenslanders, particularly in regional and rural areas, to find people to witness any written declaration that are outside of this group.

8.397 Another respondent submitted that:

> [f]or many seriously ill patients, the only people they see may well be close family, who may well be beneficiaries, and carers. Exclusion of those groups may create unnecessary difficulties in formalising the declaration paperwork.

8.398 Some respondents submitted that if a person who may benefit financially or in any other material way is ineligible to be a witness, then that would be sufficient to protect vulnerable people while still allowing more remote family members to witness the written declaration. For example, Go Gentle Australia submitted that given that a potential witness 'must already not benefit (financially or otherwise) … that is a sufficient safeguard'.

222 QLRC Consultation Paper No 79 (2020) Q-18(e), Q-19.

8.399 Other respondents supported the alternative approach that not more than one witness to the written declaration may be a family member of the person who is making the declaration.[223] One respondent described this as 'a workable and practicable provision'.

8.400 Go Gentle Australia submitted that '[t]o avoid doubt about questions of possible family coercion, we believe it is appropriate for only one family member to act as a witness'.

8.401 Other respondents were not supportive of a family member of the person being a witness in any circumstances due to concerns about family squabbles or 'obvious conflict of interest'.

8.402 One respondent considered that neither witness should be a family member, submitting this this was:

> [n]ot just to safeguard the person requesting [voluntary assisted dying] but to prevent future repercussions against the witnessing family member from other family members who could accuse them of coercion of the patient.

8.403 Another respondent considered that '[w]itnesses should not be family unless the person absolutely does not have two people in their life who are not there because of blood relation or profession'.

8.404 The Bar Association of Queensland suggested that the definition of the term 'family member' be drafted in a way that includes the concept embodied in the definition of 'parent, of a child' which appears in the *Succession Act 1981*. This recognises as a parent a person who, under Aboriginal tradition or Island custom, is regarded as a parent of a child. In that respondent's view, such an expansion would provide consistency of the cultural understanding of family within the Aboriginal and Torres Strait Islander cultural groups.[224]

Other categories of people

8.405 A member of the public considered a range of other categories of people who should not be eligible to act as a witness including, for example, pharmacists, anyone convicted of a dishonesty offence, undischarged bankrupts, and members of right to die organisations.

The Commission's view

8.406 The draft Bill requires that, to be eligible to witness the signing of a second request, a person must be aged at least 18 years. This approach is consistent with legislation in other jurisdictions, and generally with the requirements for the witnessing of other documents.

8.407 As in other jurisdictions, there are some categories of people who should not be eligible to witness the signing of the second request because of their relationship to the person making the request. Although imposing eligibility criteria about witnesses may restrict the pool of eligible witnesses available to the person,[225] doing so is a necessary safeguard.

223 One respondent submitted that at least one witness should be independent of the family.

224 See specifically, *Succession Act 1981* (Qld) s 61A. See also, *Child Protection Act 1999* (Qld) s 11; *Disability Services Act 2006* (Qld) s 37, Sch 8; *Domestic and Family Violence Protection Act 2012* (Qld) s 16; *Public Guardian Act 2014* (Qld) s 53.

225 For example, participants in one study noted that the witnessing requirements may be a barrier to access for voluntary assisted dying for some people: J Rutherford, 'Doctors and the Voluntary Assisted Dying Act 2017 (Vic): Knowledge and General Perspectives' (2020) 27 *Journal of Law and Medicine* 952, 962.

8.408 Accordingly, the draft Bill provides that a person is ineligible to witness the signing of the second request if the person:

- knows or believes that the person—
  - is a beneficiary under a will of the person making the request; or
  - may otherwise benefit financially or in any other material way from the death of the person making the request; or
- is an owner, or is responsible for the management, of any health facility at which the person making the request is being treated or resides; or
- is the coordinating practitioner or consulting practitioner for the person making the request.

8.409 First, a person who is a beneficiary under the will of the person making the request, or who would otherwise benefit from the person's death, should not be eligible to be a witness because this may give rise to an actual or perceived conflict of interests.

8.410 Second, a person should not be eligible to be a witness if that person owns, or has responsibility for the management of, any health facility at which the person making the request is being treated or resides. If this person were to act as a witness, that may give rise to some perception of impropriety.

8.411 However, a person should not be ineligible as a witness because they are:

- an employee or agent of a health facility, residential service or professional care service at which the person making the declaration is being treated or resides;
- a resident in the facility, owned or operated by a residential care provider in relation to the person, in which the person making the request resides; or
- a person who is directly involved in providing health services or professional care services to the person making the declaration.

8.412 These relationships do not, in our view, necessarily create a situation in which witnessing the person's second request for access would be perceived to be improper or give rise to a conflict of interests. Further, excluding these people as witnesses may have the effect of unduly narrowing the pool of potential witnesses available to the person. This approach recognises that, particularly for people residing in these types of facilities or services, it may be difficult to locate and arrange for the presence of two witnesses who are eligible to witness the person's written declaration.

8.413 Finally, the coordinating practitioner or the consulting practitioner should not be eligible to witness the second request. This would be inappropriate, given that the practitioner is also in the position of assessing the person's eligibility to access voluntary assisted dying. It is necessary for the witnesses to the second request to be separate from the practitioners who are assessing the person.

8.414 The draft Bill does not follow the approach taken in the Tasmanian Act of providing that only one of the witnesses must not be ineligible to act as a witness to the signing of the second request. A requirement for the second request to be witnessed by two people who both meet the eligibility criteria may sometimes be difficult for a person to satisfy; for example, because the person has a small circle of family and friends, or lives in a regional or remote area of Queensland. However, such a requirement is an important safeguard to assist in ensuring that a person is acting freely and voluntarily, and is not subject to coercion.

8.415 In addition, the criteria for determining who is ineligible to be a witness in the draft Bill, which are not as restrictive as in some other jurisdictions, will mitigate at least some of the difficulty that might be experienced by people attempting to arrange for the witnessing of a second request. Under that criteria, a second request could be witnessed by, for example, another person residing at the same facility as the person

making the request, an employee of a facility where the person is residing or receiving treatment, or another person who is providing the person with health or care services (other than the coordinating practitioner or the consulting practitioner).

8.416 The draft Bill does not include any additional limitations about a person's family members acting as witnesses to the second request. One or both witnesses may be family members of the person, provided that they are not ineligible to witness the second request for one of the reasons described previously. We consider that excluding, as a witness, anyone who is a beneficiary in the person's will or who would otherwise benefit from the person's death, is a sufficient safeguard. To include further limitations on family members acting as witnesses has the potential to create or exacerbate difficulties associated with satisfying the witnessing requirements.

8.417 As in some other jurisdictions, provision could be made for there to be a pool of volunteer witnesses that can be drawn upon in situations where a person has difficulty sourcing two people to act as witnesses.[226]

THE FINAL REQUEST FOR ACCESS TO VOLUNTARY ASSISTED DYING

8.418 In Australian jurisdictions, and in the White and Willmott Model, a person must make a final request for access to voluntary assisted dying.

Victoria and Western Australia

8.419 If the person has made a written declaration, they may make a third and final request for access, subject to the requirement about waiting periods discussed below. The final request must be made by the person to their coordinating practitioner and may be made verbally or by gestures or other means of communication available to the person. The Western Australian Act also provides that the request must be 'clear and unambiguous'.[227]

8.420 Once the person has made the final request, the coordinating practitioner is required to complete a final review. This means that they must review all the required forms (including the first assessment report form, all consulting assessment report forms and the written declaration),[228] and complete the final review form and give a copy of it to the Board.[229] The coordinating practitioner must certify that the request and assessment process has been completed in accordance with the legislation.[230] This does not, however, require the coordinating practitioner to reassess the person's eligibility for access.

8.421 This requirement was recommended by the Victorian Panel. It considered that the medical practitioner should be required to complete a final check and confirm that every step has been completed and that all the eligibility criteria have been fulfilled before they prescribe a lethal dose of medication.[231]

8.422 This is the end of the 'request and assessment process' established by the legislation in Victoria and Western Australia.[232] However, it is not the final step in the voluntary assisted dying process, which goes on to provide for the administration of the substance.

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226 Eg, Praslickova, Kelly and Wiebe, above n 182.

227 *Voluntary Assisted Dying Act 2017* (Vic) s 37; *Voluntary Assisted Dying Act 2019* (WA) ss 47, 158(2). In Victoria, the Act states that the request 'must be made by the person personally'. In Western Australia, the request must be made in person or, if that is not practicable, by audio-visual communication.

228 In Victoria, the coordinating practitioner must also review the contact person appointment form.

229 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definitions of 'final review' and 'final review form'), 41, sch 1, Form 5; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definitions of 'final review' and 'final review form'), 51.

230 *Voluntary Assisted Dying Act 2017* (Vic) s 41(1)(c); *Voluntary Assisted Dying Act 2019* (WA) s 51(3)(d).

231 Vic Ministerial Advisory Panel Final Report (2017) 132, Rec 30. This does not require the coordinating practitioner to reassess the person's eligibility for access to voluntary assisted dying.

232 *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definition of 'request and assessment process'); *Voluntary Assisted Dying Act 2019* (WA) ss 6 (definition of 'request and assessment process'), 8.

White and Willmott Model

8.423 If the person has made a written declaration, they may make a final request for access to the first medical practitioner, subject to the requirement about waiting periods discussed below. The final request must be 'clear and unambiguous', made by the person personally, and may be made verbally or by gestures or other means of communication available to the person.[233]

8.424 However, unlike Victoria and Western Australia, the White and Willmott Model requires that the final request must be made immediately before the person is provided access.[234] The final request in the request and assessment process is therefore also the final step in the voluntary assisted dying process; it is made contemporaneously with the administration of the substance.

8.425 Consequently, the White and Willmott Model also requires that the final request must be made in the presence of a witness, and that the first medical practitioner must refuse to accept the request if they are not satisfied of any of the following:[235]

- the person has made a written declaration;
- the person has decision-making capacity in relation to voluntary assisted dying;
- the person's request is made voluntarily and without coercion;
- the person's request is enduring; and
- the person understands that access will be provided immediately after making the final request.

8.426 Upon receiving a final request from a person, the first medical practitioner may provide access to that person in accordance with their final request.[236]

Tasmania

8.427 If the consulting medical practitioner determines that the person is eligible, the person may make a final request to their primary medical practitioner.[237]

8.428 The request must be made in writing in an approved form and signed by the person (or, if they are unable to sign, by another person who has been designated to sign on behalf of the person who is making the request).[238]

8.429 If the person has made a final request, the primary medical practitioner must determine the final request, by again determining the person's eligibility for access.[239] If the primary medical practitioner determines that the person is eligible, then they may go on to take the final steps associated with administration of the substance.

The Commission's view

8.430 In accordance with the decision that the draft Bill adopt a staged request and assessment process, and consistently with the approach in Victoria and Western Australia, the draft Bill provides that a person who has made a second request may make a third and final request to their coordinating practitioner for access to voluntary assisted dying. As with the first request, this request must be clear and unambiguous and must be made by the person personally and not by another person on their behalf. The person may make the final request verbally, or by gestures or another means of communication that is available to them.

233 White and Willmott Model cl 30(1)–(3).
234 White and Willmott Model cll 33(3), 34.
235 White and Willmott Model cll 30(1), (5), 32.
236 White and Willmott Model cl 34.
237 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 53 (1)–(2). The request must be made at least 48 hours after the second request to the primary medical practitioner, unless the person is likely to die within seven days or lose decision-making capacity within that 48 hour period.
238 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 53(3). A person cannot designate their primary medical practitioner or consulting medical practitioner to sign the approved form on their behalf.
239 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 55–58.

8.431 The making of the final request must also comply with the requirements about the waiting period that must elapse between a person's first and final requests, as discussed separately below.

8.432 When a person makes a final request for access, the draft Bill requires the coordinating practitioner to record in the person's medical records the date on which the request was made and, if it was made before the end of the waiting period, the reasons why it was made at that earlier time. The coordinating practitioner is also required to complete a form recording the receipt of the final request and give a copy of it to the Board.

8.433 In all the circumstances, it is appropriate to require that this final request be made. This is another step in the request and assessment process which will demonstrate the person's ongoing commitment to their decision to access voluntary assisted dying.

8.434 The draft Bill does not adopt the Tasmanian approach of requiring that the coordinating practitioner must again determine the person's eligibility for voluntary assisted dying. However, the coordinating practitioner should be required to undertake a final review, and this will include a requirement for the practitioner to indicate they are satisfied that the person has decision-making capacity and is acting voluntarily and without coercion.

8.435 As explained in connection with the administration of the substance,[240] the draft Bill also does not adopt the approach in the White and Willmott Model which requires that the final request be made immediately before the person is provided with access. It is appropriate that the prescription, supply and administration of the substance be separately regulated in the draft Bill.

8.436 As in Victoria and Western Australia, on receiving a final request for access from a person, the coordinating practitioner will be required to undertake a final review. This provides an additional 'check' to make sure that the earlier forms are in order, that the completion of the request and assessment process is compliant with the requirements of the legislation, and that the coordinating practitioner remains satisfied of particular matters relevant to eligibility.

8.437 Specifically, the draft Bill requires that the coordinating practitioner review the first assessment record form, consulting assessment record form and second request, and complete the approved form (the 'final review form'). Among other things, the final review form must certify that the request and assessment process was completed in accordance with the requirements of the legislation, and that the coordinating practitioner is satisfied that:

- the person has the required decision-making capacity;
- the person, in requesting access, is acting voluntarily and without coercion.

8.438 In the final review, the coordinating practitioner must also take account of any decision made by QCAT on review of a relevant decision.[241]

8.439 As in Victoria and Western Australia, the completion of the final review will mark the completion of the request and assessment process. The draft Bill separately provides for administration of the substance.

240 See Chapter 10 below.
241 See Chapter 16 below for the effect of a tribunal decision.

WAITING PERIODS

Victoria and Western Australia

8.440 The legislation in Victoria and Western Australia ordinarily requires a period of at least nine days between a person's first and final requests.[242]

8.441 However, that requirement does not apply if the coordinating practitioner and the consulting practitioner both consider that the person is 'likely' to die or, in Western Australia, to lose the required decision-making capacity, within that period of time.[243]

8.442 In any case, the final request must be made at least one day after the day on which the consulting assessment was completed.[244] Therefore, the minimum time over which the request and assessment process can be completed is two days.

8.443 Waiting periods are included to ensure that the process is not rushed, and that people have time to reflect and make a well-considered decision. A waiting period of nine days was considered an appropriate balance between the need to ensure a person's decision is well-considered and to avoid 'unnecessarily prolonging' the person's suffering.[245]

8.444 In Victoria, it was acknowledged that where a person's death is imminent the usual waiting period would be unreasonable, as it would 'effectively preclude them from accessing voluntary assisted dying and … impose further days of intolerable suffering'. However, it was concluded that reducing the waiting period due to an imminent loss of decision-making capacity would be 'inappropriate':[246]

> Concern about an imminent loss of decision-making capacity may pressure a person to make the decision to request voluntary assisted dying quickly, without fully considering their options and the possibility of continued enjoyment of life, whereas an imminent death within 10 days means that a person does not have the option of continued enjoyment of life.

8.445 In contrast, the Western Australian Panel recommended that the waiting period should be reduced if a person is likely to lose decision-making capacity. This recognised 'the increased suffering the person could experience through fear of losing capacity (for example by ceasing pain medications because they are worried it might cause them to lose capacity)'. However, the person must, at all points in the process for voluntary assisted dying, retain decision-making capacity for voluntary assisted dying.[247]

8.446 In some cases, a person may have decision-making capacity at the time of making their first request, but be at risk of losing that capacity due to the nature of their disease, illness or medical condition, the medication they are taking, or their closeness to death.[248] An ability to reduce the waiting period in these circumstances provides a mechanism for a person to complete the process before they lose capacity.

242 *Voluntary Assisted Dying Act 2017* (Vic) s 38(1)(a); *Voluntary Assisted Dying Act 2019* (WA) s 48(1), (2)(a). In practice, the timing differs. In Victoria, the day of the first request is not included as one of the nine days, meaning that the final request may be made on the tenth day after the first request was made. In Western Australia, the nine day period begins on the day of the first request, meaning that the final request may be made on the ninth day: Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 13, citing *Interpretation of Legislation Act 1984* (Vic) s 44; *Voluntary Assisted Dying Act 2019* (WA) s 48(1).

243 *Voluntary Assisted Dying Act 2017* (Vic) s 38(2); *Voluntary Assisted Dying Act 2019* (WA) s 48(3). In Victoria, the waiting period does not apply if the coordinating practitioner considers that the person's death is likely to occur before the expiry of the specified time period, and this is consistent with the prognosis of the consulting practitioner in the consulting assessment report form. In Western Australia, the final request may be made before the end of that period if, in the coordinating practitioner's opinion, the patient is likely to die, or to lose decision-making capacity, before the end of that period, and that opinion is consistent with the opinion of the consulting practitioner.

244 *Voluntary Assisted Dying Act 2017* (Vic) s 38(1)(b); *Voluntary Assisted Dying Act 2019* (WA) s 48(2)(b). See further Vic Ministerial Advisory Panel Final Report (2017) 124, Rec 24.

245 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 16; Vic Ministerial Advisory Panel Final Report (2017) 123–25, Recs 23, 25; WA Ministerial Expert Panel Final Report (2019) 69–71, Rec 19.

246 Vic Ministerial Advisory Panel Final Report (2017) 124, Rec 24.

247 WA Ministerial Expert Panel Final Report (2019) 71, Rec 20.

248 Ibid 24.

8.447 The requirement for the final request to be made at least one day after the day on which the consulting assessment was completed was recommended by the Victorian Panel, which explained that:[249]

> During the second independent assessment, the person will have a further opportunity to discuss and consider the required information and should have time to reflect. The final verbal request should not be a mere formality but should demonstrate the enduring nature of the person's request. The requirement that a final verbal request cannot be made on the same day that the second independent assessment is completed should never be waived. The requirement ensures that, no matter what the circumstances, a person cannot rush through the voluntary assisted dying process.

8.448 The Board reported that most applications for access took a few weeks. Specifically, it was reported that '[f]or all voluntary assisted dying applications where a final request was made, 25 per cent were progressed between the first and final request within 11 days, and 50 per cent within 17 days'.[250]

Tasmania

8.449 The Tasmanian Act does not prescribe a period that must elapse between the first and final requests. However, it provides that the person must not:[251]

- make a second request within 48 hours of making the first request; or
- make a final request within 48 hours of making the second request;

unless the person is likely to die within seven days, or the person is likely to cease to have decision-making capacity within 48 hours.

8.450 In a document prepared to assist the parliamentary debate in Tasmania, Go Gentle Australia stated:[252]

> The primary (coordinating) medical practitioner is best placed to judge the enduring nature of a person's request in the context of the trajectory of their condition. The independent secondary (consulting) medical practitioner is best placed to act as a safeguard to ensure the judgement of the coordinating doctor is reasonable. The legislation allows that these assessments, combined with the requirement that a patient be 'at the end-of-life', provide the necessary protection to ensure requests are properly considered, while also taking into account a person's condition and likely deterioration.
>
> The time between each step in the process would, of itself, provide some period for reflection. The person would always have the protection of being able to withdraw from the process at any stage.

Overseas jurisdictions

8.451 State legislation in the United States generally provides a waiting period of 15 days (or, in some states, 20 days) between the first and final request. In many of those jurisdictions, an additional waiting period of 48 hours applies between the final request and when the substance is prescribed. The legislation in Oregon was recently amended to enable the waiting periods to be shortened to any time if, in the medical practitioner's reasonable judgment, the patient will die before the expiration of those waiting periods.[253]

8.452 The federal legislation in Canada does not include a required waiting period where a person's natural death is 'reasonably foreseeable'. It was explained that this is because individuals have 'given [medical assistance in dying] a lot of consideration by the time

249 Vic Ministerial Advisory Panel Final Report (2017) 124, Rec 24.
250 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 9.
251 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 30(2), 53(2).
252 Go Gentle Australia, *A Guide to the Debate on Voluntary Assisted Dying in Australia* (August 2020) 20.
253 *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.840.3.06, 127.850.3.08. For requirements in other states, see, eg, *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.3(a).

they make a written request' and because 'the waiting period unnecessarily prolongs suffering'.[254]

8.453 However, where the person's natural death is not reasonably foreseeable, the Canadian legislation requires '90 clear days' between the commencement of the first assessment and the day on which medical assistance in dying is provided, or any shorter period if loss of capacity to consent is imminent.[255] This is an assessment period (not a reflection period) and 'will help ensure that practitioners spend sufficient time exploring the various dimensions of the person's … request, which, outside the end of life context, could be motivated by different sources of suffering requiring greater attention'.[256]

8.454 The New Zealand Act does not prescribe a waiting period. The legislation in Belgium, Luxembourg and the Netherlands provides, variously, that the person's request must be 'well considered' or made 'after reflection' but does not specify a waiting period.[257]

Submissions

8.455 The Consultation Paper asked whether the draft legislation should include provisions about the prescribed period that must elapse between a person's first request and final request, in similar terms to the Victorian and Western Australian Acts. It also asked whether, if there is a prescribed period, the draft legislation should provide that the final request can be made before the end of the prescribed period if:[258]

(a) the person is likely to die within that period; or

(b) the person is likely to lose decision-making capacity for voluntary assisted dying within that period.

8.456 On one hand, respondents considered that the inclusion of a prescribed waiting period is an 'important safeguard', and that it must be long enough to ensure that the person's request is well-considered and enduring, and free from external pressure or coercion. On the other hand, respondents considered that the prescribed period should not be so long that it unnecessarily delays the process, given that the person is dying and suffering.

8.457 Many respondents submitted that the draft legislation should include provisions about the prescribed period that must elapse between a person's first request and final request for access, in similar terms to the legislation in Victoria and Western Australia. Most of those respondents also submitted that there should be provision for the final request to be made before the end of the period if the person is likely to die, or lose decision-making capacity, within that period.[259]

8.458 AMA Queensland submitted that 'nine days strikes an appropriate balance between ensuring the decision is well considered and avoiding unnecessarily prolonging a person's suffering'.

8.459 Dying with Dignity NSW submitted that nine days 'does not seem excessive', noting that the assessment process takes time. This respondent also submitted that provision to shorten the period reflects both 'compassion and common sense', noting that '[i]n both

254 An Act to amend the Criminal Code (medical assistance in dying), Canada, Bill C7, 2020 cl 1(3), (5); J Nichol and M Tiedemann, 'Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying)' (Legislative Summary No 43-1-C7-E, Library of Parliament, Canada, 27 March 2020) [2.3]; Canada, *Parliamentary Debates*, House of Commons, 26 February 2020, 1620 (D Lametti, Minister of Justice). It was noted during parliamentary debates that there were some instances of people not taking their pain medications, to retain capacity to make a final decision following the original 10 day waiting period.
There were concerns about removing the waiting period. For example, it was suggested that statistics about applicants who subsequently have a change of mind 'demonstrate a need for a period of reflection': Nichol and Tiedemann, above n 254, [3.4].

255 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3.1)(i); Nichol and Tiedemann, above n 254, [2.3]. Concerns were raised that a 90 day waiting period would 'require individuals to suffer intolerably while waiting': Nichol and Tiedemann, above n 254, [3.4].

256 Canada, *Parliamentary Debates*, House of Commons, 26 February 2020, 1621, 1623 (D Lametti, Minister of Justice).

257 *Belgian Euthanasia Act 2002* art 3(1); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(1)(2); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(a).

258 QLRC Consultation Paper No 79 (2020) Q-20, Q-21.

259 Palliative Care Social Work Australia submitted that there should be provision for the prescribed period to be reduced 'on the proviso that the final request can only be made early if medical palliative options are insufficient to resolve the acute symptoms or pain of the patient; otherwise palliative care would be sufficient'.

cases we are talking about people very near death, and both compassion and common sense suggest that an arbitrary wait serves no purpose at all'.

8.460 Professors White and Willmott continued to support the approach in the White and Willmott Model, which includes a provision in similar terms to Victoria for a waiting period of at least nine days between the first and final request (excluding the day on which the first request is made), with provision for it to be reduced if the person is likely to die before the end of that period. They also supported including a provision for the prescribed period to be reduced if the person is likely to lose decision-making capacity, as in Western Australia.[260]

8.461 Some respondents submitted that the prescribed period should be shorter than in Victoria and Western Australia.

8.462 A member of the public submitted that a prescribed period of 48 hours would be reasonable.[261] Another member of the public submitted that the prescribed period should be five clear days between the first and last request to acknowledge 'the speed at which health can deteriorate with advanced disease'. Those respondents submitted that, if the prescribed period is kept minimal to begin with, there is no need to make provision for it to be reduced.

8.463 Some respondents submitted that the prescribed period should be seven days.[262] Most of those respondents also submitted that there should be provision for the final request to be made before the end of the period if the person is likely to die, or lose decision-making capacity, within that period. A member of the public submitted that provision to reduce the waiting period is 'consistent with the principles of compassion, respect, dignity and autonomy'. They further noted that:

> there must be exceptions to cater for people in very poor condition who experience rapid progression of grievous and irremediable distressing symptoms. In these instances it would be cruel and inhumane to force them to suffer while waiting for the seven days to lapse.

8.464 Go Gentle Australia submitted that there should be a minimum waiting period 'to enable reflection by the person about the decision to access voluntary assisted dying', but that this should be 'as short as reasonably possible', and no more than 10 days. This respondent also submitted that there should be provision for the waiting period to be reduced if the person is likely to die or lose capacity within the period, stating that:

> [i]t would be unreasonable to make them wait, as delay may effectively preclude them from accessing voluntary assisted dying and will impose further days of intolerable suffering.

8.465 However, some respondents submitted that there should be no provision to reduce the waiting period.

8.466 A church organisation delivering health and aged care services submitted that:

> It is not uncommon for people to change their mind at different stages of the process. It is therefore critical for [there to be] an adequate waiting time, without this being too long for people experiencing unrelievable suffering. We do not support a provision for a reduced timeframe because of the likelihood of death before the timeframe is completed or because of the risk of losing decision-making capacity.

260 The White and Willmott Model also provides that, in any case, the final request must be made 'at least one day after the day on which the second assessment that assessed the person as eligible for access … was completed': White and Willmott Model cl 33(1).

261 This respondent submitted that:

> Although it is useful and important to give [the person] an opportunity to reconsider their request, that waiting period is almost certain to be a period of enforced unwanted and unnecessary pain and suffering. I think a waiting period of 24 hours might be too short and impractical and that a period of 48 hours is reasonable. Longer would be too long.

262 For example, one respondent submitted that there should be a brief period of 'perhaps a week', and another submitted that the prescribed period should be five to seven days.

8.467 That respondent submitted that a minimum of two weeks between the first and final request:

> will give space for people to have as many opportunities as possible to consider their decision, to reflect deeply upon their decision, to receive palliative care and process the complex array of emotions and grief experienced by the individual, and their families and friends. This will also be an additional safeguard from external pressure to rush the process.

8.468 A member of the public submitted that a minimum waiting period should be 'strictly applied', as any reduction in the waiting period leaves the person open to abuse. This respondent considered that less stringent obligations should not apply because a person is likely to die within the period, as this 'raises concerns about people making rash decisions, or being forced into quick decisions against their will'. They also submitted that there should be no reduction if the person is at risk of losing capacity as that can be a means 'to hurry them up with dying before their loss of capacity materialises'.

8.469 Palliative Care Nurses Australia Inc. submitted that the waiting period is an 'important safeguard'. This respondent submitted that the draft legislation should not initially provide that the final request can be made before the end of the prescribed period if the person is likely to die or lose decision-making in that period, but that 'this could be considered at the scheduled review' of the legislation.

8.470 A medical defence organisation and professional indemnity insurer submitted that the inclusion of prescribed periods 'can provide clarity for doctors and reduce uncertainty about timeframes for various steps of a voluntary assisted dying process'. This respondent also stated that 'doctors could face complex challenges if the discretion to waive a minimum timeframe was essentially theirs alone'.

8.471 In contrast, a few respondents, including a New Zealand voluntary assisted dying advocacy group and a member of the public, submitted that there should be no prescribed period that must elapse between the first request and final request.

8.472 The End of Life Choice Society New Zealand Inc submitted that the inclusion of a waiting period only adds to the 'lengthy and onerous' process, potentially prolongs the person's suffering, and 'sometimes results in people dying in great suffering while waiting for the prescribed period to lapse'.[263] This respondent also submitted that 'the eligibility requirement to be in an advanced state of irreversible decline and experiencing unbearable suffering…already gives the person ample time to reconsider and retract [their request] if that is their wish'.

8.473 A former Chief Minister of the Northern Territory, the Hon Marshall Perron, similarly stated that 'most applicants will have been pondering their end of life options since receiving a terminal diagnosis', and should not be required to '"suffer a little longer" solely to show us they are serious'. Christians Supporting Choice for Voluntary Assisted Dying also noted that most people who request voluntary assisted dying will have undergone months if not years of treatment, giving them 'ample time to consider end of life options including [voluntary assisted dying]'.[264] Those respondents submitted that, if a waiting period is included, it should be kept to a minimum, and there should

263 This respondent referred to the Victorian Voluntary Assisted Dying Review Board Report of Operations January–June 2020, and stated that:

> It appears that a best-case scenario would see a minimum of 15 days elapse between first request and the release of the medication. Only 25% of people are able to achieve this turnaround time while the remaining 75% wait much longer, sometimes up to one month just to see a specialist. The 15-day timeframe is calculated as 11 days from first to final request, 2 days to consider the application and 2 days to prepare the medication …. In addition, further time must be allowed for the Statewide Pharmacy Service to make a faceto-face visit to both the coordinating physician and to the person to explain how to use the medication. General comments in the Review Board's report are that the process is experienced by the coordinating physician, person and family to be too slow: the addition of a waiting period would only add to that burden' (note omitted)

264 This respondent also noted that there are no prescribed waiting times that apply in relation to decisions to refuse life saving or life sustaining treatment, or to use terminal sedation.

be provision for it to be reduced if the person is likely to die or lose capacity within the period. Christians Supporting Choice for Voluntary Assisted Dying submitted that 'the autonomy and wishes of the dying patient should take priority'.

The Commission's view

8.474 The draft Bill includes an explicit provision about the minimum time that must elapse between a person's first and final requests for access to voluntary assisted dying. Generally, this provision adopts the approach taken in Victoria and Western Australia.

8.475 The inclusion of a waiting period is appropriate as a means of ensuring that a person's decision is not rushed, and that a person has a period of time to reflect on their choices. A decision to access voluntary assisted dying is not likely to be made suddenly or lightly, and in many cases will result from the person having already given the matter careful consideration. However, there might also be some circumstances where this is not the case. In those circumstances in particular, a period of reflection could operate as an important safeguard.

8.476 To some extent the operation of the request and assessment process will naturally create a period of time over which a person can consider (and must sustain) their decision. However, particularly as voluntary assisted dying becomes an established end of life option and access increases, this may not always be the case. The inclusion of a minimum required period of time between the first and final requests ensures that there will be a minimum period of time for consideration and reflection.

8.477 A waiting period of nine days between the 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.

8.478 However, 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 within that period. To require a person to wait in those circumstances would be unreasonable, because it would prevent the person from accessing voluntary assisted dying and require that they experience further suffering.

8.479 The waiting period should also be able to be reduced if the person is likely to lose the required decision-making capacity within that period. Requiring a person to wait in those circumstances could also preclude them from access, and may have the added effect that the person will continue to suffer for some time afterward if their death is not imminent. Further, as explained by the Western Australian Panel, fear of losing capacity may also lead to increased suffering.

8.480 As discussed elsewhere, the legislative scheme for voluntary assisted dying in Queensland will not apply to a person who loses decision-making capacity part way through the process. An ability to reduce the waiting period in circumstances where a person is at risk of losing capacity provides a mechanism for a person to complete the process before they become ineligible.

8.481 In circumstances where there is a decision to reduce the waiting period, the views of the coordinating practitioner and the consulting practitioner must be consistent. Accordingly, the coordinating practitioner must be of the opinion that the person is likely to die or to lose decision-making capacity before the end of the waiting period, and their opinion must be consistent with the opinion of the consulting practitioner as expressed in the consulting assessment. This approach makes clear that, in reaching this decision, reliance can be placed on the consulting assessment and it is not necessary for a person to undergo any further assessment.

8.482 Finally, the draft Bill includes a requirement that the final request must be made at least one day after the day on which the consulting assessment is completed. The consulting assessment includes a requirement that the person is given information, and in some circumstances the consulting practitioner may offer the person new information. In

any event, it is necessary for the person to have time to consider and reflect on the information. Further, the making of a final request is part of the overall process which demonstrates that a person's decision is ongoing. For those reasons, at least one day should elapse between the consulting assessment and the final request.

8.483 However, this does not necessarily preclude a person from making the second request and the final request for access on the same day. As long as one day has elapsed between the completion of the consulting assessment and the final request, there are no further limitations on the timing of those requests.

8.484 Accordingly, the draft Bill provides that a person may not make a final request:

- before a period of nine days has elapsed, from and including the day on which the person made their first request for access, unless an exception applies; and
- in any case, until the day after the day on which the consulting assessment that assessed the person as meeting the requirements of a consulting assessment was completed.

8.485 However, the draft Bill also provides that a person may make their final request before the end of that nine day period if:

- in the opinion of the coordinating practitioner, the person is likely to die, or to lose the required decision-making capacity, before the end of that period; and
- the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner in the consulting assessment.

NO OBLIGATION FOR A PERSON TO CONTINUE THE VOLUNTARY ASSISTED DYING PROCESS

Victoria and Western Australia

8.486 In Victoria and Western Australia, the 'request and assessment process' is defined to mean, in respect of the person, 'a first request, a first assessment, a consulting assessment, a written declaration, a final request and a final review'.[265]

8.487 The Acts each provide that the person is under no obligation to continue the request and assessment process after making the first request and can decide not to continue the process at any time.[266] This 'reflects the voluntary nature of voluntary assisted dying, and that in order for the [request and assessment] process to continue, the person's choice to participate is paramount'.[267]

8.488 If the person has decided not to continue with the request and assessment process, then that process will end. The person can commence a fresh request and assessment process by making a new first request.[268] The Victorian Panel explained that:[269]

> For clarity, when a person withdraws their request for voluntary assisted dying and subsequently makes another request, they must commence the request and assessment process from the beginning. This is because a request for voluntary assisted dying should be enduring, and not a transitory or reactionary response.

265 *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of 'request and assessment process'); *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'request and assessment process'). In Victoria, it also includes the appointment of a contact person.

266 *Voluntary Assisted Dying Act 2017* (Vic) s 12(1); *Voluntary Assisted Dying Act 2019* (WA) s 19(1).

267 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 8. See also Vic Ministerial Advisory Panel Final Report (2017) 94, stating that 'it is of fundamental importance that the person feels free to withdraw from the voluntary assisted dying process at any time and does not feel under any pressure to proceed'.

268 *Voluntary Assisted Dying Act 2017* (Vic) s 12(2)–(3); *Voluntary Assisted Dying Act 2019* (WA) s 19(2)–(3).

269 Vic Ministerial Advisory Panel Final Report (2017) 94.

8.489 The Victorian and Western Australian Acts also provide that there is no obligation for the person to continue after the final review is completed and certified (the end of the request and assessment process). The person may decide at any time not to take any further step in relation to access.[270]

8.490 In Victoria, the Board reported that, between July and December 2020, 'applications were rarely withdrawn due to the applicant deciding not to proceed' and that 'less than two per cent of withdrawn cases were due to the applicant changing their mind'.[271]

White and Willmott Model

8.491 The White and Willmott Model includes a provision that a person may decide at any time not to take any further step in relation to access. The person may express their decision verbally or by gestures or other means of communication available to the person.[272]

Tasmania

8.492 The Tasmanian Act provides that a person may withdraw from the voluntary assisted dying process at any time by informing their primary medical practitioner or administering health practitioner that they no longer wish to access voluntary assisted dying, either orally or in writing.[273] The process then ends for the person. However, the person can make another first request and commence the process from the beginning.[274]

New Zealand

8.493 The New Zealand Act provides that a person can rescind their request to exercise the option of receiving assisted dying at any time. If the person has rescinded their request, the attending medical practitioner or attending nurse practitioner must take no further action in respect of the person's request. However, if the person wishes to exercise the option of receiving assisted dying at any subsequent time, the person may make a new first request.[275]

The Commission's view

8.494 One of the key features of the proposed voluntary assisted dying scheme in Queensland is that participation in the scheme is entirely voluntary. There are no circumstances in which a person could be required to engage with the scheme.

8.495 Further, if a person has chosen to engage with the scheme, they may change their mind about doing so at any time. A person who has sought access may decide at any point, from the beginning of the process until the administration of the substance, that they no longer wish to access voluntary assisted dying.

8.496 It is critical that the legislation makes clear that participation is voluntary, and that a person can change their mind at any time. There are two points at which this should be explicitly addressed by the draft Bill.

8.497 First, the draft Bill provides that a person who has made a first request is not obliged to continue with the request and assessment process. As explained previously, that process comprises the first request, first assessment, consulting assessment, second request and final request.

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270 *Voluntary Assisted Dying Act 2017* (Vic) s 44; *Voluntary Assisted Dying Act 2019* (WA) s 53. This provision 'reflects the voluntary nature of voluntary assisted dying, and that in order for the process to continue, the patient's choice to participate is paramount and must be enduring': Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 17.

271 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 3, 5, 12. The Board also reported that 14.2% of withdrawals were due to some 'other reason' which may include, for example, 'an administrative error, deterioration or improvement in condition and thus no longer meeting eligibility criteria and a transfer of care to a different medical practitioner or health service': 12.

272 White and Willmott Model cl 36.

273 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 16(1).

274 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 16(2)–(3).

275 *End of Life Choice Act 2019* (NZ) ss 11(2)(d), 23. Additionally, the New Zealand Act requires a medical or nurse practitioner to end the voluntary assisted dying process if they suspect on reasonable grounds that the person who has expressed a wish to access it 'is not expressing their wish free from pressure of any other person': *End of Life Choice Act 2019* (NZ) s 24.

8.498 In circumstances where a person decides not to continue with the request and assessment process, that process should end. If the process ends in this way but the person later decides that they do wish to access voluntary assisted dying, the person can make a new first request and commence a new request and assessment process. A person should not be able to reinvigorate a request and assessment process that they previously decided to discontinue, because the process should be begun again so that the person can undergo a current assessment.

8.499 Accordingly, the draft Bill makes it clear that there is no obligation for a person to continue after making a first request by providing that:

- the person may decide at any time not to continue the request and assessment process;
- the request and assessment process ends if the person decides not to continue the process;
- if the request and assessment process is ended in this way, the person may begin a new request and assessment process by making a new first request.

8.500 Second, the draft Bill makes it clear that a person who has completed the request and assessment process and has been found eligible for access is not obliged to continue. For example, a person may choose not to fill their prescription for the substance, or may tell their coordinating practitioner or a treating medical practitioner that they no longer wish to access voluntary assisted dying.

8.501 Accordingly, the draft Bill also provides that a person for whom the request and assessment process is completed may decide at any time not to take any further step in relation to access.

REPORTING REQUIREMENTS

Victoria and Western Australia

8.502 At various stages in the process, the coordinating practitioner and the consulting practitioner are required to report to an independent Board that monitors the process. In Victoria and Western Australia, the Board conducts a review to ensure that the legislation is complied with and the correct process is followed in each case. Reporting requirements also assist the Board in maintaining statistics about participation in voluntary assisted dying.[276]

8.503 In particular, in both Victoria and Western Australia, reports must be given in the approved forms to notify the Board:[277]

- of the outcome of eligibility assessments (the 'first assessment report form' and the 'consulting assessment report form');[278] and
- that the final review has been completed (the 'final review form').[279]

8.504 Those reports must be given to the Board within seven days (Victoria) or two business days (Western Australia) of the eligibility assessment or final review.[280]

276 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 11.

277 Similar reporting requirements exist in New Zealand: see *End of Life Choice Act 2019* (NZ) ss 12(5)(c), 13(2), 14(4), 15(4), 16(5), 17(3).

278 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definitions of 'first assessment report form' and 'consulting assessment report form'), 21(2), 30(1)(b)(i), (2), sch 1, Forms 1–2; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definitions of 'first assessment report form' and 'consulting assessment report form') 29(2), (4), 40(2), (4).

279 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'final review form'), 41, sch 1, Form 5; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'final review form'), 51(1)(b), (3), (4).

280 The request and assessment process is not invalidated by any minor or technical error in a form. As such, a spelling mistake in a person's name or an accidentally incorrect date on a witness's signature 'does not have the effect of invalidating a person's entire request and assessment process': *Voluntary Assisted Dying Act 2017* (Vic) s 42; *Voluntary Assisted Dying Act 2019* (WA) s 52; Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 15; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 17.

8.505 In Victoria, the coordinating practitioner must give a copy of all the required forms completed in connection with the process together with the final review form. This includes a copy of the written declaration, and the form appointing the contact person.[281]

8.506 In Western Australia, the coordinating practitioner and, where relevant, the consulting practitioner must notify the Board progressively at each step of the process. In addition to the above requirements:[282]

- a medical practitioner to whom a person makes a first request must notify the Board in the approved form that the person has made the request, and of their decision to accept or refuse it, within two business days after making that decision (the 'first request form');[283]
- a medical practitioner to whom a person is referred for a consulting assessment must notify the Board in the approved form of the referral, and of their decision to accept or refuse it, within two business days after making that decision (the 'consultation referral form');[284]
- the coordinating practitioner must give a copy of the person's written declaration to the Board within two business days after its receipt;[285] and
- the coordinating practitioner must notify the Board in the approved form that the person has made a final request within two business days after its receipt (the 'final request form').[286]

8.507 In Victoria, the Voluntary Assisted Dying Portal has been established to enable medical practitioners to submit the required forms and evidence to the Board online.[287]

8.508 The secretariat for the Board undertakes an administrative check at the point the forms are submitted to 'ensure sufficient information has been provided'. Once the application is complete (either because the applicant has died or has chosen not to continue with the process), the Board undertakes a review to determine if the case was compliant with the Act.[288] The Board reported that, between July and December 2020, 95 per cent of cases were compliant.[289]

281 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'final review form'), 41(2).

282 Medical practitioners must also record matters in the person's medical record: *Voluntary Assisted Dying Act 2019* (WA) ss 21, 32, 45, 49, 56(5), 57(3)(a), 63(3)(b), 157(4)(b).

Additionally, if the person has made a selfadministration decision, a copy of the administration decision and prescription form must be given within two business days after prescribing a voluntary assisted dying substance, and a copy of the contact person appointment form must be given to the Board by the coordinating practitioner within two business days of receiving it: ss 60, 66. There is no equivalent requirement in Victoria. As explained, the Victorian Act requires the coordinating practitioner to obtain a self-administration permit or a practitioner administration permit.

283 *Voluntary Assisted Dying Act 2019* (WA) s 22. This form includes information about the person and the medical practitioner, the timing and form of the request, the practitioner's decision to accept or refuse it and any reason for refusal, and the date the practitioner informed the person of their decision and gave them the approved information. There is no equivalent requirement in Victoria.

284 *Voluntary Assisted Dying Act 2019* (WA) s 33. Generally, the information in this form is similar to the first request form. There is no equivalent requirement in Victoria.

285 *Voluntary Assisted Dying Act 2019* (WA) s 46. There is no equivalent requirement in Victoria.

286 *Voluntary Assisted Dying Act 2019* (WA) s 50. There is no equivalent requirement in Victoria.

287 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 2, 4. The Board reported feedback from medical practitioners that the portal is difficult to use, and has commenced a project to upgrade the portal, including by improving 'functionality and user experience': Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 8; Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 4.

288 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 4, noting that, in conducting the compliance review, '[t]he secretariat seeks feedback from nominated contact people, medical practitioners and other agencies that support the voluntary assisted dying process'. See also Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 14.

289 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 3, 14. The Board reported that six cases were non-compliant, but the issue was unrelated to the applicant's eligibility. Two related to the return of unused medication, and the remainder to a misinterpretation of the requirement for the coordinating practitioner to be the practitioner who receives and accepts the first request.

Between January and June 2020, 99% of cases were compliant. The Board noted that there was one case where, although the applicant was found to be eligible to apply for a voluntary assisted dying permit, a medical practitioner had not complied with the procedural requirements of the Act. The Board referred the matter to the AHPRA: Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 15.

White and Willmott Model

8.509 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should have 'thorough documentation and reporting requirements'.[290]

8.510 The White and Willmott Model requires the coordinating practitioner to report the outcome of eligibility assessments to the Board in the approved form within 14 days of the assessment being made.[291] The coordinating practitioner must also report to the Board in the approved form within 14 days of providing access. This final report must be provided together with relevant documentation, including the written declaration, the eligibility assessment reports, and a record of the first and final request.[292]

Tasmania

8.511 In Tasmania, there are similar reporting requirements at various stages of the process. Generally, a practitioner is required to notify the Voluntary Assisted Dying Commission:[293]

- that the practitioner has accepted or refused a first request;
- that the person has been given the relevant information in relation to their first request;
- of the outcome of the first request, by giving the Commission a copy of each determination and a statement, in the approved form, of the relevant practitioner's reasons for the determination;
- of the outcome of the second request, by giving the Commission a copy of the determination and a statement, in the approved form, of the practitioner's reasons for the determination;
- of the outcome of the consulting assessment by the consulting medical practitioner, by giving the Commission a copy of the determination;
- of the final request, by giving the Commission a copy of the approved form containing the final request;
- of the outcome of the final request, by giving the Commission a copy of the determination and a statement, in the approved form, of the practitioner's reasons for the determination; and
- if, at any time, a person no longer wishes to access voluntary assisted dying.

8.512 The Act also contains requirements to notify the Commission about the prescription, provision and administration of the substance, and of the person's death.

Submissions

8.513 The Consultation Paper asked at what points during the request and assessment process the coordinating practitioner or the consulting practitioner should be required to report to an independent oversight body; for example, whether they should be required to report:[294]

(a) after each eligibility assessment is completed (as in Victoria and Western Australia);

(b) after the person has made a written declaration (as in Western Australia);

(c) after the person has made their final request (as in Victoria and Western Australia); or

(d) at some other time (and, if so, when)?

290 Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.
291 White and Willmott Model cl 25.
292 White and Willmott Model cl 37.
293 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 16(4)(d), (5)(c), 20(3)(c), 23(c), 24(3), 29(1)(c), 36(1)(c), 50(1)(b), (3)(c), 53(5), 58(1)(c).
294 QLRC Consultation Paper No 79 (2020) Q-27.

8.514 Some respondents supported reporting by the coordinating practitioner or the consulting practitioner to an independent oversight body after each eligibility assessment, after a person's written declaration and after their final request.[295] Palliative Care Nurses Australia Inc. submitted that such requirements would 'support smooth transition of the application and appropriate review by the overseeing body', while the Australian and New Zealand Society for Geriatric Medicine submitted that this will allow the Board to 'make sure that the Act is being complied with'.

8.515 There was a range of other views about when medical practitioners should be required to report to the oversight body. Some respondents supported a requirement for a medical practitioner to report to an independent oversight body after each eligibility assessment and after the person makes a final request, but not after a person has made a written declaration. Other respondents supported a requirement to report only after an eligibility assessment, written declaration or final request.

8.516 Professors White and Willmott reiterated their support for the White and Willmott Model, which requires a coordinating practitioner to report to the Board overseeing the scheme within 14 days of determining a person's eligibility, and again within 14 days of providing a person access. Professors White and Willmott submitted that this is 'a more streamlined approach to reporting than the Victorian approach, while still ensuring accountability and safety'.[296]

8.517 Numerous respondents made other suggestions about how or when medical practitioners should be required to report. For example, these included reporting to an oversight body:

- in the early stages of the process when, for instance, a patient requests assistance;[297]
- when the substance is prescribed to, and possessed by, a person;
- when a person changes their mind about accessing voluntary assisted dying;
- once the person has died; and
- if questions or concerns arise about the process; or
- at each stage of the process.

8.518 Several respondents also considered the effectiveness of the existing Victorian reporting requirements. Some respondents proposed emulating the Victorian Act's reporting framework, whereas others cited early evidence that its reporting requirements impose an administrative burden on medical practitioners and may impede access.

8.519 Some respondents noted that reporting requirements should not be overly bureaucratic or burdensome for medical practitioners. For instance, Dying with Dignity NSW submitted that:

> We believe that requiring reports to be submitted at every stage of the process is extremely cumbersome and will act as a serious disincentive for medical practitioners to be willing to engage with the [voluntary assisted dying] process. Anything that adds time and complexity to the process has the potential to violate patients' rights and to add to their suffering.

8.520 Some respondents suggested that reporting should be via an online portal to maximise convenience, or that it should be limited to the reporting of simple information (such as personal details and the stage of the process that has been reached) and should not require the provision of documents and a review at each stage.

295 The Queensland Law Society expressed general support for reporting requirements.
296 Dying with Dignity Queensland and AMA Queensland also endorsed the approach taken in the White and Willmott Model.
297 One respondent specifically submitted that there should be reporting requirements about requests for access to voluntary assisted dying that are declined.

8.521 Others noted that an accurate and up-to-date reporting system would provide important oversight to the voluntary assisted dying framework. In support of Victoria's reporting framework, Go Gentle Australia submitted:

> Medical practitioners, and others involved in the process, must report in real time. This has the twin effect of reminding them of all their responsibilities under the law – and of the high likelihood that any breaches will be detected and may be investigated.

8.522 A few respondents suggested there should be thorough or comprehensive reporting requirements. For example, the Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine received suggestions that a report might include:

- Medical records including the underlying condition and treatment provided.
- A record of alternative options discussed.
- The nature and length of the practitioner's relationship with the patient.
- A record of requests for assisted dying, consent and dates of approval; and of who has been involved in the decision.
- Details relating to the prescribing and dispensing of the medication; record of the act of assisted dying.
- Security of medication information, for example, dates of return or destruction if applicable.
- The time of death.
- Any complications and lessons from the process.

8.523 The Royal Australasian College of Physicians submitted that reporting is important to enable auditing of the voluntary assisted dying scheme, and to enable monitoring, data collection, research and tracking of outcomes. This respondent submitted that:

> A central database of all who have requested and been declined or approved to access voluntary assisted dying and a research programme that transparently reports the uptake and outcomes of the new legislation over time will be necessary. Areas of key interest include the reasons for requests, patient demographics, requests amongst vulnerable groups, impact on suicide rates, the disposal of unused lethal medication and patient-level reporting processes for pharmacovigilance purposes.

8.524 A few respondents suggested a time frame within which a practitioner must be required to report a particular step, ranging from within two business days to within 14 days of a person's death.

The Commission's view

8.525 The draft Bill requires the coordinating practitioner and the consulting practitioner to record information in a person's medical record, and to report information to the Board at various intervals.

8.526 As in Western Australia, the coordinating practitioner and the consulting practitioner are required to provide progressive notifications to the Board as steps in the request and assessment process are completed.[298]

8.527 The reporting of requests, referrals and outcomes provides a necessary safeguard for both people seeking access to voluntary assisted dying and medical practitioners participating in the scheme. Cumulatively, the reporting requirements provide an ongoing system of checks to ensure compliance with the scheme.[299]

298 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

299 The implementation of these reporting requirements, including the need for information and communications technology that is fit for purpose, is discussed in Chapter 21 below.

The first assessment

8.528 Unlike the Western Australian Act, the draft Bill does not require a medical practitioner to whom a person makes a first request to notify the Board of that request, or of their decision to accept or refuse it. A broad requirement of that type has the potential to apply to many practitioners who would not otherwise be involved in the voluntary assisted dying scheme, and may be onerous in circumstances where practitioners have not completed relevant training and are not registered to use the relevant information and communications technology. It is appropriate that reporting requirements are limited to those practitioners who have involvement in the voluntary assisted dying process.

8.529 The reporting requirements in the draft Bill begin after the first assessment. Within two business days after completion of the first assessment, the coordinating practitioner must also complete a record of the assessment in the approved form (the 'first assessment record form') and give a copy of it to the Board. A copy of the form must also be given to the person as soon as practicable after its completion.

8.530 The draft Bill explicitly requires that the form must state the outcome of the first assessment, including the coordinating practitioner's decision in respect of each of the eligibility criteria. As explained in Chapter 16, the coordinating practitioner's decision in respect of certain eligibility criteria may, in the case of disagreement, be the subject of an application for review by QCAT. This provision ensures notice of the coordinating practitioner's decision will be given to the requesting person. In addition, the draft Bill provides that the first assessment record form may be accompanied by any documents supporting the coordinating practitioner's decision in respect of the eligibility criteria.

8.531 The remainder of the matters to be stated in the first assessment record form should be prescribed by regulation,[300] but as a minimum the form should also state:

- the name, date of birth and contact details of the person;
- the following information about the person—
  - gender;
  - nationality;
  - ethnicity;
  - whether the person has a disability;
  - whether the person's first language is a language other than English;
  - whether the coordinating practitioner engaged an interpreter to communicate the required information to the person;
- the name and contact details of the coordinating practitioner;
- a statement confirming that the medical practitioner is eligible to act as the coordinating practitioner;
- the date when the first request was made;
- the date when the first assessment was completed;
- the date when the person was informed of the outcome of the first assessment;
- if the person was assisted by an interpreter—the name, contact details and accreditation details of the interpreter;
- if the person was referred to a registered health practitioner or other person by the coordinating practitioner for the determination of a matter—the outcome of the referral, including a copy of any report given by the registered health practitioner or other person to whom the person was referred;

300 The draft Bill provides that the Governor in Council may make regulations, and that a regulation may prescribe a matter that must be included in an approved form.

- the palliative care and treatment options available to the person and the likely outcomes of that care and treatment; and
- that the practitioner provided the person with the required information, and that the person understood that information.

8.532 The draft Bill also requires the coordinating practitioner to inform the person of the outcome of the first assessment as soon as practicable after it is completed.

The consulting assessment

8.533 Within two business days after any practitioner decides to accept or refuse a referral for a consulting assessment, that medical practitioner must complete a record of the acceptance or refusal in the approved form and give a copy of it to the Board. This gives the Board information about referrals that are made by the coordinating practitioner in respect of the person.

8.534 Following completion of the consulting assessment, the consulting practitioner must complete a record of the assessment in the approved form (the 'consulting assessment record form') within two business days. The form will contain similar information to the first assessment record form. Among other things, it must state the outcome of the consulting assessment, including the consulting practitioner's decision in respect of each of the eligibility criteria (and may be accompanied by supporting documentation).

8.535 The consulting practitioner is required to inform the person and the coordinating practitioner of the outcome of the consulting assessment as soon as practicable after it is completed, and to give both a copy of the consulting assessment record form as soon as practicable after it is completed. A copy of the form must also be given to the Board.

The second request

8.536 The draft Bill requires that, within two business days after receiving a second request, the coordinating practitioner must give a copy of the request to the Board.

The final request

8.537 Following the final request, the draft Bill requires that, within two business days of receiving the request, the coordinating practitioner must complete a record of receiving the final request in the approved form and give a copy of it to the Board.

8.538 The coordinating practitioner must then undertake a final review and complete the approved form (the 'final review form') in relation to the person.

8.539 The draft Bill requires that the final review form certify that the request and assessment process has been completed in accordance with the requirements of the legislation, and that the coordinating practitioner is satisfied that:

- the person has the required decision-making capacity;
- the person, in requesting access, is acting voluntarily and without coercion.

8.540 The remainder of the matters to be stated in the final review form should be prescribed by regulation, but as a minimum the final review form should also state:

- the name, date of birth and contact details of the person;
- the name and contact details of the coordinating practitioner;
- that the coordinating practitioner has reviewed the first assessment record form, consulting assessment record form and second request;
- that the request and assessment process has been completed in accordance with the Act; and
- if the person was assisted by an interpreter—the name, contact details and accreditation details of the interpreter.

8.541 The coordinating practitioner must give a copy of the final review form to the person as soon as practicable after its completion, and to the Board within two business days of its completion.

RECOMMENDATIONS

8-1 The draft Bill establishes a staged request and assessment process that includes requirements for the person to make three requests for access to voluntary assisted dying, and for two medical practitioners to assess the person's eligibility for access to voluntary assisted dying.

8-2 The term 'request and assessment process' means the process consisting of the following steps:

(a) a first request;

(b) a first assessment;

(c) a consulting assessment;

(d) a second request;

(e) a final request; and

(f) a final review.

The first request for access to voluntary assisted dying

8-3 A person may make a first request to a medical practitioner for access to voluntary assisted dying. The request must be:

(a) clear and unambiguous; and

(b) made by the person personally and not by another person on their behalf.

8-4 The person may make the first request verbally or by gestures or other means of communication available to the person.

The coordinating practitioner

8-5 If the medical practitioner to whom a first request is made accepts the first request, then the practitioner becomes the coordinating practitioner for the person.

8-6 The term 'coordinating practitioner', for a person, means a medical practitioner who accepts the person's first request.

The first assessment

8-7 If the coordinating practitioner is satisfied that the person:

(a) is eligible for access to voluntary assisted dying; and

(b) understands the information given to the person under Recommendation 8-38;

the coordinating practitioner must assess the person as meeting the requirements of the first assessment.

8-8 If the coordinating practitioner is not satisfied as to any matter in Recommendation 8-7:

(a) the practitioner must assess the person as not meeting the requirements of a first assessment; and

(b) the request and assessment process ends.

8-9 The coordinating practitioner must:

(a) inform the person of the outcome of the first assessment as soon as practicable after its completion;

(b) within two business days after completing the first assessment, complete a record of the assessment in the approved form (the 'first assessment record form') and give a copy of it to the Board;

(c) as soon as practicable after completing the first assessment record form, give a copy of it, and any documents accompanying it, to the person.

8-10 The first assessment record form:

(a) must include the outcome of the first assessment, including the coordinating practitioner's decision in respect of each of the eligibility criteria; and

(b) may be accompanied by documents supporting the coordinating practitioner's decision in respect of the eligibility criteria.

8-11 Other matters that are prescribed by regulation for inclusion in the first assessment record form should, as a minimum, include:

(a) the name, date of birth and contact details of the person;

(b) the following information about the person—

(i) gender;

(ii) nationality;

(iii) ethnicity;

(iv) whether the person has a disability;

(v) whether the person's first language is a language other than English;

(vi) whether the coordinating practitioner was assisted by an interpreter to communicate the information in Recommendation 8-38 to the person;

(c) the name and contact details of the coordinating practitioner;

(d) a statement confirming that the coordinating practitioner is eligible to perform that role;

(e) the date when the first request was made;

(f) the date when the first assessment was completed;

(g) the date when the person was informed of the outcome of the first assessment;

(h) if the person was assisted by an interpreter when having the first assessment, the name, contact details and accreditation details of the interpreter;

(i) if the person was referred to a registered health practitioner or other person under Recommendation 8-35 or 8-36, the outcome of the referral, including a copy of any report given by the registered health practitioner or other person to whom the person was referred;

(j) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment;

(k) that the practitioner provided the person with the required information, and that the person understood that information.

8-12 If the coordinating practitioner assesses the person as meeting the requirements of the first assessment, then the practitioner must refer the person to another medical practitioner for a consulting assessment.

The consulting practitioner

8-13 If the medical practitioner to whom a person is referred for a consulting assessment accepts the referral, then the practitioner becomes the consulting practitioner for the person.

8-14 The term 'consulting practitioner', for a person, means a medical practitioner who accepts a referral to conduct a consulting assessment of the person.

The consulting assessment

8-15 If the consulting practitioner is satisfied that the person:

(a) is eligible for access to voluntary assisted dying; and

(b) understands the information given to the person under Recommendation 8-40;

the consulting practitioner must assess the person as meeting the requirements of the consulting assessment.

8-16 If the consulting practitioner is not satisfied as to any matter in Recommendation 8-15, the practitioner must assess the person as not meeting the requirements of the consulting assessment.

8-17 The consulting practitioner must:

(a) inform the person and the coordinating practitioner for the person of the outcome of the consulting assessment as soon as practicable after its completion;

(b) within two business days after completing the consulting assessment, complete a record of the assessment in the approved form (the 'consulting assessment record form') and give a copy of it to the Board;

(c) as soon as practicable after completing the consulting assessment record form, give a copy of it, and any documents accompanying it, to the person and the coordinating practitioner for the person.

8-18 The consulting assessment record form:

(a) must include the outcome of the consulting assessment, including the consulting practitioner's decision in respect of each of the eligibility criteria; and

(b) may be accompanied by documents supporting the consulting practitioner's decision in respect of the eligibility criteria.

8-19 Other matters that are prescribed by regulation for inclusion in the consulting assessment record form should include:

(a) the name, date of birth and contact details of the person;

(b) the name and contact details of the consulting practitioner;

(c) a statement confirming that the consulting practitioner is eligible to perform that role;

(d) the date when the first request was made;

(e) the date when the referral for the consulting assessment was made;

(f) the date when the referral for the consulting assessment was received;

(g) the date when the consulting assessment was completed;

(h) the date when the person was informed of the outcome of the consulting assessment;

(i) the date when the coordinating practitioner for the person was informed of the outcome of the consulting assessment;

(j) if the person was assisted by an interpreter when having the consulting assessment, the name, contact details and accreditation details of the interpreter;

(k) if the person was referred to a registered health practitioner or other person under Recommendations 8-35 or 8-36, the outcome of the referral, including a copy of any report given by the registered health practitioner or other person to whom the person was referred;

(l) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment; and

(m) that the practitioner provided the person with the required information, and that the person understood that information.

8-20 If the consulting practitioner assesses the person as not meeting the requirements of a consulting assessment, the coordinating practitioner for the person may refer the person to another medical practitioner for a further consulting assessment.

Acceptance or refusal of a first request or a referral

8-21 A medical practitioner must refuse a first request for access to voluntary assisted dying or a referral for a consulting assessment if they are not eligible to act as a coordinating practitioner or consulting practitioner.

8-22 A medical practitioner may refuse a first request for access to voluntary assisted dying or a referral for a consulting assessment if the practitioner:

(a) has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a coordinating practitioner or consulting practitioner; or

(b) is unavailable or otherwise unable to perform the duties of a

coordinating practitioner or consulting practitioner.

8-23 A medical practitioner who accepts a first request must, at the time of informing the person of their decision, give the person the approved information.

8-24 A medical practitioner who refuses a first request must, at the time of informing the person of their decision:

(a) inform the person that other registered health practitioners, health service providers or services may be able to assist them; and

(b) give the person:

(i) information about a registered health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person with the person's request; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to give the person information, including the name and contact details, about a health practitioner, health service provider or service who may be able to assist the person with the person's request.

8-25 A medical practitioner who receives a first request or a referral for a consulting assessment must, within the times specified in Recommendation 8-26:

(a) decide whether to accept or refuse the first request or referral; and

(b) inform the person, and in the case of a referral the coordinating practitioner, of their decision and, for a decision to refuse the request or referral, the reason for the decision.

8-26 For Recommendation 8-25, the following times apply:

(a) if the practitioner has a conscientious objection to voluntary assisted dying — immediately after the first request or referral is made;

(b) in any other case — within two business days after the first request or referral is made.

8-27 The term 'approved information' means information that is approved under the relevant clause of the draft Bill, described in Recommendation 8-28.

8-28 The chief executive of the Department must:

(a) approve information for the purposes of Recommendation 8-23; and

(b) publish the approved information on the Department's website.

8-29 A medical practitioner must record the following information in the person's medical record:

(a) the first request or referral for a consulting assessment;

(b) the practitioner's decision to accept or refuse the first request or referral;

(c) if the practitioner's decision is to refuse the first request or referral, the reason for the refusal and, for a first request, the steps taken to comply with Recommendation 8-24; and

(d) if the practitioner's decision is to accept the first request, the day on which the person is given the approved information.

8-30 Within two business days after deciding to accept or refuse a referral for a consulting assessment, the medical practitioner must complete a record of the acceptance or refusal of the referral in the approved form and give a copy of it to the Board.

Eligibility assessments

8-31 The coordinating practitioner for a person must assess whether or not the person is eligible for access to voluntary assisted dying (a 'first assessment').

8-32 The consulting practitioner for a person must assess whether or not the person is eligible for access to voluntary assisted dying (a 'consulting assessment').

8-33 Both the coordinating practitioner and the consulting practitioner may have regard to any relevant information about the person that has been prepared by, or at the instigation of, another registered health practitioner.

8-34 For the purposes of Recommendation 8-32, the consulting practitioner must, independently of the coordinating practitioner, form their own opinions on the matters to be decided.

8-35 If the coordinating practitioner or the consulting practitioner is unable to determine whether or not—

(a) the person has a disease, illness or medical condition that satisfies the eligibility criteria; or

(b) the person has decision-making capacity in relation to voluntary assisted dying;

the practitioner must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter.

8-36 If the coordinating practitioner or the consulting practitioner is unable to determine whether or not the person is acting voluntarily and without coercion, the practitioner must refer the person to another person who has appropriate skills and training to determine the matter.

8-37 If the coordinating practitioner or the consulting practitioner makes a referral under Recommendations 8-35 or 8-36, the practitioner who made the referral may adopt the determination of the registered health practitioner or other person in relation to the matter in respect of which the referral was made.

Information to be given to a person who meets the eligibility criteria

8-38 If the coordinating practitioner is satisfied the person is eligible for access to voluntary assisted dying, the coordinating practitioner must inform the person about the following matters:

(a) the person's diagnosis and prognosis;

(b) the treatment options available to the person and the likely outcomes of that treatment;

(c) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment;

(d) the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under the Act for the purposes of causing the person's death;

(e) that the expected outcome of self-administering or being administered a substance referred to in paragraph (d) is death;

(f) the method by which a substance referred to in paragraph (d) is likely to be self-administered or administered;

(g) the request and assessment process, including the requirement for a second request to be signed in the presence of two witnesses;

(h) that, if the person makes an administration decision, the person must appoint a contact person;

(i) that the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;

(j) that, if the person is receiving ongoing health services from another medical practitioner, the person may consider informing the other medical practitioner of the person's request for access to voluntary assisted dying.

8-39 The phrase 'palliative care and treatment' means care and treatment that:

(a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting; and

(b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering in order to improve their comfort and quality of life.

8-40 If the consulting practitioner is satisfied the person is eligible for access to voluntary assisted dying, the consulting practitioner must inform the person about the matters referred to in Recommendation 8-38.

8-41 Nothing in Recommendations 8-38 or 8-40 affects any duty a medical practitioner has at common law or under another Act.

The second request for access to voluntary assisted dying

8-42 If a person has made a first request and has been assessed as meeting the requirements of a first assessment and a consulting assessment, then the person may make another request in writing (the 'second request') for access to voluntary assisted dying.

8-43 The second request must be in the approved form and given to the coordinating practitioner for the person.

8-44 The second request must:

(a) specify that the person:

(i) makes it voluntarily and without coercion; and

(ii) understands its nature and effect; and

(b) be signed by the person, or a person described in Recommendation 8-45, in the presence of two eligible witnesses.

8-45 A person may sign the second request on behalf of the person making the request if:

(a) the person making the request is unable to sign the request; and

(b) the person making the request directs the person to sign the request; and

(c) the person signing the request—

(i) is at least 18 years of age; and

(ii) is not a witness to the signing of the request; and

(iii) is not the coordinating practitioner or consulting practitioner for the person making the request.

8-46 A person who signs the second request on behalf of the person making the request must do so in the presence of the person making the request.

8-47 If the person makes the second request with the assistance of an interpreter, the interpreter must certify on the request that the interpreter provided a true and correct translation of any material translated.

8-48 If the person gives a second request for access to voluntary assisted dying to the coordinating practitioner, the practitioner must record the following information in the person's medical record—

(a) the date when the second request was made;

(b) the date when the second request was received by the coordinating practitioner.

8-49 Within two business days after receiving a second request made by a person, the coordinating practitioner for the person must give a copy of it to the Board.

Witnessing requirements

8-50 Each witness to the signing of the second request must:

(a) certify in writing in the request that:

(i) in the presence of the witness, the person signed the request; and

(ii) the person appeared to sign freely and voluntarily; and

(b) state in the request that the witness is not knowingly ineligible to witness the signing of the second request.

8-51 Each witness who witnesses the signing of the second request by another person on behalf of the person making the request must:

(a) certify in writing in the request that:

(i) in the presence of the witness, the person making the request appeared to freely and voluntarily direct the other person to sign the request; and

(ii) the other person signed the request in the presence of the

person making the request and the witness; and

(b) state in the request that the witness is not knowingly ineligible to witness the signing of the second request.

8-52 For the purposes of Recommendations 8-50 and 8-51 a person is eligible to witness the signing of the second request if the person:

(a) is at least 18 years of age; and

(b) is not ineligible to witness the signing of the second request.

8-53 A person is ineligible to witness the signing of the second request if the person—

(a) knows or believes that the person—

(i) is a beneficiary under a will of the person making the request; or

(ii) may otherwise benefit financially or in any other material way from the death of the person making the request; or

(b) is an owner, or is responsible for the management, of any health facility at which the person making the request is being treated or resides; or

(c) is the coordinating practitioner or consulting practitioner for the person making the request.

The final request for access to voluntary assisted dying

8-54 A person who has made a second request may make a further request to the person's coordinating practitioner for access to voluntary assisted dying (a 'final request').

8-55 The final request must be:

(a) clear and unambiguous; and

(b) made by the person personally, and not by another person on their behalf.

8-56 The person may make the request verbally or by gestures or other means of communication available to the person.

8-57 The coordinating practitioner must record the following information in the person's medical record:

(a) the date on which the final request was made;

(b) if the final request was made before the end of nine-day period described in Recommendation 8-64(a), the reason for it being made before the end of that period.

8-58 Within two business days after receiving a final request made by the person, the coordinating practitioner must complete a record of receiving the final request in the approved form and give a copy of it to the Board.

8-59 On receiving a final request, the coordinating practitioner must:

(a) review the following matters in relation to the person —

(i) the first assessment record form;

(ii) the consulting assessment record form;

(iii) the second request; and

(b) complete the approved form (the 'final review form') in relation to the person.

8-60 When conducting the review, the coordinating practitioner must take account of any decision made by QCAT in relation to a decision made in the request and assessment process.

8-61 The final review form must certify that:

(a) the request and assessment process has been completed in accordance with the requirements of the Act; and

(b) the coordinating practitioner is satisfied of each of the following—

(i) the person has decision-making capacity in relation to voluntary assisted dying;

(ii) the person, in requesting access to voluntary assisted dying, is acting voluntarily and without coercion.

8-62 Other matters that are prescribed by regulation for inclusion in the final review form should, as a minimum, include:

(a) the name, date of birth and contact details of the person;

(b) the name and contact details of the coordinating practitioner;

(c) that the coordinating practitioner has reviewed the matters in Recommendation 8-59(a);

(d) that the request and assessment process has been completed in accordance with this Act;

(e) if the person was assisted by an interpreter—the name, contact details and accreditation details of the interpreter.

8-63 The coordinating practitioner must:

(a) within two business days of completing the final review form, give a copy of it to the Board; and

(b) as soon as practicable after completing the final review form, give a copy of it to the person.

Waiting periods

8-64 A person's final request for access to voluntary assisted dying may not be made:

(a) before a period of nine days has elapsed, from and including the day on which the person made their first request for access to voluntary assisted dying, except as provided for in Recommendation 8-65; and

(b) in any case, until the day after the day on which the consulting assessment that assessed the person as meeting the requirements of a consulting assessment was completed.

8-65 A person's final request for access to voluntary assisted dying may be made before the end of the nine day period described in Recommendation 8-64(a) if:

(a) in the opinion of the coordinating practitioner, the person is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of that nine-day period; and

(b) the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner for the person as expressed in the consulting assessment.

No obligation for a person to continue the voluntary assisted dying process

8-66 There is no obligation for a person to continue after making a first request for access to voluntary assisted dying. Specifically, the draft Bill provides:

(a) the person may decide at any time not to continue the request and assessment process;

(b) the request and assessment process ends if the person decides not to continue the process;

(c) if the request and assessment process ends that way, the person may begin a new request and assessment process by making a new first request.

8-67 A person in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

CHAPTER 9

Transfer of the role of coordinating practitioner

Chapter 9: Transfer of the role of coordinating practitioner

TRANSFER OF THE ROLE OF COORDINATING PRACTITIONER

9.1 The Victorian and Western Australian Acts provide for the transfer of the role of the coordinating practitioner to a consulting practitioner or, if the consulting practitioner refuses to accept the transfer, to another medical practitioner.[1] The transfer can be done either at the request of the person or on the initiative of the coordinating practitioner themselves.[2]

9.2 In contrast to the referral process for a consulting assessment, the transfer process deals with where the coordinating practitioner is no longer able to perform that role and provides a mechanism for transferring the role and obligations associated with that role, to another medical practitioner.

9.3 As explained in relation to the Western Australian Bill:[3]

> The ability to transfer the role ensures that a person is not disadvantaged due to unforeseen circumstances, such as the coordinating practitioner being no longer able to perform the role due to illness or other reasons. A consulting practitioner who takes on the role of the coordinating practitioner becomes responsible for coordinating the process and ensuring that all the necessary steps are completed.

9.4 The Victorian Panel noted that legislation in overseas jurisdictions does not outline what should happen when the coordinating medical practitioner becomes unavailable.[4] The Victorian Panel considered that:[5]

> It is important to ensure the voluntary assisted dying process is contained, but there must also be some flexibility. A coordinating medical practitioner may not always be available, or a person may prefer to proceed with their consulting medical practitioner. The Panel recognises that this need for flexibility must be balanced against the importance of providing continuity of care and clear accountability.

9.5 The Victorian Panel used an overseas example to demonstrate the need for a transfer mechanism. In this example, a person had been through the request and assessment process with his medical practitioner, 'but as he neared the point at which he wanted to end his life his medical practitioner informed him that she would be going on two week's leave'. This limited the person's choices to accessing voluntary assisted dying immediately or waiting another two weeks until his medical practitioner returned.[6]

9.6 The Victorian Panel commented:[7]

> This situation creates the risk that people will feel pressured to proceed immediately, and to die earlier than they intended. The ability to transfer the role of the coordinating medical practitioner to the consulting medical practitioner, as recommended by the Panel, will help to ensure these situations do not arise and that a person's preferences for their end-of-life care is prioritised.

1 The Tasmanian Act provides that after the receipt of the final request, the person's consulting medical practitioner may apply to the Commission to become the person's primary medical practitioner if the original primary medical practitioner ceases to be the primary medical practitioner for the person: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 59.

2 *Voluntary Assisted Dying Act 2017* (Vic) s 32; *Voluntary Assisted Dying Act 2019* (WA) s 157(2). See also the White and Willmott Model cl 26(1) which also suggests transfer at the request of the person or on the initiative of the coordinating practitioner.

3 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 47.

4 Vic Ministerial Advisory Panel Final Report (2017) 107, citing the examples of Oregon and Belgium.

5 Ibid.

6 Ibid 108.

7 Ibid 108.

Request to be made to consulting practitioner

9.7 In Victoria and Western Australia, the first step is for the coordinating practitioner to request to transfer the role to the consulting medical practitioner. The role can be transferred only if the consulting practitioner has assessed the person as eligible for access to voluntary assisted dying and accepts the transfer.[8]

9.8 As stated by the Victorian Panel:[9]

> As a consulting medical practitioner will already be engaged in the voluntary assisted dying process and will have conducted an assessment of the person's eligibility, they are the most appropriate person to take on the role of coordinating medical practitioner if the original coordinating medical practitioner can no longer perform this role.

9.9 Further, in considering the transfer of the role, the Panel noted the importance of ensuring continuity of care:[10]

> This transfer of role would be managed through a process of handover of the person's care… Both assessing medical practitioners should ensure the transfer of roles does not disrupt the person's care.

Timeframe for accepting or refusing the transfer

9.10 In Western Australia, the consulting practitioner must inform the coordinating practitioner of their decision whether to accept or refuse the transfer of the role within two business days after the request has been made.[11] This timeframe recognises 'the position that a medical practitioner is professionally obligated not to unduly delay a person's access to voluntary assisted dying.'[12]

9.11 In Victoria, this decision must be made within seven days of the request being made.[13] The White and Willmott Model does not include any timeframe.

Notification provisions

9.12 The Western Australian Act provides that if the consulting practitioner accepts the transfer of the role, the coordinating practitioner must:[14]

- inform the person of the transfer;
- record the transfer in the person's medical record; and
- within two business days after acceptance of the transfer, complete an approved form and give a copy of it to the Board.

9.13 These requirements track the acceptance of the role of coordinating practitioner 'by recording the request and the acceptance of the request in the patient's medical record, and via notification to the Board in an approved form'.[15]

9.14 The Victorian Act and the White and Willmott Model do not include any notification requirements.

Refusal to accept transfer of the role

9.15 In Victoria and Western Australia, if the consulting medical practitioner refuses the transfer of the role, the role may be transferred to another medical practitioner.[16]

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8 *Voluntary Assisted Dying Act 2017* (Vic) s 33(1); *Voluntary Assisted Dying Act 2019* (WA) s 157(1). See also White and Willmott Model cl 26(2), (5). The White and Willmott Model requires the person accessing voluntary assisted dying to agree, but not the consulting practitioner.

9 Vic Ministerial Advisory Panel Final Report (2017) 107.

10 Ibid.

11 *Voluntary Assisted Dying Act 2019* (WA) s 157(3).

12 Explanatory Memorandum Voluntary Assisted Dying Bill 2019 (WA) 47.

13 *Voluntary Assisted Dying Act 2017* (Vic) s 33(2).

14 *Voluntary Assisted Dying Act 2019* (WA) s 157(4), (5).

15 Explanatory Memorandum Voluntary Assisted Dying Bill 2019 (WA) 47.

16 *Voluntary Assisted Dying Act 2017* (Vic) s 33(3); *Voluntary Assisted Dying Act 2019* (WA) s 157(6).

9.16 However, the new medical practitioner would not have assessed the person's eligibility to access voluntary assisted dying. The Victorian and Western Australian Acts therefore provide that this transfer must be initially for a consulting assessment.[17] This requirement enlivens the provisions about the eligibility requirements for medical practitioners, the acceptance and refusal of referrals for a consulting assessment and the process for undertaking a consulting assessment.[18] Those provisions are discussed in Chapter 8.

9.17 If the new medical practitioner then assesses the person as eligible, the role of coordinating practitioner can be transferred upon the acceptance of transfer by the new medical practitioner.[19]

9.18 In effect, the transfer process provides for the new medical practitioner to first assume the role of consulting practitioner (albeit briefly), before then accepting the role of coordinating practitioner. It also means that the role of the coordinating practitioner is always transferred to the consulting practitioner.

9.19 In Western Australia, as the new medical practitioner has first assumed the role of consulting practitioner, the notification provisions are also then enlivened.[20]

Original consulting assessment void

9.20 The Victorian and Western Australian Acts make it clear that upon accepting the referral for a further consulting assessment, the previous consulting assessment becomes void.[21] This means that the consulting practitioner must rely on their own assessment, rather than adopting an assessment made by another medical practitioner.

9.21 As noted by the Victorian Panel:[22]

> The Panel is of the view that it would not be appropriate for a medical practitioner who has not been part of the assessment process to subsequently prescribe a lethal dose of medication to a person, relying on the assessment undertaken by another medical practitioner.

The Commission's view

9.22 The draft legislation should include a mechanism to deal with circumstances where the coordinating practitioner is unable to continue in their role and needs to transfer the role to another practitioner. This could happen, for example, where the coordinating practitioner is taking personal or annual leave, or where they become ill.

9.23 There may also be circumstances in which the person requesting access to voluntary assisted dying may wish to transfer the role of coordinating practitioner to their consulting practitioner.

9.24 To provide clarity and continuity of care while also allowing for a degree of flexibility in the system, the transfer process should enable the transfer to occur either upon the request of the person or on the coordinating practitioner's own initiative.

Request to be made to consulting practitioner

9.25 The Commission considers that, as a logical first step, the request to transfer the role of coordinating practitioner should be made to the consulting practitioner.

9.26 The consulting practitioner will already be engaged in the voluntary assisted dying process and will have already made an assessment of the person's eligibility. In addition,

17 *Voluntary Assisted Dying Act 2017* (Vic) s 33(3); *Voluntary Assisted Dying Act 2019* (WA) s 157(6).
18 *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definition 'consulting assessment'), pt 3 div 4; *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition 'consulting assessment') s 17(2), pt 3, div 4.
19 *Voluntary Assisted Dying Act 2017* (Vic) s 33(3); *Voluntary Assisted Dying Act 2019* (WA) s 157(6).
20 *Voluntary Assisted Dying Act 2019* (WA) s 157(4).
21 *Voluntary Assisted Dying Act 2017* (Vic) s 33(4); *Voluntary Assisted Dying Act 2019* (WA) s 157(7).
22 Vic Ministerial Advisory Panel Final Report (2017) 107.

the consulting practitioner will have also been assessed as appropriately qualified and have undertaken the requisite training.

Timeframe for response to request

9.27 To ensure continuity of care and to prevent undue delay, the consulting practitioner must provide a response to the transfer request within two business days.

9.28 In assuming the role of consulting practitioner, the practitioner has already had the opportunity to consider their involvement in the voluntary assisted dying process—including any conscientious objection. The alternative of seven days (as is the case in Victoria) is too long and unnecessarily lengthens the process.

Notification provisions

9.29 Upon the consulting practitioner's acceptance of the role of coordinating practitioner, the original coordinating practitioner should be required to notify both the person and the Board of such acceptance within two business days.

Refusal to accept transfer of the role

9.30 If the consulting practitioner refuses to accept the transfer of the role, a further request to transfer may be made to another medical practitioner.

9.31 In making a request to a new medical practitioner, that practitioner will need to conduct a new consulting assessment to determine the person's eligibility. This assessment should occur before the practitioner can accept the transfer of the role. This aligns with the approach in Victoria and Western Australia: the new practitioner, in effect, assumes the role of consulting practitioner prior to accepting the role of coordinating practitioner.

9.32 In requiring the new practitioner to adopt the role of consulting practitioner first, the provisions regarding the qualifications and training requirements, the acceptance and refusal of referrals for a consulting assessment, and the process for undertaking a consulting assessment should be enlivened.

9.33 We consider that the new medical practitioner should be able to take on the role of coordinating practitioner only if they assess the person as eligible. As the person had previously been assessed as eligible, they would be unfairly disadvantaged if they then were assessed as ineligible merely because the original consulting practitioner declined the transfer of the role of coordinating practitioner.

Original consulting assessment void

9.34 Upon acceptance of the referral for a further consulting assessment, the original consulting assessment should become void. The role of coordinating practitioner includes the prescription and potentially the administration of the voluntary assisted dying substance. We consider that a practitioner should rely on their own assessment when their role requires them to undertake such a task.

RECOMMENDATIONS

9-1 Legislation should provide for the transfer of the role of the coordinating practitioner for a person, either at the person's request or on the coordinating practitioner's own initiative.

9-2 The coordinating practitioner may transfer their role to the consulting practitioner for the person if the consulting practitioner has assessed the person as eligible and accepts the transfer of the role.

9-3 The consulting practitioner must inform the coordinating practitioner whether they accept or refuse the transfer within two business days after receiving the request. If the consulting practitioner accepts the transfer, the coordinating practitioner must, within two business days of the acceptance, notify the person and Board of the transfer.

9-4 If the consulting practitioner refuses the transfer, the coordinating practitioner may:

(a) refer the person to another medical practitioner for a further consulting assessment; and

(b) transfer the role of the coordinating practitioner to that medical practitioner if the practitioner:

(i) accepts the referral for a further consulting assessment;

(ii) assesses the person as eligible for access to voluntary assisted dying; and

(iii) accepts the transfer.

9-5 Upon acceptance of the referral for a further consulting assessment, the consulting assessment that previously assessed the person as eligible for access to voluntary assisted dying should become void.

CHAPTER 10

Administration of the substance

Chapter 10: Administration of the substance

CHAPTER SUMMARY

This Chapter 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.[1] We address:

- the choice between self-administration and practitioner administration;
- authorisation of the prescription, supply and administration of the substance; and
- any 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.

Also, 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'.[2]

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 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 the chapter. 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 the chapter.

Different processes of administration are typically adopted as between practitioner administration and self-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.

1 See Chapter 8 above.
2 Vic Ministerial Advisory Panel Final Report (2017) 141.

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 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 voluntary assisted dying 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 person can make an administration decision (either a self-administration decision or a practitioner administration decision) in consultation with and on the advice of the coordinating practitioner. 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 be able to 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 of requiring an additional permit from a government department is bureaucratic and causes additional delay. There are many other controls, noted in this chapter. 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 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 place 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.

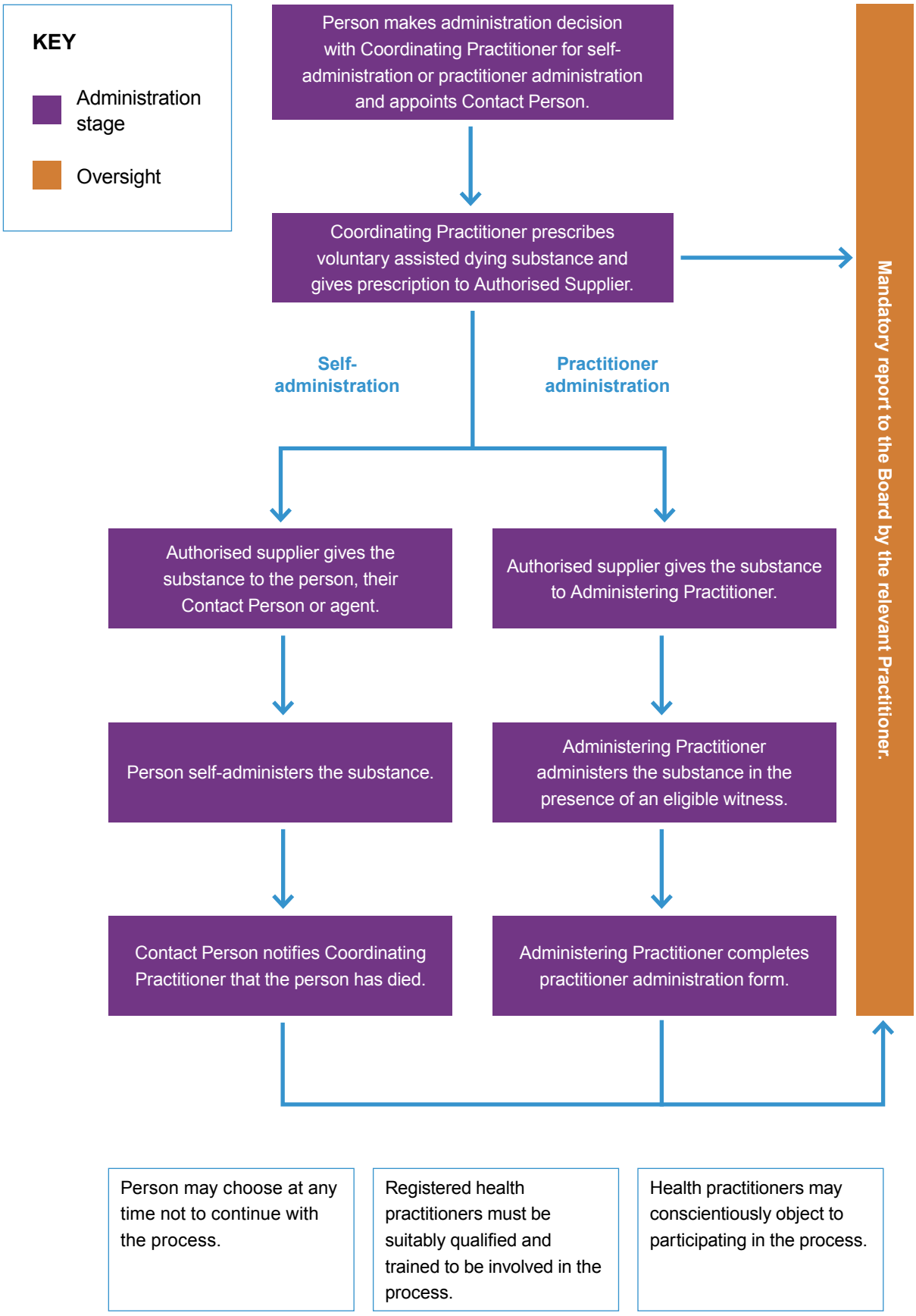
Requiring a witness for practitioner administration is an extra safeguard for the person and, in particular, the administering practitioner. At the same time, the witness requirements should not be so onerous that they create a barrier to access or are unduly obtrusive. A person is eligible to witness 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 administering practitioner for the person administered the substance to the person 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.

The proposed administration stage in detail



SELF-ADMINISTRATION OR PRACTITIONER ADMINISTRATION

10.1 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.

Choice of method of administration

10.2 Approaches in Australian and overseas jurisdictions in relation to the choice of method of administration vary.

10.3 In Victoria, practitioner administration is permitted 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.

10.4 In some overseas jurisdictions, the legislation requires the substance to be self-administered (eg, state legislation in the United States),[3] in some it must be practitioner administered (eg, Quebec),[4] and in others the person may choose either (eg, Canada, Luxembourg, and the Netherlands).[5]

10.5 The New Zealand Act allows the person to choose one of the following specific methods of administration: ingestion, triggered by the person; intravenous delivery, triggered by the person; ingestion through a tube, triggered by the attending medical practitioner or an attending nurse practitioner; injection administered by the attending medical practitioner or an attending nurse practitioner.[6]

10.6 A main reason for offering the option to self-administer is 'the return of autonomy to the patient at a time when the disease or illness is outside of their control'.[7] It has been observed that:[8]

> for patients, this route offers a more autonomous opportunity to actually take the medication themselves and have a better perceived experience of controlling the timing and circumstances of their own death.

3 *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.1(b), (p), 443.2(a), 443.11(a), (c); *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25-48-102(7), (8), 25-48-103(1), 25-48-112; *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7-661.01(5), 7-661.02(a), (c); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L–1 (definitions of 'prescription' and 'self-administer'), 327L–2, 327L–23; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.2(L), 2140.4, 2140.24; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann §§ 26:16-3 (definition of 'self-administer), 26:16-4, 26:16-20; *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.805.2.01, 127.897.6.01; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a)(1); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(12), 70.245.020(1), 70.245.220.

4 *Quebec Act respecting end of-life care*, RSQ, c S-32.0001, s 3(6). In Belgium, the legislation provides only for practitioner administration. However, the Federal Commission of Control and Evaluation of Euthanasia considers the law to include cases of self-administration provided the prescribed conditions and procedures are complied with. This includes requiring the prescribing physician to be present with the person until they die: *Belgian Euthanasia Act 2002* art 2; Federal Commission of Control and Evaluation of Euthanasia (Belgium), *Eighth report to the Legislative Chambers years 2016-2017* (Unofficial English Translation by Dying for Choice, June 2018) 26.

5 *Canada Criminal Code*, RSC 1985, c C-46, s 241.1 (definition of 'medical assistance in dying'); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 1; *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 1(b).

6 *End of Life Choice Act 2019* (NZ) s 19(2)(a)–(b). The attending medical practitioner must advise the person of the methods of administration of the medication.

7 C Harty et al, Canadian Association of MAiD Assessors and Providers, 'The Oral MAiD Option in Canada Part 1: Medication Protocols—Review and Recommendations' (April 2018) <https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf> 5–6. It was also noted that an option for self-administration may improve accessibility to medical assistance in dying, particularly in rural populations where availability of providers may be reduced. It may also:

> increase access by providing increased comfort to some clinicians who may perceive providing [a self-administration] option as less active in the patient's death than intravenous administration and therefore more acceptable for them to participate.

8 Ibid 5. See also R Syme, 'A Response to White and Willmott' (2020) 8(1) *Griffith Journal of Law and Human Dignity* 1, 7, similarly observing that an option for self-administration 'places control over the process entirely in the hands of the individual'.

Victoria

10.7 The Victorian Act does not allow the person to choose the method of administration. Self-administration is the default method; practitioner administration is permitted only if the person is physically incapable of self-administering or digesting the substance.[9]

10.8 This implements the recommendations of the Victorian Panel.[10] The Panel noted 'the general view among stakeholders that self-administration of a lethal dose of medication is a powerful safeguard to ensure voluntary assisted dying is in fact voluntary', and explained that the voluntary assisted dying framework it recommended 'is intended primarily for self-administration'.[11] However, it also considered there will be circumstances where the person is physically incapable of self-administering or digesting the substance, and that it would be unfair or discriminatory to preclude a person from accessing voluntary assisted dying because of this. The Panel therefore recommended that practitioner administration should be permitted in those limited circumstances, subject to additional safeguards to ensure that the person's decision is voluntary at the time of practitioner administration.[12]

10.9 Some academics have queried whether this approach achieves the policy goals of respect for autonomy and providing quality care. They consider that:[13]

> In terms of respecting autonomy, the limitations placed on access to practitioner administration of [voluntary assisted dying] do not accord with this policy goal. The Report refers repeatedly to the importance of choosing the 'timing and *manner*' (emphasis added) of a person's death, yet only one of the two possible lawful methods of [voluntary assisted dying] is open to the majority of eligible people.

10.10 In their view, the policy goal of respecting autonomy would be better achieved if a person is able to choose either self-administration or practitioner administration, noting that '[s]ome people may find self-administration to be an unacceptable option, or an unduly burdensome option, even if it is physically possible for them'.[14]

10.11 The authors also considered that the policy goal of providing high quality care is arguably better served when people have access to either self-administration or practitioner administration. They noted that, although there is limited evidence, practitioner administration may be a safer option, 'the legislative prohibition on practitioner administration for those able to self-administer precludes these people from accessing a potentially safer option'.[15]

Western Australia

10.12 The Western Australian Act allows the person to decide, 'in consultation with and on the advice of the coordinating practitioner', whether the substance will be self-administered or practitioner administered. However, practitioner administration is permitted only if the coordinating practitioner advises the person that self-administration is inappropriate, having regard to one or more of the following:[16]

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9 *Voluntary Assisted Dying Act 2017* (Vic) ss 47(1), 48(3)(a). The coordinating practitioner may apply for a self-administration permit for a person if the person is physically able to self-administer and digest a voluntary assisted dying substance. The coordinating practitioner must not apply for a practitioner administration permit unless they are satisfied that the person is physically incapable of self-administering or digesting a voluntary assisted dying substance.

10 Vic Ministerial Advisory Panel Final Report (2017) 141–43, Rec 36. This was also the approach suggested by the Victorian Parliamentary Committee: Vic Parliamentary Committee Final Report (2016) 220.

11 Vic Ministerial Advisory Panel Final Report (2017) 141.

12 Ibid 141–43, Rec 37. See the discussion of requirements for practitioner administration below.

13 B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 429.

14 Ibid 429–430.

15 Ibid, referring to JH Groenewoud et al, 'Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands' (2000) 342(8) *New England Journal of Medicine* 551. It was noted that, although there is limited evidence, this Dutch study that found that, 'while both means of providing [voluntary assisted dying] can experience complications and technical problems, the rate of these is higher with self-administration when compared with practitioner administration'. It was also noted, however, that '[m]ore robust data…are needed to support this conclusion'. See also the discussion of data in relation to safety and self-administration below.

16 *Voluntary Assisted Dying Act 2019* (WA) s 56(1)–(2). The person must make an administration decision, which may be either a self-administration decision or a practitioner administration decision. The person can make a practitioner administration decision only if self-administration is inappropriate, having regard to the broad circumstances listed at [10.12] above.

- 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.

10.13 Like Victoria, the Western Australian Act defaults to self-administration. However, unlike Victoria, the person can decide the method of administration in consultation with and on the advice of their coordinating practitioner. Practitioner administration is not limited to circumstances where the person is physically unable to self-administer or digest the voluntary assisted dying substance, and the coordinating practitioner must also have regard to the person's concerns. Practitioner administration would therefore also be permitted if, for example, the person has concerns or fears about any difficulties that may arise during self-administration.

10.14 During the debate on the Bill in Parliament, the Health Minister explained that this provision requires that the decision about the method of administration:[17]

> must be a decision that both the coordinating practitioner and the person discuss, and to which the person consents and the coordinating practitioner agrees. This position has been strongly supported throughout the public consultation process.
>
> It is clear that practitioner administration should not be limited only to people who are physically incapable of self-administration. For example, a physically capable person may still have an inability to self-administer due to concerns about being able to ingest or absorb the medication.

10.15 That approach implements the recommendations of the Western Australian Panel, which considered that 'self-administration is the preferred model except where there is a clinical determination that self-administration is not suitable for the person', as 'self-administration of a lethal dose of medication demonstrates that the person is acting autonomously'.[18]

10.16 The Panel also noted that:[19]

> Although practitioners may be willing to prescribe the voluntary assisted dying medications, some may be reluctant to administer lethal medications to patients — that is to say there may be a scale of practitioner willingness of involvement.

10.17 In effect, the Western Australian Act enables the person to discuss their preferences and concerns with their coordinating practitioner and make an informed choice as to the method of administration best suited to them. The requirement for the decision to be made 'in consultation with and on the advice of the coordinating practitioner' is consistent with good medical practice, which provides that '[m]aking decisions about healthcare is the shared responsibility of the doctor and the patient'.[20] This approach recognises that the person's decision in relation to the method of administration must be clinically appropriate to the person's individual circumstances.

10.18 The Western Australian approach is said to grant 'more discretion to the person and their doctor about how voluntary assisted dying is provided'.[21]

Tasmania

10.19 The Tasmanian Act requires the person to give a 'final permission' in writing in the approved form, which must include a statement as to the method of administration the person wishes.[22] The person must also request from their administering health

17 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5138 (RH Cook, Minister for Health).
18 WA Ministerial Expert Panel Final Report (2019) 78.
19 Ibid.
20 See MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.3].
21 B White et al, 'WA's take on assisted dying has many similarities with the Victorian law—and some important differences', *The Conversation* (online, 9 August 2019) <https://theconversation.com/was-take-on-assisted-dying-has-many-similarities-with-the-victorian-law-and-some-important-differences-121554>.
22 This may be to self-administer (without assistance), to self-administer with the assistance of the administering health practitioner, or to have the administering health practitioner administer a voluntary assisted dying substance to the person: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 82(1), (3)(c)(i)–(iii).

practitioner:

- if the person wishes to self-administer (without assistance)—a private self-administration certificate; or
- if the person wishes to be assisted by their administering health practitioner to self-administer, or to have the administering health practitioner administer the voluntary assisted dying substance to them—an administering health practitioner administration certificate ('AHP administration certificate').[23]

10.20 The administering health practitioner must not complete and sign a private self-administration certificate for the person unless the administering health practitioner is satisfied that the person will be able to self-administer the substance.[24]

10.21 The administering health practitioner may issue an AHP administration certificate to the person if the administering health practitioner is satisfied that it is inappropriate for the person to self-administer (without assistance), having regard to any of the following:[25]

(a) the ability of the patient to self-administer the voluntary assisted dying substance or to digest the voluntary assisted dying substance;

(b) the patient's concern about self-administering the voluntary assisted dying substance;

(c) the method of administering the voluntary assisted dying substance that is suitable for the patient.

10.22 The circumstances in which self-administration is inappropriate are the same as those in the Western Australian Act.[26]

10.23 In effect, the approach in Tasmania is similar to Western Australia, in that the person is able to discuss their wishes and concerns with their administering health practitioner and make an informed choice as to the method of administration that is best suited to them.[27] The chosen method must be clinically appropriate.

Parliamentary Committee and White and Willmott Model

10.24 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should enable the coordinating practitioner to determine whether self-administration or practitioner administration is the method best suited to the person.[28]

10.25 The White and Willmott Model enables the person to choose between practitioner administration or self-administration.[29] Enabling the person to choose the method of administration was said to promote the value of autonomy.[30] In an earlier article, those authors explained that:[31]

> The value of autonomy grounds the suggestion that a person be able to choose to receive assistance to die either by a doctor directly providing that assistance or by enabling the person to bring about his or her own death.

Current administration practices

10.26 There are currently 14 jurisdictions where assisted dying legislation is operational. They are, Victoria, the Netherlands, Luxembourg, Belgium, Canada, and eight States and one District in the United States. To identify current practices in relation to voluntary assisted

23 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 83–84, 86.
24 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 84(1).
25 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 86(5); Tas Review Panel Report (2021) [3.4.1].
26 See [10.12] ff above.
27 Although, unlike Western Australia, the Tasmanian Act enables the person to indicate their wishes with respect to the method of administration in writing in the final permission: Tas Review Panel Report (2021) [4.3.2].
28 Qld Parliamentary Committee Report No 34 (2020) [9.4], Rec 12.
29 White and Willmott Model cll 6, 31, 34. The person's final request must specify whether they are requesting practitioner administration or supervised self-administration.
30 White and Willmott Model, Explanatory Notes 2.
31 L Willmott and B White, 'Assisted Dying in Australia: A Values-based Model for Reform' in I Freckelton and K Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 501.

dying in other jurisdictions the most recent data report from the relevant oversight or reporting body was accessed and reviewed. The numbers and methods of voluntary assisted dying deaths are summarised in the following table:[32]

Table 10.1 International Comparison of Voluntary Assisted Dying Deaths

Jurisdiction	Number of voluntary assisted dying deaths (reporting period)[33]	Per cent practitioner administration
Australia		
Victoria	175 (2020)	18
Europe		
Belgium	2 309 (2017)	99
Netherlands	6 361 (2019)	96
North America		
Canada	5 631 (2019)	99.8
California	378 (2019)	0
Colorado	188 aid-in-dying prescriptions (2020)	0
District of Columbia	2 (2018)	0
Hawaii	15 (2019)	0
Maine	1 (Sept-Dec 2019)	0
New Jersey	12 (2019)	0
Oregon	245 (2020)	0
Vermont	29 (May 2013 – June 2017)	0
Washington	203 (2018)	0

10.27 In Europe and Canada, where both self-administration and practitioner administration are permitted, there is an overwhelming preference for practitioner administration. The total number of voluntary assisted dying deaths in these jurisdictions is also significantly higher than in the United States. In Canada, for example, there was more than five times the reported number of voluntary assisted dying deaths in one year than in all applicable states in the United States combined (5 631 compared to 1 073).[34]

32 The table collates data from the following sources: Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021); Federal Commission of Control and Evaluation of Euthanasia (Belgium), *Eighth report to the Legislative Chambers* (2016-2017) (Unofficial English Translation by Dying for Choice, June 2018); Regional Euthanasia Review Committees (the Netherlands), *Annual Report* (2019) (English translation); Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (2020); California Department of Public Health, *California End of Life Option Act 2019 Data Report (2020)*; Colorado Department of Public Health and Environment, *Colorado End-of-Life Options Act, Year Four 2020 Data Summary, with 2017–2020 Trends and Totals* (2021); District of Columbia Department of Health, *District of Columbia Death with Dignity Act 2018 Data Summary* (2019); Hawaii Department of Health, *Hawaii's Our Care, Our Choice Act 2019 Annual Report* (Report to the Thirtieth Legislature, 2020); Maine Department of Health and Human Services, *Patient-Directed Care at End of Life Annual Report* (2020); New Jersey Office of the Chief State Medical Examiner, *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019 Data Summary* (Report, 2020); Oregon Health Authority, Public Health Division, *Oregon Death with Dignity Act 2020 Data Summary* (Report, 2021); Vermont Department of Health, *Report Concerning Patient Choice at the End of Life* (2018); Washington State Department of Health, *2018 Death with Dignity Act Report* (2019). The table does not include data from Luxembourg, as there is no English translation of the National Commission for Control and Evaluation (Luxembourg), *Fifth Report of the Law of March 16 2009 on Euthanasia and Assisted Suicide* (2017-2018).

33 Colorado does not record whether a person has died as a result of taking a voluntary assisted dying substance. For this jurisdiction, the number of prescriptions dispensed is presented. In Washington there was a further 19 people who died after the medication was dispensed, but it is not known whether they ingested the medication.

34 This assumes that the people in Colorado who were issued with a prescription, and the voluntary assisted dying substance was dispensed, died as a result of taking the voluntary assisted dying substance. As it is not possible to identify the year in which people in Vermont died, the total of the reporting period are included.

Data about the preferences of the person seeking access

10.28 A review of current academic literature was undertaken to identify if the preferences of the person seeking voluntary assisted dying influences the method that is provided. While there is substantial literature describing the reasons people seek access to voluntary assisted dying, and experiences of families and caregivers navigating voluntary assisted dying processes, no studies were found that considered which method of administration was preferred by the person accessing it.

10.29 The choice of method, therefore, appears to be driven by requirements of the legislation,[35] external circumstances,[36] institutional policies,[37] or individual voluntary assisted dying practitioners' preference.[38] For example, Wiebe et al report that in the period immediately after voluntary assisted dying became legal in Canada there were no suitable barbiturates available for oral administration.[39] Consequently, local protocols were established for practitioner administered intravenous voluntary assisted dying, but not for self-administration.[40]

10.30 More recently, to support the individual's autonomy, the Canadian Association of MAiD Assessors and Providers has published a medication protocol for self-administration.[41] The extent to which this protocol is applied in practice is yet to be seen. However, the experience in the Netherlands suggests that the choice of method is frequently determined by an assessing practitioner, rather than the person seeking access to voluntary assisted dying,[42] and if practitioners are more familiar with practitioner administration than self-administration then practice may not change significantly.

Data about safety and self-administration

10.31 Practitioner administration is frequently reported as being safer than self-administration of voluntary assisted dying substances and therefore the preferred option for many voluntary assisted dying providers.[43] A study published in 2000 is often cited as support for the comparative safety of practitioner administration.[44] In this study researchers analysed data collected on 535 cases of euthanasia and 114 cases of physician-assisted suicide completed in the Netherlands between 1990–91 and 1995–96.[45]

10.32 The study reported that the most frequent problem associated with euthanasia (practitioner administration) was that the time to death was longer than expected, or

35 See, eg, *Voluntary Assisted Dying Act 2017* (Vic) s 46(c); *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.1(b), (p), 443.2(a), 443.11(a), (c); *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25-48-102(7), (8), 25-48-103(1), 25-48-112; *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7-661.01(5), 7-661.02(a), (c); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L–1 (definitions of 'prescription' and 'self-administer'), 327L–2, 327L–23; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.2(L), 2140.4, 2140.24; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann §§ 26:16-3 (definition of 'self-administer), 26:16-4, 26:16-20; *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.805.2.01, 127.897.6.01; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann §§ 5283(a)(1); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(12), 70.245.020(1), 70.245.220.

36 When the Canadian law first changed, practitioners were not able to access the substances required for self-administration: E Wiebe, S Green and K Wiebe, 'Medical assistance in dying (MAiD) in Canada: practical aspects for healthcare teams' (2021) 10(3) *Annals of Palliative Medicine* 3586, 3589.

37 See, eg, M Li et al, 'Medical Assistance in Dying—Implementing a Hospital-Based Program in Canada' (2017) 376(21) *New England Journal of Medicine* 2082, 2083. Early in the development of the MAiD framework, the University Health Network in Toronto chose to limit voluntary assisted dying to intravenous administration of voluntary assisted dying substances in the hospital because of the predictability of the outcome, lower rate of complications and structure of the medical care at the facility.

38 PSC Kouwenhoven et al, 'Euthanasia or physician-assisted suicide? A survey from the Netherlands' (2014) 20 *European Journal of General Practice* 25, 30.

39 Wiebe, Green and Wiebe, above n 36, 3589.

40 J Brown et al, 'Medical Assistance in Dying: Patients', Families' and Health Care Providers' Perspectives on Access and Care Delivery' (2020) 23(11) *Journal of Palliative Medicine* 1468, 1469.

41 C Harty et al, Canadian Association of MAiD Assessors and Providers, 'The Oral MAiD Option in Canada Part 1: Medication Protocols—Review and Recommendations' (April 2018) <https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf>.

42 Kouwenhoven et al, above n 38, 30.

43 IM Ball et al, 'A Canadian Academic Hospital's Initial MAiD Experience: A Health-Care Systems Review' (2019) 34(2) *Journal of Palliative Care* 78, 82.

44 See, eg, E Emanuel et al, 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe' (2016) 316(1) *Journal of the American Medical Association* 79, 86; Kouwenhoven et al, above n 38, 30; ML Rurup et al, 'The first five years of euthanasia legislation in Belgium and the Netherlands: description and comparison of cases' (2012) 26(1) *Palliative Medicine* 43, 47; Li et al, above n 37, 2083.

45 JH Groenewoud et al, 'Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands' (2000) 342(8) *New England Journal of Medicine* 551.

the person did not become comatose (4 per cent of cases). Difficulty finding a vein in which to inject the medication was the second most frequent problem (2 per cent of cases). Other less frequently reported problems were spasm or myoclonus (1 per cent of cases), cyanosis (less than 1 percent of cases), and nausea and vomiting (less than 1 percent of cases). Complications reported as 'other' included a person's eyes remaining open, excessive production of mucous, and extreme gasping.[46]

10.33 There were 21 cases that commenced with the intention of being assisted suicide, but the physician ultimately administered the substance that caused the death. In most of these cases, the physician felt compelled to intervene because the person did not die as soon as anticipated after taking the medication.[47]

10.34 In cases of assisted suicide, the time to death being longer than expected or the person not becoming comatose were also the most frequent problems (12 per cent of cases) followed by difficulty swallowing (6 per cent of cases).[48] Nausea and vomiting were reported to have occurred in four cases (3 per cent). Spasm or myoclonus was reported once, as was cyanosis, accounting for less than one per cent of cases.[49]

10.35 The study found that cases of practitioner administration (euthanasia) experienced fewer technical issues, complications and problems with completion compared to self-administration (assisted suicide).[50]

10.36 The findings should be read with caution, however, because the data were collected nearly 30 years ago, and before the Netherlands' euthanasia laws were passed.[51] It may be that in the interim standardised practices and experience have reduced the number of problems associated with administration of voluntary assisted dying substances.[52]

10.37 Other than the Netherlands, collectively the nine jurisdictions in the United States have the most experience of voluntary assisted dying, albeit only with self-administration. However, as there is no requirement for a practitioner to be present when the person takes the voluntary assisted dying substance reporting of complications is sporadic. Even when practitioners are present, such as in California where a healthcare practitioner was present in nearly 50 per cent of cases, no adverse events were reported.[53]

10.38 Some States in the United States provide an indication of the types of adverse events people experienced after self-administering the substance. In 2020 there were 245 confirmed voluntary assisted dying deaths in Oregon, but only five reported complications. Three of these were people who experienced difficulty ingesting the substance, one person experienced a seizure, and one complication was described as 'other'. In 67 cases there were no complications, and in 173 the presence of complications was unknown.[54] In Washington, there were eight cases out of 203 deaths where people experienced complications described as 'regurgitation, seizures, awakening, other'.[55] This snapshot of the available data suggests that adverse events associated with self-administration are infrequently reported, but it is not possible to say how frequently they occur.

46 Ibid 555.
47 Ibid 554.
48 Ibid 555.
49 Ibid.
50 Ibid.
51 *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.*
52 Emanuel et al, above n 44, 79, 86.
53 California Department of Public Health, *California End of Life Option Act 2019 Data Report* (2020) 6.
54 Oregon Health Authority, Public Health Division, *Oregon Death with Dignity Act 2020 Data Summary* (Report, 2021) 12.
55 Washington State Department of Health, *2018 Death with Dignity Act Report* (2019) 13.

10.39 Emanuel et al caution that all medical procedures and interventions have associated risks and complications.[56] Being alert to any potential complications associated with the administration of a voluntary assisted dying substance enables steps to be taken to reduce their occurrence and address the consequences if they do.[57]

Submissions

10.40 The Consultation Paper asked whether the draft legislation should provide that practitioner administration is only permitted if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance (as in Victoria).[58] Alternatively, we asked whether the draft legislation should provide (as in Western Australia) that:[59]

(a) the person can decide in consultation with and on the advice of the coordinating practitioner, whether the voluntary assisted dying substance will be self-administered or practitioner administered; and

(b) practitioner administration is only permitted if the coordinating practitioner advises the person that self-administration is inappropriate, having regard to one or more of the following:

(i) the ability of the person to self-administer the substance;

(ii) the person's concerns about self-administering the substance;

(iii) the method for administering the substance that is suitable for the person.

10.41 Several respondents submitted that the draft legislation should adopt the approach in Victoria and permit practitioner administration only if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance. One respondent submitted that practitioner administration should not be permitted at all. Self-administration was said to ensure that it is the person's voluntary choice, and to be a safeguard to protect the vulnerable. A member of the public supported the Victorian approach on the basis that the administration of the voluntary assisted dying substance should not be medicalised or 'a bureaucratic exercise'.

10.42 Many respondents did not, however, support limiting practitioner administration to circumstances where the person is physically incapable of self administering or digesting a voluntary assisted dying substance. A member of the public submitted that this approach 'is too limiting'. Two academics jointly submitted that this approach 'may place too great a burden on the patient'.

10.43 Some respondents observed that a person may have fears that make self-administration inappropriate, even if they are physically capable of self-administering. Dying with Dignity NSW submitted that there may be cases where a person 'genuinely fear[s] self-administration'. One respondent submitted that the fear of self-administration may increase the suffering of the person.

10.44 Some respondents submitted that the draft legislation should adopt the approach in Western Australia, which enables the person to decide the method of administration in consultation with and on the advice of the coordinating practitioner, and permits practitioner administration only if self-administration is inappropriate, having regard to particular matters (including the person's concerns).

10.45 Other respondents submitted that the person should be able to decide the method of administration in consultation with and on the advice of the coordinating practitioner.

56 Emanuel et al, above n 44, 86.

57 F Bakewell and VN Naik, Canadian Association of MAiD Assessor and Providers, 'Complications with Medical Assistance in Dying (MAID) in the Community in Canada: Review and Recommendations' (March 2019) <https://camapcanada.ca/wp-content/uploads/2019/05/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf>.

58 QLRC Consultation Paper No 79 (2020) Q-29.

59 Ibid Q-30.

10.46 Some respondents noted that the Western Australian model, including the requirement for the decision to be made 'in consultation with and on the advice of the coordinating practitioner', allows for a person to exercise their autonomy and is consistent with person-centred care. Two members of the public jointly submitted:

> The issue of administration of a voluntary assisted dying substance should be modelled on the Western Australia legislation. This allows for a person to exercise their autonomy regarding voluntary assisted dying… Additionally, the principle of patient-centred care strongly favours the notion that such a decision should be made between a clinician and a patient. Therefore, the legislation should allow for a person to decide the method of administration that is suitable, having regard to their individual circumstances.

10.47 A registered nurse submitted that 'there can be a range of variables that influence treatment options', and for this reason, the decision as to the method of administration should be made 'in consultation with the practitioner':

> As with all health care, [voluntary assisted dying] services, including the administration of the [voluntary assisted dying] medication, must be patient-focused, allowing for individual variance and situations outside the norm.

10.48 VALE Group noted that it 'is important to focus on the individual':

> The individual should be allowed to self-administer and should also have the option to seek assistance from the practitioner if the individual requires assistance.

10.49 The Queensland Law Society submitted that '[t]he most appropriate method should be determined in the context of the individual, their family, support persons and healthcare practitioners'.

10.50 Professors White and Willmott continued to support the White and Willmott Model, which allows the person to choose either practitioner administration or self-administration. They submitted that:

> allowing the patient a choice as to the mode of [voluntary assisted dying] administration (in consultation with their doctor)… best reflects the principles that we consider should underpin [voluntary assisted dying] legislation.

10.51 The former Chief Minister of the Northern Territory, The Hon Marshall Perron, supported the White and Willmott Model. He also expressed support for the provisions in the *End of Life Choice Act 2019* (NZ), which enable the person to choose the specific method of administration after having them explained by their doctor.

10.52 The Clem Jones Group noted that the White and Willmott Model enables the person to specify their choice of administration at the time of their final request. It submitted:

> We suggest that in practice the question of self-administration versus practitioner administration should be a matter decided in principle at the beginning of the application and approval process through discussions between a patient and their medical practitioners… we believe flexibility is needed in relation to the timing of decisions on the type of administration of a [voluntary assisted dying] substance and that such a decision on practitioner administration or self-administration be the subject of in-principle agreement between a patient and their medical practitioner at the start of the application and approval process while incorporating provisions in any [voluntary assisted dying] Bill allowing for the possibility that the physical condition of a patient may alter the practicalities of any earlier decision on self-administration at the time of their last request.

10.53 A few respondents noted that some practitioners may be willing to participate in voluntary assisted dying but may not want to administer the voluntary assisted dying substance to the person.

10.54 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld, in supporting the Victorian approach that permits practitioner

administration only if the person is physically incapable of self-administering, noted the challenges faced by doctors and other health professionals in participating in and having responsibility for voluntary assisted dying.

10.55 Ms Jodhi Rutherford, an academic, reported the findings of a study of medical practitioners' general knowledge and perspectives of the Victorian Act. She submitted that 'only a small number of participants' indicated a willingness to provide practitioner administration:[60]

> Some participants who are willing to write a script for self-administration hesitate at practitioner-administration. Some participants agree that there is no ethical distinction between [self-administration and practitioner administration], yet still sense a moral difference in the acts based on the degree of the agency required for practitioner-administration. Some are willing, as a result, to do 'everything but' practitioner-administration…

10.56 She also submitted:

> There is a need to strike a balance between supporting the request of those applicants who cannot administer the substance personally, and those doctors who feel they cannot be responsible for practitioner-administration.

The Commission's view

10.57 A person should be able to make an informed decision about the method of administration (self-administration or practitioner administration) best suited to them.

10.58 Self-administration should be the default method of administration, as the act of self-administering the voluntary assisted dying substance is itself the final indication that the person is acting voluntarily. This option maximises the person's autonomy to control the timing and circumstances of their death.[61]

10.59 However, the person should be able to decide to have the substance administered to them if self-administration is inappropriate, subject to some additional safeguards to ensure voluntariness.[62] Practitioner administration should not be limited to circumstances where the person is physically incapable of self-administering or digesting the voluntary assisted dying substance. It should be permitted in broader circumstances, and the coordinating practitioner should be required to have regard to the person's concerns. This recognises there may be circumstances where it is inappropriate for the person to self-administer even if the person is physically able to, including if the person has fears or concerns about self-administering. Permitting practitioner administration in broader circumstances gives the person more discretion to choose the method of administration best suited to them and is one way of ensuring the person is provided with high quality care.

10.60 Accordingly, the draft Bill provides that the person may, in consultation with and on the advice of the coordinating practitioner, decide:

- to self-administer a voluntary assisted dying substance (a 'self-administration decision'); or
- that a voluntary assisted dying substance is to be administered to the person by their administering practitioner (a 'practitioner administration decision').

10.61 It also provides that 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:

60 This respondent referred to the findings of a study of 25 Victorian medical practitioners with no in-principle objection towards the legalisation of voluntary assisted dying on their experience of the *Voluntary Assisted Dying Act 2017* (Vic) in the first 12 months of its operation. See also J Rutherford, 'Doctors and the *Voluntary Assisted Dying Act 2017* (Vic): Knowledge and Perspectives' (2020) 27(4) *Journal of Law and Medicine* 952, discussing that study.

61 See the discussion of requirements for self-administration below.

62 See the discussion of requirements for practitioner administration below.

- 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.

10.62 In effect, the person will be able to discuss their wishes and concerns with the coordinating practitioner 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. The requirement for the decision to be made 'in consultation with and on the advice of the coordinating practitioner' is consistent with good medical practice.

10.63 We note that, unlike other jurisdictions, the New Zealand Act enables the person to choose a specific method of administration from those listed in the Act, such as intravenous delivery, ingestion through a tube or injection.[63] It is not necessary for the draft Bill to include this level of clinical detail about the methods of administration. The specific method of administration will be the subject of discussions between the person and their coordinating practitioner, having regard to all of the available methods. It is preferable for the draft Bill to distinguish between self-administration and practitioner administration and for the specific details of each type of administration to be left to clinical practice. Clinical practices may evolve over time.

AUTHORISATION OF PRESCRIPTION, SUPPLY AND ADMINISTRATION OF A SUBSTANCE

10.64 The legislation in Victoria, Western Australia and Tasmania regulates the prescription, supply and administration of a voluntary assisted dying substance.[64] There are 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.

10.65 The prescription, supply and administration of a voluntary assisted dying substance is variously authorised by:

- In Victoria—a voluntary assisted dying permit (either a self-administration permit or a practitioner administration permit);
- In Western Australia—an administration decision (either a self-administration decision or a practitioner administration decision);
- In Tasmania—a voluntary assisted dying substance authorisation, the final permission in writing, and either a private self-administration certificate or an AHP administration certificate.

10.66 The White and Willmott Model does not specifically regulate the prescription and supply of a voluntary assisted dying substance. It provides that the first medical practitioner may provide access to voluntary assisted dying upon receiving the person's final (third) request.

63 See [10.5] above.

64 It also includes a number of other substance management provisions regulating, among other things, the collection, storage, return and disposal of the voluntary assisted dying substance. See Chapter 11 below.

Authorisation process

Victoria and Western Australia

10.67 After the person's third request for access to voluntary assisted dying, the coordinating practitioner must conduct a final review and give a copy of the final review form to the Board.[65] The Board has a monitoring and oversight function to ensure compliance with the legislation.[66]

10.68 Before the prescription, supply and administration of a substance is authorised, the coordinating practitioner must apply for a voluntary assisted dying permit (Victoria), or the person must make an administration decision (Western Australia).

10.69 A voluntary assisted dying permit can be applied for (Victoria), or an administration decision made (Western Australia), only if the coordinating practitioner has certified in the final review form that the request and assessment process has been completed in accordance with the requirements in the legislation.[67] The coordinating practitioner must also be satisfied the person has decision-making capacity for voluntary assisted dying and the person's request for access to voluntary assisted dying is enduring (and, in Western Australia, the person in requesting access to voluntary assisted dying is acting voluntarily and without coercion).[68]

10.70 In Victoria, the coordinating practitioner must apply to the Secretary of the Department of Health and Human Services for the approval of a voluntary assisted dying permit. This may be either a self-administration permit or, if the person is physically incapable of self-administering or digesting a voluntary assisted dying substance, a practitioner administration permit.[69] The application must be made in the approved form, and the Secretary must determine the application within three business days.[70] The Secretary may refuse to issue a permit if the Secretary is not satisfied that all the pre-conditions in the legislation have been met and that the request and assessment process has been completed.[71]

10.71 The requirement for a permit was recommended by the Victorian Panel.[72] It considered that this provides an additional independent check to 'ensure the [coordinating practitioner has] completed every step of the process before the medical practitioner can receive an authorisation to prescribe the lethal dose of medication'.[73] The Panel also

65 On receiving the person's final (third request) for access to voluntary assisted dying, the coordinating practitioner must review all of the required forms (including the first assessment report form, the consulting assessment report form, and the written declaration) and complete the final review form and give a copy to the Board. In Victoria, the final review form must be accompanied by copies of all the relevant forms. In Western Australia, the coordinating practitioner is required to provide copies of these forms to the Board progressively: *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'request and assessment process'), 41; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'request and assessment process'), 51. See the discussion of the third request for access to voluntary assisted dying in Chapter 8 above.

66 *Voluntary Assisted Dying Act 2017* (Vic) s 93; *Voluntary Assisted Dying Act 2019* (WA) s 118. The Board can refer matters to an appropriate investigator or regulator. See also, Voluntary Assisted Dying Review Board Report of Operations 2018–2019 (2019) 3; Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 4, 9; Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: Glossary of terms' (2021) 'Voluntary Assisted Dying Board' <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Glossary-of-Terms.pdf>.

67 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'request and assessment process'), 43; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'request and assessment process'), 8, 51(3), 55.

68 In Victoria, the coordinating practitioner must not apply for a voluntary assisted dying permit unless satisfied of those matters. For a practitioner administration permit, the coordinating practitioner must also be satisfied that the person is physically incapable of self-administration or digestion of a voluntary assisted dying substance: *Voluntary Assisted Dying Act 2017* (Vic) ss 47(3), 48(3).
In Western Australia, an administration decision can be made only if the coordinating practitioner certifies in the final review form that the coordinating practitioner is satisfied of those matters: *Voluntary Assisted Dying Act 2019* (WA) ss 51(3), 55.

69 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definitions of 'voluntary assisted dying permit', 'self-administration permit' and 'practitioner administration permit'), 49(2)(a)(i)–(ii). If the person is physically able to self-administer or digest the voluntary assisted dying substance, the coordinating practitioner may apply for a self-administration permit: s 47(1). The coordinating practitioner must not apply for a practitioner administration permit unless the coordinating practitioner is satisfied that the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance: s 48(1), (3)(a).

70 *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definitions of 'voluntary assisted dying permit', 'self administration permit' and 'practitioner administration permit'), pt 4 div 2; *Voluntary Assisted Dying Regulations 2018* (Vic) reg 7, sch 1, Forms 1–2. A voluntary assisted dying permit comes into force on the day specified in the permit. The Secretary may amend a voluntary assisted dying permit, either on the request of the coordinating practitioner or in the Secretary's discretion, if satisfied that the permit contains an administrative error or a minor defect: *Voluntary Assisted Dying Act 2017* (Vic) ss 50–51.

71 *Voluntary Assisted Dying Act 2017* (Vic) s 49(3).

72 Vic Ministerial Advisory Panel Final Report (2017) 133–4, Rec 31.

73 Ibid 133.

considered that '[t]his process will ensure it is clear who is administering the lethal dose of medication and who is responsible for the medication'.[74] It further suggested that the Victorian permit process should be consistent with the existing medication authorisation processes in the *Drugs, Poisons and Controlled Substances Act 1981* (Vic), adapted for voluntary assisted dying.[75]

10.72 However, some concerns have been expressed that the time required for the Secretary to consider the application may cause unnecessary delay and hardship to a person who is suffering and wishes to access voluntary assisted dying. In particular, it was considered that the utility of the Secretary's review, which is limited to an administrative check to ensure that all of the forms have been completed, 'raises doubts about the effectiveness of such a safeguard, particularly given the delays it will cause'.[76]

10.73 The Victorian Voluntary Assisted Dying Review Board reported that, between 1 July and 31 December 2020, 174 permits were issued. 19 permit applications were initially not issued. Of these, 18 were not issued due to administrative errors related to the prescribing of the voluntary assisted dying substance (such as errors related to the medications, dosages or formulations). 17 of these were resubmitted and subsequently approved with errors corrected. One was resubmitted, however the applicant died before the permit was issued.[77]

10.74 It also reported that:[78]

> the Secretary, Department of Health has three business days to determine the outcome of a permit application. Once the necessary evidence and forms have been submitted in line with legislative requirements, all permit applications for the reporting period were either issued or not issued within this time period. More than 99 per cent (99.4 per cent) of permit applications' outcomes were determined within two business days.

10.75 In Western Australia, there is no requirement for a permit. The person must make an administration decision in consultation with and on the advice of their coordinating practitioner. This may be either a self-administration decision or, if self-administration is inappropriate, a practitioner administration decision.[79] An administration decision must be clear and unambiguous and made to the coordinating practitioner by the person.[80] It may be made verbally or in another way (for example, by gestures). The coordinating practitioner must record the decision in the person's medical record and notify the Board of the administration decision within two business days of prescribing the voluntary assisted dying medication.[81]

10.76 During the debate on the Bill on Parliament, it was explained that a requirement for a permit is an additional 'bureaucratic' layer that 'does not confer additional protection'.[82]

10.77 The Western Australian Panel observed that this requirement 'is a third tier of approval, separate and independent from the first two approvals given by medical practitioners', and noted that 'such intervention is not currently required for other end

74 Ibid 141.

75 Ibid 134, referring to *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 34, which 'requires medical practitioners who consider it necessary to prescribe a Schedule 8 medication to a drug dependent person to apply to the Secretary to the Department of Health and Human Services for a permit to do so': 133.

76 B Onwuteaka-Philipsen, L Willmott and B White, 'Regulating voluntary assisted dying in Australia: some insights from the Netherlands' (2019) 211(10) *Medical Journal of Australia* 438. See also White et al, above n 13, 441, noting that:

> a procedurally-focused review is unlikely to be an effective safeguard to ensure compliance in practice with the substantive criteria of the legislation, making the cost to the policy goals of respecting autonomy and alleviating suffering unjustifiable.

77 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 13. One permit was not issued as the applicant was not able to establish eligibility due to insufficient evidence of Australian citizenship or permanent residency. This case was the subject of an application for review to the Victorian Civil and Administrative Tribunal.

78 Ibid.

79 *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definitions of 'administration decision', 'self-administration decision' and 'practitioner administration decision'), 56. See the discussion of when self-administration is inappropriate at [10.12] above.

80 It must be made in person before the coordinating practitioner (although, if that is not practicable, it may be made by audiovisual communication).

81 *Voluntary Assisted Dying Act 2019* (WA) ss 56(5), 60.

82 Western Australia, *Parliamentary Debates*, Legislative Council, 22 November 2019, 9181 (S Dawson, Minister for Environment).

of life options open to patients', such as to receive terminal sedation, or to refuse artificial food and hydration.[83]

10.78 The Panel also considered that the authorisation for prescription of the voluntary assisted dying substance could be managed through existing mechanisms in the *Medicines and Poisons Act 2014* (WA), without the need for a permit.[84]

Tasmania

10.79 Unlike Victoria and Western Australia, there is no requirement for the primary medical practitioner to conduct a final review and certify that the requirements of the request and assessment process have been complied with.

10.80 However, before the prescription, supply and administration of a voluntary assisted dying substance is authorised, the primary medical practitioner must request the Voluntary Assisted Dying Commission for a voluntary assisted dying substance authorisation. The Voluntary Assisted Dying Commission is required to issue the authorisation 'as soon as reasonably practicable', and can refuse if it has not received all of the required notices during the request and assessment process or suspects the requirements of the Act have not been met.[85]

10.81 That authorisation authorises the primary medical practitioner to prescribe the voluntary assisted dying substance for the person, and the pharmacist to supply the voluntary assisted dying substance specified in the prescription to the primary medical practitioner.[86]

10.82 Before the supply of the substance to the person's administering health practitioner (if not the same person as the primary health practitioner) and administration is authorised, the person must give a final permission in writing in the approved form to their administering health practitioner.[87]

10.83 The administering health practitioner must, within 48 hours before receiving the final permission from the person, have made a final determination that the person has decision-making capacity and is acting voluntarily.[88]

10.84 Among other things, the final permission must include a statement as to whether the person wishes:[89]

- to self-administer a voluntary assisted dying substance (without assistance);
- to be assisted by the administering health practitioner to self-administer a voluntary assisted dying substance; or

83 WA Ministerial Expert Panel Final Report (2019) 72. See also WA Joint Select Committee on End of Life Choices Report (2018) [6.84], noting that:

> It is difficult to contemplate any other scenario where it would be appropriate for the government to insert itself in the private medical decisions made by a patient in consultation with their doctors.

84 WA Ministerial Expert Panel Final Report (2019) 72–3, Recs 21, 22.

85 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 66, 67, 68. The voluntary assisted dying substance authorisation is an instrument in writing that contains the relevant details in relation to the person and the details of the voluntary assisted dying substance that the person's primary medical practitioner is authorised to prescribe, including the maximum amount that can be prescribed. This may relate to a voluntary assisted dying substance that may be self-administered or a voluntary assisted dying substance that may be practitioner administered: s 67.

86 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 70–71.

87 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 82. The final permission must be completed and signed by the person. Another person may complete or sign it on the person's behalf if the person is unable to do so, however this must not be the person's primary medical practitioner, consulting medical practitioner, or administering health practitioner. The Bill does not require the final permission to be completed and signed in the presence of anyone or include any witnessing requirements.

88 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 78, 81(a), 82(1). If the administering health practitioner determines that the person has decision-making capacity and is acting voluntarily the administering health practitioner must, as soon as reasonably practicable but in any case within 24 hours, advise the person of a number of matters related to the administration, including that the person is entitled to receive assistance to die and must, if they wish to receive assistance to die, give a final permission in writing: s 81. If the administering medical practitioner determines that the person does not have decision-making capacity or is not acting voluntarily, the administering medical practitioner must, as soon as reasonably practicable but in any case within 24 hours, notify the person, a guardian of the person or another person who cares for or who has responsibility for the person, of the determination, and notify the Commission of the determination, and, if the administering medical practitioner is not the person's primary medical practitioner, notify the person's primary medical practitioner of the determination: s 80.

89 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 82(1), (3)(c).

- to have the person's administering health practitioner administer a voluntary assisted dying substance.

10.85 The person must also request their administering health practitioner for either a private self-administration certificate or an AHP administration certificate.

10.86 A request for a private self-administration certificate must be made in the approved form and given to the person's administering health practitioner.[90] A private self-administration certificate is an instrument, in the approved form, certifying that the person is entitled to self-administer, without the person's administering health practitioner being required to be present. If the person requests a private administration certificate and the administering health practitioner is satisfied that the person will be able to self-administer (without assistance), the administering health practitioner must complete and sign a self-administration certificate and, as soon as practicable but in any case within 48 hours, provide a copy of it to the person, the person's primary medical practitioner (if not the same person as the administering health practitioner), and the Voluntary Assisted Dying Commission.[91]

10.87 A request for an AHP administration certificate must be made to the administering health practitioner.[92] The administering health practitioner may issue an AHP administration certificate if satisfied that it is inappropriate for the person to self-administer (without assistance).[93]

Parliamentary Committee and White and Willmott Model

10.88 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should, among other things, include 'rigorous governance of systems' for prescribing and dispensing any voluntary assisted dying medications.[94] In making this recommendation, the Parliamentary Committee noted the view of Palliative Care Queensland that, to assist in preventing coercion, there should be no 'advance prescribing'.[95]

10.89 The White and Willmott Model combines the third request for access to voluntary assisted dying with the administration of the voluntary assisted dying substance.

10.90 Unlike Victoria and Western Australia, there is no requirement for the coordinating practitioner to report to the Board and certify that the requirements of the request and assessment process have been complied with before prescribing the voluntary assisted dying substance for the person. The first medical practitioner is required to report to the Board only after the voluntary assisted dying substance has been administered.[96]

10.91 The person may make a final (third) request for the first medical practitioner to provide access to voluntary assisted dying if:[97]

- the person has made a second request (the written declaration);
- the person has decision-making capacity in relation to voluntary assisted dying;

90 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 83. The request must be completed and signed by the person. Another person may complete or sign it on the person's behalf if the person is unable to do so, however this must not be the person's primary medical practitioner, consulting medical practitioner, or administering health practitioner). The Bill does not require the request to be completed and signed in the presence of anyone or include any witnessing requirements.

91 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 84.

92 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 86(4). Unlike for a private self-administration request, the Act does not set out any requirements in relation to when or how a request for an AHP administration certificate is made.

93 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 86(5). See the discussion of when self-administration (without assistance) is inappropriate at [10.21] above. Unlike for a private self-administration certificate, the Act does not include any requirements to notify the person or the Voluntary Assisted Dying Commission if an AHP administration certificate is issued.

94 Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

95 Ibid 130.

96 White and Willmott Model cl 37. The first medical practitioner must, within 14 days of the administration of the voluntary assisted dying substance, give the Board a report in the approved form. The report must include a copy of a record of the first request, the first assessment report, any second assessment report, the second request, a record of the final request, the witness's certification of the final request, and any other information required by regulation: cl 37(2).

97 White and Willmott Model 30(1).

- the person's request for to voluntary assisted dying is made voluntarily and without coercion; and
- the person's request for access to voluntary assisted dying is enduring; and
- the person understands that access to voluntary assisted will be provided immediately after the making of the final request.

10.92 The person's final (third) request must be made immediately before the person is provided access to voluntary assisted dying, in the presence of a witness.[98] The request must be 'clear and unambiguous', made by the person personally, and may be made verbally or by gestures or other means of communication available to the person.[99]

10.93 The first medical practitioner must refuse to accept the person's request if they are not satisfied of any of the matters listed above.[100]

10.94 The person must specify in the final request whether they are requesting practitioner administration or supervised self-administration.[101] Upon receiving the person's final request, the first medical practitioner may provide the person with access to voluntary assisted dying, in accordance with the final request.[102]

10.95 The approach in the White and Willmott Model is partly possible because, unlike Victoria, Western Australia and Tasmania, the White and Willmott Model provides that self-administration must always be medically supervised (that is, the first medical practitioner must be present for administration). It is therefore not necessary to establish separate pathways for self-administration and practitioner administration, and the voluntary assisted dying substance will always remain under the control of the first medical practitioner.[103]

10.96 Unlike the legislation in Victoria, Western Australia and Tasmania, the White and Willmott Model does not contain any provisions regulating the prescription and supply of the substance, or provide any guidance in relation to the timing of its prescription, or who is authorised to prescribe and supply it.

Cancellation, revocation or amendment of authorisation

10.97 The person's coordinating practitioner (Victoria), administering practitioner (Western Australia) or administering health practitioner (Tasmania) can administer the substance to the person only if they are authorised to do so.[104]

10.98 In Victoria, if a person who is the subject of a self-administration permit becomes physically incapable of self-administration and wishes to have the coordinating practitioner administer the substance to them, they must request the coordinating practitioner to apply for a practitioner administration permit. The request must be made by the person personally, and may be made verbally or by gestures or other means of communication available to the person.[105]

10.99 A self-administration permit is cancelled on the coordinating practitioner destroying any unfilled prescription, or on the pharmacist giving the Board a copy of the completed voluntary assisted dying substance disposal form.[106] If a self-administration permit is

98 White and Willmott Model cll 30(1), (4), 33(3).
99 White and Willmott Model cl 30(2)–(3).
100 White and Willmott Model cl 30(5). See the matters listed in [10.91] above.
101 White and Willmott Model cl 31.
102 White and Willmott Model cll 31, 34.
103 The White and Willmott Model provides that the collection, storage and disposal of the voluntary assisted dying substance by the first medical practitioner must occur in accordance with regulations: White and Willmott Model cl 35.
104 That is, under a practitioner administration permit (Victoria), a practitioner administration decision (Western Australia), or if there is an AHP administration certificate in relation to the person and if to do so is in accordance with the wishes of the person as stated in their final permission (Tasmania).
105 *Voluntary Assisted Dying Act 2017* (Vic) s 53.
106 *Voluntary Assisted Dying Act 2017* (Vic) s 52. If the voluntary assisted dying substance has already been supplied, the person or their contact person must, before making the request, return the voluntary assisted dying substance to a pharmacist at the dispensing pharmacy: s 55. On receiving the request, the coordinating practitioner must destroy any unfilled prescription made under the self-administration permit: s 54.

cancelled, the coordinating practitioner may apply to the Secretary of the Department of Health for a practitioner administration permit.[107]

10.100 The Western Australian Act provides that a person may at any time:[108]

- revoke a self-administration decision by informing their coordinating practitioner that they have decided not to self-administer a voluntary assisted dying substance; or
- revoke a practitioner administration decision by informing their administering practitioner that they have decided not to proceed with the administration of the voluntary assisted dying substance.

10.101 The person may inform the coordinating practitioner or the administering practitioner of their decision in writing, verbally or in another way (for example, by gestures).[109] If the person has revoked an administration decision, the coordinating practitioner or administering practitioner who is informed of the person's decision must record the revocation in the person's medical record and, if the practitioner is not the coordinating practitioner, inform the coordinating practitioner of the revocation, and within two business days after the revocation, complete the approved revocation form and give a copy of it to the Board. The revocation of an administration decision does not prevent the person from making another administration decision.[110]

10.102 The Tasmanian Act provides that a person may amend the statement of wishes given in their final permission as to the method of receiving voluntary assisted dying. The person must give their administering health practitioner an instrument in writing completed and signed by the person amending that statement. If the person is unable to complete and sign the instrument, it may be completed and signed by an adult who is designated by the person to complete and sign it on the person's behalf. However, this must not be the person's primary medical practitioner, consulting medical practitioner, or administering health practitioner.[111] Additionally, the Voluntary Assisted Dying Commission may, either at the request of the person's primary medical practitioner or on their own motion, amend or revoke a voluntary assisted dying substance authorisation.[112]

10.103 The legislation in Victoria, Western Australia, and Tasmania also enables the person to decide, at any stage, to withdraw from the voluntary assisted dying process completely. However, if a person has decided to withdraw from the process and they later wish to access voluntary assisted dying, they must begin the process again by making a new first request.[113]

Submissions

10.104 Our Consultation Paper asked whether it is necessary or desirable for the draft legislation to require the coordinating practitioner to apply for a voluntary assisted dying permit before the voluntary assisted dying substance can be prescribed and administered (as in Victoria).[114]

10.105 Some respondents submitted that the legislation should not include a requirement for the coordinating practitioner to apply for a voluntary assisted dying permit approved

107 *Voluntary Assisted Dying Act 2017* (Vic) s 56. The application process is the same as explained at [10.70] above. However, the application must also be accompanied by evidence to the satisfaction of the Secretary that any unfilled prescription under the self-administration permit has been destroyed, or that any voluntary assisted dying substance supplied under that self-administration permit has been disposed of by a pharmacist at the dispensing pharmacy: s 48(2)(g).

108 *Voluntary Assisted Dying Act 2019* (WA) s 57(1).

109 *Voluntary Assisted Dying Act 2019* (WA) s 57(2).

110 *Voluntary Assisted Dying Act 2019* (WA) s 57(3)–(5). If the person has revoked a self-administration decision, the contact person must, as soon as practicable and in any event within 14 days after the day on which the decision is revoked, give any prescribed substance that has been supplied to an authorised disposer: s 105. Failure to give the unused or remaining substance to the authorised disposer is an offence, with a penalty of imprisonment for 12 months. If the person has revoked a practitioner administration decision, the administering practitioner must dispose of any of the voluntary assisted dying substance in their possession when the decision is revoked: s 77(1)–(3).

111 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 82(4).

112 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 69.

113 See the discussion of no obligation for a person to continue the voluntary assisted dying process in Chapter 8 above.

114 QLRC Consultation Paper No 79 (2020) Q-28.

by a government department before the voluntary assisted dying substance can be prescribed and administered, as in Victoria. Respondents variously submitted that such a requirement is overly bureaucratic or burdensome, causes unnecessary delays, potentially prolongs suffering, and does not provide a substantive benefit.

10.106 Ms Jodhi Rutherford, an academic, submitted on the basis of her research that:[115]

> There have been difficulties with the permitting process experienced by some participants in [voluntary assisted dying] in Victoria, particularly where a permit for self-administration requires a transfer to practitioner-administration, or where spelling mistakes in the prescribed medications cause a permit application to be rejected.

10.107 Professors White and Willmott submitted:

> We continue to support the [White and Willmott] Model approach to not require an additional permit or approval process (as is also the case in Western Australia). We consider this is unnecessarily bureaucratic and, for this additional delay, does not substantively improve the safety of the system.

10.108 Some respondents considered that a permit is not necessary if there are other 'robust' safeguards prior to prescription, such as reporting requirements to the Board.

10.109 In contrast, some respondents submitted that there should be a requirement for the coordinating practitioner to obtain a permit, or for some other approval process (for example, by the Board), before the substance can be prescribed and administered.

10.110 Go Gentle Australia submitted that permits would protect doctors:

> We support the process as outlined in the law in Victoria and note that we feel it should be in line with existing Queensland legislation, such as the Health (Drugs and Poisons) Regulation 1996. The issue of the permit is the final sign-off that the process has been completed in accordance with the law. It also provides protection to the doctor under the law.

10.111 MIGA submitted '[h]aving an approval process could well be of assistance to doctors in providing confirmation and reassurance that they are meeting their obligations'.

10.112 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld submitted that an approval process, after the request and assessment process is completed and before the voluntary assisted dying substance can be prescribed and administered, provides a safeguard and ensures due process is being followed.

10.113 The Australian Lawyers Alliance submitted that medical practitioners or nursing staff should be required to obtain permits from the Board before the substance can be prescribed and supplied to a person. It submitted that:

> [t]he request should be accompanied by the written request of the person and the written assessments of the medical practitioners. The requirement for the Board to issue a permit before medications are dispensed not only provides protections to medical and/or nursing practitioners but ensures that if there are any concerns regarding the application that those issues are investigated further before a permit is issued.

The Commission's view

10.114 The draft Bill must regulate the prescription, supply and administration of a voluntary assisted dying substance. Although there are general authorisations for the use of scheduled substances under the *Medicines and Poisons Act 2019*, they cannot be relied on for this purpose. The voluntary assisted dying scheme is unique in that it authorises the prescription, supply and administration of a lethal dose of a voluntary assisted dying substance for a person who is eligible under the scheme, for the purpose of causing their death. The draft Bill includes specific safeguards and clear guidance in relation

115 See n 60 above.

to the prescription, supply and administration of a voluntary assisted dying substance under the scheme, including in relation to the timing of the prescription and who is authorised to prescribe and supply a voluntary assisted dying substance.

10.115 We have had regard to the approaches in other Australian States. While a requirement for the coordinating practitioner to obtain a voluntary assisted dying permit from a government department (as in Victoria) provides an additional compliance check before the prescription, supply and administration of the voluntary assisted dying substance is authorised, it also causes additional delay. We consider that the approach in Western Australia, which authorises the prescription, supply and administration of a voluntary assisted dying substance under an administration decision, is more streamlined, while providing appropriate safeguards and clear guidance about the prescription, supply and administration of a voluntary assisted dying substance.

Administration decision

10.116 The draft Bill provides that the person may make an administration decision in consultation with and on the advice of their coordinating practitioner. This may be either a self-administration decision or a practitioner administration decision.

10.117 An administration decision can be made only if the person has made a final request and the coordinating practitioner has completed the final review form. The final review form must certify that the request and assessment process has been completed in accordance with the Act and the coordinating practitioner is satisfied that the person has decision-making capacity in relation to voluntary assisted dying, and that the person, in requesting access to voluntary assisted dying, is acting voluntarily and without coercion.[116] The coordinating practitioner is required to give a copy of the final review form to the Board within two business days of completing it.[117] This makes it clear the prescription, supply and administration of a voluntary assisted dying substance can be authorised only if the requirements of the request and assessment process have been complied with and the person is eligible.

10.118 An administration decision must be clear and unambiguous and made to the coordinating practitioner by the person personally and not by another person on their behalf. It may be made verbally or by gestures or other means of communication available to the person. The coordinating practitioner must record the administration decision in the person's medical record and notify the Board of the administration decision within two business days of prescribing a voluntary assisted dying substance to the person.

Revocation of administration decision

10.119 The draft Bill also provides a mechanism for the person to revoke an administration decision and, if they wish, make a new administration decision. This may be necessary if, for example, the person's condition deteriorates after making a self-administration decision such that self-administration becomes inappropriate. The person may wish to revoke their self-administration decision and make a practitioner administration decision, authorising the administering practitioner to administer a substance to them.

10.120 The draft Bill provides that the person may at any time:

- revoke a self-administration decision by informing the coordinating practitioner for the person that the person has decided not to self-administer a voluntary assisted dying substance; or
- revoke a practitioner administration decision by informing the administering practitioner for the person that the person has decided not to proceed with the administration of a voluntary assisted dying substance.

116 See Chapter 8 above.

117 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

10.121 The person may inform the coordinating practitioner or administering practitioner of the person's decision in writing, verbally or by gestures or other means of communication available to the person.

10.122 The coordinating practitioner or administering practitioner who is informed of the person's decision must record the revocation in the person's medical record and, if the practitioner is not the coordinating practitioner for the person, inform the coordinating practitioner of the revocation. They must also complete a record of the revocation in the approved form and give a copy of it to the Board within two business days after the revocation.

10.123 The draft Bill makes it clear that revoking an administration decision does not prevent the person from making another administration decision.

REQUIREMENTS FOR SELF-ADMINISTRATION

10.124 In Victoria and Western Australia, there is no requirement for the coordinating practitioner or another health practitioner to be present while the person self-administers. The Tasmanian Act also provides an option for a person to self-administer, without requiring the person's administering health practitioner to be present.

10.125 This is consistent with the approach in state legislation in the United States, which enables a voluntary assisted dying substance to be prescribed and supplied to a person to self-administer.[118]

10.126 In contrast, the White and Willmott Model provides that self-administration must be medically supervised, which means that the person's first medical practitioner must always be present while the person self-administers.

10.127 This is consistent with the New Zealand Act, which requires the attending medical practitioner or attending nurse practitioner to always be present at the arranged time of administration (either self-administration or practitioner administration).[119]

10.128 Unlike New Zealand, the legislation in Belgium, Luxembourg, the Netherlands and Canada does not state that a health practitioner must be present for self-administration.[120] In practice, however, self-administration generally occurs under the supervision of a medical practitioner (or, in Canada, a nurse practitioner).[121] The Canadian Association of MAiD Assessors and Providers observed that, while it:[122]

> currently advocates clinician presence at the time of oral [self-]administration, with more experience, a system could develop that safely dispenses and confirms appropriate use and effectiveness of the medication, but does not necessarily require clinician presence.

118 *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.1(b), (p), (i); *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-102(7); *District of Columbia Death with Dignity Act 2016*, DC Code § 7-661.01(10); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L–1 (definitions of 'informed decision', 'prescription' and 'self-administer'); *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140.2(G), (L); *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:16-3 (definitions of 'informed decision' and 'self-administer'); *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.800.1.01(7); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a)(1); *Washington Death with Dignity Act 2008*, RCW § 70.245.010(7), (12).

119 *End of Life Choice Act 2019* (NZ) s 20. A person who is eligible for assisted dying must complete an approved form choosing the date and time of administration and make provisional arrangements with their attending medical practitioner, including choosing the method of administration: ss 18–9. At the chosen date and time of administration, the Act requires that the attending medical practitioner or attending nurse practitioner must be available to the person until the person dies (or arrange for another medical practitioner or nurse practitioner to be available to the person). The practitioner is available to the person if they are in the same room or area as the person, or in close proximity to the person (but not in the same room or area): s 20(5)–(6).

120 *Belgian Euthanasia Act 2002*; *Luxembourg Law on Euthanasia and Assisted Suicide 2009*; *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*; *Canada Criminal Code*, RSC 1985, c C-46.

121 See, eg, Royal Dutch Medical Association and Royal Dutch Society for the Advancement of Pharmacy, *Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide* (August 2012) 13; Federal Commission of Control and Evaluation of Euthanasia (Belgium), *Eighth report to the Legislative Chambers years 2016-2017* (Unofficial English Translation by Dying for Choice, June 2018) 26; C Harty et al, Canadian Association of MAiD Assessors and Providers, 'The Oral MAiD Option in Canada Part 1: Medication Protocols—Review and Recommendations' (April 2018) <https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf> 5. Information from Luxembourg was not available in English translation.

122 C Harty et al, Canadian Association of MAiD Assessors and Providers, 'The Oral MAiD Option in Canada Part 1: Medication Protocols—Review and Recommendations' (April 2018) <https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf> 5, 25.

Victoria and Western Australia

10.129 If the person is the subject of a self-administration permit (Victoria), or if a self-administration decision has been made and not revoked (Western Australia), the person can receive the voluntary assisted dying substance and have it in their possession to self-administer at a time of their choosing.[123]

10.130 The legislation includes a number of provisions governing the safe management of the voluntary assisted dying substance, including in relation to the prescription, supply, storage, return and disposal of the substance.[124]

10.131 On prescribing the substance, the coordinating practitioner must inform the person of a number of matters, including how to self-administer (and, in Western Australia, prepare) the voluntary assisted dying substance.[125]

10.132 On supplying the voluntary assisted dying substance, the dispensing pharmacist is required to give particular information, including how to self-administer (and, in Western Australia, prepare) it.[126]

10.133 Statewide Pharmacy Services have been established in Victoria and Western Australia, and have sole responsibility for the supply of the prescribed voluntary assisted dying substance. They are a key part of the implementation of the voluntary assisted dying scheme. The Statewide Pharmacy Service provides information and instructions in relation to the administration of the voluntary assisted dying substance (either self-administration or practitioner administration) and support to relevant health practitioners, the person who is accessing voluntary assisted dying, and others who have been nominated by that person.[127]

10.134 Once the person has obtained the prescribed substance, they can decide to take it at a time of their choice. The person is not obliged to take it.[128] Educational material provided by the Victorian government explains:[129]

> Deciding whether you want to take the medication, and if so, the right time, is entirely up to you.
>
> …
>
> Some people will never take the medication — knowing they have the option to control the timing and manner of their death gives them enough comfort. It is okay if you decide the time is never right.

123 *Voluntary Assisted Dying Act 2017* (Vic) s 45; *Voluntary Assisted Dying Act 2019* (WA) s 58. In Victoria, the person is authorised, under a self-administration permit, to obtain, possess, store, use and self-administer the voluntary assisted dying substance. In Western Australia, if the person has made a self-administration decision, the person is authorised to receive the substance from an authorised supplier, their contact person or agent, possess it for the purpose of preparing and self-administering it, and prepare and self-administer the substance.

124 See Chapter 11 below.

125 *Voluntary Assisted Dying Act 2017* (Vic) s 57(a)–(b), (d); *Voluntary Assisted Dying Act 2019* (WA) s 69(e). See further Vic Guidance for Health Practitioners (2019) 59, explaining that:

> Detailed information and instructions about the self-administration process including pre-medications are contained in the medication protocol made available to medical practitioners after they complete the voluntary assisted dying training.

126 *Voluntary Assisted Dying Act 2017* (Vic) s 58(a), (c); *Voluntary Assisted Dying Act 2019* (WA) s 72(2)(c). The pharmacist is also required to provide information in relation to other matters, including the safe storage of the voluntary assisted dying substance and the safe return of any unused voluntary assisted dying substance. In Victoria, the information must be given to the person to whom the voluntary assisted dying substance is being dispensed. In Western Australia, the information must be given to the recipient, in writing. The recipient may be the patient, their contact person or agent.

127 See Department of Health & Human Services (Vic), 'Voluntary Assisted Dying Statewide Pharmacy Service' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-services-information>; Vic Guidance for Health Practitioners (2019) 6, 51, 56–7; Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the WA Voluntary Assisted Dying Statewide Pharmacy Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Statewide-Pharmacy-Service.pdf>.

128 The person is not obliged to take any further step after the request and assessment process is completed. The coordinating practitioner is required, on prescribing the substance, to inform the person that they are not under any obligation to obtain the voluntary assisted dying substance, or self-administer it. The dispensing pharmacist is required, on supplying the prescribed voluntary assisted dying substance, to inform the person that the person is not under any obligation to self-administer the voluntary assisted dying substance. See further *Voluntary Assisted Dying Act 2017* (Vic) ss 44, 57(b), (d), 58(c); *Voluntary Assisted Dying Act 2019* (WA) ss 53, 69(b)–(c), 72(2)(a).

129 Department of Health & Human Services (Vic), 'Preparing to take the medications' (August 2019) 1 <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/voluntary-assisted-dying-process/preparing-to-take-medications>.

10.135 The Victorian Guidance for health practitioners notes that:[130]

> The patient may also choose not to use voluntary assisted dying medication for any number of reasons, such as being either comforted by the knowledge that the time and manner of their death is in their control, or never reaching the point of deterioration they feared.

10.136 The Victorian Voluntary Assisted Dying Review Board reported that, since the commencement of the Act, 32 per cent of permit holders died without administering the voluntary assisted dying substance (either before the substance was dispensed or the substance was not taken and subsequently disposed of).[131] There may be a number of reasons why those people did not take the substance after it was dispensed, and the report does not provide this data. However, in a previous report the Board gave an example of information provided by the contact person of a person who obtained the voluntary assisted dying substance, but ultimately did not self-administer:[132]

> "She had always planned to have the medication as a plan B should her disease progress past bearable, however she died peacefully and calmly from natural causes in hospital". — Contact person

10.137 There is no requirement for the coordinating practitioner or another health practitioner to be present when the person self-administers, although this is not precluded by the legislation. The person may choose to have their coordinating practitioner or another health practitioner present when they self-administer, if the practitioner agrees.[133] They must arrange this with the practitioner.[134] The Victorian guidance states that:[135]

> [t]he patient may request that a health practitioner is with them during their self-administration of the voluntary assisted dying medication…The choice to attend or not is a decision for the individual health practitioner, whether the patient is self-administering the voluntary assisted dying medication in their own home or within a health service.

10.138 The person may also choose to have their family members, friends, carer or support person with them. As the Victorian Panel observed:[136]

> Most people who are at the end of their life are being cared for by loving family and friends, in all settings. Having a family member or carer who is able to care for a person who wishes to die at home is key in supporting this to happen.

10.139 The person will have discussions with their coordinating practitioner in relation to the administration of the voluntary assisted dying substance. The Victorian guidance provides:[137]

> In addition to discussing the voluntary assisted dying medication, the coordinating medical practitioner should spend some time with the patient discussing the patient's plans for their death. With the patient's consent, a plan for approaching their end of life should be made with the patient, their carers, family and friends. If a patient does not choose to involve carers, family or friends, the coordinating medical practitioner may contact the voluntary assisted dying care navigators for help to support the patient through this time, provided the patient consents.

130 Vic Guidance for Health Practitioners (2019) [5.1].
131 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 11.
132 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 9.
133 Vic Ministerial Advisory Panel Final Report (2017) 137, Rec 34; WA Ministerial Expert Panel Final Report (2019) 78.
134 Department of Health & Human Services (Vic), 'Preparing to take the medications' (August 2019) 2 <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/voluntary-assisted-dying-process/preparing-to-take-medications>.
135 Vic Guidance for Health Practitioners (2019) [5.1].
136 Vic Ministerial Advisory Panel Final Report (2017) 41.
137 Vic Guidance for Health Practitioners (2019) [4.2]. The legislation in Victoria and Western Australia provides that the coordinating practitioner must, if the person consents, take all reasonable steps to fully explain to a member of the family of the person all relevant clinical guidelines, and a plan in respect of the self-administration of a voluntary assisted dying substance for the purpose of causing death: *Voluntary Assisted Dying Act 2017* (Vic) s 19(2); *Voluntary Assisted Dying Act 2019* (WA) s 27(2).

Presence of the coordinating practitioner or another practitioner not required or precluded

10.140 The approach in Victoria and Western Australia, which does not require or preclude the presence of the coordinating practitioner or another health practitioner for self-administration, implements the recommendations of the Victorian Panel and the Western Australian Panel.[138]

10.141 The Victorian Panel considered, '[m]any people may like to have a health practitioner present at the time they self-administer the medication, and the legislation should not preclude this'. It also observed that:[139]

> People accessing voluntary assisted dying are likely to be engaged with a range of health practitioners and, in many circumstances, will have formed a close relationship with these practitioners. Some people may feel comforted by the presence of a health practitioner when they ingest a lethal dose of medication.

10.142 In formulating its recommendations, the Victorian Panel was guided by some key principles, including the need to respect the person's autonomy and provide people who are eligible for access to voluntary assisted dying with 'some control over the timing and manner of their death'.[140] However, it also considered the need to balance this with safeguards to protect vulnerable people and ensure that the person's decision to access voluntary assisted dying is made voluntarily and without coercion. The Panel explained:[141]

> Providing people with genuine choice at the end of their life is important; however, this must also be weighed against the need to ensure there are appropriate safeguards in place to protect individuals and the community. This means there must be strong checks to ensure people are acting voluntarily as well as constant monitoring of the lethal dose of medication to prevent improper use.
>
> The desire for strong oversight must, however, be balanced by the recognition that invasive requirements may have unintended consequences. For example, constantly checking up on the lethal dose of medication may inadvertently pressure people to self-administer the medication earlier than they had intended.

10.143 It noted the general view among stakeholders that self-administration is a 'powerful safeguard' that demonstrates the voluntary nature of the person's request.[142]

10.144 The Panel also noted that its recommendations 'provide an extensive framework for ensuring a person's request to access voluntary assisted dying is voluntary, properly informed and enduring',[143] and that a final check of compliance with these requirements is required before the prescription and supply of the voluntary assisted dying substance to the person is authorised.[144]

10.145 The Western Australian Panel considered whether the person's administering practitioner should have to be present for self-administration, observing that:[145]

> There is growing commentary that calls for a medical practitioner to be present in all cases of voluntary assisted dying, including oral self-administration, to ensure the highest standard of quality care and to reduce any perceived risk of assisted dying medications being present in the community.
>
> …

138 Vic Ministerial Advisory Panel Final Report (2017) 137–39, Rec 34; WA Ministerial Expert Panel Final Report (2019) 78, Rec 23.
139 Vic Ministerial Advisory Panel Final Report (2017) 137.
140 Ibid 44.
141 Ibid 45.
142 Ibid 141.
143 *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(c)–(d), 29(1)(c)–(d), 41; *Voluntary Assisted Dying Act 2019* (WA) ss 16(1)(d)–(f), 24, 28(1)(a), 35, 39(1)(a), 51.
144 Vic Ministerial Advisory Panel Final Report (2017) 129.
145 WA Ministerial Expert Panel Final Report (2019) 78.

> The presence of a health practitioner during self-administered voluntary assisted dying would provide benefits in terms of clinical support, ensuring appropriate administration, and governance of medications.

10.146 However, it also considered that '[f]rom a quality and safety perspective there is only a small amount of evidence that practitioner administration may be safer than self-administration'.[146]

10.147 On balance, the Panel considered that, while some people 'may want to choose to have a health practitioner present' for self-administration, others 'may wish for complete independence and privacy at this time'. It therefore concluded that 'the presence of a health practitioner should be a decision between the practitioner and the person', rather than being required by the legislation.[147]

Assistance that may be provided by health practitioners and others who are present for self-administration

10.148 The legislation in Victoria and Western Australia establishes two pathways for administration (self-administration or practitioner administration) and clearly states what is authorised in relation to each.

10.149 If the person is the subject of a self-administration permit (Victoria), or if a self-administration decision has been made and not revoked (Western Australia), the person is authorised, among other things, to self-administer the prescribed voluntary assisted dying substance.[148] No one else can administer it to them; it is a crime for another person to knowingly administer (or, in Western Australia, administer) the substance that was prescribed to the person to self-administer.[149]

10.150 The legislation distinguishes between 'using' (Victoria) or 'preparing' (Western Australia) the voluntary assisted dying substance and administering it.[150] In Western Australia, 'prepare', in relation to a prescribed substance, is defined to mean 'to do anything necessary to ensure that the substance is in a form suitable for administration', and 'includes to decant, dilute, dissolve, mix, reconstitute, colour or flavour the substance'.[151]

10.151 Others who are present while the person self-administers are not prohibited from assisting the person by preparing the voluntary assisted dying substance, for example by mixing the substance, if provided in powder form, with a liquid. The person must, however, administer the substance to themselves (take the substance).

10.152 The coordinating practitioner and the Statewide Pharmacy Service provide the person with education, instructions and support in relation to self-administration, including how to prepare the substance and what is authorised under the legislation.[152]

10.153 If a health practitioner is present while the person self-administers, they can provide the person with treatment to make them comfortable and respond to any unexpected events. The Victorian guidance for health practitioners provides:[153]

> If there are complications or the voluntary assisted dying medication takes longer than expected to cause death, health practitioners present may provide treatment to ensure the patient is comfortable but cannot intentionally hasten the patient's death.

146 Ibid 77.

147 Ibid 78.

148 *Voluntary Assisted Dying Act 2017* (Vic) s 45(a)–(b); *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'prepare'), 58(5)(c)–(d).

149 It is also a crime to induce a person to self-administer a voluntary assisted dying substance: *Voluntary Assisted Dying Act 2017* (Vic) ss 84, 86; *Voluntary Assisted Dying Act 2019* (WA) ss 99, 101. See the discussion of criminal offences under voluntary assisted dying legislation in Chapter 17 below.

150 *Voluntary Assisted Dying Act 2017* (Vic) s 45(b); *Voluntary Assisted Dying Act 2019* (WA) s 58(5)(c)–(d).

151 *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'prepare'). The Victorian Act does not include a definition of 'use' of the voluntary assisted dying substance.

152 There is a protection from liability for persons who, in good faith, assist access to voluntary assisted dying (or, in Western Australia, who are present when another person self-administers): *Voluntary Assisted Dying Act 2017* (Vic) s 79; *Voluntary Assisted Dying Act 2019* (WA) s 113.

153 Vic Guidance for Health Practitioners (2019) [5.1]. See also [5.2].

10.154 If the person chooses not to have a health practitioner present, the Victorian guidance notes that 'instructions in comfort care can be provided to carers, family and friends', and that '[i]f an unexpected event does occur, paramedics can also provide comfort care if called to attend a patient accessing voluntary assisted dying'.[154]

10.155 Health practitioners who are present, or paramedics who are called to attend a person accessing voluntary assisted dying, are under no obligation to provide life-saving or life-sustaining measures to a person who has self-administered a voluntary assisted dying substance, unless the person requests this.[155]

10.156 The coordinating practitioner (Victoria) or administering practitioner (Western Australia) can administer the substance to the person only if they are authorised to do so under a practitioner administration permit (Victoria) or a practitioner administration decision (Western Australia), and if the requirements in relation to practitioner administration are complied with.[156]

10.157 In Victoria, if the person deteriorates after a self-administration permit has been approved and becomes physically incapable of self-administration, they may ask the coordinating practitioner to apply for a practitioner administration permit.[157]

10.158 In Western Australia, if the person has made a self-administration decision and self-administration becomes inappropriate, they may revoke the decision and make a practitioner administration decision.[158]

10.159 If unexpected complications arise during self-administration, the practitioner may 'provide symptom relief in the manner they ordinarily would to a dying person', but cannot administer a voluntary assisted dying substance to the person to intentionally hasten their death. As the Victorian Panel explained:[159]

> The framework for voluntary assisted dying clearly outlines the circumstances in which a medical practitioner may administer a lethal dose of medication to a person, and a failed self-administration is not one of those circumstances. **It is important to make and uphold this distinction to ensure there is clarity and transparency around what has occurred** (emphasis added).

10.160 The Victorian Voluntary Assisted Dying Review Board reported that, from June 2019 until December 2020, 224 people had died from taking a prescribed voluntary assisted dying substance. Of these, the voluntary assisted dying substance was self-administered in 184 cases.[160] The Report does not include information about whether unexpected complications were experienced in any of those cases.

Tasmania

10.161 The Tasmanian Act provides an option for self-administration under a private self-administration certificate (in which case the person's administering health practitioner is not required to be present), or for assisted self-administration under an AHP administration certificate (in which case the person's administering health practitioner must be present).[161]

154 Ibid [5.2].

155 *Voluntary Assisted Dying Act 2017* (Vic) s 81; *Voluntary Assisted Dying Act 2019* (WA) s 115. The protection applies if the registered health practitioner or paramedic believes, on reasonable grounds, that the person is dying after self-administering a voluntary assisted dying substance. See also Vic Guidance for Health Practitioners (2019) [5.2]; Vic Ministerial Advisory Panel Final Report (2017) 139.

156 *Voluntary Assisted Dying Act 2017* (Vic) ss 46, 83–84; *Voluntary Assisted Dying Act 2019* (WA) ss 59(5), 99(b). This includes a requirement for practitioner administration to occur in the presence of a witness, and for the coordinating practitioner (Victoria) or administering practitioner (Western Australia) to be satisfied that: the person has decision-making capacity in relation to voluntary assisted dying at the time of administration, and that their request is voluntary and enduring. See the discussion of requirements for practitioner administration below.

157 *Voluntary Assisted Dying Act 2017* (Vic) s 53.

158 *Voluntary Assisted Dying Act 2019* (WA) s 57.

159 Vic Ministerial Advisory Panel Final Report (2017) 139.

160 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 5.

161 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 82(3)(c), 83, 84, 86, 87, 89, 91.

Self-administration (without assistance)

10.162 If there is a private administration certificate in relation to the person, the administering health practitioner is authorised to supply the voluntary assisted dying substance to the person if to do so is in accordance with the statement of the person in their final permission.[162] The person is authorised to possess and store a voluntary assisted dying substance, and self-administer, without the person's administering health practitioner required to be present.[163] The administering health practitioner is to show the person how to self-administer the supplied voluntary assisted dying substance.[164]

10.163 An earlier version of the Tasmanian Bill released for public consultation did not provide an option for self-administration without assistance. During consultation, however, some members of the public gave feedback that a person should be able to self-administer without a requirement for the administering health practitioner to be present. An option to self-administer without assistance was subsequently included in the Bill as introduced to parliament.[165]

Self-administration with the assistance of the administering health practitioner

10.164 If there is an AHP administration certificate in relation to the person, the administering health practitioner is authorised, if to do so is in accordance with the statement of the person's wishes included in the final permission, to:[166]

(a) supply to the person a voluntary assisted dying substance for self-administration while the AHP is in close proximity to the person in accordance with sections 87 and 88; or

(b) supply to the person, and assist the person to self-administer, a voluntary assisted dying substance; or

(c) administer a voluntary assisted dying to the person.

10.165 If the substance is not to be privately self-administered, the person's administering health practitioner must remain in the same room or place as the person, or in a room or place near to the person in which any noise made by the person may be heard, while a voluntary assisted dying substance is administered to, or self-administered by, the person. The administering health practitioner must remain present or in close proximity until the person has died or is removed from the room or the place to receive medical treatment, as the case may be.[167]

10.166 If unexpected complications arise after the person has self-administered the substance, or the administering health practitioner has administered the substance to the person, the administering health practitioner must follow the wishes of the person set out in the final permission in writing to either 'administer to the person a substance (which may be a [voluntary assisted dying substance]) that will enable the person to die more quickly and painlessly than would otherwise be the case', or 'take action that is reasonable for the person's [administering health practitioner] to take to preserve the person's life'.[168]

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162 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 89.

163 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 91. However, no more than six months (or, if the person has a neurodegenerative disease, 12 months) must have expired since the certificate was issued: s 91(3).

164 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 90.

165 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 64 (M Gaffney, Independent Member for Mersey).

166 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 86. The administering health practitioner may issue an administering health practitioner certificate if they are satisfied that it is inappropriate for the person to self-administer a voluntary assisted dying substance, having regard to: the ability of the patient to self-administer the voluntary assisted dying substance or to digest the voluntary assisted dying substance; the patient's concern about self-administering the voluntary assisted dying substance; the method of administering the voluntary assisted dying substance that is suitable for the patient: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 86(5).

167 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 87. The administering medical practitioner is to consider the wishes of the person in determining which room or place to be in, or remain in.

168 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 88. If the person does not intend to self-administer without assistance under a private self-administration certificate, they must state in their final permission what action they wish their administering health practitioner to take if unexpected complications arise from the administration of a voluntary assisted dying substance: s 82(3)(d).

10.167 The Tasmanian Act states that the requirements that apply for self-administration assisted by the administering health practitioner (that is, for the administering health practitioner to be present at the time of assisted self-administration and to follow the wishes of the person stated in their final permission if complications arise) do not apply if there is a private self-administration certificate in relation to the person.[169]

Parliamentary Committee and White and Willmott Model

10.168 The White and Willmott Model enables the person to choose either practitioner administration or self-administration. However, it provides that self-administration must always occur 'under the supervision of a registered medical practitioner', which means that the person's first medical practitioner must be present while the person self-administers the voluntary assisted dying substance.[170] The voluntary assisted dying substance will always remain under the control of the first medical practitioner.

10.169 If the person has made a written declaration (second request), the person may make a final request for access to voluntary assisted dying in the presence of a witness. The first medical practitioner may provide access to voluntary assisted dying immediately following that request if the medical practitioner is satisfied, among other things, that the person has decision-making capacity in relation to voluntary assisted dying, the person's request for access to voluntary assisted dying is made voluntarily and without coercion, and the person's request for access to voluntary assisted dying is enduring.[171]

10.170 The authors of the White and Willmott Model acknowledge that this approach, which requires the medical practitioner to be present at the time of administration (either self-administration or practitioner administration) has some disadvantages, including:[172]

> access implications for persons living in rural and remote areas; burdens on medical practitioners to supervise voluntary assisted dying; and some limits on a person's autonomy in terms of timing of their death and who is present.

10.171 However, they considered that there may be ways to address some of these concerns.[173] For example, in relation to access implications in rural and remote areas, the authors noted that 'permitting nurse practitioners to provide voluntary assisted dying has been one response to address access issues'.[174]

10.172 In relation to the person's autonomy, the authors noted that, while the practitioner must be present to supervise the self-administration, they anticipated that 'this could be done unobtrusively by the medical practitioner so as to respect the person's wishes about how their death occurs'.[175]

10.173 In their view, the benefits of supervised self-administration outweighed its disadvantages. In particular, they considered that requiring the medical practitioner to be present:[176]

- only disadvantages people who would specifically want to self-administer and who do not want a medical practitioner present to supervise;[177]
- prioritises and enhances the safety and quality of voluntary assisted dying for the person;[178] and

169 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 91(3).
170 White and Willmott Model cl 6(2), (3). See also White and Willmott Model, Explanatory Notes 2.
171 White and Willmott Model cll 30, 33(3), 34. The medical practitioner must also be satisfied that the person has made a written declaration, and that the person understands that access to voluntary assisted dying will be provided immediately after making the final request.
172 White and Willmott Model, Explanatory Notes 2.
173 White and Willmott Model, Explanatory Notes 2.
174 White and Willmott Model, Explanatory Notes 2, n 6.
175 White and Willmott Model, Explanatory Notes 2.
176 White and Willmott Model, Explanatory Notes 2–3.
177 It was noted that this is likely to occur in only a small number of cases, as many people are likely to choose practitioner administration: White and Willmott Model, Explanatory Notes 3. The authors noted that, 'where both options are available internationally, people overwhelmingly choose practitioner administration': White and Willmott Model, Explanatory Notes 2, n 4, referring to data from the Netherlands and Canada.
178 It was noted that, 'while the evidence base is limited, that which exists suggests that practitioner administration is safer than self-administration with fewer complications': White and Willmott Model, Explanatory Notes 2, referring to Emanuel et al, above n 44.

- ensures that the voluntary assisted dying substance is safely managed as it will always be in the possession or under the direct supervision of a registered medical practitioner.[179]

10.174 The Parliamentary Committee did not make any specific recommendations in relation to the requirements for self-administration, or whether a health practitioner should be required to be present at the time of self-administration. However, one member of the Parliamentary Committee noted in a statement of reservation that medical supervision is required by the White and Willmott Model. That member commented that 'given the additional challenges posed by remoteness in Queensland', consideration should be given to 'whether it is necessary … to mandate that any medical practitioner or registered nurse be present for self-administration of [the voluntary assisted dying substance]'. He further noted that '[t]his is not required under the Victorian scheme and it may not be appropriate in a state as large and decentralised as Queensland'.[180]

Submissions

10.175 Our Consultation Paper sought submissions on whether the draft legislation should provide that the coordinating practitioner or another health practitioner must be present when the person self-administers the substance.[181]

10.176 A number of respondents submitted that the presence of the coordinating practitioner or another health practitioner should not be mandatory for every case of self-administration, although the coordinating practitioner or another health practitioner should be permitted to be present if the person requests it. They considered that this approach provides the person with more autonomy. Respondents considered that it should be the person's choice as to the timing of death and manner of death, including whether the coordinating practitioner or another health practitioner is present. Some respondents also considered that the person's death should not be 'medicalised', or 'a bureaucratic exercise'.

10.177 A member of the public considered that 'death should be private if so desired at a time right for the person'. VALE Group submitted that:

> the time and date of the proposed ingestion should not be to suit a medical practitioner's diary commitments. The option should be there for a practitioner to be with the individual should the individual wish that to be the case… The timing of this must be at the individual's discretion. The individual should not feel obliged to commit to a date.

10.178 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld submitted that this approach (which enables the person to self-administer with or without the coordinating practitioner or another health practitioner present) recognises the person's autonomy to choose who is present, and also recognises 'the emotional impact on medical practitioners in the voluntary assisted dying process'. This respondent also noted that this approach gives the person more control in relation to the manner of their death, including:

> allowing for the unique cultural, family, social, religious and spiritual traditions and practices for that individual at the end of life, and who should be present at this time.

10.179 AMA Queensland noted divided opinion among its members and submitted:

> AMA Queensland believes that the patient should have the autonomy to choose who they have as witnesses of their death, including the coordinating practitioner or other practitioner (provided that they agree to being present).

179 It was noted that this 'means that complex provisions relating to the medication's collection, storage and disposal, such as those in the *Voluntary Assisted Dying Act 2017* (Vic), are not required': White and Willmott Model, Explanatory Notes 3.

180 Qld Parliamentary Committee Report No 34 (2020) 202 (Michael Berkman MP) (emphasis in original).

181 QLRC Consultation Paper No 79 (2020) Q-31.

10.180 STEP Queensland noted that requiring the coordinating practitioner or another health practitioner to always be present while the person self-administers 'may cause unnecessary anxiety to a person who may wish for complete privacy or who may only want close family or friends around them at the time'.

10.181 Some respondents submitted there is no need for the person's coordinating practitioner or another health practitioner to be present to supervise every case of self-administration. Palliative Care Nurses Australia Inc. submitted that the presence of a health practitioner is not required for self-administration if the person is 'capable of self-administration, has met all of the eligibility criteria and has received all information and education'. Dying with Dignity Victoria Inc submitted:

> As the whole process is designed to have the person in control, and as the medication is safe and effective, it should be left to the person what company is sought.

10.182 A few respondents submitted that the legislation should not include a requirement for the coordinating practitioner or another health practitioner to be present for self-administration, noting that this may cause difficulties in rural, regional and remote areas where the medical workforce is limited.

10.183 Other respondents, however, submitted that the draft legislation should require the coordinating practitioner or another health practitioner to be present while the person self-administers. Two academics jointly submitted that there should be a requirement for the coordinating practitioner or another health practitioner to be present during self-administration, subject to an exception if 'the patient expressly and in writing refuses to permit a health practitioner to be in attendance'.

10.184 Some respondents submitted that a requirement for self-administration to always be medically supervised would mean that appropriate treatment can be administered if there are any unwanted side effects or emergencies. Palliative Care Social Work Australia submitted:

> It is preferable that some health practitioner is present so that in case of emergency or reaction, there is help available.

10.185 The Hon Marshall Perron, former Chief Minister of the Northern Territory, submitted that the attending health practitioner could provide reassurance and comfort, answer any questions, and certify that death has occurred:

> [t]he attending doctor could ensure the patient and others present knew what to expect during administration and would be available to comfort individuals after the death if necessary. Importantly, the doctor would determine when death had occurred and issue the death certificate.

10.186 Some respondents submitted that a requirement for the coordinating practitioner or another health practitioner to be present for self-administration provides a safeguard to ensure the person is acting voluntarily, noting that the practitioner would be able to certify that the substance was used as intended.

10.187 Several respondents submitted that requiring the coordinating practitioner or another health practitioner to always be present for self-administration would overcome the need for additional substance management provisions, as the voluntary assisted dying substance would remain under the control of the coordinating practitioner or another health practitioner.

10.188 Mr Perron also submitted that:

> [r]equiring a doctor to be present overcomes the cumbersome provisions adopted in Victoria and [Western Australia] on the prescribing, possession, packaging, delivery, storage, return and disposal of [voluntary assisted dying] drugs. The doctor would always be in control of the drugs, including any portion that is unused.

10.189 The Clem Jones Group similarly submitted that this approach:

> means that a medical practitioner is present and supervises the security of the [voluntary assisted dying] substance even in instances of self-administration. We believe this is a logical, safe, and workable way to avoid the extra regulatory burden involved in the Victorian law as the medical practitioner present can therefore retain control over the [voluntary assisted dying] substance used and is already subject to existing regulations in relation to such dangerous medications.

10.190 Professors White and Willmott continued to support the White and Willmott Model, which provides that self-administration must always be medically supervised, with one variation. They submitted that they would no longer require the person's first medical practitioner (equivalent to coordinating practitioner) to supervise self-administration, and considered it appropriate for this role to be undertaken by another medical practitioner or nurse practitioner, to 'increase access to [voluntary assisted dying] and the flexibility of the system, without compromising safety'.

10.191 Other respondents who supported a requirement for self-administration to be medically supervised similarly submitted that this role could be extended to another suitably qualified medical practitioner or nurse practitioner to address accessibility issues, especially in rural, regional and remote areas.

10.192 A few respondents considered that, if the coordinating practitioner or another health practitioner is present for self-administration, their obligations should be clear.

10.193 Go Gentle Australia submitted that 'the health practitioner should have no obligation to assist with preparing the drug'.

10.194 MIGA submitted that a requirement for the coordinating practitioner or another practitioner to be present to supervise self-administration 'could create uncertain obligations for doctors if there were issues arising at the time, or raised later, around how administration occurred'. It observed that:

> [g]iven the gravity of the act involved, the profession cannot be left in any doubt about what are appropriate circumstances for practitioners to administer or supervise administration if this is permitted.

10.195 In this respect, some respondents submitted that if the legislation requires a health practitioner to be present, then there must also be a requirement for another witness to be present as a safeguard.

10.196 In relation to health practitioner professional ethics and codes of conduct, AHPRA noted that:

> a common feature of voluntary assisted dying schemes provides for a third party, such as a medical practitioner or a nursing practitioner, to provide assistance in ending a person's life. The power to lawfully provide this assistance often comes with requirements for the registered practitioner, in order to ensure the legislative provisions are upheld. A decision by a registered practitioner to assist the ending of another person's life may raise questions of the practitioner's professional ethics and conduct.

The Commission's view

10.197 The law should not require the coordinating practitioner or another health practitioner to be present for self-administration.

10.198 If it is appropriate for the person to self-administer and the person makes a self-administration decision, the person should be able to receive the voluntary assisted dying substance to take at a time of their choosing. Even if a person ultimately chooses not to self-administer the substance, for some people having it in their control can reduce their suffering.

10.199 This approach maximises the person's autonomy to control the timing and circumstances of their death, including who is present. While many people may choose

to have their coordinating practitioner or another health practitioner present, some may wish for independence and privacy. Whether the coordinating practitioner or another health practitioner is present during self-administration should be a matter for the person to decide in consultation with and on the advice of the coordinating practitioner, taking into account the person's individual circumstances.

10.200 Also, a requirement for the coordinating practitioner or another health practitioner to be present for self-administration may cause difficulties in rural, regional and remote areas where the medical workforce is limited. Such a requirement raises a significant obstacle to access for voluntary assisted dying in many parts of Queensland.

10.201 Accordingly, the draft Bill provides that, if the person makes a self-administration decision, the person is authorised to self-administer the voluntary assisted dying substance (take it themselves). The person is also authorised to receive, possess and prepare the substance.[182] The presence of the coordinating practitioner or another health practitioner is neither required nor precluded.

10.202 The draft Bill establishes two options for administration—self-administration and practitioner administration—and clearly sets out what is authorised in relation to each.

10.203 If the person makes a self-administration decision, the person must take the voluntary assisted dying substance themselves. The act of self-administering the substance is the final indication that the person is acting voluntarily. It is a crime to administer a voluntary assisted dying substance to another person unless the person is authorised to do so.[183]

10.204 The draft Bill clarifies that another person may assist the person who is accessing voluntary assisted dying by preparing the voluntary assisted dying substance at that person's request, for example, by mixing the voluntary assisted dying substance, if supplied as a powder, into the liquid. This may be the coordinating practitioner or another health practitioner, the person's carer or support person, or a family member or friend. There is, however, no obligation for another person to prepare the voluntary assisted dying substance.[184]

10.205 If the coordinating practitioner or another health practitioner is present for self-administration, they will be able to provide comfort care in the manner they ordinarily would to a dying person and respond if any unexpected events arise. They cannot, however, intentionally hasten the person's death. The administering practitioner can administer the voluntary assisted dying substance to the person only if the person makes a practitioner administration decision and the requirements for practitioner administration are complied with.

10.206 This approach is consistent with Victoria and Western Australia and ensures transparency of process.

10.207 The person will have discussions with the coordinating practitioner to make an informed choice about the method of administration. This ensures that, if the person makes a self-administration decision, self-administration is clinically appropriate and safe for the person. Unlike Victoria, practitioner administration is not limited to circumstances where the person is physically incapable of self-administration. It is permitted in broader circumstances that include having regard to the person's concerns, giving the person and the coordinating practitioner more discretion to decide the method of administration best suited to the person.[185] The person will make a plan for administration with the coordinating practitioner.

10.208 The draft Bill also provides flexibility by enabling the person to revoke an administration decision and make a new one. If the person has made a self-administration decision,

182 See Chapter 11 below.
183 See Chapter 17 below.
184 See the discussion of administration of the voluntary assisted dying substance in Chapter 11 below.
185 See [10.59] ff above.

and self-administration subsequently becomes inappropriate (for example, because the person's condition deteriorates), the person may revoke the self-administration decision and make a practitioner administration decision.[186]

10.209 For those reasons, we do not consider that it is appropriate to provide a third option for assisted self-administration, as in Tasmania, which enables the administering health practitioner to administer a voluntary assisted dying substance to the person following a failed self-administration attempt, if to do so is in accordance with the wishes of the person stated in writing prior to administration. Such an approach is also potentially inconsistent with the requirement in the draft Bill that the administering practitioner must be satisfied the person has decision-making capacity in relation to voluntary assisted dying at the time of administering a voluntary assisted dying substance to the person (for example, if the person is unconscious following a failed self-administration attempt).

10.210 The draft Bill contains a number of provisions to support the person to self-administer, without requiring the coordinating practitioner or another practitioner to be present. The coordinating practitioner is required, on prescribing the voluntary assisted dying substance, and the authorised supplier is required, on supplying the voluntary assisted dying substance, to give the person information and clear instructions in relation to the self-administration of the voluntary assisted dying substance.[187] In Victoria and Western Australia, a Statewide Pharmacy Service and a Care Navigator Service have been established as a key part of the implementation of the Scheme. We have recommended that similar services be established in Queensland to provide information and support to persons accessing voluntary assisted dying who have decided to self-administer.[188]

10.211 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.[189]

REQUIREMENTS FOR PRACTITIONER ADMINISTRATION

10.212 The legislation in Victoria and Western Australia includes additional safeguards that apply to practitioner administration, including a requirement that a witness must be present. The Victorian Panel explained:[190]

> When a person self-administers a lethal dose of medication it is a final indication that their decision is voluntary. When a medical practitioner administers a lethal dose of medication there must be a similar final affirmation that the person's decision is voluntary.

10.213 The Panel also considered, however, that 'this concern must be weighed against the need to ensure the process is not too onerous for people who are extremely unwell and suffering at the end of their life'.[191]

10.214 The White and Willmott Model requires the person's final request to be made in the presence of a witness, immediately before administration.

10.215 The Tasmanian Act does not, however, require a witness to be present for practitioner administration.

10.216 Overseas jurisdictions do not require a witness to be present at the time of administration. However, the New Zealand Act provides that, at the chosen time for the administration, the attending medical practitioner, or the attending nurse practitioner, must ask the person if they choose to receive the medication at that time. It is only if the person chooses to receive the medication at that time that the attending medical practitioner or attending nurse practitioner can administer the medication to the person

186 See [10.119] ff above.
187 See Chapter 11 below.
188 See Chapter 21 below.
189 See Chapter 11 below.
190 Vic Ministerial Advisory Panel Final Report (July 2017) 141.
191 Ibid.

(or supply the medication to the person to self-administer).[192] The federal legislation in Canada requires the medical practitioner or nurse practitioner, immediately before providing medical assistance in dying, to 'give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying'.[193]

Victoria and Western Australia

10.217 In Victoria, the coordinating practitioner has the role of administering the voluntary assisted dying substance under a practitioner administration permit, when the person is physically incapable of self-administering the substance.[194] In Western Australia, the administering practitioner has the role of administering the voluntary assisted dying substance when the person has made a practitioner administration decision. The administering practitioner may be either the coordinating practitioner, or another suitably qualified medical practitioner or nurse practitioner who is eligible for this role and accepts a transfer of the role.[195]

10.218 In Victoria, after the practitioner administration permit has been approved, the person may make a request for the coordinating practitioner to administer the substance. The administration request must be made personally and may be made verbally or by other means of communication available to the person.[196] The coordinating practitioner must refuse the person's administration request if the coordinating practitioner is not satisfied, among other things, that the person has decision-making capacity in relation to voluntary assisted dying, and the person's request is enduring.[197]

10.219 Under the practitioner administration permit, the coordinating practitioner is authorised to administer in the presence of a witness the substance immediately after the administration request if they are satisfied, among other things, that the person has decision-making capacity and is acting voluntarily and without coercion.[198]

10.220 In Western Australia, if the person has made a practitioner administration decision and it has not been revoked, the administering practitioner is authorised, in the presence of a witness, to administer the voluntary assisted dying substance to the person if the administering practitioner is satisfied at the time of administration that:[199]

(a) the patient has decision-making capacity in relation to voluntary assisted dying; and

(b) the patient is acting voluntarily and without coercion; and

(c) the patient's request for access to voluntary assisted dying is enduring.

10.221 Following the administration of the substance to the person, the coordinating practitioner (Victoria) or administering practitioner (Western Australia), must complete the approved form certifying, among other things, that the practitioner was satisfied that the person

192 *End of Life Choice Act 2019* (NZ) s 20(2)–(4). If the person chooses not to receive the medication at that time, the attending medical practitioner or attending nurse practitioner must immediately take the medication away, and complete an approved form recording the action taken and send it to the Registrar.

193 *Canada Criminal Code*, RSC 1985, c C-46, ss 241.2(3)(h), 241.2(3.1)(k).

194 *Voluntary Assisted Dying Act 2017* (Vic) s 46. The coordinating practitioner can, either at the person's request or on their own initiative, transfer the role of coordinating practitioner to a consulting practitioner who has assessed the person as eligible and who accepts the transfer of the role: *Voluntary Assisted Dying Act 2017* (Vic) ss 32–33.

195 *Voluntary Assisted Dying Act 2019* (WA) ss 54, 63.

196 *Voluntary Assisted Dying Act 2017* (Vic) ss 46(b), 64(1)–(3).

197 The coordinating practitioner must also refuse the person's administration request if the coordinating practitioner is not satisfied the person is the subject of the permit, and the person understands that the voluntary assisted dying substance is to be administered immediately after the making of the administration request: *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of 'administration request'), s 64(1), (5).

198 *Voluntary Assisted Dying Act 2017* (Vic) s 46. Under the practitioner administration permit, the practitioner is authorised to administer in the presence of a witness the voluntary assisted dying substance to the person if: the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance; and the person at the time of making the administration request has decision-making capacity in relation to voluntary assisted dying; and the person in requesting access to voluntary assisted dying is acting voluntarily and without coercion; and the person's request to access voluntary assisted dying is enduring; and the person is administered the voluntary assisted dying substance immediately after making the administration request.

199 *Voluntary Assisted Dying Act 2019* (WA) s 59(5).

had decision-making capacity in relation to voluntary assisted dying at the time of administration, that the person was acting voluntarily and without coercion, and that the person's request for access to voluntary assisted dying was enduring. A copy of the form must be provided to the Board within seven days (Victoria) or two business days (Western Australia) of administering the voluntary assisted dying substance.[200]

Witness requirements for practitioner administration

10.222 In Victoria a witness must be present at the time the person makes the administration request, and the practitioner must administer the voluntary assisted dying in the presence of a witness immediately following the administration request. The witness must certify in writing in the approved form that:[201]

(i) the person at the time of making the administration request appeared to have decision-making capacity in relation to voluntary assisted dying; and

(ii) the person in requesting access to voluntary assisted dying appeared to be acting voluntarily and without coercion; and

(iii) the person's request to access voluntary assisted dying appeared to be enduring.

10.223 In Western Australia, the witness must be present when the administering practitioner administers the substance and is required to certify in the approved form that the patient's request for access to voluntary assisted dying appeared to be free, voluntary and enduring.[202]

10.224 In Victoria and Western Australia, the witness must also state in the approved form that the practitioner administered the substance to the person.[203]

10.225 The witness must be 18 years or over and must be independent of the coordinating practitioner (Victoria) or the administering practitioner (Western Australia).[204]

10.226 The requirement for the witness to be independent is to ensure 'that the witness to the request for administration and the [coordinating practitioner or administering practitioner] do not have a conflict of interest'.[205] It was considered that:[206]

> the presence of an independent witness provides an additional safeguard to ensure medical practitioners act appropriately and protects the medical practitioner from claims of impropriety.

10.227 In Victoria, the guidance explains that this means that the witness must not be an employee at the same health service as the medical practitioner.[207] The Western Australian Act provides that the witness must not be a family member of the administering practitioner, or be employed, or engaged under a contract for services, by the administering practitioner.[208]

10.228 The witness may be a family member, friend, or carer of the person. The Victorian Panel explained that:[209]

> [t]he Panel considered requiring another independent medical practitioner to be present or another witness independent of the person. But given the extensive process

200 *Voluntary Assisted Dying Act 2017* (Vic) s 66; *Voluntary Assisted Dying Act 2019* (WA) s 61. In Victoria, the coordinating practitioner must also certify that they were satisfied the person was physically incapable of self-administration or digestion of the voluntary assisted dying substance. In Western Australia, the administering practitioner must also certify that the person had made a practitioner administration decision and did not revoke that decision.

201 *Voluntary Assisted Dying Act 2017* (Vic) s 65(2).

202 *Voluntary Assisted Dying Act 2019* (WA) ss 59(5), 62(3).

203 *Voluntary Assisted Dying Act 2017* (Vic) s 65(2)(b); *Voluntary Assisted Dying Act 2019* (WA) s 62(3)(b).

204 *Voluntary Assisted Dying Act 2017* (Vic) s 65(1); *Voluntary Assisted Dying Act 2019* (WA) s 62(1)–(2).

205 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 23.

206 Vic Ministerial Advisory Panel Final Report (2017) 143.

207 Vic Guidance for Health Practitioners (2019) [5.2].

208 *Voluntary Assisted Dying Act 2019* (WA) s 62(1)(b), (2).

209 Vic Ministerial Advisory Panel Final Report (July 2017) 142.

that must be completed before a person may even reach this point, the involvement of further witnesses is unnecessary. It would also be insensitive and onerous to require a person to arrange for a number of others to observe their death, and this could be extremely confronting for family members.

10.229 The Victorian guidance notes that one of the people that the person has selected to be with them at the end of their life may act as a witness, however, '[i]t is important that the witness is a person the patient is comfortable with and that the witness is also prepared to undertake the role'.[210]

Tasmania

10.230 In Tasmania, the administering health practitioner must have made a final determination that the person has decision-making capacity and is acting voluntarily within 48 hours before the person may give a final permission in writing. The final permission includes a statement that access to voluntary assisted dying will be provided 'as soon as practicable' after that permission is given.[211]

10.231 Unlike Victoria and Western Australia, however, there is no requirement for a witness to be present at the time of practitioner administration, or for the practitioner to certify that they were satisfied of that the person had decision-making capacity and was acting voluntarily at the time of administration.

Parliamentary Committee and White and Willmott Model

10.232 The Parliamentary Committee did not make a specific recommendation in relation to the requirements for practitioner administration, or whether there should be a witness present.

10.233 The White and Willmott Model requires the person to make a final request in the presence of a witness, which must be made immediately before administration (either supervised self-administration or practitioner administration).[212] The witness must be 18 years or more and must not be employed by or working under the supervision of the first medical practitioner, or a family member of the first medical practitioner. The witness must certify in the approved form that the person appeared to have decision-making capacity in relation to voluntary assisted dying, appeared to be acting voluntarily and without coercion, and that the person's request appeared to be enduring.[213]

10.234 The first medical practitioner must refuse to accept the person's final request if they are not satisfied, among other things, that the person has decision-making capacity in relation to voluntary assisted dying, the person's request for access to voluntary assisted dying is made voluntarily and without coercion, and the person's request for access to voluntary assisted dying is enduring.[214]

Submissions

10.235 Our Consultation Paper sought submissions on whether the draft legislation should provide that a witness, who is independent of the administering practitioner, must be present when the practitioner administers the voluntary assisted dying substance.[215]

10.236 Many respondents submitted that a witness, who is independent of the administering practitioner, should be present when the practitioner administers the voluntary assisted dying substance to the person.

10.237 A number of respondents submitted that this is an important safeguard to protect both the person and the practitioner, to document and ensure transparency in the process.

210 Vic Guidance for Health Practitioners (2019) [5.2].
211 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 78, 80, 81, 82(3)(b).
212 White and Willmott Model cll 30(1), (4), 33(3), 34.
213 White and Willmott Model cl 32.
214 White and Willmott Model cll 30(1), (5), 33(3), 34.
215 QLRC Consultation Paper No 79 (2020) Q-32.

MIGA noted that it provides 'protection for the practitioner if there is any subsequent issues raised around their actions, and reassurance to the community'. The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld considered that:

> This is an additional safeguard to certify that the person has decision-making capacity and is acting voluntarily [and] without coercion.

10.238 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine noted that many of its members 'expressed discomfort with the role of a health practitioner actively administering a lethal dose of medication' and considered that 'additional safeguards should be required when a medical practitioner administers the lethal dose of medication'. It submitted that:

> There should be one final proclamation or affirmation by the patient that they want to go ahead with administering the lethal dose of medication and that an impartial witness (for example, another medical practitioner or a registered health practitioner) be present to ensure that the medication has been administered at the request of the patient and that the legally required paperwork has been completed and signed-off to indicate this.

10.239 Australian Lawyers Alliance submitted that there should be a requirement to report to the Board after the administration has occurred.

10.240 A number of respondents, however, submitted that the draft legislation should not require a witness to be present for practitioner administration. Some respondents considered that it is unnecessary for there to be a witness independent of the practitioner. A member of the public expressed concern that this may 'offend the person's right to privacy'. VALE Group considered that this may turn the person's death into a 'formal and bureaucratic event'.

10.241 Two members of the public jointly submitted that if there were other ways in which to 'legally protect the practitioner such that they can be the sole witness if the dying person wishes this, then this is preferable', noting that 'there may be circumstances where the dying person does not wish anyone else to be present'.

10.242 Dying with Dignity NSW submitted that a witness is not necessary as the 'health professional has the skills required and would conform to all relevant ethical requirements in the situation'.

10.243 A registered nurse submitted that:

> It's currently legal for a practitioner to administer the final (life-ending) dose of 'terminal sedation' without any witness (independent, or not) being present. The administration of [voluntary assisted dying] medications should be treated no differently to the administration of terminal sedation medications.

10.244 Some respondents raised concerns about the practical effect of requiring an independent witness and the difficulties in having such a requirement across Queensland.

10.245 In relation to who should be able to witness, a member of the public submitted that:

> the witness must be an adult, should not be an heir or otherwise stand to benefit from the person's death, and should be independent of the administering physician and other physicians involved in the decision.

10.246 The Clem Jones Group submitted that the witness should be independent of the health practitioners involved.

10.247 One respondent, however, queried what the requirement for the witness to be 'independent' would mean:

> How do we define 'independent'? If they work in the same hospital or GP Clinic are they considered to be independent? I can see that the requirement for 'independence' (however defined) may prove more troublesome than helpful.

10.248 Dying with Dignity Queensland submitted that the witness:

> can be the coordinating registered medical practitioner, or can be the [voluntary assisted dying] trained administering registered medical practitioner who is under the direction of the coordinating registered practitioner or the [voluntary assisted dying] trained administering registered nurse who is [under] the direction of the coordinating registered practitioner, or other eligible witness.

The Commission's view

10.249 The Commission considers that there should be additional safeguards for practitioner administration to ensure the person is acting voluntarily and provide transparency of process, consistent with the approach in Victoria and Western Australia.

10.250 The draft Bill provides that, if the person makes a practitioner administration decision, the administering practitioner is authorised to administer the voluntary assisted dying substance to the person, 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.

10.251 The administering practitioner must certify in the approved form (the 'practitioner administration form') that they were satisfied of those matters at the time of administration, and give a copy of the form to the Board within two business days after administering the voluntary assisted dying substance.[216]

10.252 Requiring a witness for practitioner administration is an additional 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. The draft Bill provides that a person is eligible to witness the administration of the voluntary assisted dying substance if the person is at least 18 years of age. The witness may be a family member of the person accessing voluntary assisted dying, or another health practitioner.

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

10.254 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.

216 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

TRANSFER OF THE ROLE OF ADMINISTERING PRACTITIONER

10.255 In Victoria, the coordinating practitioner has the role of administering the voluntary assisted dying substance under a practitioner administration permit.[217]

10.256 In Western Australia, the coordinating practitioner may transfer this role to another medical practitioner or nurse practitioner who is eligible to act in this role, and who accepts a transfer of the role.[218] The role of administering practitioner can be transferred if the person has made a practitioner administration decision, and the coordinating practitioner for the person has prescribed a voluntary assisted dying substance for the person, and if either the coordinating practitioner or another administering practitioner to whom the role has previously been transferred (the original practitioner) is 'unable or unwilling for any reason' to administer the prescribed substance to the person.[219]

10.257 If the practitioner accepts the role of administering practitioner, the original practitioner must inform the person of the transfer and of the name and contact details of the new administering practitioner, must record the transfer in the person's medical records, and must within two business days after the transfer of the role is accepted complete the approved form (the administering practitioner transfer form) and give a copy of it to the Board. If the original practitioner has possession of the prescribed substance when the role is transferred, the original practitioner is authorised to supply it to the new administering practitioner, and the administering practitioner is authorised to receive it. The coordinating practitioner remains the coordinating practitioner for the person despite any transfer of the role of administering practitioner.[220]

10.258 The Tasmanian Act provides that the person's primary medical practitioner becomes the person's administering health practitioner, unless they advise the person that they do not intend to be the person's administering health practitioner and request the Voluntary Assisted Dying Commission in writing to appoint an administering health practitioner for the person.[221] The Commission may appoint an administering health practitioner for the person by an instrument in writing signed by the Commission, and must notify the person's primary medical practitioner of the appointment as soon as practicable.[222] The administering health practitioner appointed by the Commission must be a suitably qualified and trained medical practitioner or registered nurse who is eligible for this role,[223] and agrees to be appointed for the person.[224]

The Commission's view

10.259 If the person has made a practitioner administration decision, the coordinating practitioner should, in the first instance, be responsible for administering the voluntary assisted dying substance to the person. However, if the coordinating practitioner is unable or unwilling for any reason to administer the voluntary assisted dying substance

217 *Voluntary Assisted Dying Act 2017* (Vic) s 46. The coordinating practitioner can, either at the person's request or on their own initiative, transfer the role of coordinating practitioner to a consulting practitioner who has assessed the person as eligible and who accepts the transfer of the role: *Voluntary Assisted Dying Act 2017* (Vic) ss 32–33.

218 *Voluntary Assisted Dying Act 2019* (WA) ss 54, 63. See the discussion of eligibility requirements for administering practitioners in Chapter 13 below.

219 *Voluntary Assisted Dying Act 2019* (WA) s 63(1)–(2).

220 *Voluntary Assisted Dying Act 2019* (WA) s 63(3)–(6). There is separate provision enabling the coordinating practitioner, either at the person's request or on their own initiative, to transfer the role of coordinating practitioner to the consulting practitioner if the consulting practitioner accepts the transfer of the role: s 157.

221 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 60, 61, 81, 62(1)–(2). If the primary medical practitioner has determined the person's final request by determining that the person is eligible for access to voluntary assisted dying, the primary medical practitioner must, as soon as reasonably practicable but in any case within 48 hours, advise the person as to whether the primary medical practitioner will be the person's administering medical practitioner, or whether the primary medical practitioner intends to request the Commission to appoint an administering medical practitioner for the person. If the primary medical practitioner has advised the person that they do not intend to be administering medical practitioner they must, as soon as reasonably practicable but in any case within two days, request the Commission to appoint an administering medical practitioner for the person.

222 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 62, 65.

223 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 62(2), 63(1)(b)(iv), (2). See the discussion of eligibility requirements for administering practitioners in Chapter 13 below.

224 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 63(1), 64. The administering health practitioner must sign a statutory declaration stating that they meet the eligibility requirements for this role.

to the person, they should be able to transfer that role (in the capacity of administering practitioner) to another suitably qualified and trained medical practitioner, nurse practitioner or registered nurse who is eligible to act in the role, and who accepts the transfer of the role.[225] Another person who has accepted that role should also be able to transfer the role, if they subsequently become unable or unwilling to administer the voluntary assisted dying substance to the person.

10.260 Accordingly, the draft Bill provides that the coordinating practitioner for the person, or another person to whom the role of administering practitioner has previously been transferred (the original practitioner) must transfer the role of administering practitioner to another person who is eligible to act as an administering practitioner for the person and accepts the transfer of the role if:

- a person has made a practitioner administration decision; and
- the coordinating practitioner for the person has prescribed a voluntary assisted dying substance for the person; and
- the original practitioner is unable or unwilling for any reason to administer the voluntary assisted dying substance to the person.

10.261 If a person accepts the role (the new practitioner), the original practitioner who transferred the role to them (whether the coordinating practitioner, or another person to whom the role had previously been transferred) is required to:

- inform the person requesting access to voluntary assisted dying of the transfer and the name, address, telephone number and email address of the new practitioner; and
- record the transfer in the person's medical record; and
- within two business days after the acceptance of the transfer, complete a record of the acceptance of the transfer in the approved form and give a copy of it to the Board.[226]

10.262 If the original practitioner has possession of the voluntary assisted dying substance when the role is transferred, they are authorised to supply the substance to the new practitioner, and the new practitioner may receive it.

10.263 The draft Bill should make it clear the coordinating practitioner for the person remains the coordinating practitioner, despite any transfer of the role of administering practitioner.

225 See the discussion of eligibility requirements for administering practitioners in Chapter 13 below.

226 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

RECOMMENDATIONS

Self-administration or practitioner administration

10-1 A person may in consultation with and on the advice of the coordinating practitioner:

(a) decide to self-administer a voluntary assisted dying substance (a 'self-administration decision'); or

(b) decide that the substance is to be administered by the administering practitioner (a 'practitioner administration decision').

10-2 A practitioner administration decision may only be made if the coordinating practitioner advises the person that self-administration of the substance is inappropriate having regard to any of the following:

(a) the person's ability to self-administer the substance;

(b) the person's concerns about self-administering the substance;

(c) the method for administering the substance that is suitable for the person.

Authorisation of prescription, supply and administration of the substance

Administration decision

10-3 An administration decision may be made only if:

(a) a person has made a final request; and

(b) the person's coordinating practitioner has completed the final review form.

10-4 An administration decision must be clear and unambiguous, and made by the person personally and not by another person on their behalf.

Revocation of administration decision

10-5 An administration decision may be revoked by the person at any time by informing the coordinating practitioner (in the case of a self-administration decision) or the administering practitioner (in the case of a practitioner administration decision). The relevant practitioner must record the revocation and give a copy of the approved form to the Board.

Requirements for self-administration

10-6 If the person makes a self-administration decision, they are authorised to self-administer the substance.

Requirements for practitioner administration

10-7 If the person makes a practitioner administration decision, 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:

(a) has decision-making capacity in relation to voluntary assisted dying; and

(b) is acting voluntarily and without coercion.

10-8 A person is eligible to witness the administration of the substance to another person if the witness is at least 18 years of age.

10-9 The witness must certify in the approved form (the 'practitioner administration form') that:

(a) the person appeared to be acting voluntarily and without coercion; and

(b) the administering practitioner administered the substance to the person in the presence of the witness.

10-10 If the administering practitioner administers the substance, the administering practitioner must certify in the practitioner administration form:

(a) that the person made a practitioner administration decision and did not revoke the decision; and

(b) that the administering practitioner was satisfied at the time of administering the substance that the person:

(i) had decision-making capacity in relation to voluntary assisted dying; and

(ii) was acting voluntarily and without coercion; and

(c) any other matter prescribed by regulation to be certified.

10-11 The administering practitioner must give a copy of the practitioner administration form to the Board within two business days after administering the substance.

Transfer of the role of administering practitioner

10-12 If a practitioner administration decision is made and the substance has been prescribed but the administering practitioner is unable or unwilling for any reason to administer the substance, the role of the administering practitioner must be transferred to another eligible practitioner. If the new practitioner accepts the role, they may be supplied the substance and must inform the person of the transfer, record the transfer and give a copy of the approved form to the Board.

CHAPTER 11

Management of the substance

Chapter 11: Management of the substance

CHAPTER SUMMARY

This chapter considers provisions 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 explained in this chapter. The safeguards include a requirement for a person to appoint a 'contact person'.

Where a self-administration decision has been made, the contact person may assist the person by receiving the voluntary assisted dying substance from an authorised supplier and supplying it to the person.

Another key aspect of a contact person's role where a self-administration decision has been made is to give 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 the self-administration decision being revoked.

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.

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

THE VOLUNTARY ASSISTED DYING SUBSTANCE

11.1 Voluntary assisted dying involves the administration of a substance to cause a person's death. It is necessary to define what the substance is for the purposes of the scheme to ensure it is regulated appropriately.

11.2 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland not limit or prescribe the medications that may be used for voluntary assisted dying.[1]

Other jurisdictions

11.3 The specific substance to be used is not prescribed in the Victorian Act. Victoria defines 'voluntary assisted dying substance' broadly to mean a poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person's death.[2]

11.4 Western Australia does not prescribe the specific substance to be used, defining 'voluntary assisted dying substance' as a Schedule 4 or Schedule 8 poison as defined in the *Medicines and Poisons Act 2014* (WA), approved by the CEO of the Department of Health for use under the *Voluntary Assisted Dying Act 2019* (WA) for the purpose of causing a patient's death.[3] The Western Australian Joint Select Committee

1 Qld Parliamentary Committee Report No 34 (2020) 135, Rec 11.

2 *Voluntary Assisted Dying Act 2017* (Vic) s 3. 'Poison or controlled substance' and 'drug of dependence' are defined to have the same meaning as in section 4 of the *Drugs, Poisons and Controlled Substances Act 1981* (Vic), which defines 'poison or controlled substance' to mean a Schedule 1, 2, 3, 4, 5, 6, 7, 8 or 9 poison or a regulated poison other than a Schedule 7 poison, and 'drug of dependence' to include a drug specified in Schedule 11.

3 *Voluntary Assisted Dying Act 2019* (WA) s 7. Section 3 of the *Medicines and Poisons Act 2014* (WA) defines 'schedule 4 poison' to mean a substance classified by regulations made under section 4(1) as a poison included in Schedule 4. 'Schedule 8 poison' is defined to mean a substance classified by regulations made under section 4(1) as a poison included in Schedule 8.

recommended that 'the choice of lethal medication for voluntary assisted dying should remain a clinical decision based on the prescribed list of medications for this purpose'.[4] The Western Australian Panel agreed with this recommendation, noting that it ensures the medical practitioner 'can determine the most clinically appropriate option as per usual practice', in consultation with the person.[5]

11.5 The White and Willmott Model suggests defining 'voluntary assisted dying medication' to mean a poison or controlled substance or a drug of dependence prescribed by the first medical practitioner for the purpose of causing a person's death.[6]

11.6 Unlike the White and Willmott Model, Victoria and Western Australia do not include reference to who prescribes the substance in the definition of 'voluntary assisted dying substance'.[7] The explanatory notes to the White and Willmott model do not elaborate on the rationale for the suggested inclusion of this requirement in the definition of 'voluntary assisted dying medication'.[8]

The Commission's view

11.7 We consider that the voluntary assisted dying scheme should not limit or prescribe the substances that may be used for voluntary assisted dying.

11.8 The draft Bill provides that a voluntary assisted dying substance is a Schedule 4 or Schedule 8 substance, or a combination of those substances, as defined in the Poisons Standard,[9] approved by the chief executive of the Department for use under the Act for the purpose of causing a person's death.

RECOMMENDATION

11-1 'Voluntary assisted dying substance' should mean a Schedule 4 or Schedule 8 substance, or a combination of those substances, as defined in the Poisons Standard, approved by the chief executive for use under the Act for the purpose of causing a person's death.

THE NEED TO REGULATE THE VOLUNTARY ASSISTED DYING SUBSTANCE

11.9 The Poisons Standard classifies medicines and poisons into schedules for inclusion in relevant State and territory legislation. A substance is categorised into a schedule based on the level of regulatory control required to deal with the public health and safety risks associated with it.

11.10 A Schedule 4 (S4) substance includes prescription only medicine and prescription animal remedies that are not classified as Schedule 8 substances (S8s), such as local anaesthetics, antibiotics, strong analgesics such as Panadeine Forte, and most

4 WA Joint Select Committee on End of Life Choices Report (2018) 228.
5 WA Ministerial Expert Panel Final Report (2019) 74.
6 White and Willmott Model sch 1.
7 Who can prescribe a voluntary assisted dying substance is, however, dealt with by other provisions in the Victorian Act and the Western Australian Act. See the discussion of who is authorised to prescribe below.
8 White and Willmott Model, Explanatory Notes.
9 For the purposes of the draft Bill, 'Poisons Standard' is defined in Schedule 1 to mean the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* (Cth), section 52A(1). The current Poisons Standard prepared under s 52D(2)(b) of the *Therapeutic Goods Act 1989* is the *Poisons Standard February 2021*. This definition is consistent with the definition in the *Medicines and Poisons Act 2019* (Qld).

benzodiazepines (which are depressants, for example Valium). S8s are controlled drugs such as opioid analgesics (fentanyl, methadone, morphine, oxycodone and pethidine), some benzodiazepines and the anaesthetic ketamine. S4s and S8s are subject to a range of controls under the Medicines and Poisons framework[10] because of their higher potential for misuse, abuse and dependence.

11.11 Given the purpose of the voluntary assisted dying substance is to bring about a person's death, the substance or combination of substances used to carry out voluntary assisted dying will be lethal if ingested, adding to the level of risk posed by the substance.

11.12 Under the draft Bill, a person may decide whether to access voluntary assisted dying by self-administration or, if self-administration is inappropriate, practitioner administration.[11] Where practitioner administration occurs, controls will be in place to ensure the substance remains in the possession, or under the direct supervision, of the administering practitioner, who is trained in appropriate medication management and is subject to a range of professional standards, policies and guidelines.[12]

11.13 There is no requirement for the coordinating practitioner or another health practitioner to be present for self-administration. This may occur in an unregulated environment such as the person's home. Where a registered health practitioner does not maintain control of the voluntary assisted dying substance, there may be concerns about the risk posed to the public if the substance is not appropriately managed.

11.14 The Victorian Panel noted stakeholder concerns about storage and retrieval of the voluntary assisted dying substance and the competing need to recognise a person's autonomy in storing and administering the substance in their home.[13]

11.15 In determining appropriate safeguards, it is therefore necessary to consider provisions to regulate the prescription, supply, storage, administration and disposal of the voluntary assisted dying substance.

11.16 The *Medicines and Poisons Act 2019* was passed by the Legislative Assembly in September 2019 and is expected to commence in the second half of 2021. This Act will introduce a new framework for the regulation of medicines and poisons in Queensland, replacing the *Health Act 1937* and the *Pest Management Act 2001*.[14]

11.17 The Medicines and Poisons framework provides for people to carry out a range of activities with substances including medicines. A person is authorised to carry out a particular activity with a substance if they hold a relevant authority or are a member of a prescribed class of persons (an 'approved person').[15]

11.18 A number of regulations will be made to support the Act, including the *Medicines and Poisons (Medicines) Regulation 2021*. This will set out requirements relating to prescribing, supplying, administering, storing and disposing of medicines, including specific requirements for particular classes of approved persons, for example, medical practitioners, pharmacists and nurse practitioners. These matters are currently regulated by the *Health (Drugs and Poisons) Regulation 1996* and the *Health Regulation 1996*.[16]

10 The Medicines and Poisons framework includes the *Medicines and Poisons Act 2019* (Qld), and any regulations made under that Act: see [11.16]–[11.18] below.

11 See the discussion of self-administration or practitioner administration in Chapter 10 above.

12 See Health Practitioner Regulation National Law (Queensland) pt 5 div 3, pt 6; and, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020); Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018); International Council of Nurses, *The ICN Code of Ethics for Nurses* (2012). Non-compliance may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional, and may result in disciplinary action: Health Practitioner Regulation National Law (Queensland) s 5 (definitions of 'unsatisfactory professional performance', 'unprofessional conduct' and 'professional misconduct'), pt 8 divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107.

13 Vic Ministerial Advisory Panel Final Report (2017) 129.

14 Queensland Health, 'New medicines, poisons and pest management regulatory framework' (28 April 2021) <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/medicines-poisons-act>; Medicines and Poisons Bill 2019 (Qld), Explanatory Notes.

15 *Medicines and Poisons Act 2019* (Qld) ss 30, 54.

16 Medicines and Poisons Bill 2019 (Qld), Explanatory Notes.

11.19 S4 and S8 medicines will be subject to a range of controls under the Medicines and Poisons framework, including the introduction of real-time prescription monitoring to manage the use of dependence forming medicines, limiting the conditions under which particular approved persons may administer or prescribe S8 medicines, and a range of offences for misuse of medicines.[17]

11.20 Despite this, there is a need to specifically regulate the voluntary assisted dying substance in the draft Bill to ensure appropriate authorisations are in place and the roles and responsibilities of relevant parties are clear. It is also necessary to specifically regulate the voluntary assisted dying substance given the distinct purpose the substance will be used for; that is, causing a person's death, which does not align with the Medicines and Poisons framework's regulation of medicines used for therapeutic purposes.[18]

Submissions

11.21 Our Consultation Paper did not specifically seek submissions on how the voluntary assisted dying substance should be managed, but sought submissions on the voluntary assisted dying process, including in relation to administration of the substance.[19]

11.22 Of the respondents who addressed management of the substance, many considered there should be safeguards to ensure it is managed safely. Several respondents submitted that safeguards should include regulating the safe storage, return and disposal of the substance.

11.23 Some respondents submitted that self-administration should occur under the supervision of a registered health practitioner to ensure the substance can be monitored at all times.

11.24 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that the 'prescribed lethal dose of medication must be dispensed, held and administered under supervision so that it is tracked at all times'.

OVERVIEW OF LEGISLATIVE APPROACHES IN AUSTRALIA AND OVERSEAS

Parliamentary Committee and the White and Willmott Model

11.25 The Parliamentary Committee recommended that any voluntary assisted dying scheme include 'rigorous governance of systems for prescribing, dispensing and disposing of any voluntary assisted dying medications'.[20]

11.26 The White and Willmott Model does not suggest including detailed provisions relating to medication management, instead including a provision that the first medical practitioner may provide access to voluntary assisted dying upon receiving the person's final request.[21] However, as self-administration must occur under the supervision of a registered medical practitioner, the voluntary assisted dying substance will always be in the possession, or under the direct supervision, of the registered medical practitioner.[22] The explanatory notes state that:[23]

> the safety and quality of voluntary assisted dying for the person should be prioritised. This is enhanced by medical supervision.

17 For example, *Medicines and Poisons Act 2019* (Qld) ss 33–42.
18 *Medicines and Poisons Act 2019* (Qld) ss 11(2) (definition of 'medicine'), 12(2) (definition of 'poison').
19 See QLRC Consultation Paper No 79 (2020) Q-29–Q-33.
20 Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.
21 White and Willmott Model cl 34. See also cll 30–32, 33(3).
22 White and Willmott Model cl 6(2)(b), (3).
23 White and Willmott Model, Explanatory Notes 3.

11.27 The explanatory notes further state that self-administration should occur under supervisions as:[24]

> The voluntary assisted dying medication will be safely managed as it will always be in the possession or under the direct supervision of a registered medical practitioner. This also means that complex provisions relating to the medication's collection, storage and disposal, such as those in the *Voluntary Assisted Dying Act 2017* (Vic), are not required. Registered medical practitioners are subject to existing regulations in relation to the dangerous medications and the Bill provides scope for regulations to address this further if needed.

11.28 Accordingly, the White and Willmott Model suggests that regulations should specify requirements for collection, storage and disposal of medication.[25]

Victoria and Western Australia

11.29 The Victorian Act and Western Australian Act include requirements for prescribing, supplying, labelling, storage, administration and disposal of the voluntary assisted dying substance.[26]

11.30 The Victorian Panel noted that existing processes are in place under the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) for disposal of unused medication and penalties for unauthorised possession of prescription medication.[27] However, the Panel made several recommendations relating to the management of the voluntary assisted dying substance through the voluntary assisted dying framework.[28] The Panel considered that a 'tightly controlled process'[29] for managing the voluntary assisted dying substance would:[30]

> create a number of protections to ensure safety through constant monitoring of the lethal dose of medication, with a clear line of accountability.

11.31 The Western Australian Panel also recommended that the Western Australian Government establish regulatory processes for the secure prescription, dispensing, handling, administration and disposal of the voluntary assisted dying substance to ensure its safe and secure management and clear roles and responsibilities for persons involved.[31]

11.32 As neither jurisdiction requires the practitioner or a witness to be present for self-administration, both frameworks provide for the appointment of a contact person who is required to return any unused voluntary assisted dying substance to a pharmacist.[32] The Victorian Panel considered this would:[33]

> ensure there is a clear line of accountability that makes it possible for the Voluntary Assisted Dying Review Board to monitor lethal doses of medication in the community.

11.33 Consequential amendments were also made to the drugs and poisons legislation in each jurisdiction.

24 White and Willmott Model, Explanatory Notes 3.
25 White and Willmott Model cl 35.
26 See, eg, *Voluntary Assisted Dying Act 2017* (Vic) pt 5 divs 1, 2; *Voluntary Assisted Dying Act 2019* (WA) pt 4.
27 Vic Ministerial Advisory Panel Final Report (2017) 130.
28 Ibid 26–7, Recs 29–40, 50.
29 Ibid 129.
30 Ibid 17.
31 WA Ministerial Expert Panel Final Report (2019) 83, Rec 24.
32 *Voluntary Assisted Dying Act 2017* (Vic) ss 39, 40; *Voluntary Assisted Dying Act 2019* (WA) pt 4 div 3.
33 Vic Ministerial Advisory Panel Final Report (2017) 130.

Tasmania

11.34 The Tasmanian Act includes provisions relating to prescription, supply, storage, administration and disposal of the voluntary assisted dying substance.[34] It also provides for the appointment of a contact person.[35]

Overseas jurisdictions

11.35 Overseas jurisdictions do not provide comprehensive frameworks for management of the voluntary assisted dying substance.

11.36 The New Zealand Act includes requirements for prescribing and administering the voluntary assisted dying substance and destroying prescriptions that are no longer required, but does not contemplate the supply, storage or disposal of the substance.[36]

11.37 State legislation in the United States includes limited medication management provisions.

11.38 In Oregon, the person's attending physician may prescribe a voluntary assisted dying substance after verifying the person is making an informed decision, and if all the requirements have been complied with. The voluntary assisted dying substance can then be supplied to the person for self-administration by a pharmacist or the attending physician.[37] Attending physicians are subject to specific eligibility requirements and all dispensing must be reported to the Oregon Health Authority.[38] However, the legislation does not provide for storage or disposal of the substance.

11.39 Other state legislation in the United States is modelled on the voluntary assisted dying framework in Oregon,[39] but includes additional provisions for disposal. California's state legislation outlines similar dispensing and eligibility requirements, while including postal delivery as a means of dispensing and requiring a person with custody or control of any unused voluntary assisted dying substances after administration to dispose of it in accordance with existing drug return programs.[40] The legislation in Vermont establishes a similar framework while requiring its Department of Health to provide rules for disposal of unused voluntary assisted dying substances.[41]

11.40 There is 'minimal recognition of the role of pharmacists' in overseas jurisdictions, with reporting requirements on the dispenser in Oregon and Canada.[42]

11.41 In Canada, policies and practice guidelines recommend the substance be dispensed directly to the prescriber rather than to the person, removing concerns about it being in the community.[43]

11.42 The legislation in Belgium requires the prescribed substance to be given to the physician in person by the pharmacist, in accordance with the requirements for the prescription and delivery of the substance.[44] The legislation in Luxembourg and the Netherlands does not include similar substance management provisions.[45]

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34 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) pt 12 div 1, ss 89(1), 91.

35 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 85, 92.

36 *End of Life Choice Act 2019* (NZ) ss 19(3)–(5), 20, 22.

37 *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.1.01(2), 127.815.3.01(i)–(L).

38 *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.815.3.01(L)(A), 127.865.3.11.

39 W Bonython, 'From Oregon to Belgium to Victoria—the different ways suffering patients are allowed to die', *The Conversation* (online, 6 December 2017) <https://theconversation.com/from-oregon-to-belgium-to-victoria-the-different-ways-suffering-patients-are-allowed-to-die-88324>; R Kuznia, 'In Oregon, pushing to give patients with degenerative diseases the right to die', *The Washington Post* (online, 12 March 2018) <https://www.washingtonpost.com/national/in-oregon-pushing-to-give-patients-with-degenerative-diseases-the-right-to-die/2018/03/11/3b6a2362-230e-11e8-94da-ebf9d112159c_story.html>.

40 *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.19(2)(c), 443.20; Vic Ministerial Advisory Panel Final Report (2017) 129.

41 *Vermont Patient Choice at End of Life Act 2013,* 18 VT Stat Ann § 5291.

42 Vic Ministerial Advisory Panel Final Report (2017) 135.

43 WA Ministerial Expert Panel Final Report (2019) 82, referring to C Harty et al, Canadian Association of MAiD Assessor and Providers, 'The Oral MAiD Option in Canada Part 2: Processes for Providing—Review and Recommendations' (April 2018) <https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Process.pdf>.

44 *Belgian Euthanasia Act 2002* art 3 bis. It also requires data to be provided to the Federal Control and Evaluation Commission, including the details of the pharmacist and the substance: art 7.

45 *Luxembourg Law on Euthanasia and Assisted Suicide 2009; The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.*

PRESCRIBING THE VOLUNTARY ASSISTED DYING SUBSTANCE

Other jurisdictions

Who is authorised to prescribe

11.43 In Victoria, Western Australia and Tasmania, prescribing the voluntary assisted dying substance is the responsibility of the coordinating practitioner (or, in Tasmania, the primary medical practitioner).[46]

Timing of prescribing

11.44 In Victoria, Western Australia and Tasmania, the request and assessment process must be completed before a voluntary assisted dying substance can be prescribed.[47]

11.45 The Western Australian Panel recommended that the substance must not be prescribed before the person makes their third request 'to ensure that the process affords the person an adequate time for reflection and demonstrates the enduring nature of their decision'.[48]

Information to be provided before prescribing

11.46 The Victorian Act and Western Australian Act requires that, where a voluntary assisted dying substance is to be self-administered, the coordinating practitioner must provide particular information to the person before prescribing the substance.[49] The Victorian Panel considered this consistent with good medical practice.[50] In Western Australia, the information must be provided in writing. In Western Australia, the coordinating practitioner must also provide information to a person who has made a practitioner administration decision before prescribing the substance.[51]

Information to be included in prescription

11.47 The Western Australian Act and Tasmanian Act specify the information that must be included in the prescription.[52]

11.48 The Victorian Act does not specify information to be included in the prescription. In practice, the Voluntary Assisted Dying Statewide Pharmacy Service, which has been established at the Alfred Hospital in Melbourne, 'provides a single point of support and advice for medical practitioners about voluntary assisted dying medication'.[53] The coordinating medical practitioner is required to contact the Statewide Pharmacy Service before prescribing the substance to discuss the prescription with the pharmacist.[54]

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46 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'request and assessment process'), 45(a), 46(a); *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'request and assessment process'), 8, 55, 56, 58(2), 59(2); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 70. See the discussion of authorisation of the prescription, supply and administration of a voluntary assisted dying substance in Chapter 10 above. See also Chapter 8 above, in relation to the request and assessment process.

47 *Voluntary Assisted Dying Act 2017* (Vic) s 43; *Voluntary Assisted Dying Act 2019* (WA) s 55(a); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 66(1).

48 WA Ministerial Expert Panel Final Report (2019) 71, Rec 19.

49 *Voluntary Assisted Dying Act 2017* (Vic) s 57; *Voluntary Assisted Dying Act 2019* (WA) s 69(2). The information to be provided includes how to self-administer the substance, storage requirements, that the person is not under any obligation to self-administer the substance and the requirement for the person or their contact person to return any unused or remaining substance for disposal. Western Australia also requires information be provided about the particular poisons or combination of poisons constituting the substance, the expected effects of self-administration, the period within which the patient is likely to die after self-administration and the potential risks of self-administration of the substance.

50 Vic Ministerial Advisory Panel Final Report (2017) 134.

51 *Voluntary Assisted Dying Act 2019* (WA) s 69(3). This includes informing the person that they are not under any obligation to have the substance administered and the potential risks of administration of the substance.

52 *Voluntary Assisted Dying Act 2019* (WA) s 70; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 70(3). The Western Australian Act requires the prescription to include a statement clearly indicating that the prescription is for a voluntary assisted dying substance, a statement certifying that the voluntary assisted dying process has been completed in accordance with the Act and that the person has made either a self-administration decision or a practitioner administration decision, and the person's telephone number. The legislation also specifies that the prescription cannot be in the form of a medication chart, cannot provide for the substance to be supplied on more than one occasion and that the coordinating practitioner must give the prescription directly to an authorised supplier. The Tasmanian Act requires the prescription to include the name and address of the person, name of the primary medical practitioner who has issued the prescription, details of the voluntary assisted dying substance and the maximum amount of the substance authorised by the prescription.

53 Vic Guidance for Health Practitioners (2019) 54.

54 Vic Guidance for Health Practitioners (2019) 56.

Destruction of unfilled prescriptions

11.49 In Victoria, the coordinating practitioner is required to destroy any unfilled prescription where the person is granted a self-administration permit, but then loses their physical capacity to self-administer or digest the voluntary assisted dying substance and requests the coordinating practitioner to apply for a practitioner administration permit.[55] This is also the approach in the Tasmanian Act.[56] There is no equivalent requirement to destroy unfilled prescriptions in the Western Australian Act.

Who may provide the prescription to the pharmacist

11.50 In Victoria, Western Australia and Tasmania, the prescription is sent directly to the pharmacy:

- In Victoria—the coordinating practitioner must prescribe and supply the voluntary assisted dying substance under a permit.[57] In practice, the coordinating practitioner provides the prescription directly to the Statewide Pharmacy Service.[58]
- In Western Australia—the coordinating practitioner must give the prescription directly to an authorised supplier.[59]
- In Tasmania—the pharmacist receives the prescription from the primary medical practitioner.[60]

The Commission's view

11.51 The draft Bill should include requirements for prescription of the voluntary assisted dying substance.

11.52 The draft Bill authorises the coordinating practitioner to prescribe a voluntary assisted dying substance for the person in a sufficient dose to cause death, if the person makes an administration decision (either a self-administration decision or a practitioner administration decision). The person may make an administration decision only if the person has made a final request and the coordinating practitioner has completed the final review form.[61]

11.53 It also provides that the coordinating practitioner may not prescribe a voluntary assisted dying substance before receiving the contact person appointment form.[62] This will ensure that the appointment of the contact person and acceptance of the role has taken place before prescribing occurs.

11.54 Limiting the authority to prescribe a voluntary assisted dying substance to the coordinating practitioner and requiring relevant steps to have been completed before prescribing can occur are important safeguards. This will ensure that access to the voluntary assisted dying substance is not granted until the requirements of the request and assessment process have been complied with.

11.55 The draft Bill requires the coordinating practitioner to give the person certain information before the substance is prescribed.

11.56 If the person makes a self-administration decision, the coordinating practitioner must inform the person, in writing, of the following:

55 *Voluntary Assisted Dying Act 2017* (Vic) s 54.
56 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 72. The Act provides that the primary medical practitioner is to destroy the prescription in certain circumstances, including if they cease to be the person's primary medical practitioner or the person no longer wishes to access voluntary assisted dying.
57 *Voluntary Assisted Dying Act 2017* (Vic) ss 45, 46.
58 Vic Guidance for Health Practitioners (2019) 56.
59 *Voluntary Assisted Dying Act 2019* (WA) s 70(6).
60 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71(1).
61 See Chapter 10 and Recommendation 10-3 above.
62 See the discussion of the role of the contact person and Recommendation 11-13(h) below.

- the S4 substance or S8 substance, or combination of substances, constituting the voluntary assisted dying substance;
- that the person is not under any obligation to self-administer the substance;
- that the substance must be stored in accordance with requirements prescribed by regulation;
- how to prepare and self-administer the substance;
- the expected effects of self-administration;
- the period within which the person is likely to die after self-administration;
- the potential risks of self-administration;
- the requirement for the contact person to give the substance, or any unused or remaining substance, to an authorised disposer for disposal if the person dies or decides not to self-administer;
- the name of one or more authorised suppliers; and
- the name of one or more authorised disposers.

11.57 If the person makes a practitioner administration decision, the coordinating practitioner must inform the person, in writing, of similar matters in relation to practitioner administration. This includes that the person is not under any obligation to have the substance administered to them and the potential risks of administration of the substance.

11.58 The requirement for the coordinating practitioner to provide information before prescribing the voluntary assisted dying substance is consistent with the established clinical approach to informed patient decision-making,[63] ensuring that the person is made fully aware of the risks and requirements associated with the substance before it is prescribed.

11.59 To add further rigour to the prescribing process and ensure that the prescription can be easily identified as being for a voluntary assisted dying substance, the draft Bill requires the prescription to include:

- a statement that clearly indicates it is for a voluntary assisted dying substance;
- a statement certifying that the request and assessment process has been completed in accordance with the Act and that the person has made either a self-administration decision or a practitioner administration decision;
- details of the substance and the maximum amount of the substance authorised by the prescription; and
- the person's name and telephone number.

11.60 The draft Bill also states that the prescription may not provide for the substance to be supplied on more than one occasion and that the coordinating practitioner must give the prescription directly to an authorised supplier.

11.61 Given the nature of the substance, there is no need for the prescription to provide for it to be supplied on more than one occasion. If a person revoked their self-administration decision and made a request for practitioner administration because self-administration was no longer appropriate, a new prescription would need to be issued in accordance with the practitioner administration decision.

11.62 Requiring the coordinating practitioner to give the prescription directly to an authorised supplier will facilitate the substance being supplied while ensuring the prescription and substance remain in the control of the coordinating practitioner and authorised supplier until the person requires access to it. This is appropriate given the nature of the substance and is consistent with the approach in Victoria and Western Australia.

63 Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017).

11.63 The coordinating practitioner must complete a record in the approved form stating the person's administration decision and that they have prescribed a voluntary assisted dying substance for the person. The coordinating practitioner must give a copy of the form to the Board within two business days after prescribing the substance.[64] Ensuring all administration decisions and instances of the substance being prescribed are recorded in the approved form will assist the Board in its monitoring and review role and provide a safeguard for safe management of the substance.

11.64 The prescribing requirements in the draft Bill may be supported by additional requirements prescribed by regulation, if required.

RECOMMENDATIONS

11-2 The prescription of the substance be regulated by:

(a) authorising the coordinating practitioner, if the person has made an administration decision, to prescribe the substance for the person that is of a sufficient dose to cause death;

(b) requiring the coordinating practitioner to provide particular information in writing to the person before the substance is prescribed;

(c) requiring the prescription to include particular information;

(d) requiring that the prescription not provide for the substance to be supplied on more than one occasion;

(e) requiring the coordinating practitioner to give the prescription directly to an authorised supplier;

(f) requiring the coordinating practitioner to complete a record in the approved form stating the person's administration decision and that they have prescribed a voluntary assisted dying substance for the person, and give the form to the Board within two business days of prescribing the substance;

(g) providing for further prescribing requirements to be provided in regulation.

64 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

SUPPLYING THE VOLUNTARY ASSISTED DYING SUBSTANCE

Meaning of 'supply' and 'dispense'

11.65 'Supply' is defined in the *Medicines and Poisons Act 2019*, in relation to a regulated substance, to mean 'sell or give the substance to a person'.[65] Supplying a regulated substance does not include administering a medicine, applying a poison or disposing of waste from a substance. Other supply-related terms are also defined in the *Medicines and Poisons Act 2019*.[66] 'Dispense', in relation to a medicine, means to 'sell the medicine to a person on prescription'.[67]

Other jurisdictions

Who is authorised to supply the substance

11.66 The Victorian Act defines 'dispensing pharmacy' as the pharmacy, pharmacy business or pharmacy department from which a pharmacist sold or supplied a voluntary assisted dying substance.[68] In practice, the Alfred Hospital in Melbourne has established a Voluntary Assisted Dying Statewide Pharmacy Service responsible for importing, storing, preparing and dispensing medications for voluntary assisted dying.[69] The Statewide Pharmacy Service provides 'a single point of support and advice for medical practitioners, patients and their families' and is responsible for ensuring 'clear accountability for the voluntary assisted dying medication'.[70]

11.67 The Victorian Act does not expressly authorise a pharmacist to supply or dispense the substance. The Victorian Panel noted its intent that the pharmacist should be able to dispense the substance only in accordance with a prescription and a valid permit, but did not specifically recommend this be reflected in the legislation.[71] The Panel noted that:[72]

> The involvement of a pharmacist is an important safeguard because it provides additional independent input from another health practitioner.

11.68 In Western Australia, the CEO of the Department of Health is empowered to authorise a registered health practitioner or class of registered health practitioners to supply a voluntary assisted dying substance (an 'authorised supplier').[73] The coordinating practitioner cannot direct an authorised health professional to supply a voluntary assisted dying substance unless the authorised health professional is an authorised supplier.[74] The authorised supplier who is given the prescription is authorised to possess, prepare and supply the substance.[75] Western Australia has established a Voluntary Assisted Dying Statewide Pharmacy Service to undertake this role, to be based at a metropolitan tertiary hospital in Perth.[76] The aim of establishing a Statewide Pharmacy Service is ensure the substance is provided in a safe, equitable and patient-centred manner.[77]

11.69 Similarly, the Tasmanian Act provides that, on receiving a voluntary assisted dying substance prescription and a copy of a voluntary assisted dying substance authorisation

65 *Medicines and Poisons Act 2019* (Qld) s 24.
66 *Medicines and Poisons Act 2019* (Qld) s 25.
67 *Medicines and Poisons Act 2019* (Qld) s 25(2).
68 *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of 'dispensing pharmacy').
69 AlfredHealth, 'State-wide pharmacy service for Voluntary Assisted Dying' (27 February 2019) <https://www.alfredhealth.org.au/news/state-wide-pharmacy-service-for-voluntary-assisted-dying/>.
70 Vic Guidance for Health Practitioners (2019) 56.
71 Vic Ministerial Advisory Panel Final Report (2017) 135.
72 Ibid.
73 *Voluntary Assisted Dying Act 2019* (WA) s 79. The CEO must publish an up-to-date list of authorised suppliers on the Department's website.
74 *Voluntary Assisted Dying Act 2019* (WA) s 80(2)(a).
75 *Voluntary Assisted Dying Act 2019* (WA) ss 58(4), 59(3).
76 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the WA Voluntary Assisted Dying Statewide Pharmacy Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Statewide-Pharmacy-Service.pdf>.
77 Ibid.

issued to the primary medical practitioner, a pharmacist may supply the substance specified in the prescription.[78] 'Pharmacist' is defined to mean a person who holds general registration under the Health Practitioner Regulation National Law (Tasmania) in the pharmacy profession (other than a student).[79]

Who the substance may be supplied to

11.70 The Victorian Act does not state who the pharmacist is to supply the substance to, only that they must provide information to the person to whom the substance is being dispensed upon dispensing the prescription.[80] In practice, once the prescription has been provided to the Statewide Pharmacy Service:[81]

- In the case of self-administration — the person contacts the Statewide Pharmacy Service to arrange to have the substance dispensed directly to them. If the person is unable to travel, the Statewide Pharmacy Service will deliver the substance to them.
- In the case of practitioner administration — the coordinating medical practitioner contacts the Statewide Pharmacy Service to arrange to have the substance dispensed to them.

11.71 In Western Australia, in the case of self-administration, the authorised supplier may supply the substance to the patient, their contact person or agent.[82] In the case of practitioner administration, the authorised supplier may supply the substance to the administering practitioner.[83] If required, the Statewide Pharmacy Service will visit patients and practitioners anywhere in Western Australia to provide the substance and education about the substance.[84]

11.72 The agent of the patient has a discrete role under the Western Australian Act. An agent is authorised to receive the substance from an authorised supplier, possess it and supply it to the patient.[85] During the Parliamentary debates on the Bill, it was noted that the concept of an agent:[86]

> is contemplated under the Medicines and Poisons Act in terms of a person whom a patient asks to receive, or pick up, the medication for them and supply, or deliver, to the patient.

11.73 Authorising an agent to undertake this role ensures accessibility of the scheme for people living in rural and remote parts of Western Australia. It was noted that not including the ability of the agent to transport the substance 'could limit the patient's ability to obtain the prescribed substance in a timely way'.[87]

11.74 The Tasmanian Act provides that, on receiving a prescription and a copy of a voluntary assisted dying substance authorisation issued to the primary medical practitioner, a pharmacist may supply the substance specified in the prescription to the primary medical practitioner.[88]

78 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71.
79 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5 (definition 'pharmacist').
80 *Voluntary Assisted Dying Act 2017* (Vic) s 58.
81 Vic Guidance for Health Practitioners (2019) 56.
82 *Voluntary Assisted Dying Act 2019* (WA) s 58(4)(c).
83 *Voluntary Assisted Dying Act 2019* (WA) s 59(3)(c).
84 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the WA Voluntary Assisted Dying Statewide Pharmacy Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Statewide-Pharmacy-Service.pdf>
85 *Voluntary Assisted Dying Act 2019* (WA) s 58(7).
86 Western Australia, *Parliamentary Debates*, Legislative Council, 29 November 2019, 9639 (S Dawson, Minister for Environment).
87 Ibid 9646 (S Dawson, Minister for Environment).
88 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71(1).

Requirements to be met prior to supplying

11.75 In Victoria and Western Australia, the pharmacist is required to provide information when supplying the substance for self-administration.[89] The information is similar to that required to be provided by the coordinating practitioner before prescribing the substance. The Victorian Panel noted that pharmacists play an important education role when dispensing medication, including providing guidance to people on storing, handling and taking medication.[90] The inclusion of this requirement reflects that role.

11.76 The Western Australian Act also states that the authorised supplier must not supply the substance unless they have confirmed the authenticity of the prescription, the identity of the person who issued it and the identity of the person to whom the substance is to be supplied.[91]

11.77 The Tasmanian Act provides that as a pre-condition of supplying the substance to the primary medical practitioner, the pharmacist is required to discuss the person's medical condition with the person (either in person or via audio-visual link) to ensure the substance is suitable for use.[92]

Labelling requirements

11.78 The Victorian Act and Western Australian Act have specific requirements for labelling of the voluntary assisted dying substance.[93]

11.79 The Tasmanian Act also includes a requirement for the labelling of the packaging or container the substance is contained in to include particular information.[94]

Record keeping and reporting requirements

11.80 In Victoria, Western Australia and Tasmania, the pharmacist is subject to record keeping and reporting requirements.[95]

11.81 The Victorian Panel considered this would provide a 'practical safeguard' by assisting 'in tracking the lethal medication and its use'.[96]

Who else is authorised to supply the substance

11.82 In Victoria, a self-administration permit authorises the coordinating practitioner to supply the voluntary assisted dying substance to the person for self-administration and a practitioner administration permit authorises the coordinating practitioner to supply the substance to the person for practitioner administration.[97]

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89 *Voluntary Assisted Dying Act 2017* (Vic) s 58; *Voluntary Assisted Dying Act 2019* (WA) s 72. In Western Australia, the information must be provided in writing.

90 Vic Ministerial Advisory Panel Final Report (2017) 135.

91 *Voluntary Assisted Dying Act 2019* (WA) s 71.

92 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71(2).

93 *Voluntary Assisted Dying Act 2017* (Vic) s 59; *Voluntary Assisted Dying Regulations 2018* (Vic) reg 9 and sch 1, Forms 5 and 6; *Voluntary Assisted Dying Act 2019* (WA) s 73. In Victoria, the pharmacist must attach a labelling statement in the approved form to the package or container, including relevant warnings and information about the substance. In Western Australia, the legislation provides that the authorised supplier must attach a statement to the relevant package or container in the approved form warning of the purpose of the substance, the dangers of administration, and for self-administration, storage and disposal requirements. These requirements are in addition to the requirements set out under, respectively, the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) and the *Medicines and Poisons Act 2014* (WA).

94 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71(5).

95 *Voluntary Assisted Dying Act 2017* (Vic) s 60; *Voluntary Assisted Dying Act 2019* (WA) s 74; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71(4)(a) and (b). In Victoria, upon dispensing a voluntary assisted dying substance, the dispensing pharmacist must immediately record that the substance was dispensed and that the requirements to provide the person with information and label the substance correctly were satisfied. The record must be made in the approved form and submitted to the Board within seven days of dispensing.

In Western Australia, the authorised supplier must immediately record the supply in the approved form. The authorised supplier must give a copy of the form to the Board within two business days after supplying the substance. Information must be recorded, including the patient's details, authorised supplier's details, and statements certifying that the substance was supplied and the requirements to provide the person with information and label the substance correctly were complied with.

In Tasmania, a pharmacist who supplies a voluntary assisted dying substance to a primary medical practitioner must make a record of the supply, and notify the Voluntary Assisted Dying Commission of the supply, as soon as reasonably practicable and within three business days.

96 Vic Ministerial Advisory Panel Final Report (2017) 170.

97 *Voluntary Assisted Dying Act 2017* (Vic) ss 45(a), 46(a). Victoria does not provide for any other person to supply the substance to the person, for example the contact person or an agent of the person.

11.83 The Western Australian Act authorises a contact person or agent of the person to receive the substance from an authorised supplier, possess it and supply it to the person where a self-administration decision has been made.[98]

11.84 The Tasmanian Act provides for the supply of the substance to the administering health practitioner by the primary medical practitioner [99] and supply of the substance to the person by the administering health practitioner for self-administration.[100]

Submissions

11.85 Some respondents submitted that pharmacists should play a key role in the voluntary assisted dying process. Two members of the public jointly submitted that pharmacists are appropriately placed within the health care system to provide expert advice and information on the use of a voluntary assisted dying substance and will also have an important role to play in the return of unused or unwanted medicines.

11.86 The Australian Lawyers Alliance submitted that pharmacists should be required to give information to persons when dispensing the substance about safe storage and what will happen if the substance is administered. This respondent also submitted that pharmacists should be required to notify the Board when the substance is dispensed.

11.87 The Pharmacy Guild of Australia, Queensland Branch submitted that pharmacies that are or are not involved as dispensing pharmacies should not be publicly identified.

The Commission's view

11.88 The draft Bill should include requirements for the supply of the voluntary assisted dying substance.

11.89 The draft Bill authorises an authorised supplier who is given the prescription to supply a voluntary assisted dying substance.

11.90 For the purposes of the draft Bill, an 'authorised supplier' means an appropriately qualified registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive of the Department to supply a voluntary assisted dying substance under the Act. This is consistent with the Western Australian Act and will enable the Department to establish an appropriate delivery model for voluntary assisted dying pharmacy services. The draft Bill provides that the chief executive must, on request, give a person who is acting as a coordinating practitioner the name of one or more authorised suppliers. This will ensure that the coordinating practitioner and the person are able to contact the authorised supplier when the voluntary assisted dying substance is required.

11.91 The draft Bill should clearly establish the role of relevant health practitioners in the process and set out what they are authorised to do. Accordingly, it authorises an authorised supplier to: possess the substance for the purpose of preparing and supplying it; prepare the substance; and supply the substance to:

- if the person makes a self-administration decision—the person, their contact person or agent; or
- if the person makes a practitioner administration decision—the administering practitioner.

11.92 This approach is consistent with the Western Australian Act. Permitting a contact person or agent to receive the substance, if the person has made a self-administration decision, will assist in ensuring voluntary assisted dying is accessible to people in rural and remote parts of Queensland, while providing a clear chain of

98 *Voluntary Assisted Dying Act 2019* (WA) ss 58(7), 67(1).
99 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 74. This only applies where the primary medical practitioner is not acting as the administering health practitioner.
100 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 86.

responsibility for the substance. This is appropriate given Queensland's geographical and demographic profile.

11.93 Allowing the contact person or an agent to supply the substance to the person for self-administration is consistent with the current regulation of scheduled substances.[101] Additionally, if the contact person or agent used the substance other than as authorised under the draft Bill, they would be subject to offences under the draft Bill, *Medicines and Poisons Act 2019* and *Drugs Misuse Act 1986*.[102]

11.94 Requiring the authorised supplier to supply the substance to the administering practitioner, if the person makes a practitioner administration decision, will ensure the substance stays in the control of a registered health practitioner for practitioner administration.

11.95 The draft Bill sets out requirements the authorised supplier must comply with before supplying the substance. As noted by the Victorian Panel, pharmacists play an important education role when dispensing medicines.[103] Authorised suppliers will act as an essential check and balance on the process.

11.96 Similar to the requirement on the coordinating practitioner, the authorised supplier is required to provide relevant information in writing to the recipient when supplying the substance for self-administration. As outlined above, the authorised supplier may supply the substance to the person, their contact person or agent in the case of a self-administration decision. This should include:

- that the person is not under any obligation to self-administer the substance;
- the S4 substance or S8 substance, or combination of substances, constituting the voluntary assisted dying substance;
- how to prepare and self-administer the substance;
- that the substance must be stored in accordance with requirements prescribed by regulation;
- the expected effects of self-administration;
- the period within which the person is likely to die after self-administration;
- the potential risks of self-administration;
- the requirement for the contact person to give the substance, or any unused or remaining substance, to an authorised disposer for disposal, if the person dies or decides not to self-administer.

11.97 The authorised supplier is required to confirm the authenticity of the prescription, the identity of the person who issued it and the identity of the person to whom the substance is to be supplied before supplying the substance.

11.98 The draft Bill should provide for specific labelling requirements. It is important to be able to readily identify a voluntary assisted dying substance, given its nature. An authorised supplier must comply with labelling requirements prescribed by regulation when supplying a voluntary assisted dying substance. The requirements should include that the authorised supplier must attach a statement to the package or container warning of the purpose of the substance, the dangers of administration, and for self-administration, storage and disposal requirements.

11.99 The authorised supplier must also comply with record keeping and reporting requirements. This will support the safe management of the substance by ensuring all instances of supply are recorded and assisting the Board in its monitoring and review role.

101 See *Health (Drugs and Poisons) Regulation 1996* (Qld) s 74(1); *Medicines and Poisons Act 2019* (Qld) s 51.

102 See, eg, Voluntary Assisted Dying Bill (QLRC), cll 140 and 141; *Medicines and Poisons Act 2019* (Qld) s 35; *Drugs Misuse Act 1986* (Qld) ss 6, 9.

103 Vic Ministerial Advisory Panel Final Report (2017) 135.

11.100 The authorised supplier must complete a record of the supply of the substance in the approved form (the 'authorised supply form'). In accordance with the *Acts Interpretation Act 1954* (Qld), this should be done as soon as possible.[104] Information that must be recorded should include the person's details, the authorised supplier's details, a statement that the substance was supplied and that requirements were complied with, including authentication of the prescription, providing information to the recipient in the case of self-administration, and labelling the substance correctly. The authorised supplier must give a copy of the form to the Board within two business days after supplying the substance.[105]

11.101 To enable an authorised supplier to supply the substance to the person, their contact person or agent in the case of self-administration, the draft Bill authorises the following, if the person has made a self-administration decision:

- the person to receive the substance from the authorised supplier, their contact person or agent;
- the contact person or agent to receive the substance from an authorised supplier.

11.102 If the person has made a practitioner administration decision, the administering practitioner is authorised to receive the substance from an authorised supplier.

11.103 Further requirements relating to supply of the substance may be prescribed by regulation.

RECOMMENDATIONS

11-3 The supply of the substance be regulated by:

(a) authorising the authorised supplier who is given the prescription to:

(i) possess the substance for the purpose of preparing and supplying it;

(ii) prepare the substance; and

(iii) supply the substance;

(b) authorising the authorised supplier to supply the substance:

(i) if the person has made a self-administration decision—to the person, their contact person or agent;

(ii) if the person has made a practitioner administration decision—to the administering practitioner;

(c) requiring the authorised supplier to:

(i) provide particular information in writing to the recipient of the substance when supplying it following a self-administration decision;

(ii) confirm the authenticity of the prescription, the identity of the person who issued it and the identity of the person to whom the substance is to be supplied;

104 *Acts Interpretation Act 1954* (Qld) s 38(4).

105 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

(iii) comply with labelling requirements prescribed by regulation;

(iv) complete a record of the supply of the substance in the approved form (the 'authorised supply form') and give a copy of the form to the Board within two business days of supplying the substance.

(d) if the person has made a self-administration decision—authorising:

(i) the person to receive the substance from the authorised supplier, their contact person or agent;

(ii) the contact person or agent to receive the substance from the authorised supplier;

(e) if the person has made a practitioner administration decision—authorising the administering practitioner to receive the substance from the authorised supplier;

(f) providing for further supply requirements to be provided in regulation.

11-4 'Authorised supplier' should mean a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive to supply a voluntary assisted dying substance under the Act.

11-5 The chief executive:

(a) may authorise an appropriately qualified registered health practitioner, or person in a class of registered health practitioners, to supply the substance under the Act;

(b) must, on request, give a person who is acting as a coordinating practitioner the name of one or more authorised suppliers.

POSSESSION AND STORAGE OF THE VOLUNTARY ASSISTED DYING SUBSTANCE

Other jurisdictions

Self-administration

11.104 In Victoria and Western Australia, the legislation does not require the coordinating practitioner or another health practitioner to be present for self-administration.[106] The Victorian Panel considered specific measures, including to ensure the safe storage of the substance in a locked box, would 'provide comfort to the community' and assist the contact person to locate and return any unused substance.[107]

11.105 In Victoria, a self-administration permit authorises the person to obtain, possess and store the substance.[108]

11.106 The Western Australian Act provides that, if a patient has made a self-administration decision that has not been revoked, the patient is authorised to receive the substance

106 *Voluntary Assisted Dying Act 2017* (Vic) s 45; *Voluntary Assisted Dying Act 2019* (WA) s 58.
107 Vic Ministerial Advisory Panel Final Report (2017) 136.
108 *Voluntary Assisted Dying Act 2017* (Vic) s 45(b).

from an authorised supplier, their contact person or agent, and possess the substance for the purpose of preparing and self-administering it.[109] The agent or contact person is authorised to receive, possess and supply the substance.[110] The Western Australian Act does not expressly provide authorisations for the storage of the substance.

11.107 Under the Tasmanian Act, a private self-administration certificate authorises the person to transport, possess and store a voluntary assisted dying substance supplied by the administering health practitioner.[111]

11.108 In Victoria, the substance must be stored by the person in a locked box constructed of steel, that is 'not easily penetrable' and 'lockable with a lock of sturdy construction'.[112] The Statewide Pharmacy Service provides an approved locked box to the person when dispensing the substance.[113] Similarly, the Tasmanian Act sets out requirements on the primary medical practitioner, administering health practitioner, person and contact person to keep the substance in 'a locked receptable that is not readily accessible by any other person'.[114]

11.109 The Western Australian Act does not set out specific storage requirements, simply providing that the authorised supplier must inform the recipient, on supplying the substance, how to store it in a safe and secure way.[115]

11.110 As outlined above, Victoria and Western Australia require both the coordinating practitioner and pharmacist to inform the person of a number of matters, including storage requirements, where a self-administration decision has been made.[116] Both states also require the label on the substance to state that the substance must be stored in accordance with relevant storage requirements.[117] The Tasmanian Act does not include such requirements.

11.111 Under the White and Willmott Model, self-administration must occur under the supervision of a registered medical practitioner.[118] Consequently, the substance is always in the possession, or under the direct supervision, of the registered medical practitioner. The White and Willmott Model suggests that any provisions relating to storage of the substance could be prescribed by regulation.[119]

Practitioner administration

11.112 In Victoria and Western Australia, the default method of administration is self-administration; practitioner administration is permitted if the person is physically incapable of self-administering (Victoria) or if self-administration is inappropriate (Western Australia).[120] Where practitioner administration is the method of administration, the voluntary assisted dying substance remains in the possession of the practitioner, and there is less of a need to set out additional regulatory controls for the management of the substance.

11.113 In Victoria, a practitioner administration permit authorises the coordinating medical practitioner to possess the substance.[121] The Western Australian Act provides that, if a patient has made a practitioner administration decision that has not been revoked, the

109 *Voluntary Assisted Dying Act 2019* (WA) s 58(5)(a)–(b).
110 *Voluntary Assisted Dying Act 2019* (WA) ss 58(7), 67(1).
111 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 91(1). The person is authorised to transport the substance to their residence, a place where the person is to self-administer, or to their administering health practitioner.
112 *Voluntary Assisted Dying Act 2017* (Vic) s 61; *Voluntary Assisted Dying Regulations 2018* (Vic) reg 10.
113 Vic Guidance for Health Practitioners (2019) 58.
114 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 73(1)(a), 75(1)(a), 91(2), 92(1).
115 *Voluntary Assisted Dying Act 2019* (WA) s 72(2)(b).
116 *Voluntary Assisted Dying Act 2017* (Vic) ss 57(c), 58(b); *Voluntary Assisted Dying Act 2019* (WA) ss 69(2)(d), 72(2)(b).
117 *Voluntary Assisted Dying Act 2017* (Vic) s 59(1)(c) and Voluntary Assisted Dying Regulations 2018 (Vic) reg 9, sch 1 Forms 5, 6; *Voluntary Assisted Dying Act 2019* (WA) s 73(1)(c)(i).
118 White and Willmott Model cll 6(2)(b), (3).
119 White and Willmott Model cl 35.
120 *Voluntary Assisted Dying Act 2017* (Vic) s 48(3)(a); *Voluntary Assisted Dying Act 2019* (WA) s 56(2). See the discussion of self-administration or practitioner administration in Chapter 10 above.
121 *Voluntary Assisted Dying Act 2017* (Vic) s 46(c).

administering practitioner is authorised to receive the substance from an authorised supplier and possess it for the purpose of preparing and administering it.[122]

11.114 Neither Victoria or Western Australia specifically authorise the coordinating practitioner or administering practitioner to store the substance or require the practitioner to comply with specific storage requirements, instead relying on general requirements.[123]

11.115 The Tasmanian Act sets out requirements on the primary medical practitioner, administering health practitioner, person and contact person to keep the substance in a locked receptable that is not readily accessible by any other person. In limited circumstances the primary medical practitioner and administering health practitioner may be exempt from these requirements, including where the substance is in their immediate physical possession or being transported to another place for administration to the person.[124]

Submissions

11.116 Palliative Care Social Work Australia submitted that there may be instances of a person obtaining the substance and then deciding not to administer it. This respondent considered that this would be a community safety issue.

11.117 Some respondents considered whether there should be a requirement to use the substance within a set time limit. The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that placing such a time limit on the person in possession of the substance may place them under undue pressure.

11.118 A member of the public submitted that the safe storage of lethal drugs in homes and institutions is necessary to protect members of the public and prevent theft and wrongful use.

11.119 The Australian Lawyers Alliance considered that measures should be implemented to ensure that dispensed medications are safely stored.

11.120 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine considered that the substance could be held in a lockable receptacle or safe in the house and that the location and form of storage should be documented. This respondent submitted that management of the medication should prevent inadvertent ingestion (for example by a child) or deliberate ingestion by a third person.

The Commission's view

11.121 The draft Bill should support people who decide to self-administer, without requiring the coordinating practitioner or another health practitioner to be present, and enable this to happen safely. This requires the draft Bill to set out what a person is authorised to do with the voluntary assisted dying substance once it leaves the control of an authorised supplier and requirements relating to the safe storage.

11.122 The draft Bill provides that a person who has made a self-administration decision is authorised to possess the substance for the purpose of preparing and self-administering it. The person's contact person and agent should also be authorised to possess the substance for the purpose of supplying it to the person and supply the substance to the person for them to self-administer.

11.123 To ensure the substance is managed safely once it has left the control of an authorised supplier, the draft Bill provides that a person who receives a voluntary assisted dying substance must store it in accordance with requirements prescribed by regulation. The requirements should include that the person must keep the substance in a locked box not easily penetrable by other people.

122 *Voluntary Assisted Dying Act 2019* (WA) s 59(4).
123 *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) ch 2, pt 7 div 2; *Medicines and Poisons Regulations 2016* (WA) pt 9, divs 4, 6.
124 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 73(2), 75(2).

11.124 To ensure the person is aware of the storage requirements the coordinating practitioner is required, as outlined above, to inform the person of these requirements before prescribing the substance for self-administration and the authorised supplier should be required to inform the recipient (the person, contact person or agent) of the storage requirements when supplying the substance for self-administration. The authorised supplier will also be required to comply with labelling requirements prescribed by regulation. The prescribed labelling requirements should provide for relevant storage requirements to be included on the label on the container or package containing the substance.

11.125 The draft Bill provides that, if the person has made a practitioner administration decision, the administering practitioner is authorised to possess the substance for the purpose of preparing it and administering it to the person. As outlined above, the draft Bill provides that a person who receives a voluntary assisted dying substance must store it in accordance with requirements prescribed by regulation.

RECOMMENDATIONS

11-6 The possession and storage of the substance be regulated by:

(a) authorising a person who has made a self-administration decision to possess the substance for the purpose of preparing and self-administering it;

(b) authorising the person's contact person or agent to possess the substance for the purpose of supplying it to the person and supply the substance to the person, if the person has made a self-administration decision;

(c) authorising the administering practitioner to possess the substance for the purpose of preparing it and administering it to the person, if the person has made a practitioner administration decision;

(d) providing that a person who receives a voluntary assisted dying substance must store it in accordance with requirements prescribed by regulation.

ADMINISTRATION OF THE VOLUNTARY ASSISTED DYING SUBSTANCE

11.126 Under the draft Bill, a person may make either a self-administration decision or a practitioner administration decision in consultation with and on the advice of the coordinating practitioner.[125]

Other jurisdictions

11.127 The Victorian Act and Western Australian Act specify who is authorised to prepare and administer a voluntary assisted dying substance.[126]

11.128 In Victoria, the person is authorised under a self-administration permit to use and self-administer the substance.[127] Another person, such as a carer, family member or health practitioner, is not precluded from assisting the person to prepare the substance for self-administration. However, the person must self-administer (take the substance themselves).[128]

11.129 Under a practitioner administration permit, the coordinating medical practitioner is authorised to use and administer the substance to the person, in the presence of a witness, if certain requirements are met.[129]

11.130 The Western Australian Act provides that, if the person has made a self-administration decision and not revoked it, the person is authorised to prepare and self-administer the substance.[130] If the person has made a practitioner administration decision and not revoked it, the administering practitioner is authorised to prepare the substance, and to administer it to the person, in the presence of a witness, if the administering practitioner is satisfied at the time of administration that certain requirements are met.[131]

11.131 'Prepare' is defined in the Western Australian Act to mean 'to do anything necessary to ensure that the substance is in a form suitable for administration', and 'includes to decant, dilute, dissolve, mix, reconstitute, colour or flavour the substance'.[132] The Western Australian Act defines 'administration' to include self-administration.[133]

11.132 The Tasmanian Act specifies who is authorised to prepare and administer the substance under a private self-administration certificate or an AHP administration certificate.[134]

11.133 Under the White and Willmott Model, the first medical practitioner for the person is authorised to provide access to voluntary assisted dying to the person upon receiving the person's final request, in accordance with the final request.[135] 'Voluntary assisted dying' is defined for the model to mean the administration of voluntary assisted dying medication to a person and includes steps reasonably related to administration.[136]

125 See Chapter 10 above.
126 See the discussion of requirements for self-administration in Chapter 10 above.
127 *Voluntary Assisted Dying Act 2017* (Vic) s 45(b).
128 See the discussion of requirements for self-administration and, in particular, assistance that may be provided by health practitioners and others, in Chapter 10 above.
129 *Voluntary Assisted Dying Act 2017* (Vic) s 46(c). See the discussion of requirements for practitioner administration in Chapter 10 above.
130 *Voluntary Assisted Dying Act 2019* (WA) s 58(5)(c)–(d).
131 *Voluntary Assisted Dying Act 2019* (WA) s 59(4)(c) and (5). See the discussion of requirements for practitioner administration in Chapter 10 above.
132 *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'prepare').
133 *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'administration').
134 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 86, 91. If there is a private administration certificate in relation to the person, the person is authorised, among other things, to possess, store, and self-administer the substance. If there is an AHP administration certificate in relation to the person, the administering health practitioner is authorised to either: supply the substance to the person to self-administer while the administering health practitioner is in close proximity; supply the substance to the person and assist the person to self-administer; or administer the substance to the person.
135 White and Willmott Model cl 34. See also cll 30, 31, 33(3). The final request must be made in the presence of a witness. See further Chapter 10 above.
136 White and Willmott Model cl 6.

The Commission's view

11.134 The draft Bill sets out relevant authorisations for preparing and administering the voluntary assisted dying substance in accordance with a self-administration decision or practitioner administration decision.

11.135 The preparation of the substance should be clearly distinguished from administration. The administration of the substance must be strictly regulated by the draft Bill to ensure only authorised individuals administer the substance in accordance with an administration decision.

11.136 'Administer' is defined in the *Medicines and Poisons Act 2019* in relation to a medicine to mean introducing a dose of medicine into the body by any means or giving a dose of the medicine to a person to be taken immediately.[137] This definition would not be suitable for the draft Bill. Although the definition of 'administer' excludes dispensing the medicine, giving a dose of the medicine to a person to be taken immediately would capture a person supplying the substance to a person for self-administration. It is also considered desirable to include specific definitions for the draft Bill rather than to adopt definitions from the *Medicines and Poisons Act 2019*, given the need to distinguish the regulation of the voluntary assisted dying substance from the regulation of medicines for therapeutic use under the general Medicines and Poisons framework.

11.137 As it is necessary to clearly distinguish between administration of the substance and other related steps, 'administer' is defined in the draft Bill to mean, in relation to a voluntary assisted dying substance, 'to introduce the substance into the body of a person by any means'.

11.138 'Prepare' is defined to mean 'to do anything necessary to ensure that the substance is in a form suitable for administration and includes to decant, dilute, dissolve, reconstitute, colour or flavour the substance'. This is consistent with the Western Australian definition and will clearly distinguish preparation from administration.

11.139 As outlined above, the draft Bill provides that the authorised supplier who is given the prescription should be authorised to prepare the substance.

11.140 Where a self-administration decision has been made, the draft Bill provides that the person is authorised to prepare and self-administer the substance.

11.141 Additionally, it provides that where a self-administration decision has been made, another person, who is requested by the person to prepare the substance for the person, is authorised to possess the substance for the purpose of preparing it, prepare the substance and supply the substance to the person. This makes it clear that another person is able to assist with the preparation of the substance at the person's request, for example, by mixing the substance, if supplied as a powder, into the liquid. Another person may include the coordinating practitioner or another health practitioner, a carer or support person, or a family member or friend, and may include the person who is appointed to be the contact person.

11.142 Including an authorisation for another person to prepare the substance is in keeping with the approach taken in the draft Bill to clearly set out who is authorised to deal with the substance and the limits of the authorisations. This will not create an obligation for anyone to prepare the voluntary assisted dying substance.

11.143 The draft Bill makes a clear distinction between the preparation and administration of the substance. Only the person requesting access to voluntary assisted dying will be authorised to self-administer the substance, and the draft Bill includes an offence for unauthorised administration of the substance, which carries a maximum penalty of 14 years imprisonment.[138]

137 *Medicines and Poisons Act 2019* (Qld) s 26.
138 See Chapter 17 below.

11.144 Where a practitioner administration decision has been made, the draft Bill provides that the administering practitioner is authorised to prepare the substance, and to administer the substance to the person in the presence of an eligible witness, if the requirements are met.[139]

RECOMMENDATIONS

11-7 The administration of the substance be regulated by:

(a) if a self-administration decision has been made by the person—authorising:

(i) the person to prepare and self-administer the substance;

(ii) another person, requested by the person to prepare the substance, to:

(A) possess the substance for the purpose of preparing it;

(B) prepare the substance;

(C) supply the substance to the person;

(b) if a practitioner administration decision has been made—authorising the administering practitioner to prepare the substance, and administer the substance in the presence of an eligible witness, in accordance with the practitioner administration decision.

11-8 'Prepare' the substance should mean 'to do anything necessary to ensure that the substance is in a form suitable for administration and includes to decant, dilute, dissolve, reconstitute, colour or flavour the substance';

11-9 'Administer' the substance should mean 'to introduce the substance into the body of a person by any means'.

139 See Chapter 10 above.

DISPOSAL OF THE VOLUNTARY ASSISTED DYING SUBSTANCE

Other jurisdictions

11.145 The Victorian Panel noted that other jurisdictions that provide for self-administration 'generally rely on existing laws for the safe disposal of the medication'.[140]

11.146 The Panel also noted that:[141]

> there are existing mechanisms in place for retrieving unused medications in Victoria, as well as penalties for unauthorised possession of prescription medication.

11.147 However, the Panel recognised stakeholder concerns about the voluntary assisted dying substance being in the community and considered that specific measures dealing with disposal were necessary.[142] The Victorian Act therefore includes specific requirements for the safe return and disposal of the substance. This is also the approach taken in Western Australia and Tasmania.

11.148 The White and Willmott Model suggests that any provisions relating to disposal of the substance could be prescribed by regulation.[143]

Requirement to return any unused or remaining substance

11.149 The legislation in Victoria, Western Australia and Tasmania sets out the requirement to return any unused or remaining voluntary assisted dying substance to the relevant pharmacy.

11.150 The Victorian Act provides for any unused or remaining substance to be returned to the pharmacist at the dispensing pharmacy. The contact person is required to return any unused or remaining substance to the pharmacist at the dispensing pharmacy where the person dies or, where the person decides not to self-administer, at the person's request[144] and is authorised under the self-administration permit to possess and store the substance for this purpose and to carry and transport the substance to the pharmacy.[145] If the person requests practitioner administration after previously seeking a self-administration permit, the person or their contact person must return the substance, if it has been supplied, to a pharmacist at the dispensing pharmacy.[146] In practice, the Statewide Pharmacy Service collects the substance if the contact person is unable to transport it to the Alfred Hospital for disposal.[147]

11.151 In Western Australia, the CEO of the Department of Health is empowered to authorise a registered health practitioner or class of registered health practitioners to dispose of a voluntary assisted dying substance (an 'authorised disposer').[148] The contact person is responsible for giving the substance to the authorised disposer for disposal if a person revokes their self-administration decision after an authorised supplier has supplied the prescribed substance, or after the person dies.[149]

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140 Vic Ministerial Advisory Panel Final Report (2017) 129, referring to *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.20; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5291.

141 Vic Ministerial Advisory Panel Final Report (2017) 130, referring to *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 36B(2).

142 Ibid 129.

143 White and Willmott Model cl 35.

144 *Voluntary Assisted Dying Act 2017* (Vic) s 39(2). It is an offence for the contact person to fail to return any unused or remaining substance within 15 days after the person's death. A penalty of 12 months imprisonment or 120 penalty units or both applies: s 89.

145 *Voluntary Assisted Dying Act 2017* (Vic) s 45(c)–(d).

146 *Voluntary Assisted Dying Act 2017* (Vic) s 55.

147 Vic Guidance for Health Practitioners (2019) 64.

148 *Voluntary Assisted Dying Act 2019* (WA) s 79. The CEO is required to publish an up-to-date list of authorised disposers on the Department's website.

149 *Voluntary Assisted Dying Act 2019* (WA) s 105. It is an offence for the contact person to fail to give the substance to an authorised disposer as soon as practicable and within 14 days of the decision being revoked or the person's death. The penalty for non-compliance is 12 months imprisonment.

11.152 There is no specific requirement in either Victoria or Western Australia for the coordinating practitioner to return unused or remaining substance to the pharmacy in the case of practitioner administration.

11.153 The Tasmanian Act sets out requirements for the primary medical practitioner and administering health practitioner to return the remaining substance to the dispensing pharmacist.[150] There are additional requirements for the person to supply the substance to their administering health practitioner or contact person for return to the administering health practitioner where the person chooses not to self-administer[151] and for the contact person to return any unused or remaining substance to the administering health practitioner.[152]

Requirement to inform

11.154 As outlined above, in Victoria and Western Australia, the coordinating practitioner is required to inform the person of a number of matters before prescribing the voluntary assisted dying substance for self-administration, including requirements for the person or contact person to return the substance to the pharmacist in certain circumstances.[153] Similar information must be provided by the pharmacist when supplying the substance for self-administration.[154] The label on the package or container must also state that any unused or remaining substance must be returned to the pharmacist at the dispensing pharmacy.[155]

11.155 The Tasmanian Act does not include requirements for the coordinating practitioner or dispensing pharmacist to inform the person of the requirement to the return the substance, or for the label on the substance to state the requirement.

Requirement to dispose of any unused or remaining substance

11.156 The Victorian Act provides that if a person with a self-administration permit or the contact person specified in the permit returns any of the dispensed substance to a pharmacist at the dispensing pharmacy, the pharmacist must dispose of it as soon as practicable.[156]

11.157 In Western Australia, disposal requirements apply where a substance, or any unused or remaining substance, is given to an authorised disposer by the person's contact person. The authorised disposer is authorised to possess the substance and dispose of it. They are required to dispose of the substance as soon as practicable after receiving it and must comply with any requirements of the *Medicines and Poisons Act 2014* (WA) relating to disposal.[157]

11.158 The Tasmanian Act provides that where a voluntary assisted dying substance is returned to a pharmacist, the pharmacist must destroy the substance as soon as practicable.[158]

150 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 76(3), 77(3).

151 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 91(4).

152 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 92(3), (4). It is an offence for a contact person not to return any unused or remaining voluntary assisted dying substance to the administering health practitioner within 14 days after the person dies after self-administering a voluntary assisted dying substance. The penalty is a fine not exceeding 50 penalty units: s 130.

153 *Voluntary Assisted Dying Act 2017* (Vic) s 57(f), (g); *Voluntary Assisted Dying Act 2019* (WA) s 69(2)(j), (k). In Victoria, this includes a requirement for the coordinating medical practitioner to inform the person that they or their contact person must return any dispensed voluntary assisted dying substance to the pharmacist at the dispensing pharmacy for disposal if they decide not to self-administer, and that the contact person must return any remaining substance to the pharmacist after the person dies. In Western Australia, this information must be provided in writing. See also *Voluntary Assisted Dying Act 2019* (WA) s 69(3)(g): in Western Australia, where a practitioner administration decision is made after revocation of a self-administration decision, the coordinating practitioner is also required to inform the person that their contact person must give any substance received by the patient, their contact person or agent to an authorised disposer for disposal.

154 *Voluntary Assisted Dying Act 2017* (Vic) s 58(d), (e); *Voluntary Assisted Dying Act 2019* (WA) s 72(2)(d), (e).

155 *Voluntary Assisted Dying Act 2017* (Vic) s 59(1)(d); *Voluntary Assisted Dying Act 2019* (WA) s 73(1)(c)(ii).

156 *Voluntary Assisted Dying Act 2017* (Vic) s 62.

157 *Voluntary Assisted Dying Act 2019* (WA) s 75.

158 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 76(4), 77(4).

Record keeping and reporting requirements

11.159 In Victoria, the pharmacist who disposes of the substance must immediately record the disposal in the approved form and give a copy of the form to the Board within seven days after disposing of the substance.[159] Failure to give a copy of the disposal form to the Board is an offence.[160] The Victorian Panel considered the requirement for the pharmacist to report to the Board would 'further support the monitoring and oversight role of the Board'.[161] The Western Australian Act[162] and Tasmanian Act[163] also include record keeping and reporting requirements.

Disposal by the administering practitioner

11.160 The Western Australian Act includes requirements for disposal of the substance by the administering practitioner where there has been a practitioner administration decision. The administering practitioner is authorised to possess and dispose of the substance where the patient makes a practitioner administration decision and then revokes the decision, and the practitioner has possession of the substance when the decision is revoked, or where the person dies and the practitioner has possession of the substance or unused or remaining substance.[164]

11.161 The prescribed substance must be disposed of as soon as practicable after the practitioner administration decision is revoked or after the person's death. The disposal must comply with any requirements of the *Medicines and Poisons Act 2014* (WA) that apply to the disposal.[165]

11.162 The administering practitioner must immediately record the disposal in the approved form and provide a copy of the form to the Board within two business days of the disposal.[166] It is an offence to fail to give a copy of the form to the Board.[167]

11.163 The Victorian Act does not provide for the coordinating medical practitioner to dispose of the substance.

Submissions

11.164 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine considered that the recovery of unused doses of the voluntary assisted dying substance could be quite complex and that there is potential for the substance to not be found. This respondent also submitted that the documentation required to effectively monitor the substance should be minimal and not place undue pressure on either prescriber or patient.

11.165 The Australian Lawyers Alliance submitted that a person who decides not to proceed with voluntary assisted dying 'should return the unused medications to the dispensing pharmacist within a specified timeframe' and 'if some but not all of the dispensed medication is ingested, that the unused medication should be returned to the dispensing pharmacist by a nominated person'.

159 *Voluntary Assisted Dying Act 2017* (Vic) s 63.
160 *Voluntary Assisted Dying Act 2017* (Vic) s 90. A penalty of 60 penalty units applies for non-compliance with this requirement.
161 Vic Ministerial Advisory Panel Final Report (2017) 171.
162 *Voluntary Assisted Dying Act 2019* (WA) s 76. The authorised disposer must immediately record the disposal in the approved form and provide a copy of the form to the Board within two business days of the disposal. It is an offence to fail to give a copy of the form to the Board, and a penalty of $10,000 applies for non-compliance with this requirement: s 108.
163 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 76(4), 77(4). Where a voluntary assisted dying substance is returned to a pharmacist, the pharmacist must destroy the substance as soon as practicable and record that the substance has been destroyed. The primary medical practitioner and administering health practitioner also have a duty to notify the Voluntary Assisted Dying Commission that the remaining substance has been returned to the pharmacist: ss 76(3)(b), 77(3)(b).
164 *Voluntary Assisted Dying Act 2019* (WA) s 77(1)–(5).
165 *Voluntary Assisted Dying Act 2019* (WA) s 77(6)–(7).
166 *Voluntary Assisted Dying Act 2019* (WA) s 78.
167 *Voluntary Assisted Dying Act 2019* (WA) s 108. A penalty of $10,000 applies for non-compliance with this requirement.

The Commission's view

11.166 To ensure the voluntary assisted dying substance is managed appropriately while in the community, the draft Bill should set out requirements for the safe return and disposal of the substance.

11.167 The voluntary assisted dying substance, or any unused or remaining substance, must be given to an authorised disposer where the person has died or revoked their self-administration decision.

11.168 'Unused or remaining substance' is defined for the draft Bill to mean 'any of the voluntary assisted dying substance supplied for a person that remains unused or remaining after the person's death'.

11.169 For the purposes of the draft Bill, an 'authorised disposer' means an appropriately qualified registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive of the Department to dispose of a voluntary assisted dying substance under the Act. This is consistent with the approach in Western Australia. As outlined above, this will enable the Department to establish an appropriate delivery model for voluntary assisted dying pharmacy services. The draft Bill provides that the chief executive must, on request, give a person who is acting as a coordinating practitioner the name of one or more authorised disposers. This will ensure that the coordinating practitioner can inform the person and their contact person of the authorised disposer's details to support safe disposal of the substance.

11.170 If the person dies after an authorised supplier has supplied the substance, whether from natural causes or by self-administering the substance, the person's contact person must give any unused or remaining substance to an authorised disposer as soon as practicable and within 14 days of the person's death.

11.171 If the person revokes a self-administration decision after an authorised supplier has supplied the substance, the contact person must give the substance to an authorised disposer as soon as practicable and within 14 days of the decision being revoked.

11.172 The contact person should be authorised to possess the substance for the purpose of giving it to an authorised disposer and give the substance, or any unused or remaining substance, to an authorised disposer. These requirements will ensure that the chain of responsibility for managing the substance is maintained once the person has died.

11.173 Under the draft Bill, it is an offence for the contact person to fail to give the substance, or any unused or remaining substance to the authorised disposer within 14 days of the person's death or the self-administration decision being revoked.[168]

11.174 To ensure the person is aware of these requirements, the coordinating practitioner is required to inform the person of these requirements in writing before prescribing the substance for self-administration and the authorised supplier is required to inform the recipient of the substance (the person, contact person or agent) of these requirements in writing when supplying the substance for self-administration. As outlined above, the authorised supplier is also required to include the requirement to give the substance, or any unused or remaining substance, to an authorised disposer on the label of the substance.

11.175 The draft Bill requires the authorised disposer to dispose of the substance, or any unused or remaining substance, as soon as practicable after it has been given to them by the contact person. The authorised disposer is authorised to possess and dispose of the substance to comply with this requirement. Further requirements relating to disposal may be prescribed by regulation.

168 Failure to do so will carry a maximum penalty of 100 penalty units (presently $13 345). See Chapter 17 below.

11.176 The authorised disposer should also be required to complete a record of the disposal in the approved form (the 'authorised disposal form') and give a copy of the form to the Board within two business days of the disposal. This will ensure the whereabouts of the substance can be controlled and assist the Board in its monitoring and review role.[169]

11.177 Where a person has made a practitioner administration decision, the administering practitioner has possession of the substance, and the person either revokes their decision or dies (whether from being administered the substance or not), the administering practitioner should be authorised to possess and dispose of the substance. The draft Bill provides that the administering practitioner must dispose of the substance, or any unused or remaining substance, as soon as practicable after the decision being revoked or the person's death.

11.178 This approach is consistent with Western Australia. It will facilitate accessibility in regional and remote areas of Queensland by allowing the administering practitioner to dispose of the substance safely instead of travelling potentially long distances to an authorised disposer.

11.179 The administering practitioner will be required to comply with any relevant disposal requirements prescribed by regulation. If they are unable to comply, the administering practitioner may give the substance to an authorised disposer for disposal.

11.180 Consistent with the requirement for authorised disposers, the administering practitioner is required to complete a record of the disposal in the approved form (the 'practitioner disposal form') and give a copy of the form to the Board within two business days of the disposal.[170]

RECOMMENDATIONS

11-10 The return and disposal of the substance be regulated by:

(a) requiring the contact person to give any unused or remaining substance, if it has been supplied, to an authorised disposer as soon as practicable and within 14 days if the person dies, whether from natural causes or by self-administering the substance;

(b) requiring the contact person to give the substance, if it has been supplied, to an authorised disposer as soon as practicable and within 14 days of the person revoking their self-administration decision;

(c) authorising the contact person to possess the substance for the purpose of giving it to an authorised disposer and give the substance, or any unused or remaining substance, to an authorised disposer;

(d) requiring the authorised disposer to dispose of the substance, or any unused or remaining substance, as soon as practicable after receiving it from the contact person. The authorised disposer must comply with any disposal requirements prescribed by regulation;

169 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

170 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

(e) requiring the authorised disposer to complete a record of the disposal in the approved form (the 'authorised disposal form') and give a copy of the form to the Board within two business days of the disposal;

(f) requiring the administering practitioner to dispose of the substance, or any unused or remaining substance in their possession, as soon as practicable after the practitioner administration decision being revoked or the person's death. The administering practitioner must comply with any disposal requirements prescribed by regulation;

(g) requiring the administering practitioner to complete a record of the disposal in the approved form (the 'practitioner disposal form') and give a copy of the form to the Board within two business days of the disposal.

11-11 'Authorised disposer' should mean a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive to dispose of a voluntary assisted dying substance under the Act.

11-12 The chief executive:

(a) may authorise an appropriately qualified registered health practitioner, or person in a class of registered health practitioners, to dispose of a voluntary assisted dying substance under the Act;

(b) must, on request, give a person who is acting as a coordinating practitioner the name of one or more authorised disposers.

11-13 'Unused or remaining substance' should mean 'any of the voluntary assisted dying substance supplied for a person that remains unused or remaining after the person's death'.

REQUIREMENT TO APPOINT A CONTACT PERSON

Other jurisdictions

11.181 In Victoria, Western Australia and Tasmania, a voluntary assisted dying substance can be supplied to the person for self-administration, without requiring the practitioner to be present. The legislation therefore provides for the appointment of a contact person.[171] In Victoria, a person must appoint a contact person after making a final request for access to voluntary assisted dying and before applying for a voluntary assisted dying permit (either a self-administration permit or a practitioner administration permit).[172] In Western Australia, a contact person is required only where the person has made a self-administration decision.[173] The Tasmanian Act requires the appointment of a contact person where a person makes a private self-administration request to their primary medical practitioner and is given a private self-administration certificate by their administering health practitioner.[174]

11.182 As outlined above, under the White and Willmott Model, self-administration is always supervised by the first medical practitioner.[175] The White and Willmott Model therefore does not suggest the appointment of a contact person, as the substance remains in the possession or under the direct supervision of a registered medical practitioner once it has been supplied.

Role of the contact person

11.183 The Victorian Panel recommended that a person seeking access to voluntary assisted dying should be required to appoint a contact person who will be responsible for returning any unused medication to the dispensing pharmacist and act as a point of contact for the Board.[176] The Panel considered that this would: [177]

> ensure the safe retrieval of unused lethal medication in recognition of the widespread stakeholder concern about unused lethal medication in the community.

11.184 The Panel considered that the appointment of the contact person and acceptance of the role should take place before the voluntary assisted dying substance is prescribed.[178] In Victoria, the role of the contact person is primarily to return any unused or remaining substance to the pharmacist at the dispensing pharmacy. Where the person has died and there is unused or remaining substance, the substance must be returned within 15 days of the death.[179] Where the person decides to request practitioner administration or decides not to self-administer, the contact person must return the substance at the person's request.[180] The Board may contact the contact person to request information.[181]

11.185 Under the person's self-administration permit, the contact person is authorised to possess, store, carry and transport the substance, or any unused or remaining substance, where the person has died, decided not to self-administer or, in the case of an order made by the Victorian Civil and Administrative Tribunal ('VCAT'), for the

171 *Voluntary Assisted Dying Act 2017* (Vic) s 39; *Voluntary Assisted Dying Act 2019* (WA) s 65; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 85.
172 *Voluntary Assisted Dying Act 2017* (Vic) ss 39, 47(2)(d), 48(2)(d).
173 *Voluntary Assisted Dying Act 2019* (WA) s 64.
174 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 83, 84, 85(1).
175 White and Willmott Model cl 6(2)(b).
176 Vic Ministerial Advisory Panel Final Report (2017) 26, Rec 29.
177 Ibid 131.
178 Ibid.
179 *Voluntary Assisted Dying Act 2017* (Vic) s 39(2)(a). It is an offence for the contact person who is the subject of a self-administration permit to fail to return any unused voluntary assisted dying substance that the contact person knows is unused or remaining after the death to a pharmacist at the dispensing pharmacy within 15 days after the person's death. A penalty of 12 months imprisonment or 120 penalty units or both applies: s 89.
180 *Voluntary Assisted Dying Act 2017* (Vic) s 39(2)(b).
181 *Voluntary Assisted Dying Act 2017* (Vic) s 39(3). Within seven days of being notified by the Registrar about the person's death, the Board must also provide information to the contact person about the requirement to return any unused or remaining substance to a pharmacist and the support services available to assist the contact person with the performance of this requirement: s 106.

purpose of returning it to a pharmacist at the dispensing pharmacy.[182] The contact person does not have a formal role outside of returning the substance to the dispensing pharmacy and providing information to the Board.

11.186 In Western Australia, where the patient has made a self-administration decision the coordinating practitioner cannot prescribe a voluntary assisted dying substance before receiving the contact person appointment form.[183] The role of the contact person is to receive the substance from an authorised supplier, possess it, supply it to the person and give the substance, or any unused or remaining substance, to an authorised disposer as soon as practicable and within 14 days of the person revoking a self-administration decision or dying.[184]

11.187 The contact person is required to inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or from some other cause.[185] There is no timeframe specified for this requirement. The Board is required to send information to the contact person within two business days of receiving a copy of the contact person appointment form.[186]

11.188 Under the Tasmanian Act, the role of the contact person is to store and return any unused or remaining substance to the administering health practitioner where the person has died after self-administering the substance in accordance with a private self-administration certificate. The contact person is authorised to possess and store the unused or remaining substance for 14 days. It must be kept in a locked receptacle that is not readily accessible by any other person. The contact person must return any unused or remaining substance to the person's administering health practitioner as soon as reasonably practicable and within 14 days of the death.[187] The contact person is authorised to possess the substance for the purpose of transporting it to the administering health practitioner, transport it, and supply it to the administering health practitioner.[188]

11.189 The contact person must also notify the administering health practitioner of the death of the person as soon as reasonably practicable and within 24 hours after becoming aware of the death. [189]

Formal requirements for appointing contact person

11.190 The Victorian Act[190] and Western Australian Act[191] set out requirements for appointing a contact person.

182 *Voluntary Assisted Dying Act 2017* (Vic) s 45(c)–(d).

183 *Voluntary Assisted Dying Act 2019* (WA) s 66(6).

184 *Voluntary Assisted Dying Act 2019* (WA) ss 67, 105. The penalty for failure to give the substance to an authorised disposer is 12 months imprisonment.

185 *Voluntary Assisted Dying Act 2019* (WA) s 67(2).

186 *Voluntary Assisted Dying Act 2019* (WA) s 149. The information must explain the requirements to give the substance, or any unused or remaining substance to an authorised disposer and outline the support services available to assist the contact person to comply with the requirements. The Board may also request any person, including the contact person, give information to the Board to assist it in performing any of its functions: s 150.

187 It is an offence for the contact person not to return any unused or remaining substance to the administering health practitioner within 14 days after the person dies: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 130.

188 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 92.

189 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 92(2). If the person has not died at their usual place of residence, the contact person must also notify the police of the location of the body.

190 *Voluntary Assisted Dying Act 2017* (Vic) ss 39(1), 40. The contact person must be aged at least 18 years and cannot be appointed unless they accept the appointment. The appointment must be made in the approved form and signed by the person and the contact person, in the presence of another person aged 18 or over.

191 *Voluntary Assisted Dying Act 2019* (WA) ss 65(2)–(6), 66, 68. The contact person must be aged at least 18 years. The person may appoint their coordinating practitioner, consulting practitioner or another registered health practitioner as their contact person; the contact person must consent to the appointment; the person may revoke the appointment, in which case they must inform the contact person and make another appointment. The appointment must be made in the approved form, include statements that the contact person consents to the appointment and that they understand their role under the Act, and must be signed by the person and the contact person. The person or contact person must give the form to the coordinating practitioner, who must give a copy to the Board within two business days of receiving it. The Western Australian Act provides that the contact person may refuse to continue in the role. They are required to inform the person of their refusal, upon which they cease to be the contact person and the person must make another appointment.

The Commission's view

11.191 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 they have made a self-administration decision, ensuring 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 voluntary assisted dying substance.

11.192 A contact person is also required to be appointed if the person makes a practitioner administration decision, as this will provide the Board with a point of contact, assisting it in its oversight and monitoring role.

11.193 The role of the contact person should be established in the draft Bill. The contact person is authorised to assist the person by receiving the substance from an authorised supplier, possessing it and supplying it to the person where a self-administration decision has been made. The contact person's role in supplying the substance is appropriate given Queensland's geographic and demographic profile and the need to ensure voluntary assisted dying is accessible to people in rural and remote areas of Queensland who may not be able to travel to receive the substance.

11.194 Another key aspect of the contact person's role where a self-administration decision has been made is to give the substance, or any unused or remaining substance, to an authorised disposer for disposal as soon as practicable and within 14 days of the person's death or a self-administration decision being revoked. As outlined above, the contact person for a person who has made self-administration decision should be authorised to possess the substance for the purpose of giving it to an authorised disposer, and give the substance, or any unused or remaining substance, to an authorised disposer for disposal.

11.195 As outlined above, the draft Bill provides that it is an offence for the contact person to fail to give the substance, or any unused or remaining substance to the authorised disposer within 14 days of the person's death or the self-administration decision being revoked.[192]

11.196 The draft Bill provides that where a self-administration decision has been made, the contact person is required to inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or from some other cause, within two business days of becoming aware of the death. Where a practitioner administration decision has been made, the contact person is required to inform the coordinating practitioner if the person dies from a cause other than the administration of the substance, within two business days of becoming aware of the death.

11.197 The contact person should also act as a point of contact for the Board, to assist in its oversight and monitoring role. The draft Bill provides that the Board may contact the contact person to request information. The draft Bill also provides that where a person makes a self-administration decision, the Board is required to give information to the contact person within two business days of receiving a copy of the contact person appointment form. The information must explain the requirement to give the substance, or any unused or remaining substance, to an authorised disposer for disposal and outline the support services available to assist the contact person to fulfill the requirement.

11.198 The draft Bill provides that the requirements for appointing a contact person are:

- the contact person must be at least 18 years of age;
- the contact person cannot be appointed unless they consent to the appointment;

192 Failure to do so will carry a maximum penalty of 100 penalty units (presently $13 345). See Chapter 17 below.

- the appointment must be made in the approved form (the 'contact person appointment form') and signed and dated by the person and the contact person. Another person (a second person) may complete the form on the person's behalf at their request if the person is unable to complete the form, the second person is at least 18 years of age and the second person signs the appointment form in the presence of the person. The contact person appointment form must include:
  - the details of the person accessing voluntary assisted dying, the contact person and the coordinating practitioner;
  - a statement that the contact person consents to the appointment;
  - a statement that the contact person understands their role under the Act, including the requirements to give the substance, or any unused or remaining substance, to an authorised disposer and the penalties for non-compliance; and
  - if the person was assisted by an interpreter when making the appointment, the interpreter's details (including their accreditation details) and a statement signed by the interpreter certifying that they provided a true and correct translation of any information translated;
- the person may revoke the appointment of the contact person. If the person revokes the appointment, they must inform the contact person of the revocation, upon which they cease to be the contact person and the person must make another appointment;
- the contact person may refuse to continue in the role. They are required to inform the person of their refusal, upon which they cease to be the contact person and the person must make another appointment.

11.199 The draft Bill requires the person or contact person to give the contact person appointment form to the coordinating practitioner. As outlined above, the draft Bill provides that the coordinating practitioner should not prescribe a voluntary assisted dying substance before receiving the contact person appointment form. This will ensure that the appointment of the contact person and acceptance of the role has taken place before prescribing occurs. The draft Bill further provides that the coordinating practitioner must give a copy of the appointment form to the Board within two business days of receiving it.[193]

11.200 The appointment of a contact person where a person has made a self-administration decision will assist the person throughout the process, ensure there is accountability for the substance once the person either dies or decides not to self-administer the substance and provide a point of contact for the Board. The appointment of a contact person where a person has made a practitioner administration decision will provide a point of contact for the Board.

193 Generally, it is an offence for a practitioner to fail to report to the Board as required by the draft Bill. The maximum penalty is 100 penalty units. The offence of failing to report as required to the Board is discussed separately in Chapter 17 below.

RECOMMENDATIONS

11-14 The requirement to appoint, and the responsibilities of, a contact person, be regulated, including requirements that:

(a) the person must appoint a contact person if the person has made an administration decision;

(b) the contact person for a person who has made a self-administration decision is authorised to receive the substance from an authorised supplier, possess it and supply it to the person for self-administration;

(c) the contact person for a person who has made a self-administration decision is authorised to possess the substance for the purpose of giving it to an authorised disposer and give the substance, or any unused or remaining substance, to an authorised disposer for disposal. The contact person is required to give the substance to the authorised disposer as soon as practicable and within 14 days of the person's death or a self-administration decision being revoked;

(d) the contact person for a person who has made a self-administration decision is required to inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or from some other cause, within two business days of becoming aware of the death;

(e) the contact person for a person who has made a practitioner administration decision is required to inform the coordinating practitioner if the person dies from a cause other than the administration of the voluntary assisted dying substance, within two business days of becoming aware of the death;

(f) the formal requirements for appointing a contact person are that:

(i) the contact person must be at least 18 years of age;

(ii) the contact person cannot be appointed unless they consent to the appointment;

(iii) the appointment must be made in the approved form (the 'contact person appointment form') and signed and dated by the person and the contact person. Another person (a second person) may complete the form on the person's behalf at their request if the person is unable to complete the form, provided the second person is at least 18 years of age and the second person signs the appointment form in the presence of the person;

(iv) the contact person appointment form must include:

(A) the details of the person, the contact person and the coordinating practitioner;

(B) a statement that the contact person consents to the appointment;

(C) a statement that the contact person understands their role under the Act, including the requirements to give the substance, or any unused or remaining

substance, to an authorised disposer and the penalties for non-compliance; and

(D) if the person was assisted by an interpreter when making the appointment, the interpreter's details and a statement signed by the interpreter certifying that they provided a true and correct translation of any information translated;

(v) the person may revoke the appointment of the contact person. If the person revokes the appointment, they must inform the contact person of the revocation, upon which they cease to be the contact person and the person must make another appointment;

(vi) the contact person may refuse to continue in the role. They are required to inform the person of their refusal, upon which they cease to be the contact person and the person must make another appointment;

(g) the person or contact person is required to give the contact person appointment form to the coordinating practitioner;

(h) the coordinating practitioner may not prescribe the substance before receiving the contact person appointment form;

(i) the coordinating practitioner must give a copy of the contact person appointment form to the Board within two business days of receiving it;

(j) the Board may contact the contact person to request information;

(k) the Board, if the person has made a self-administration decision, is required to give information to the contact person within two business days of receiving the contact person appointment form about:

(i) the requirement to give the substance, or any unused or remaining substance, to an authorised disposer for disposal; and

(ii) the support services available to assist the contact person to fulfil the requirement.

CONSEQUENTIAL AMENDMENTS

Current laws regulating scheduled substances

11.201 As outlined above, the *Medicines and Poisons Act 2019* is expected to commence in the second half of 2021, introducing a new framework for the regulation of medicines and poisons in Queensland.

11.202 The *Drugs Misuse Act 1986* (Qld) provides the legislative framework relating to the misuse of drugs, including offences relating to trafficking in, supplying, producing and possessing dangerous drugs. Dangerous drugs are defined to include a range of S4 and S8 drugs such as fentanyl, pentobarbital, phenobarbital and morphine.[194]

The Commission's view

11.203 As outlined above, the voluntary assisted dying substance should be regulated specifically in the draft Bill, given the purpose of the substance (to cause a person's death) is distinct from the therapeutic use of medicines. Supporting requirements needed to regulate the use of the voluntary assisted dying substance, including in relation to the labelling, storage and disposal of the substance, should be prescribed in a standalone Voluntary Assisted Dying Regulation.

11.204 This removes the need to make extensive consequential amendments to the Medicines and Poisons framework, however specific controls on the management of the voluntary assisted dying substance in the draft Bill require minor consequential amendments to the *Medicines and Poisons Act 2019* and *Drugs Misuse Act 1986*.

11.205 Minor consequential amendments should be made to the *Medicines and Poisons Act 2019* to provide clarity on the relationship with the draft Bill and apply the Medicines and Poisons enforcement provisions for the purposes of ensuring compliance with the Act. It will be necessary for the interaction between the two frameworks to be considered further during drafting of the Voluntary Assisted Dying Regulation, noting that the *Medicines and Poisons (Medicines) Regulation 2021* and *Medicines and Poisons (Poisons) Regulation 2021* will not commence until later in 2021.

11.206 It is unnecessary to make consequential amendments to the *Drugs Misuse Act 1986* as conduct authorised under the draft Bill will not breach the relevant *Drugs Misuse Act 1986* offences.

RECOMMENDATIONS

11-15 To avoid doubt, the draft Bill includes consequential amendments to the *Medicines and Poisons Act 2019*, including to provide clarity on the relationship between the Voluntary Assisted Dying scheme and the *Medicines and Poisons Act 2019*.

11-16 Any additional requirements needed to regulate the use of the voluntary assisted dying substance, including in relation to the labelling, storage and disposal of the substance, should be prescribed in a standalone Voluntary Assisted Dying Regulation.

194 *Drugs Misuse Regulation 1987* (Qld) sch 2.

CHAPTER 12

Notification and certification of death

Chapter 12: Notification and certification of death

CHAPTER SUMMARY

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.

This chapter 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.

DEATH CERTIFICATION PROCESS

Death certification process in Queensland

12.1 There are three key documents which form part of the death certification process in Queensland:

- the certificate of causes of death (the 'cause of death certificate');
- the registration of death form—an approved form required by the *Births, Deaths and Marriages Registration Act 2003* to register a person's death; and
- the death certificate.

Medical certificate of causes of death

12.2 The *Births, Deaths and Marriages Registration Act 2003* requires a medical practitioner to complete a cause of death certificate if they can form an opinion about the probable cause of a person's death. The cause of death certificate is then given to the Registrar-General under the *Births, Deaths and Marriages Registration Act 2003* (the 'Registrar').[1]

12.3 A cause of death certificate is important. For example, the information may be relevant:[2]

- for legal purposes—for example, the information may be relevant to the determination of the validity of a will, or life insurance payment;
- for statistical and public health purposes—the information recorded on death certificates[3] is coded by the Australian Bureau of Statistics (ABS) and is the major source of Australia's mortality statistics, which enable the evaluation and development of measures to improve the health of Australians; and
- for family members—to know what caused the death and to be aware of conditions that may occur in other family members.

12.4 The cause of death certification process 'is also an important safeguard against the disposal of bodies without professional scrutiny of the requirement for further investigation, particularly in relation to suspicious deaths'.[4]

1 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 30. However, a medical practitioner must not issue a cause of death certificate in relation to an apparently reportable death unless the coroner advises that it is not reportable, or in relation to a death that the coroner is investigating unless the coroner authorises it: *Coroners Act 2003* (Qld) s 26(5).

2 S Bird, 'How to Complete a Death Certificate: A Guide for GPs' (2011) 40(6) *Australian Family Physician* 446, 446–7.

3 The death certificate is different to the cause of death certificate completed by a medical practitioner, as discussed below.

4 Bird, above n 2, 447.

12.5 The medical practitioner must give the cause of death certificate to the person who is arranging for disposal of the deceased person's body (usually, the funeral director) or to the Registrar.[5]

Registration of death

12.6 Registration services in Queensland are delivered by the Registry of Births, Deaths and Marriages ('the Registry') under the legislative framework of the *Births, Deaths and Marriages Registration Act 2003* and the *Births, Deaths and Marriages Registration Regulation 2015*.

12.7 All deaths occurring in Queensland are required to be registered.[6]

12.8 The death must be registered by a spouse or relative of the deceased person.[7] Where this does not happen, the Registrar may require the person in charge of the place where the person died (such as a nursing home or hospital), the person finding the body, or the person arranging for the disposal of the deceased person's body (such as a funeral director) to register the death.[8] In practice, deaths in Queensland will generally be registered by a funeral director.[9]

12.9 An application to register a person's death must be in the approved form.[10] This allows the Registry to officially register the death.

Death certificate

12.10 The death certificate is different to the cause of death certificate completed by a medical practitioner. The death certificate contains information about a death that is made available to certain persons upon application to the Registrar.[11] This includes the cause of death.

12.11 Usually, a death certificate is issued to the funeral director or family of the person who has died.[12] The Registrar must have regard to certain things in determining whether an applicant has an adequate reason for obtaining the requested information.[13] The Act also imposes an obligation on the Registrar when giving information from the register to protect the privacy of individuals to whom the information relates.[14]

Voluntary assisted dying and the death certification process

12.12 The cause of death recorded on a cause of death certificate issued by a medical practitioner has implications for the cause of death as it is registered and listed on the death certificate.

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5 If the original cause of death certificate is given to the person arranging for disposal of the body, they are required to give the certificate to the Registrar within 14 days after receiving it: *Births, Deaths and Marriages Registration Act 2003* (Qld) s 30(8). In any event, the medical practitioner is required to give a copy of the cause of death certificate to the person who is arranging for disposal of the deceased person's body: s 30(2)(c).

6 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 26.

7 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 28(1).

8 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 28(2).

9 Queensland Government, 'Registering a death' (3 April 2020) <https://www.qld.gov.au/law/births-deaths-marriages-and-divorces/deaths-wills-and-probate/registering-a-death>.

10 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 29(1). The approved form requires the person to indicate how the cause of death was certified—either by cause of death certificate, or by autopsy ordered by the coroner: Department of Justice and Attorney-General (Qld), *Form 8: Death registration application* (2013) <https://www.publications.qld.gov.au/dataset/death-registration-form/resource/347f2571-d028-4d60-8efb-d2dfb9e2745c>. See also Queensland Government, 'Registering a death' (3 April 2020) <https://www.qld.gov.au/law/births-deaths-marriages-and-divorces/deaths-wills-and-probate/registering-a-death>.

11 A death extract contains: the deceased person's full name, age and occupation, the date and place of death, the cause of death, the date and place of the burial, the name of the last person, if any, to whom the deceased person was married, and the registration number: *Births, Deaths and Marriages Registration Regulation 2015* (Qld) s 25.

12 A 'funeral director will apply for a standard death certificate when they submit the death registration application form': Queensland Government, 'Registering a death' (3 April 2020) <https://www.qld.gov.au/law/births-deaths-marriages-and-divorces/deaths-wills-and-probate/registering-a-death>. An individual may also apply for a death certificate: Queensland Government, 'Applying for a death certificate' (29 March 2021) <https://www.qld.gov.au/law/births-deaths-marriages-and-divorces/birth-death-and-marriage-certificates/death-certificates/applying-for-a-death-certificate>.

13 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 44(3). These include: the relationship, if any, between the applicant and the person to whom the information relates, the reason that the applicant wants the information, the use to be made of the information, the age of the entry, the contents of the entry or source document, the sensitivity of the information, and any other relevant factors.

14 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 46. The Registrar may, for this purpose, impose conditions when giving someone information, or access to information, contained in a register.

Victoria

12.13 In Victoria, a medical practitioner who confirms a person's death will, similarly to Queensland, issue a medical certificate of cause of death. In addition, they must notify the Registrar of Births, Deaths and Marriages of their reasonable belief or knowledge that the person was the subject of a voluntary assisted dying permit and whether the person accessed voluntary assisted dying, and of the disease, illness or medical condition that was the grounds for the person to access voluntary assisted dying.[15]

12.14 In Victoria, guidance for health practitioners states:[16]

> A reasonable belief may be based on, for example:
>
> - evidence that the medications have been used – for example, no medications in the bottle or locked box and/or a used cup
> - the patient had notified the medical practitioner of the day and time they had decided to take the medication.

12.15 On receiving this notification, the Registrar must register the person's death by recording:[17]

- the person's cause of death as the disease, illness or medical condition that was the grounds of the person to access voluntary assisted dying; and
- if notified that the person accessed voluntary assisted dying, that voluntary assisted dying was the manner of death.

12.16 The *Births, Deaths and Marriages Registration Act 1996* (Vic) provides that the Registrar may issue a death certificate which certifies particulars contained in an entry.[18] This does not include any details about voluntary assisted dying.[19]

12.17 Victorian educational material developed for people considering voluntary assisted dying states that:[20]

> For people who access voluntary assisted dying, the Register of Births, Deaths and Marriages will record both the cause and manner of death. The cause of death will be the underlying disease (for example, cancer, motor neurone disease). The manner of death will be recorded as 'voluntary assisted dying'. The extract from the Register (commonly called the death certificate) that your family receives will not say that you accessed voluntary assisted dying. It will only record your underlying disease.

12.18 This approach gives effect to the recommendations of the Victorian Panel.[21] The Panel noted that 'it would be inconsistent to include voluntary assisted dying on a death certificate when other interventions are not recorded', observing that:[22]

> the proposed legislation provides access to voluntary assisted dying under limited circumstances for those people at the end of their life. They would die from that condition even if they did not choose voluntary assisted dying. Other medical

15 *Voluntary Assisted Dying Act 2017* (Vic) s 67; *Births, Deaths and Marriages Registration Act 1996* (Vic) s 37(1); Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 10.

16 Vic Guidance for Health Practitioners (2019) 64.

17 *Births, Deaths and Marriages Registration Act 1996* (Vic) s 40(1), (1A).

18 *Births, Deaths and Marriages Registration Act 1996* (Vic) s 46.

19 Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 10. See also Department of Health & Human Services (Vic), 'Voluntary assisted dying newsletter' (January 2020) <https://www.vision6.com.au/v/47492/7117956/email.html?k=u6THttw9TeH9VscZRwm0gilHO1XiM-jwD_tTpXzosVM>.

20 Department of Health & Human Services (Vic), 'Voluntary Assisted Dying—Information for people considering voluntary assisted dying', (2020) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/information-for-people-considering-voluntary-assisted-dying>, 39.

21 Vic Ministerial Advisory Panel Final Report (2017) 149–52, Recs 41, 43. In reaching its recommendation, the Victorian Panel noted (at 150) that:

> the predominant stakeholder view was that death certificates should record the underlying condition as the cause of death. It was frequently noted that the person would not be accessing voluntary assisted dying without the underlying condition, which would inevitably cause their death in the immediate future. There was concern raised that those who accessed voluntary assisted dying should not be discriminated against on the basis of their choice for the purpose of benefits such as insurance.

22 Ibid 150.

treatments or actions taken that may hasten death or prolong life are not included on death certificates currently.

12.19 The Panel also noted that 'identifying voluntary assisted dying on death certificates may inadvertently compromise the privacy of the clinical relationship between a medical practitioner and their patient'. The Panel therefore considered it 'appropriate for the death certificate to identify the underlying condition as the cause of death'.[23]

Western Australia

12.20 In Western Australia, a medical practitioner must issue a cause of death certificate.[24] The Western Australian Act provides that a medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate,[25] which has the effect that the person's underlying medical condition will be listed as the cause of death.

12.21 The Western Australian Panel acknowledged 'the importance of data collection at both the state and national level in relation to the underlying disease or illness' and felt it was 'important that such data collection is not adversely impacted by the introduction of voluntary assisted dying'. The Panel concluded that continuing to record a person's underlying disease or illness on the cause of death certificate completed by a medical practitioner would satisfy this requirement.[26]

12.22 The Panel also acknowledged the importance of protecting the privacy of the person and their family. Given that the cause of death certificate is seen by third parties, such as funeral directors, the Panel concluded that it was necessary to protect privacy by requiring that voluntary assisted dying be separately reported. Similarly, due to the need to protect the person and their family, the Panel concluded that information about voluntary assisted dying should not be included on the death certificate issued by the Registrar.[27]

Tasmania

12.23 The Tasmanian Act is silent about how a person's death is to be recorded on a cause of death certificate completed by a medical practitioner, but does require a person's administering health practitioner to notify the Voluntary Assisted Dying Commission of the person's death.[28]

12.24 The Tasmanian Panel, however, observed that '[a]lthough the Tasmanian Bill is silent on the issue of recording [the cause of] death following [voluntary assisted dying], it appears to be generally accepted that the cause of death is the underlying terminal illness, and should be recorded as such'.[29]

Overseas jurisdictions

12.25 In several overseas jurisdictions, the cause of death is recorded as the underlying illness.[30] The Oregon law is silent on the matter; however the Department of Human Services suggests that physicians record the underlying illness as the cause of death on the death certificate rather than the administration of assisted dying medication.[31]

23 Ibid.
24 *Births, Deaths and Marriages Registration Act 1998* (WA) s 44.
25 *Voluntary Assisted Dying Act 2019* (WA) s 82(6).
26 WA Ministerial Expert Panel Final Report (2019) 88.
27 Ibid 88–9, Rec 25.
28 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 93.
29 Tas Review Panel Report (2021) 86. Some respondents to that review suggested that it is important to note that voluntary assisted dying has occurred for statistical purposes.
30 Eg, *Colorado End of Life Options Act 2016,* Colo Rev Stat § 25-48-109(2); *District of Columbia Death with Dignity Act 2016,* DC Code § 7-661.05(h); *Hawaii Our Care Our Choice Act 2018,* Haw Rev Stat § 327L-4(b); *Washington Death with Dignity Act 2008,* RCW § 70.245.040(2).
31 See further, Vic Ministerial Advisory Panel Final Report (2017) 150, citing The Task Force to Improve the Care of Terminally-Ill Oregonians Center for Ethics in Health Care, Oregon Health & Science University, *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* (2008) 14.

12.26 In Canada, the Minister for Health 'must establish guidelines on the information to be included on death certificates' where a person has been provided with medical assistance in dying, which may include the way to 'clearly identify medical assistance in dying as the manner of death', as well as the illness, disease or disability that lead to the request. Generally, these guidelines provide that the person's immediate cause of death is to be recorded as the toxicity of the drug administered, and the underlying cause of death as the person's disease or condition. The manner of death should be certified as 'natural'.[32]

12.27 The New Zealand Act requires the death certificate to include the terminal illness that gave rise to the person's eligibility for assisted dying, the fact that the person died as a result of assisted dying, and the interval between that illness and the person's death.[33]

Submissions

12.28 Our Consultation Paper asked how the death of a person who has accessed voluntary assisted dying should be treated for the purposes of the *Births, Deaths and Marriages Registration Act 2003*.[34]

Cause of death

12.29 Most respondents considered that, for the purposes of death certification, the person's cause of death should be listed as their underlying disease, illness or medical condition. Dying with Dignity Queensland submitted '[t]his will protect the privacy of the person and their family and more accurately reflect the end of life medical conditions of the person'.

12.30 Cancer Council Queensland considered it essential that the death certificate record the underlying condition by which the person was eligible for voluntary assisted dying as 'this will enable the Queensland Cancer Registry and other relevant agencies to retain complete and accurate records of all deaths relevant to their remit.'

12.31 Go Gentle Australia Ltd supported a requirement that voluntary assisted dying be listed as a contributing cause of death on the cause of death certificate competed by a medical practitioner, but only if this information is publicly unavailable:

> Death certificates are used for a range of purposes, and there is no reason to include information about voluntary assisted dying on such a public document. This is to preserve the privacy of the person, their family, and health practitioners.

12.32 Dying with Dignity NSW submitted that a person's cause of death should be recorded on the death certificate as the underlying condition, and noted that:

> The death will of course be reported to the Board and, if necessary, it can send de-identified information about [voluntary assisted dying] deaths to the Registry of Births, Deaths and Marriages for statistical purposes.

12.33 In contrast, a few respondents thought that the cause of death should be noted as voluntary assisted dying with mention of the contributing illness. According to one respondent:

> The cause of death is the administration of a substance to cause death. If the process of voluntary assisted dying is considered acceptable and to be implemented in law it is difficult to understand why this should not be reflected in a death certificate.

12.34 Several respondents stated that the voluntary assisted death must not be treated as a suicide and that the draft Bill should clearly declare that voluntary assisted dying is not suicide. However, one respondent submitted that the cause of death should be listed as suicide.

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32 *Canada Criminal Code*, RSC 1985, c C-46, s 241.31(3.1); Government of Canada, 'Guidelines for death certificates' (26 April 2017) <https://www.canada.ca/en/health-canada/services/publications/health-system-services/guidelines-death-certificates.html>.

33 *End of Life Choice Act 2019* (NZ) sch, pt 2, Amendments to *Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995* (SR 1995/183).

34 QLRC Consultation Paper No 79 (2020) Q-49. One respondent noted the need for consistency across Australian jurisdictions.

Manner of death

12.35 A few respondents noted that it would be appropriate that the Registrar be notified that the manner of the person's death was voluntary assisted dying.

12.36 Several respondents considered that the cause of death should be recorded as the disease, illness or medical condition that qualified the person for voluntary assisted dying, with the person's death noted as having occurred as a result of or while the person was eligible for voluntary assisted dying.

12.37 One respondent submitted that the person's cause of death should be listed as their diagnosed disease for the purposes of a death certificate, but noted that:

> There is possibly some benefit in also recording as a supplemental note on official records that [voluntary assisted dying] was accessed, or suspected, in anticipation of the rare but foreseeable circumstances where a person may be exhumed, and return toxicology results that are inconsistent with the listed cause of death. Those records may be kept by the Board; or alternatively it may be annotated on the Register.
>
> The Board should have the power to refer any concerns about deaths by [voluntary assisted dying] to the coroner for investigation.

12.38 The Royal Australian College of Physicians submitted:

> Instances of voluntary assisted dying must be reported to enable audit of the scheme. It is acknowledged there may be stigma felt by individuals in knowing that voluntary assisted dying may be listed as the cause of death on the death certificate. Even so, there is overriding public interest in having this information available in a de-identified manner. Enabling both the immediate and underlying causes of death to be listed and reported should be considered. Cause of death data must remain completely accurate for future planning of medical care. The cause of death must not only include the terminal illness that made the patient eligible, but also that a substance was taken to provide active assistance to the patient in dying.

12.39 However, AMA Queensland submitted that the manner of death—being administration of voluntary assisted dying medication—should not be recorded on the death certificate.

The Commission's view

12.40 The question of whether, or to what extent, voluntary assisted dying should be listed as a cause of death on the cause of death certificate prepared by a medical practitioner raises several competing considerations.

12.41 Privacy and confidentiality are relevant. The cause of death may be included on a publicly available death certificate; and the cause of death certificate prepared by a medical practitioner may be accessed by a funeral director. However, while ensuring privacy, it is also important that information is collected about deaths resulting from voluntary assisted dying.

12.42 This policy tension was summarised by the Western Australian Panel:[35]

> At the core of the discussion is the balance between privacy and confidentiality of the person, and the need to ensure accuracy and collect information about voluntary assisted dying.

12.43 In addition, information about voluntary assisted dying deaths should be recorded consistently to ensure Australian Bureau of Statistics ('ABS') data is accurate and reliable.

35 WA Ministerial Expert Panel Final Report (2019) 85. See also, eg, Vic Ministerial Advisory Panel Final Report (2017) 149.

12.44 This balance is best struck by requiring that:

- the person's underlying disease, illness or medical condition is listed as the cause of death on the cause of death certificate prepared by a medical practitioner; and
- voluntary assisted dying is not listed on that cause of death certificate.

12.45 This approach ensures the privacy of the individual and their family, while also ensuring consistency with the approach in Victoria and Western Australia and for data collection by the ABS. Death accessed through voluntary assisted dying will be recorded through notification to the Board (discussed below).

RECOMMENDATIONS

12-1 The medical practitioner completing the cause of death certificate for the person must:

(a) include the underlying disease, illness or medical condition as the cause of death on the cause of death certificate;

(b) not include any reference to voluntary assisted dying on the cause of death certificate.

NOTIFICATION OF DEATH TO THE VOLUNTARY ASSISTED DYING REVIEW BOARD

12.46 In both Victoria and Western Australia, the Voluntary Assisted Dying Review Board[36] monitors and reports on matters relating to voluntary assisted dying.[37] In Chapter 18 of this Report, we recommend a similar function for the Voluntary Assisted Dying Review Board established under the draft Bill.

12.47 It is important that the Board is notified of instances when a person has been administered, or self-administered, a voluntary assisted dying substance in accordance with the legislative requirements.

Victoria

12.48 As previously discussed, the Victorian Act provides that the medical practitioner attending the death must notify both the Registrar of Births, Deaths and Marriages and the coroner of their reasonable belief or knowledge that the person was the subject of a voluntary assisted dying permit and:[38]

- did not self-administer the voluntary assisted dying substance or have it administered to them; or
- self-administered the voluntary assisted dying substance; or
- had the voluntary assisted dying substance administered to them.

12.49 The medical practitioner must also provide information about the disease, illness or medical condition that was the grounds for the patient to access voluntary assisted dying.

36 Referred to as the Voluntary Assisted Dying Board in Western Australia.
37 *Voluntary Assisted Dying Act 2017* (Vic) s 93; *Voluntary Assisted Dying Act 2019* (WA) s 118.
38 *Voluntary Assisted Dying Act 2017* (Vic) s 67. See also, Vic Guidance for Health Practitioners (2019) 64. This may be a medical practitioner other than the person's coordinating practitioner.

12.50 In addition to registering and recording the person's death as previously described, the Registrar is then required to notify the Board of the registration of the death and the other information that was given to the Registrar by the medical practitioner in accordance with the Victorian Act.[39]

Western Australia

12.51 In Western Australia, where the coordinating practitioner or the administering practitioner becomes aware that the person has died (whether or not as the result of a voluntary assisted dying substance), the practitioner is required to notify the Board of the death within two business days.[40] However, this is not required if the administering practitioner has already notified the Board through the practitioner administration form.[41]

12.52 In addition, a medical practitioner who is required to give a cause of death certificate for the person[42] and who reasonably believes or knows that the cause of the person's death was the administration of a voluntary assisted dying substance in accordance with the voluntary assisted dying legislation, must notify the Board in the approved form and within two business days of the person's death. This does not apply if the practitioner is the person's coordinating practitioner or their administering practitioner.[43]

12.53 These provisions aim to:[44]

> ensure that the Board is notified progressively of the person's participation in the voluntary assisted dying process, including the outcome of each assessment, to monitor that the correct process is being followed in each case of voluntary assisted dying, and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

12.54 Under the Western Australian Act, one of the Board's functions is to refer to the Registrar of Births, Deaths and Marriages any matter identified by the Board in relation to voluntary assisted dying that is relevant to the Registrar's functions.[45]

12.55 As explained previously, the Western Australian Act makes clear that a medical practitioner must not refer to voluntary assisted dying on the cause of death certificate.[46]

12.56 In connection with the cause of death certificate completed by a medical practitioner, the Western Australian Panel noted concerns about privacy and about third parties (such as funeral directors) 'becoming aware that a death has occurred through voluntary assisted dying and exposing the family to negative treatment'.[47] In light of those concerns, the Panel recommended a 'separate reporting mechanism' whereby the medical practitioner reports information about voluntary assisted dying as the cause of death directly to the oversight body, which in turn reports this information to the Registrar of Births Deaths and Marriages. Although the Panel recognised concerns about a mismatch of information reported from different sources, it ultimately prioritised 'the importance of maintaining a family's privacy'.[48]

39 *Births, Deaths and Marriages Registration Act 1996* (Vic) s 40A.
40 *Voluntary Assisted Dying Act 2019* (WA) s 82(2).
41 *Voluntary Assisted Dying Act 2019* (WA) s 82(3).
42 'This is usually the medical practitioner responsible for the person's medical care immediately before death, or who examined the person's deceased body': Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 27.
43 *Voluntary Assisted Dying Act 2019* (WA) s 82(4)–(6).
44 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 27.
45 *Voluntary Assisted Dying Act 2019* (WA) s 118(c)(ii).
46 *Voluntary Assisted Dying Act 2019* (WA) s 82(6).
47 WA Ministerial Expert Panel Final Report (2019) 88.
48 Ibid 88, Rec 25.

Tasmania

12.57 The Tasmanian Act requires the administering health practitioner to notify the Voluntary Assisted Dying Commission of a person's death if a voluntary assisted dying substance was administered or if the practitioner was notified of the person's death by self-administration of a voluntary assisted dying substance.[49]

New Zealand

12.58 The New Zealand Act provides that the attending medical practitioner or nurse practitioner must send the Registrar (assisted dying) a report detailing the death of the person and the method of administration. The Registrar (assisted dying) is required to send the report to the Review Committee.[50] It must also report to the Minister each financial year, about the number of voluntary assisted dying deaths and the method of administration for each of these deaths.[51]

12.59 The Registrar (assisted dying) is separate from the Registrar of Births, Deaths and Marriages.[52]

Submissions

12.60 Respondents were divided as to whether Queensland should adopt the approach in Victoria or Western Australia for notifying the Board of a death through voluntary assisted dying. One respondent stated:

> Similar to Victoria and Western Australia, the Queensland legislation should require that the person's underlying medical condition is listed as the cause of death, but that the medical practitioner is to inform the Voluntary Assisted Dying Board of the death where voluntary assisted dying was accessed, and the Board in turn is to inform the Registrar of Births, Deaths and Marriages.
>
> We agree with the Western Australian Ministerial Expert Panel, that this ensures the relevant information is collected and recorded for statistical purposes, but the person's privacy is preserved.

12.61 However, another respondent preferred the Victorian approach of requiring the medical practitioner 'to notify the Registrar of Births, Deaths and Marriages of their belief or knowledge that the person accessed voluntary assisted dying so the Registrar can notify the Voluntary Assisted Dying Review Board of these matters'.

12.62 The Queensland Registry of Births, Deaths and Marriages noted the different approaches adopted by Victoria and Western Australia in notifying the Board and queried:

> whether information received from the [Voluntary Assisted Dying] Board is more accurate and verified by the governing body than the 'knowledge or belief' of a medical practitioner.

12.63 The Queensland Registry of Births, Deaths and Marriages also noted that the Victorian model requires the Registrar to take an active approach in notifying the Board that a person has accessed voluntary assisted dying:

> This creates an additional step in [Registry] processes and may create a margin for error in [Registry] collecting and forwarding information. The [Western Australian] model by comparison, requires the [Voluntary Assisted Dying] Board to inform [the Registry] that [voluntary assisted dying] was accessed. This may eliminate the need for [the Registry] to be a third party in the passing of information and in turn decrease administrative burden and the potential for error.

49 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 93(1).
50 *End of Life Choice Act 2019* (NZ) s 21.
51 *End of Life Choice Act 2019* (NZ) s 27(7).
52 *End of Life Choice Act 2019* (NZ) s 27(1).

> It is important that the registration of a death (and the issuing of a death certificate) is not delayed by any [voluntary assisted dying] notification processes. The consultation paper notes that both models list the person's cause of death as the underlying disease, illness or medical condition that was the ground for the person accessing [voluntary assisted dying]. [The Registry] considers either approach would result in the timely registration of deaths and issuing of death certificates.

12.64 Other respondents considered that the Registrar should be informed that the person accessed voluntary assisted dying and that this information be shared with the oversight body to ensure all instances of voluntary assisted dying are properly reported.

The Commission's view

12.65 The Queensland Parliamentary Committee recommended a system of 'thorough documentation and reporting at all stages of the voluntary assisted dying process'.[53]

12.66 The draft Bill establishes a Voluntary Assisted Dying Review Board which has data collection and research functions.[54] This should include data about how many people have died through accessing voluntary assisted dying and the method of administration used.

12.67 As noted, two avenues exist by which this information may be reported to the Board:

- requiring the medical practitioner to inform the Registrar, who in turn reports to the Voluntary Assisted Dying Board (the Victorian model); or
- requiring the medical practitioner to inform the Board directly, and giving the Board power to inform the Registrar (the Western Australian model).

12.68 The Victorian model relies on the Registrar informing the Board that a person accessed voluntary assisted dying. Relying on the Registry to forward information to the Board may create a margin of error.

12.69 In Queensland, the Registrar's functions are to establish the registers under the *Births, Deaths and Marriages Registration Act 2003*, as well as to administer the Act and perform the functions given under that Act or another Act.[55] If information about voluntary assisted dying is not to be included on the register, it then raises the question as to the purpose of reporting voluntary assisted dying as the manner of death to the Registrar.

12.70 The Western Australian model ensures the privacy of the individual and the family by requiring the medical practitioner not to disclose the manner of death on the cause of death certificate. It requires the medical practitioner to inform the Board of the death within the same time frame as applies to providing the cause of death certificate to the Registrar.[56]

12.71 Requiring the medical practitioner to report to the Board directly provides the greatest protection for privacy of the individual and their family, while also minimising any potential error in relying on the Registrar to forward relevant information to the Board.

12.72 It is also necessary to consider what knowledge the medical practitioner must hold to trigger the notification provisions. The Victorian model requires the medical practitioner to have a *reasonable belief or knowledge* that the person held a voluntary assisted dying permit and self-administered the voluntary assisted dying substance or had the substance administered to them.[57]

12.73 The Western Australian Act requires the coordinating practitioner or the administering practitioner to notify the Board within two business days *after becoming aware* that

53 Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

54 See the discussion of the proposed oversight body's functions in Chapter 18 below.

55 *Births, Deaths and Marriages Registration Act 2003* (Qld) s 34(3).

56 The *Births, Deaths and Marriages Registration Act 1998* (WA) s 44 requires the medical practitioner to provide a cause of death certificate within 48 hours after the person's death. The *Voluntary Assisted Dying Act 2019* (WA) s 2 requires a practitioner to notify the Board within two business days after becoming aware that the patient has died.

57 *Voluntary Assisted Dying Act 2017* (Vic) s 67(1)(a).

their patient has died (for any reason). Further, if a medical practitioner completing a cause of death certificate (other than the coordinating practitioner or the administering practitioner) knows or reasonably belies the person self-administered or was administered a voluntary assisted dying substance, they must notify the Board of the person's death within two business days.[58]

12.74 The notification requirement should be consistent with Western Australia and apply upon the medical practitioner 'becoming aware' of the person's death. This provides more certainty than requiring the medical practitioner to hold a 'reasonable belief'. Also, the time period for notification required under Western Australian approach aligns with the process that a medical practitioner is already required to comply with in providing the medical cause of death certificate within 48 hours after the person's death.[59]

12.75 However, the medical practitioner responsible for completing the medical cause of death certificate may not be the coordinating or administering practitioner. To ensure accurate notification to the Board, it is important that training for medical practitioners include an overview of the legal requirements to report to the Board where a voluntary assisted dying substance was self-administered or administered by a practitioner under the legislative scheme.

RECOMMENDATIONS

12-2 The coordinating practitioner and administering practitioner must each notify the Voluntary Assisted Dying Review Board of the person's death in the approved form, within two business days of becoming aware of the person's death (whether or not after self-administering or being administered a voluntary assisted dying substance in accordance with the Act). This requirement should not apply if the administering practitioner has already notified the Board of the death of the person.

12-3 A medical practitioner who is required to give a cause of death certificate for the person and who reasonably believes or knows that the person self-administered or was administered a voluntary assisted dying substance in accordance with the Act, must, within two business days after becoming aware that the person has died, notify the Voluntary Assisted Dying Review Board, in the approved form, of the person's death. This requirement should not apply if the medical practitioner is the coordinating practitioner or administering practitioner.

AMENDMENT OF THE *CORONERS ACT 2003*

12.76 Under the *Coroners Act 2003*, coroners are responsible for investigating reportable deaths that occur in Queensland. A 'reportable death' includes a death that was violent or otherwise unnatural, occurred in care or in custody, was related to health care, or happened in suspicious circumstances.[60]

58 *Voluntary Assisted Dying Act 2019* (WA) s 82.
59 *Births, Deaths and Marriages Registration Act 1998* (WA) s 44; *Births, Deaths and Marriages Registration Act 1998* (Qld) s 30(4).
60 *Coroners Act 2003* (Qld) ss 8(3), 11.

12.77 The purpose of these investigations is to identify the cause of death and consider ways to prevent similar deaths in the future. This may involve an autopsy and in some cases an inquest, resulting in a coroner making findings and, potentially, recommendations for how to prevent similar types of death occurring again.[61]

12.78 In Victoria and Western Australia, death through the administration or self-administration of a voluntary assisted dying substance in accordance with their legislation is not a reportable death under their respective Coroners Acts.[62] In both states, the Board can refer an issue about deaths by voluntary assisted dying to their state coroner.[63]

12.79 In Victoria, a medical practitioner who was responsible for a person's medical care immediately before death, or who examined a person's body after death, and knows or reasonably believes that the person was the subject of a voluntary assisted dying permit, must notify the coroner of:[64]

- their reasonable belief or knowledge that the person was the subject of a voluntary assisted dying permit, and whether the person accessed voluntary assisted dying (including if access was by self-administration or practitioner administration); and
- the disease, illness or medical condition that was the grounds for the person to access voluntary assisted dying.

12.80 The *Coroners Act 2008* (Vic) includes a power for the coroner to investigate whether a death is a reportable death. If a person's death was, or may be, due to self-administration or administration of a voluntary assisted dying substance in a way not in accordance with the Victorian Act, the coroner could investigate that death.[65]

12.81 In Western Australia, a medical practitioner is not obliged to advise the coroner of a death where a person was approved for access, or did access, voluntary assisted dying. As in Victoria, a coroner has jurisdiction to investigate a death if it appears it may be a reportable death.[66]

12.82 The White and Willmott Model also suggests that the draft Bill could or should address that 'the death is not a "reportable death" for coronial investigation'.[67]

12.83 The Victorian Panel considered that, while it is important that the coroner maintain the jurisdiction to investigate a suspicious death, in these circumstances the person's death would be expected and 'it would be unnecessary and burdensome as well as intrusive for grieving families [for] the Coroner to review each voluntary assisted death'.[68]

12.84 The Western Australian Panel had a similar view. However, the Panel concluded that an oversight body should have authority to refer cases to the coroner and recommended that the death should not be a reportable death 'unless the death is referred to the coroner by the oversight body'.[69]

12.85 The Tasmanian Act states that 'the death of a person who has been administered or self-administered a [voluntary assisted dying] substance in accordance with the Act is not a reportable death for the purposes of the *Coroners Act 1995* (Tas)'.[70] The Bill initially provided that the coroner should be notified of a death, but would not always be required to investigate that death. During parliamentary debates, it was considered preferable that the legislation makes clear that a death is not a reportable death to avoid

61 *Coroners Act 2003* (Qld) s 3; Queensland Health, Clinical Excellence Division, 'Coronial Investigations explained: Emergency Department fact sheets' (2018) <https://clinicalexcellence.qld.gov.au/sites/default/files/2018-02/coronial-investigation.pdf>.
62 *Coroners Act 2008* (Vic) s 4(3); *Coroners Act 1996* (WA) s 3A (not commenced), as inserted by *Voluntary Assisted Dying Act 2019* (WA) s 168.
63 *Voluntary Assisted Dying Act 2017* (Vic) s 93(1)(e)(iv); *Voluntary Assisted Dying Act 2019* (WA) s 118(c)(iii).
64 *Voluntary Assisted Dying Act 2017* (Vic) s 67(2).
65 *Coroners Act 2008* (Vic) ss 4(3) note, 14(1).
66 *Coroners Act 1996* (WA) s 19(1).
67 White and Willmott Model pt 9.
68 Vic Ministerial Advisory Panel Final Report (2017) 155, Rec 45.
69 WA Ministerial Expert Panel Final Report (2019) 89-90, Rec 26.
70 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 93.

individuals being subject to coronial processes, but it was explained that this would not prevent the coroner from investigating a death.[71]

Submissions

12.86 Our Consultation Paper asked how the death of a person who has accessed voluntary assisted dying should be treated for the purposes of the *Coroners Act 2003*.[72]

12.87 Many respondents considered that a death occurring under voluntary assisted dying legislation should not be regarded as a reportable death. Royal Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that:

> Death as a result of [voluntary assisted dying] should not be reportable if undertaken in accordance with the legislative requirements, as the death would not meet the criteria of being unexpected or illegal. However, unusual or suspicious circumstances surrounding a death should be dealt with in the usual manner, including a report being made to the coroner.

12.88 Professors White and Willmott noted that this would not prevent the coroner from receiving notification of a death, for example, if the Voluntary Assisted Dying Review Board considered it appropriate for further investigation. Similarly, AMA Queensland submitted that if the voluntary assisted dying oversight board has any concerns about the death, they can report it to the coroner for further investigation.

12.89 One respondent submitted that the Board should be able to refer any concerns about voluntary assisted dying to the coroner.

The Commission's view

12.90 A death which occurs as a result of administration of a voluntary assisted dying substance in accordance with the requirements of the draft Bill should not be a reportable death for the purposes of the *Coroners Act 2003*.

12.91 We share the views of the Victorian and Western Australian Panels that a coronial investigation for a voluntary assisted dying death would be unnecessarily intrusive for the person's family.

12.92 The nature of a reportable death is generally one which is unexpected or where suspicious circumstances surround the death.[73] By contrast, a death through access to lawful voluntary assisted dying is planned and expected. Despite this, any suspicions surrounding the death of a person through accessing voluntary assisted dying may still be reported to the coroner for investigation.[74]

12.93 Death by suicide is a reportable death and referred to the coroner. However, as discussed in Chapters 1 and 20, the draft Bill provides that access to voluntary assisted dying is not suicide. This is the approach adopted in Western Australia and in Tasmania.[75]

12.94 In addition to the concerns raised in Chapter 20 about the Commonwealth carriage service provisions, the Victorian Panel, in considering the terminology adopted in some jurisdictions of 'assisted suicide' noted that there is 'significant social stigma attached to the term "suicide"'[76]. The Panel noted that:[77]

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71 End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) cl 93(2); Tasmania, *Parliamentary Debates*, House of Assembly, 3 March 2021, 116-28.

72 QLRC Consultation Paper No 79 (2020) Q-49. One respondent noted the need for consistency across Australian jurisdictions.

73 *Coroners Act 2003* (Qld) s 8(3).

74 A coroner must investigate a death if the coroner considers that it is reportable, regardless of whether it was reported. In addition, 'the State Coroner may direct a coroner to investigate a death if the State Coroner considers the death is a reportable death; or the State Coroner has been directed by the Minister to have the death investigated, whether or not the death is a reportable death': *Coroners Act 2003* (Qld) s 11(2), (4).

75 *Voluntary Assisted Dying Act 2019* (WA) s 12; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 140.

76 Vic Ministerial Advisory Panel Final Report (2017) 8.

77 Ibid.

> In Victoria, there is a range of critical work being undertaken to prevent suicide and to support those who may be considering suicide. Deaths as a result of suicide are avoidable, and every effort should be made to prevent these deaths. By contrast, the cohort of people who are the focus of this report will face an inevitable, imminent death as a result of an incurable disease, illness or medical condition. It would not be appropriate to use the same terminology to describe their decision to hasten their impending death.

12.95 The Western Australian Panel similarly noted:[78]

> Suicide involves the tragic loss of life of a person who is typically not dying, whereas voluntary assisted dying involves a person's choice about their mode of death when they are already dying. Suicide is usually undertaken alone, whereas voluntary assisted dying is a pathway involving medical and family support.

12.96 Finally, there may be flow on consequences for accessing life insurance if a death is noted as suicide. This is discussed further below.

RECOMMENDATION

12-4 The draft Bill amends the *Coroners Act 2003* to provide that the death of a person who has been administered or has self-administered a voluntary assisted dying substance in accordance with the draft Bill's provisions is not a reportable death for the purposes of the *Coroners Act 2003*.

INSURANCE AND SUPERANNUATION LAWS

12.97 The death of a person through voluntary assisted dying raises questions as to its impact on access to life insurance or the receipt of a death benefit from a superannuation fund.

Insurance

12.98 There are three key categories of insurance in Australia: health, life and general insurance. Life insurance, which encompasses a variety of products that provide payment upon death or injury, is the most relevant in this context.

12.99 At the Commonwealth level, the insurance industry is governed by two primary pieces of legislation—the *Insurance Act 1973* (Cth) and the *Insurance Contracts Act 1984* (Cth).[79] The *Life Insurance Act 1995* (Cth) recognises that insurers may expressly exclude cover for suicide; however, it does not define 'suicide'.[80]

12.100 Under this legislative framework, insurance policy terms and conditions are a private contractual matter between the insured and the insurer. Although dependent on the terms and conditions of an individual life insurance contract, generally, a life insurance contract would only cover suicide after a specific exclusion period—usually 13 months.[81]

78 WA Ministerial Expert Panel Final Report (2019) 10.

79 Part V of the *Insurance Contracts Act 1984* (Cth) provides for several prescribed classes of insurance contract. Prescribed contracts are outlined in the *Insurance Contracts Regulations 2017* (Cth) and encompass a range of insurance policies, including sickness and accident insurance. The Regulations outline the minimum requirements for such policies, for example the minimum sum insured and the insured events covered by the contract.

80 *Life Insurance Act 1995* (Cth) s 228. Specifically, this section states 'a life company may only avoid a life policy on the ground that the person whose life is insured by the policy committed suicide if the policy expressly excludes liability in case of suicide'.

81 P Yip et al, 'Assessing the Impact of Suicide Exclusion Periods on Life Insurance' (2010) 31(4) *Crisis* 217, 217.

12.101 In addition, a life insurance policy may include terminal illness cover. Also known as an 'advanced death benefit', terminal illness cover is a lump sum payment made to nominated beneficiaries where a person has less than 12 months to live. The availability of such payments is dependent on the terms and conditions of individual life insurance policies.

12.102 Chapter 7 of the *Corporations Act 2001* (Cth) governs the regulation of insurance intermediaries such as agents and brokers. The Financial Services Council ('FSC') is the industry association for the financial services sector, which includes the life insurance industry.[82] Compliance with the FSC Code of Ethics and Code of Conduct is compulsory for all FSC members.[83]

Superannuation

12.103 Superannuation funds are managed by the *Superannuation Industry (Supervision) Act 1993* (Cth), its regulations, trust deeds and governing rules.[84]

12.104 Superannuation funds are supervised by the Australian Securities and Investments Commission, the Australian Prudential Regulation Authority and the Commissioner of Taxation.[85] The FSC is also the industry association for superannuation.[86]

12.105 The *Superannuation Industry (Supervision) Regulations 1994* (Cth) provide conditions for the release of superannuation benefits—that is, when, and in what form, benefits may be accessed by superannuation fund members. A superannuation death benefit is a payment made to a dependent beneficiary or to the trustee of a deceased estate after the member has died.[87]

12.106 The form of the benefit payment, and who it is paid to, will depend on the governing rules of the superannuation fund and the relevant requirements of the *Superannuation Industry (Supervision) Regulations 1994* (Cth).

12.107 Legislation allows for the early release of superannuation if a person is diagnosed with a terminal medical condition.[88] A terminal illness lump sum benefit is paid tax-free.[89] However, whether such early release is available will largely depend on the terms and conditions of the deed governing a particular superannuation fund.

Victoria

12.108 The Victorian Panel recommended that 'accessing voluntary assisted dying should not affect insurance payments or other annuities'. It stated:[90]

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82 Financial Services Council, 'About the FSC's Members' (2021) <https://www.fsc.org.au/about/membership>.

83 Financial Services Council, *FSC Standard No 1, Code of Ethics & Code of Conduct* (14 April 2020).

84 *Superannuation Industry Supervision Act 1993* (Cth) ss 3, 52.

85 *Superannuation Industry Supervision Act 1993* (Cth) s 3(1).

86 Financial Services Council, 'About the FSC's Members' (2021) <https://www.fsc.org.au/about/membership>.

87 *Income Tax Assessment Act 1997* (Cth) s 307–5(4); *Superannuation Industry (Supervision) Regulations 1994* (Cth) reg 6.17A; Australian Taxation Office, 'Paying superannuation death benefits' (19 May 2020) <https://www.ato.gov.au/super/apra-regulated-funds/paying-benefits/paying-superannuation-death-benefits/>.

88 *Superannuation Industry (Supervision) Regulations 1994* (Cth), regs 6.01A, 6.19A, sch 1. Specifically:

> a ***terminal medical condition*** exists in relation to a person at a particular time if the following circumstances exist:
>
> (a) two registered medical practitioners have certified, jointly or separately, that the person suffers from an illness, or has incurred an injury, that is likely to result in the death of the person within a period (the certification period) that ends not more than 24 months after the date of the certification;
>
> (b) at least one of the registered medical practitioners is a specialist practicing in an area related to the illness or injury suffered by the person;
>
> (c) either:
>
> (i) if there is one certification period—the certification period has not ended;
>
> (ii) otherwise—neither of the certification periods has ended.

89 *Income Tax Assessment Act 1997* (Cth) ss 303-10, 995-1.

90 Vic Ministerial Advisory Panel Final Report (2017) 150, Rec 42.

As to jurisdictions in the United States, see: *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.13; *Colorado End of Life Options Act 2016*, Colo Rev Stat § 2548115; *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.875; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5287; *Washington Death with Dignity Act 2008*, RCW § 70.245.170. For example, Oregon's Act states:

> The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

The legislation in Washington also provides that death by self-administration of an aid-in-dying drug is not suicide.

> As the person is already at the end of their life, the Panel recommends that accessing voluntary assisted dying should not affect insurance payments or other annuities. The person has not made a decision to end their life prematurely, they have made a decision about the manner of their death and they should not be punished for this. The person's underlying disease, illness or medical condition will inevitably cause their death, and, for the purposes of insurance and other annuities, their death as a result of voluntary assisted dying should be treated as though they died as a result of the disease, illness, or medical condition. This is consistent with approach taken in [some jurisdictions of the United States]. (note omitted)

12.109 However, the Victorian Act does not include a provision to the effect that accessing voluntary assisted dying must not have an effect upon a life, health or accident insurance or annuity policy.

12.110 Rather, the Victorian Act appears to rely on the requirement that the death certificate identifies the underlying disease, illness or medical condition as the cause of death and reference to voluntary assisted dying does not appear on someone's death certificate.[91]

12.111 As noted by the Voluntary Assisted Dying Review Board:[92]

> A death certificate is provided to the next of kin from Births, Deaths and Marriages Victoria weeks to months after a death. The certificate does not include any details about voluntary assisted dying and can be used for insurance and other legal requirements.

Western Australia

12.112 The Western Australian Panel observed that, during its consultation process, members of the community were concerned that a death from voluntary assisted dying may have an adverse impact on life insurance, in a similar way that an act of suicide may have an impact on life insurance.[93]

12.113 In considering this issue, the Western Australian Panel noted:[94]

> Life insurance policies vary, and individual circumstances vary regarding policy coverage. If a person has a pre-existing life insurance policy with an insurer, the issue of whether the person is covered for voluntary assisted dying depends on the terms of the insurance policy. It is open to an insurer to refuse to provide life insurance cover to any person.

12.114 The Western Australian Panel also noted that:[95]

> …life insurance policies commonly include terminal illness cover. This means that in the event that a person is diagnosed with a terminal illness and is not expected to live more than a specified period (for example 12 months) they will be entitled to receive their benefits in full prior to their death. This aligns with the Panel's recommendation regarding eligibility criteria for voluntary assisted dying in respect to time to death: *That death is a reasonably foreseeable outcome for the person within a period of 12 months.* (emphasis in original)

12.115 While ultimately determining that this issue was outside the scope of its terms of reference, the Western Australian Act contains some provisions which may mitigate any adverse impact of voluntary assisted dying on access to life insurance benefits.

12.116 For example, as noted by the Panel, eligibility criteria about the timeframe until death may mean that a person who is eligible for access to voluntary assisted dying may also be entitled to receive their insurance benefits in full before their death.[96]

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91 *Births, Deaths and Marriages Registration Act 1996* (Vic) s 40(1A); Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 6.

92 Voluntary Assisted Dying Review Board Report of Operations June-December 2019 (2020) 10.

93 WA Ministerial Expert Panel Final Report (2019) 106.

94 Ibid 107.

95 Ibid.

96 Ibid; *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c).

12.117 Further, and as is the case in Victoria, the Western Australian Act has the effect that the person's underlying disease, illness or medical condition is recorded as their cause of death. The Western Australian Act provides that voluntary assisted dying is not suicide,[97] and that a medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate completed when the person dies.[98]

Tasmania

12.118 The Tasmanian Act provides that a person who dies as a result of the administration or self-administration of a voluntary assisted dying substance does not die by suicide.[99]

White and Willmott Model

12.119 The White and Willmott Model suggests that the effect that voluntary assisted dying legislation has on wills, insurance policies, contracts and other statutes may be a matter that the model could or should address.[100]

New Zealand

12.120 The New Zealand Act provides that:[101]

> A person who dies as a result of assisted dying is, for the purposes of any life insurance contract, or any other contract,—
>
> (a) taken to have died as if assisted dying had not been provided; and
>
> (b) taken to have died from the terminal illness referred to in section 5(1)(c) from which they suffered.

Submissions

12.121 Several respondents noted concerns about the potential impact of a voluntary assisted dying scheme on insurance, superannuation and other contractual arrangements.

12.122 In particular, STEP Queensland and STEP Australia raised concerns:

> about the impact accessing voluntary assisted dying may have upon a person's life insurance, whether it be through their superannuation fund, connected to the provision of credit or as a standalone policy. In implementing voluntary assisted dying, we support measures being taken to ensure that a person who accesses voluntary assisted dying does not invalidate their life insurance policies.

12.123 Respondents supported the aim of ensuring that any draft legislation should 'ensure that the manner of a death occurring under a [voluntary assisted dying] law should not adversely impact wills, insurance policies, contracts or other instruments'. One respondent noted that explicitly declaring in legislation that voluntary assisted dying is not suicide is 'important in relation to insurance issues so that anyone undertaking voluntary assisted dying does not void any insurance cover'.

97 *Voluntary Assisted Dying Act 2019* (WA) s 12.
98 *Voluntary Assisted Dying Act 2019* (WA) s 82(6).
99 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 140.
100 White and Willmott Model pt 9.
101 *End of Life Choice Act 2019* (NZ) s 35.

The Commission's view

12.124 The terms of reference require us to make recommendations about an appropriate voluntary assisted dying scheme for Queensland. While ensuring the 'appropriateness' of the scheme may arguably include consideration of consequential impacts on access to life insurance and superannuation benefits, we are disinclined to recommend amendments to Commonwealth laws. In addition, the terms and conditions of a life insurance policy are largely a private contractual arrangement.

12.125 The timeframe until a person's death has a practical importance in this context. If a person with a known 'terminal illness' sought to take out life insurance, then insurance law would require the condition to be disclosed. The requested policy would be declined or any death from the condition (or any death from voluntary assisted dying based on it) would be expressly excluded from the new policy.

12.126 If, however, the policy was taken out before the person or the insurer knew about the terminal condition and the person's death occurs outside any exclusion period in relation to death by suicide, then beneficiaries under a life insurance policy may be able to claim it, even if the insurer treats death by voluntary assisted dying as 'suicide' within the meaning of the policy.

12.127 We acknowledge the concerns of respondents about the potential impact of voluntary assisted dying on insurance and superannuation contracts. However, various provisions in the draft Bill will mitigate, to a certain extent, any adverse impact.

12.128 We have recommended as an eligibility criterion, that the person must be diagnosed with a disease, illness or medical condition that is expected to cause death within 12 months. Such a prognosis means that a person may be able to get early access to their lump sum benefits from their superannuation fund tax-free and payments through their life insurance policy.

12.129 Further, we have also made recommendations about reporting a person's death, which will have the effect that the death certificate relied upon for life insurance claims will have no reference to voluntary assisted dying, but rather state the underlying cause of death.

12.130 In addition, because of its potential effect on insurance contracts and other documents entered into after the passage of any voluntary assisted dying law, we recommend that the draft Bill contain a general provision that access to voluntary assisted dying is not suicide.

12.131 It should also provide, to the same effect as the New Zealand law, that the person is taken to have died from the disease, illness or medical condition from which they suffered, and which made them eligible at the end of their life to access voluntary assisted dying.

12.132 As recommended in Chapter 1, the draft Bill provides that for the purposes of the law of Queensland, and for the purposes of a contract, deed or other instrument entered into in Queensland or governed by its law, a person who dies as the result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act:

- 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.

CHAPTER 13

Health practitioners' qualifications and training

Chapter 13: Health practitioners' qualifications and training

CHAPTER SUMMARY

This chapter 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. It 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 to be eligible to act in any of these roles, the practitioner must 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 time until the death of a person dying of a certain cancer. They can refer the 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
- hold general registration and have practised for at least five years as the holder of that registration; or

- hold specialist registration and have practised for at least five years as the holder of general 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 four bases, the medical practitioners probably will have practised for several years before attaining the registration.

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 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.

REGULATION OF HEALTH PRACTITIONERS

13.1 Under the Health Practitioner Regulation National Law (Queensland) a person practising in a health profession must be a 'registered health practitioner'.[1] This includes medical practitioners, nurses, and pharmacists.[2]

13.2 Registered health practitioners must comply with relevant registration and professional standards (including codes of ethics, codes of conduct and competency

1 Health Practitioner Regulation National Law (Queensland) pt 7. The Health Practitioner Regulation National Law (Queensland) applies by virtue of the *Health Practitioner Regulation National Law Act 2009* (Qld) s 4.

2 Health Practitioner Regulation National Law (Queensland) s 5 (definitions of 'health practitioner', 'health profession', 'registered health practitioner', 'health service' and 'health service provider'), pt 7. For each health profession there is a corresponding National Board. For example, medical practitioners must be registered with the MBA, and nurses with the Nursing and Midwifery Board of Australia: pt 5. The National Law also establishes AHPRA, which is required to work with National Boards to establish and manage the registration and accreditation scheme.

standards), policies and guidelines.[3] Non-compliance may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional.[4] This finding may result in disciplinary action, for example cautioning or reprimanding a practitioner, or the suspension or cancellation of, or imposition of conditions on, a practitioner's registration.[5]

13.3 There are different types of registration for medical practitioners and also for registered nurses.

Medical practitioners

13.4 There are five types of medical registration offered by the Medical Board of Australia ('MBA'). They are:[6]

- provisional registration;
- general registration;
- specialist registration;
- limited registration; and
- non-practising registration (not addressed in this report).

13.5 Provisional registration is granted to medical graduates of Australian and New Zealand medical schools so they can undertake intern training to become eligible for general registration.[7]

13.6 The internship is a period of mandatory supervised general clinical experience, where graduates consolidate and apply their clinical knowledge and skills. Successful completion of the internship leads to general medical registration.[8]

13.7 General registration is granted to Australian and New Zealand medical graduates who completed an accredited internship in Australia or New Zealand, and who meet the MBA mandatory registration standards.[9]

13.8 Specialist registration is available to medical practitioners who have been assessed by an Australian Medical Council ('AMC') accredited specialist medical college as being eligible for the fellowship.[10]

13.9 There are currently 16 specialist medical colleges in Australia that offer accredited postgraduate vocational training programs.[11] One example is the Royal Australian

3 See Health Practitioner Regulation National Law (Queensland) pt 5 div 3, pt 6; and, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020); Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018); International Council of Nurses, *The ICN Code of Ethics for Nurses* (2012). Non-compliance may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional, and may result in disciplinary action: Health Practitioner Regulation National Law (Queensland) s 5 (definitions of 'unsatisfactory professional performance', 'unprofessional conduct' and 'professional misconduct'), pt 8 divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107.

4 Specifically, it may be decided that the way a registered health practitioner practices the profession, or the practitioner's professional conduct, is or may be unsatisfactory; or that a practitioner has behaved in a way that constitutes 'unsatisfactory professional performance', 'unprofessional conduct' or 'professional misconduct': Health Practitioner Regulation National Law (Queensland) pt 8, divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107. See also, for the definition of those terms, Health Practitioner Regulation National Law (Queensland) s 5.

5 Health Practitioner Regulation National Law (Queensland) pt 8, divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107. In limited instances, disciplinary action may also include imposition of a fine. See, eg, *Medical Board of Queensland v Freeman* [2010] QCA 93.

6 Medical Board and AHPRA, 'Types of Medical Registration' (25 August 2014) <https://www.medicalboard.gov.au/Registration/Types.aspx>.

7 Medical Board and AHPRA, 'Interns' (27 August 2018) <https://www.medicalboard.gov.au/Registration/Interns.aspx>. There are different requirements for Australian and New Zealand medical graduates who have completed a medical internship in another country, and for international medical graduates seeking to obtain general registration in Australia.

8 Medical Board and AHPRA, 'Provisional Registration' (27 August 2018) <https://www.medicalboard.gov.au/Registration/Types/Provisional-Registration.aspx>.

9 Medical Board and AHPRA, 'Australian and New Zealand medical graduates' (27 August 2018) <https://www.medicalboard.gov.au/Registration/Types/General-Registration/Australian-and-NZ-medical-graduates.aspx>. Australian and New Zealand medical graduates who have completed a medical internship in another country are required to complete twelve months of supervised practice in Australia in order to be eligible to apply for general registration with the MBA.

10 Medical Board and AHPRA, 'Specialist Registration' (20 April 2021) <https://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>.

11 Australian Medical Council Limited, 'Specialist medical colleges' (2020) <https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/specialist-medical-colleges/>.

College of General Practitioners, which offers the Australian General Practice Training Program. It involves clinical practice experience in hospitals and general practice, as well as training in extended clinical skills. The program takes between three and four years to complete.[12] Medical practitioners who have completed an accredited program such as this will have the qualifications necessary for specialist registration.[13]

13.10 International medical graduates (IMGs) seeking registration so they can practise medicine in Australia must first apply to the AMC to have their medical qualification verified. They may then be included on an appropriate assessment pathway leading to general or specialist registration in Australia.[14]

13.11 Depending on the assessment pathway, an IMG may be eligible for either provisional or limited registration which permits them to undertake a period of supervised practice before applying for the relevant registration type.[15]

13.12 IMGs who are overseas-trained specialists may apply to have their specialist qualifications and experience assessed as comparable to the standard of a specialist trained in that specialty in Australia (specialist recognition).[16] The relevant specialist college will undertake this assessment. If the qualifications and experience are assessed as partially or substantially comparable, the overseas-trained specialist may seek an offer of employment and either provisional or limited registration with the MBA. Once attained, the overseas-trained specialist can complete the training requirements stipulated by the college and be eligible for specialist registration in Australia.[17]

13.13 Alternatively, an overseas-trained specialist may have the skills and expertise to support a community that has been unable to secure the services of a medical practitioner with general or specialist registration and apply for a specialist position in an 'Area of Need'.[18]

13.14 It is the IMG's prospective employer that applies to have a position declared an area of need. In Queensland, Area of Need positions are declared by the Minister for Health or an authorised delegate.[19]

13.15 Once they have secured an offer of employment and been assessed by the college as suitable for an Area of Need, an overseas-trained specialist can apply for limited registration.[20]

13.16 All registrants with limited or provisional registration must be supervised.[21] The MBA requires supervisors to have specialist registration, and be appropriately qualified, preferably in the same field as the position proposed for the international graduate. Several factors, including the IMG's qualifications and previous experience, can be considered when determining the level of supervision required.[22]

12 Royal Australian College of General Practitioners, 'Frequently asked questions' (2021) <https://www.racgp.org.au/education/registrars/fellowship-pathways/australian-general-practice-training-program-agpt/agpt/frequently-asked-questions/general>.

13 Medical Board and AHPRA, 'Specialist Registration' (20 April 2021) <https://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>.

14 MBA, 'International medical graduates (IMGs)' (16 October 2020) <https://www.medicalboard.gov.au/Registration/International-Medical-Graduates.aspx>. The three pathways are: Competent Authority pathway, Standard pathway or Specialist pathway.

15 Ibid.

16 Australian Medical Council Limited, 'Overview of assessment pathways' (2020) <https://www.amc.org.au/assessment/pathways/overview/>.

17 Medical Board and AHPRA, 'Specialist pathway—specialist recognition' (4 January 2021) <https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway/Specialist-recognition.aspx>

18 An Area of Need is 'geographical location where the medical needs of its population are going unmet': Medical Board and AHPRA, 'Specialist pathway—area of need' (22 August 2018) <https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway/Area-of-need.aspx>; Department of Health (Cth), 'Area of Need' (5 July 2019) <https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/area-of-need>.

19 Queensland Health, 'Area of Need' (23 February 2021) <https://www.health.qld.gov.au/employment/overseas/area-of-need>.

20 Medical Board and AHPRA, 'Standard pathway' (12 November 2020) <https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Standard-Pathway.aspx>

21 MBA, *Guidelines: Supervised practice for international medical graduates* (January 2016) 1.

22 Ibid 2-3.

Registered nurses and nurse practitioners

13.17 The types of registration offered by the Nursing and Midwifery Board of Australia ('NMBA') include:[23]

- general registration;
- limited registration;[24] and
- provisional registration.[25]

13.18 The NMBA also offers endorsement of registration to identify practitioners with additional qualifications and expertise. The endorsements for nurses include:[26]

- registered nurse – supply scheduled medicines (rural and isolated practice), and
- nurse practitioner.

13.19 All registered nurses with general registration are expected to determine, coordinate, and provide safe, quality nursing care within their scope of practice.[27] Registered nurses who incorporate elements of professional leadership, education, and research within their scope of practice may be seen as demonstrating nursing practice at an advanced level, known as advanced practice nursing (APN).[28]

13.20 Registered nurses in APN roles use expert knowledge gained through education and experience to provide expert nursing care and assume a range of leadership roles.[29] For example, in their study describing the role of palliative care clinical nurse consultants, which is an APN role, O'Connor et al report that the role is multidimensional and complex, and consultants developed 'the ability to be flexible and not to become overwhelmed by the diversity of functions and relationships they had to negotiate'.[30]

13.21 The skills and knowledge employed in APN roles currently support the delivery of many Queensland public health services.[31] However, it has been observed that these roles are developed in an inconsistent and ad hoc manner and this compromises the extent to which they are utilised.[32] It also makes it difficult to inform policymakers, administrators, and other healthcare practitioners about the role, and how it is differentiated from other roles.[33]

23 Nursing and Midwifery Board and AHPRA, 'Registration & endorsement' (20 November 2020) <https://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement.aspx>. There is also student registration and non-practising registration.

24 There were no nurses with limited registration in Australia during the 2019–2021 reporting period: Medical Board and AHPRA, '2019/20 annual summary' (2 April 2021) 2019/20 data tables, Table 2: Nurses and midwives (including pandemic response sub-register), by registration type and state or territory <https://www.medicalboard.gov.au/News/Annual-report.aspx>.

25 Provisional registration is offered for nurses who have not practised for between 5 and 10 years, have previously held registration in Australia and do not hold current registration but seek to re-enter practice: Nursing and Midwifery Board of Australia, 'Provisional registration: Information for nurses and midwives' (Fact Sheet, 11 February 2019) <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/fact-sheet-provisional-registration-nurses-midwives.aspx>.

26 Nursing and Midwifery Board and AHPRA, 'Registration & endorsement' (20 November 2020) <https://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement.aspx>. There is also an endorsement for midwife – prescribe scheduled medicines.

27 Nursing and Midwifery Board of Australia, *Registered Nurses Standards for Practice* (June 2016).

28 Chief Nursing & Midwifery Officers Australia, *Advanced Nursing Practice: Guidelines for the Australian Context* (2020) 4.

29 MA Ramis, CJ Wu and A Pearson, 'Experience of being an advanced practice nurse within Australian acute care settings: a systematic review of qualitative evidence' (2013) 11 *International Journal of EvidenceBased Healthcare* 161.

30 M O'Connor et al, 'The palliative care clinical nurse consultant: An essential link' (2008) 15 *Collegian* 151, 153.

31 C Douglas et al, 'Nurse-led services in Queensland: A scoping study' (2018) 25(4) *Collegian* 363, 365–66. Services include nurse-led primary care community health clinics in rural and regional areas, and chronic disease management services such as cardiac, renal, diabetes or respiratory clinics. Smaller in number were the nurse-led proceduralist roles such as endoscopy, vascular devices, or dialysis.

32 G Gardner et al, 'Identifying advanced practice: A national survey of a nursing workforce' (2016) 55 *International Journal of Nursing Studies* 60, 68–69; CM Duffield et al, 'National regulation in Australia: A time for standardisation in roles and titles' (2011) 18(2) *Collegian* 45.

33 International Council of Nurses, *Guidelines on Advanced Practice Nursing* (2020) 7.

13.22 Registered nurses working in rural hospitals can expand their scope of practice by attaining the supply scheduled medicines (rural and isolated practice) endorsement.[34] Although the title of the endorsement highlights the supply of scheduled medicines, the NMBA approved training required to achieve it also assesses competency in advanced assessment and clinical nursing skills such as advanced cardiac life support, intravenous cannulation and venipuncture, suturing, and advanced airway management.[35]

13.23 Employing these skills, endorsed registered nurses use purposefully designed and approved policies and protocols to assess and treat people who present to rural and remote healthcare facilities with emergency, general medical, paediatric, obstetric, and mental health conditions.[36] Where required, they can also administer and supply certain controlled and restricted medications without requiring a medical practitioner order.[37]

13.24 The authority granted to registered nurses under the supply scheduled medicines (rural and isolated practice) endorsement is restricted to the extent necessary to practice nursing in a rural hospital or an isolated practice area as defined in the *Health (Drugs and Poisons) Regulation 1996*.[38] So, for example, an endorsed registered nurse could not practice to the same extended scope if they worked in a metropolitan Hospital and Health Service.

13.25 To be endorsed as a nurse practitioner a registered nurse must demonstrate 5000 hours of practice at the APN level, successful completion of an NMBA approved program of study, and compliance with the NMBA's nurse practitioner standards for practice.[39]

13.26 When assuming the title and scope of practice of a nurse practitioner, the practitioner also assumes additional responsibilities and accountabilities to those of the registered nurse.

13.27 Nurse practitioners integrate clinical skills associated with nursing and medicine to assess, diagnose, and manage patients in primary, secondary, and tertiary healthcare settings.[40] They are the primary provider or work as part of a multi-disciplinary team. Nurse practitioners are responsible for following up on any components of care initiated and self-monitoring their work.[41]

13.28 Once endorsed, nurse practitioners can work in both the public and private health sectors. Queensland Health reports that approximately three-quarters of all nurse practitioners work in the public sector.[42] Those nurse practitioners who work privately generally provide direct patient care to those with chronic and complex needs predominantly in the community and primary healthcare settings.[43]

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34 This endorses the nurse as qualified to obtain, supply and administer Schedule 2, 3, 4 and 8 medicines for nursing practice in a rural and isolated practice area: Nursing and Midwifery Board of Australia, *Registration standard for endorsement for scheduled medicines registered nurses (rural and isolated practice)* (July 2010). See also, Nursing and Midwifery Board of Australia, 'Endorsement for scheduled medicines for registered nurses (rural and isolated practice)' (Fact Sheet, 6 June 2019) <https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/faq/fact-sheet-rn-endorsement-for-scheduled-medicines-rural-and-isolated-practice.aspx>, noting that it is proposed to discontinue this endorsement, but the Nursing and Midwifery Board of Australia 'is committed to ensuring that there is no adverse impact on health service provision with the planned discontinuation of the current endorsement to supply'.

35 RW Timmings, 'Rural and Isolated Practice Registered Nurses (RIPRN)—Emergency nurses of the Queensland "bush"' (2006) 9 *Australasian Emergency Nursing Journal* 29, 31. The author reports that participants choose to undertake the assessments after seeking educational opportunities in their local districts.

36 Queensland Health, *Drug Therapy Protocol QH-DTP-RIPAEN-01:2020, Rural and Isolated Practice Area Endorsed Nurse* (21 July 2020); Queensland Health and the Royal Flying Doctor Service (Queensland Section), *Primary Clinical Care Manual* (10th rev ed, 2019). See also, Timmings, above n 35, 30.

37 *Health (Drugs and Poisons) Regulation 1996* (Qld) s 67(2). See also, Timmings, above n 35, 30.

38 *Health (Drugs and Poisons) Regulation 1996* (Qld) ss 67(2), 175(2).

39 Nursing and Midwifery Board of Australia, *Registration Standard: Endorsement as a Nurse Practitioner* (June 2016). To demonstrate the Advanced Nursing Practice requirement nurses must submit a CV detailing employment, clearly noting title and description of all advanced nursing practice dates and hours per week/educational details and evidence of professional activities. They must also provide certified copies of statements of service which support their 5000 hours of advanced nursing practice: Nursing and Midwifery Board of Australia, *Guidelines for Nurses Applying for Endorsement as a Nurse Practitioner* (June 2016).

40 International Council of Nurses, *Guidelines on Advanced Practice Nursing* (2020) 18.

41 Nursing and Midwifery Board of Australia, *Nurse practitioner standards for practice* (March 2021) 2.

42 Information provided by Workforce Strategy Branch, Queensland Health, 9 January 2021.

43 J Currie, M Chiarella and T Buckley, 'Practice activities of privately-practicing nurse practitioners: Results from an Australian survey' (2018) 20(1) *Nursing & Health Sciences* 16, 22.

13.29 Nurse practitioners are highly skilled and qualified and authorised to autonomously manage complete episodes of care for people with a variety of health needs, and they frequently do this on a background of extensive experience in the healthcare system.[44] For example, Nurse practitioner models of care have recently been introduced at the North West Hospital and Health Service, in recognition of their expertise.[45]

Health practitioners' scope of practice

13.30 The Health Practitioner Regulation National Law (Queensland) regulates health practitioner titles through registration but does not determine a practitioner's scope of practice. Rather, the scope is determined by the practitioner's qualifications, education, training, experience, and competence, and the capability of the facility in which they work.[46]

13.31 Medical practitioners have professional obligations to recognise and work within the limits of their medical competence and scope of practice, and ensure they have the necessary knowledge and skills to provide safe clinical care.[47] Where aspects of care are beyond a practitioner's expertise, they should refer the person to another suitably qualified, skilled and experienced practitioner for an opinion or treatment.[48] The MBA expects that registered medical practitioners will exercise their professional judgement and work within their level of competence, and holds practitioners to account in disciplinary processes.[49]

13.32 The NMBA broadly defines the scope of practice for nurses as being 'that in which nurses are educated, competent to perform and permitted by law'.[50] The definition recognises that an individual's scope of practice is influenced by 'the context in which the nurse practises, the health needs of the people, the level of competence and confidence of the nurse and the policy requirements of the service provider'.[51]

13.33 To clearly define individual health practitioners' scopes of practice and as part of a wider organisational quality and risk management system,[52] Hospital and Health Services require medical practitioners, nurse practitioners and nurses intending to engage in a specific scope of practice to undergo a process of 'credentialing'.[53] This ensures that only suitably experienced and appropriately qualified health practitioners practice within the health service.

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44 See, eg, G Lowe et al, 'Nurse Practitioner work patterns: A cross sectional study' (2021) 8(2) *Nursing Open* 966. Experience as a registered nurse ranged from five to 46 years. See also, A Scanlon et al, 'A National Study of Australian Nurse Practitioners' Organizational Practice Environment' (2018) 14(5) *Journal for Nurse Practitioners* 414, 416. The mean years of experience as a registered nurse was 25. A Gardner et al, 'Development of nurse practitioner metaspecialty clinical practice standards: A national sequential mixed methods study' (2021) 77 *Journal of Advanced Nursing* 1453, 1459. Study participants' median years as a registered nurse was 30.

45 Queensland Health, *North West Hospital and Health Service Annual Report 2018-2019* (2020), 38, 42.

46 Australian Commission on Safety and Quality in Healthcare, *Credentialing health practitioners and defining their scope of practice: A guide for managers and practitioners* (December 2015) 8. Queensland Health has also developed a series of documents regarding the credentialing and defining of the scope of clinical practice of health professionals in hospitals and health services: see, eg, Queensland Health, *Department of Health Guideline QH-GDL-390-1-1:2017, Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 58. See also Private Health Facilities (Standards) Notice 2016 (Qld) s 3, sch 1; Chief Health Officer, *Credentials and Clinical Privileges Standard* (Version 5) (May 2019), in relation to licensed private health facilities.

47 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.2.1]–[3.2.2].

48 Ibid [6.3].

49 Medical Board and AHPRA, 'Newsletters: August 2014' (23 March 2021) <https://www.medicalboard.gov.au/News/Newsletters/August-2014.aspx>.

50 Nursing and Midwifery Board of Australia, *Registered Nurses Standards for Practice* (June 2016) 6.

51 Ibid.

52 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 10, Actions 1.23 and 1.24.

53 'Credentialing' means 'the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high quality healthcare services within specific organisational environments': Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (2nd ed, November 2017) 70 (definition of 'credentialing'). See also Queensland Health, *Department of Health Guideline QH-GDL-390-1-1:2017, Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 53 (definition of 'credentialing').

QUEENSLAND HEALTH PRACTITIONER DATA

13.34 Queensland Health has provided information about the health practitioner workforce for this report. This included information about the number, location, areas of speciality and years of practice experience of medical practitioners and registered nurses working in Queensland in 2019. This was the most complete recent data set available.[54]

13.35 This section refers to that information, except where otherwise specified.

Medical practitioners

13.36 There were 20 935 medical practitioners working in the registered profession in Queensland in 2019. Medical practitioners with general or specialist registration work in both the private and public health sectors.

13.37 In the private sector, medical benefits are offered for clinically relevant services through Medicare.[55] To be eligible to provide medical services that attract Medicare benefits, practitioners must be a recognised specialist, consultant physician or general practitioner.[56] Some Medicare benefits are only payable for services provided by general practitioners who are included on a vocational register.[57]

13.38 Vocational registration was introduced in 1989 to recognise general practice as a speciality in its own right.[58] Being a vocationally registered general practitioner gives access to special Medicare item numbers and higher Medicare rebates. Vocationally registered general practitioners are on the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine Fellows list, or the Vocational Register with Medicare.[59]

Medical practitioners with provisional or general registration

13.39 In 2019, there were 8178 medical practitioners with provisional or general registration in Queensland. 2592 were hospital 'non-specialists' mostly likely to be medical practitioners who are in their first 3 years post-graduation. 3367 were specialists in training. There were 1756 medical practitioners without specialist registration, who were recorded as general practitioners (1534), and specialists (222).[60]

13.40 Among the general practitioners with general registration, 598 had been practising for five to nine years, and 644 for ten years or more. It is not known where these general practitioners were located.

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54 Information provided by Workforce Strategy Branch, Queensland Health, on 9 January 2021. The Medical Workforce and Nursing Workforce data was drawn from the Queensland Unit record of the National Workforce Data Set for 2019 as downloaded by the Workforce Strategy Branch, Queensland Health. The National Workforce Data Set is comprised of the workforce surveys undertaken annually by AHPRA of the registered clinical workforce.

55 Australian Government, Department of Health, *Medicare Benefits Schedule Book* (July 2020) 15, [GN.1.2].

56 Ibid 16, [GN.2.4].

57 Ibid 20, [GN.4.13]. For the purposes of the Medicare Benefits Schedule, a general practitioner is a medical practitioner who is:

(a) vocationally registered under section 3F of the *Health Insurance Act 1973*…; or

(b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or

(c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

(d) is undertaking an approved general practice placement in a training program for *either* the award of FRACGP *or* a training program recognised by the RACGP being of an equivalent standard; or

(e) is undertaking an approved general practice placement in a training program for *either* the award of FACRRM *or* a training program recognised by ACRRM as being of an equivalent standard.

Note, however, that passage of the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020* (Cth) means that from June 16 2021 medical practitioners' access to Medicare will be determined by their continued registration with AHPRA, and the vocational register will be phased out.

58 *Community Service and Health Legislation Amendment Act 1989* (Cth) s 10; F Woodhouse, 'Medicare, mayhem and the Vocational Register 1989–1996', Royal Australian College of General Practitioners (2021) <https://www.racgp.org.au/the-racgp/history/history-of-general-practice/medicare-mayhem-and-the-vocational-register>.

59 F Woodhouse, 'Medicare, mayhem and the Vocational Register 1989–1996', Royal Australian College of General Practitioners (2021) <https://www.racgp.org.au/the-racgp/history/history-of-general-practice/medicare-mayhem-and-the-vocational-register>.

60 The remaining 463 medical practitioners are recorded as 'non-clinician' or 'other clinician'. According to Queensland Health, they are likely to be working in research or teaching.

Medical practitioners with specialist registration

13.41 Medical practitioners with appropriate qualifications can be registered as a specialist. In 2019, there were approximately 12 500 specialist medical practitioners working in the medical profession in Queensland. Some practitioners are registered in more than one specialty, or more than one speciality sub-type or 'field of specialty practice'.[61] When renewing their registration with the MBA, medical practitioners are asked to complete a workforce survey that collects information on their employment characteristics, work locations and work activity.[62] The following information relates to the self-reported primary specialty of medical practitioners in Queensland.

13.42 In 2019, 5429 medical practitioners listed general practice as their area of specialist practice.[63] Of these:[64]

- 2200 had five to nine years practice experience; and
- 2980 had ten or more years practice experience.

13.43 The number of self-reported general practice specialists varied between urban catchments like Metro North (1244 practitioners) or the Gold Coast (691 practitioners), cities like Cairns and Hinterland (320 practitioners) or Townsville (260 practitioners), and regional catchments like North West (44 practitioners), Torres and Cape (43 practitioners) or Central West (13 practitioners).[65]

13.44 Other areas of specialty practice of particular relevance for voluntary assisted dying include cardiology (272 practitioners), intensive care medicine (154 practitioners), medical oncology (106 practitioners), geriatric medicine (97 practitioners), neurology (90 practitioners) and palliative care medicine (49 practitioners).[66]

13.45 A high proportion of medical practitioners had ten or more years of speciality practice experience, including intensive care medicine (121 of 154 practitioners), medical oncology (82 of 106 practitioners), geriatric medicine (69 of 97 practitioners) and palliative care medicine (39 of 49 practitioners).

13.46 More medical practitioners reported specialist practice in dense urban catchments like Metro South (40 intensive care practitioners, 25 oncology practitioners, 28 geriatric medicine practitioners and 15 palliative care practitioners) than in regional catchments like Darling Downs (four intensive care practitioners, five in geriatric medicine practitioners and three or fewer oncology and palliative care practitioners, respectively) or Central Queensland (no medical practitioners practising in palliative care and three or fewer practising in intensive care, oncology and geriatric medicine specialties, respectively). In the Central West, North West, South West and Torres and Cape catchments no medical practitioners reported practising in intensive care, oncology, geriatric medicine, or palliative care specialties.

13.47 Table 13.1 shows the number of medical practitioners in Queensland for selected areas of specialty in 2019 and the Hospital and Health Services where they were located.[67]

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61 Medical Board and AHPRA, 'Glossary' (30 May 2019) 'specialty' <https://www.ahpra.gov.au/Support/Glossary.aspx#Specialty>.

62 Australian Institute of Health and Welfare, 'National Health Workforce Data Set: medical practitioners 2010: National Health Workforce Data Set, 2010; Data Quality Statement', *METeOR* (30 January 2013) <https://meteor.aihw.gov.au/content/index.phtml/itemId/480086>.

63 There were 20 875 registered medical practitioners listed with an area of specialist practice whose principal place of practice is in Queensland. However, of these, 8178 did not have a designated 'area of specialist practice'. Further information provided by Queensland Health clarified that these medical practitioners have general registration only.

64 This includes GP specialists with AHPRA endorsed General Practitioner status (includes rural) with the Medical College.

65 See 'Table 13.1: Number of practitioners in selected areas of speciality', below.

66 Comparatively larger specialisations included anaesthesia (998 practitioners), psychiatry (758 practitioners) and emergency medicine (537 practitioners).

67 The Table is based on information provided by Workforce Strategy Branch, Queensland Health, on 9 January 2021. See [13.35] n 54 above.
The National Health Workforce Data set from which this data is drawn has a suppression of three or less in the reporting system. Queensland Health advised that, where workforce numbers are three or less, these have been removed and replaced with '3 or less'. These have not been included in the calculation totals. The Workforce Branch noted that, while this can elevate the totals slightly when reporting, the variance is negligible.
For information on each Health and Hospital Service, including maps of the services areas, see Queensland Health, 'About Hospital and Health Services' (9 September 2016) <https://www.health.qld.gov.au/system-governance/health-system/hhs>.

Table 13.1: Number of practitioners in selected areas of specialty

Hospital and Health Service Areas	Selected areas of specialty							
	General Practice	Intensive Care Medicine	Palliative Medicine	Physician—Geriatric Medicine	Physician—Medical Oncology	Physician—Neurology	Physician—General Medicine	Physician—Cardiology
Cairns and Hinterland	320	7	3 or less	5	4	3 or less	16	12
Central Queensland	194	3 or less	–	3 or less	3 or less	–	10	4
Central West (Qld)	13	–	–	–	–	–	–	–
Darling Downs	286	4	3 or less	5	3 or less	3 or less	18	10
Gold Coast	691	18	5	7	16	12	32	35
Mackay	143	4	–	–	3 or less	–	4	3 or less
Metro North (Qld)	1244	40	14	25	29	38	54	94
Metro South (Qld)	1198	40	15	28	25	24	48	57
North West (Qld)	44	–	–	–	–	–	3 or less	3 or less
South West (Qld)	41	–	–	–	–	–	–	–
Sunshine Coast	507	14	3 or less	13	7	3 or less	25	20
Torres and Cape	43	–	–	–	–	–	–	–
Townsville	260	11	3 or less	3 or less	4	4	7	15
West Moreton	256	3 or less	3 or less	6	3 or less	–	9	5
Wide Bay	171	3 or less	–	3 or less	5	3 or less	19	6
Total in Qld	5429	154	49	97	106	90	257	272

13.48 Table 13.2 shows the number of medical practitioners in Queensland for selected areas of specialty by years of experience.[68]

Table 13.2: Medical practitioners' years of experience in area of specialty

	1 year	2 to 4 years	5 to 9 years	10 or more years
General practice	53	162	2200	2980
Intensive care medicine	–	3 or less	31	121
Palliative Medicine	–	–	10	39
Geriatric Medicine	–	3 or less	26	69
Medical oncology	3 or less	3 or less	22	82
Neurology	3 or less	3 or less	37	50
Cardiology	–	3 or less	64	205
General Medicine	5	3 or less	78	168

Medical practitioners who are international medical graduates with limited or provisional registration

13.49 Queensland Health reports that the Queensland Hospital and Health Service medical workforce consists of 4.43 per cent of international medical graduates ('IMGs').[69] In 2020, there were 534 IMGs in the public sector and a further 252 in the private sector in Queensland.[70] The Hospital and Health Services where IMGs constituted a higher percentage of the medical workforce were Wide Bay (82 IMGs/18.14 per cent); Central Queensland (63 IMGs/16.49 percent) and Mackay (44 IMGs/12.43 per cent).

13.50 In 2020, there were 61 IMGs with limited registration practising in an Area of Need.[71] Of these, eight were staff specialists employed by a Hospital and Health Service, and 53 were in private practice.[72]

13.51 A total of 114 IMGs were on the specialist pathway, most of whom were employed in positions of Registrar or above meaning that they are likely to have at least five years of post-graduate experience.[73]

Registered nurses and nurse practitioners

13.52 In 2019, there were 68 894 nurses working in Queensland. More than 50 000 were registered nurses and a further 10 640 were enrolled nurses. The remainder were midwives or nurses registered to practice as any combination of enrolled nurse, registered nurse and midwife. 451 of Queensland's nurses were endorsed as nurse practitioners.

13.53 As with medical practitioners, a high proportion of nurses had five or more years of post-registration experience. Of Queensland's 68 894 working registered nurses, 10 213 had been registered for five to nine years and 30 358 for ten years or more.

68 The Table is based on information provided by Workforce Strategy Branch, Queensland Health, on 9 January 2021. See [13.35], n 54 above. Data was not available linking the location data with the years of experience.

69 Queensland Health, *Statewide International Medical Graduate Workforce Profile* (December 2020) 13.

70 Ibid 21.

71 Medical Board and AHPRA, 'Medical Board of Australia Registrant data: 01 October 2020 to 31 December 2020' (10 February 2021) <https://www.medicalboard.gov.au/News/Statistics.aspx>.

72 Queensland Health, *Statewide International Medical Graduate Workforce Profile* (December 2020) 21.

73 Queensland Health, 'Medical recruitment—clinical career structure' (16 May 2016) <https://www.health.qld.gov.au/employment/work-for-us/clinical/medical/career-structure>.

13.54 Registered nurses represented the largest group of nurses in all Hospital and Health Services, with the rest either registered solely as enrolled nurses or midwives. Metropolitan catchments had far more registered nurses, with large concentrations in Metro North (12 812), Metro South (12 312), the Gold Coast (6473) and the Sunshine Coast (4433). The remainder were distributed between regional cities or catchments such as Townsville (3889), Darling Downs (3001) or Cairns and Hinterland (2725), and sparser catchments like North West (358), South West (281) and Central West (127).

HEALTH PRACTITIONER ROLES IN VOLUNTARY ASSISTED DYING

Coordinating practitioners and consulting practitioners

13.55 In Victoria, Western Australia and Tasmania, only medical practitioners who meet the eligibility requirements in the legislation can be a coordinating practitioner (or, in Tasmania, a primary medical practitioner) or a consulting practitioner, and undertake an assessment of the person's eligibility for access to voluntary assisted dying.[74]

13.56 The Victorian Panel explained that:[75]

> Medical practitioners necessarily play a central role in voluntary assisted dying because they have a lead role in providing treatment and care as well as stewardship of the medications that are appropriate for voluntary assisted dying.

13.57 The Panel recognised that in practice a wide range of health practitioners are involved in providing end of life care and that the person and the coordinating practitioner and consulting practitioner may be supported during the voluntary assisted dying process by other health practitioners. However, it explained that the legal process established by the legislation places obligations on the assessing medical practitioners. The Panel noted that:[76]

> While the legal process recommended by the Panel places obligations on medical practitioners, it is expected that multidisciplinary teams will continue to provide people with high-quality care. It is likely that other health practitioners, as well as medical practitioners, will receive requests for information about voluntary assisted dying, and it is important they are provided with guidance and support. Other health practitioners may also play an important role in supporting medical practitioners and the person who makes the request through the request and assessment process… Guidelines about the role of health practitioners will need to be developed, but legislation is not the appropriate mechanism for providing this clinical guidance.

13.58 The White and Willmott Model similarly provides that the first medical practitioner and second medical practitioner, who are each responsible for assessing the person's eligibility, must be registered medical practitioners who meet the minimum qualification and experience requirements.[77]

13.59 The Parliamentary Committee considered that two (medical) practitioners should assess a person's eligibility for voluntary assisted dying. It observed that 'it is appropriate and prudent to require two practitioners to determine a patient's eligibility for voluntary assisted dying'.[78] However, it was also mindful that this requirement may create difficulties 'in rural and remote areas where facetoface access to two independent

74 In Victoria, medical practitioners who undertake eligibility assessments are referred to as co-ordinating medical practitioners or consulting medical practitioners: *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definitions of 'co-ordinating medical practitioner' and 'consulting medical practitioner'). In Western Australia medical practitioners who undertake eligibility assessments are referred to as coordinating practitioners or consulting practitioners: *Voluntary Assisted Dying Act 2019* (WA) s 5 (definitions of 'coordinating practitioner' and 'consulting practitioner'). This Report adopts the term coordinating practitioner and consulting practitioner for both Victoria and Western Australia.

In Tasmania, the roles are referred to as the primary medical practitioner ('PMP') and consulting medical practitioner ('CMP'): *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5 (definitions of 'PMP' and 'CMP').

75 Vic Ministerial Advisory Panel Final Report (2017) 99.

76 Ibid 98.

77 White and Willmott Model cll 12, 13, 15, 20.

78 Qld Parliamentary Committee Report No 34 (2020) 140.

doctors, or even one medical doctor, may be problematic'.[79] It therefore recommended that consideration should be given to:[80]

> including flexibility in any voluntary assisted dying scheme … for applicants in rural and remote areas of Queensland where a doctor or second doctor are not available, to permit a registered nurse who meets the training and other requirements to participate in the scheme to assess an applicant for voluntary assisted dying and to administer the voluntary assisted dying medication.

13.60 The Western Australian Panel also considered that, while the 'primary responsibility' of being the coordinating practitioner should remain with a medical practitioner, the role of the consulting practitioner who conducts the second eligibility assessment 'could be safely and appropriately performed by a nurse practitioner'.[81] This was intended to 'ensure that there is appropriate access to voluntary assisted dying across the geographically diverse state of Western Australia'.[82] However, this approach was not implemented.[83]

13.61 In Victoria, Western Australia and Tasmania, in addition to meeting the qualification and experience requirements, medical practitioners must also complete approved training before participating in voluntary assisted dying. Similar provision is made in the White and Willmott Model.[84]

13.62 The legislation in most overseas jurisdictions requires two medical practitioners to assess a person's eligibility for voluntary assisted dying.[85] An exception is the federal legislation in Canada, which provides that a medical practitioner or a nurse practitioner can provide medical assistance in dying. Nurse practitioners can assess whether the person meets all of the eligibility criteria.[86] In 2019, 5.9 % of medically assisted deaths in Canada were provided by nurse practitioners.[87]

Administering practitioners

13.63 In Victoria, the coordinating practitioner is responsible for administering the voluntary assisted dying substance to the person under a practitioner administration permit.[88]

13.64 In Western Australia, if the person makes a practitioner administration decision, the coordinating practitioner is responsible for administering the substance to the person. However, if the coordinating practitioner is unable or unwilling for any reason to assume this role, they must transfer the role (in the capacity of administering practitioner) to another suitably qualified and trained medical practitioner, or a nurse practitioner who agrees to the transfer.[89]

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79 Ibid.

80 Ibid, Rec 15.

81 WA Ministerial Expert Panel Final Report (2019) 60–61, Rec 16.

82 Ibid.

83 Western Australia, *Parliamentary Debates*, Legislative Assembly, 4 September 2019, 6400–01 (RH Cook, Minister for Health), noting that the government took a more 'cautious approach' in relation to the role of nurse practitioners than was recommended by the Western Australian Ministerial Expert Panel.

84 See the discussion of approved training below.

85 See, eg, *Belgian Euthanasia Act 2002* art 3(1), (2)(3); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(3); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(e); *End of Life Choice Act 2019* (NZ) ss 13–14. State legislation in the United States requires the person's diagnosis and prognosis to be 'medically confirmed' by a second physician: see, eg, the definition of 'consulting physician' and 'medically confirmed' in *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.800.1.01(4), (8).

86 *Canada Criminal Code*, RSC 1985, c C-46, ss 241.1 (definitions of 'medical assistance in dying' and 'nurse practitioner'), 241.2(1)–(2), 241.2(3)(a). The assessment of the first medical practitioner or nurse practitioner must be independently confirmed by another medical practitioner or nurse practitioner: s 241.2(3)(e), (6).

Cf *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, ss 3(6), 26, 29(1), (3), 30, under which only physicians can provide medical aid in dying. It has been explained that '[n]urse practitioners can provide [medical assistance in dying] in Prince Edward Island, Nova Scotia, Ontario, Saskatchewan, Alberta, and British Columbia, but not in Newfoundland and Labrador, New Brunswick, Manitoba and the three territories': Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (2020) [5.3] (note omitted).

87 Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (2020) [5.3]. Similarly, '[n]ational data collected on the occupation of the health professional that provided the second opinion/assessment showed that 92.9% were physicians and 7.1% were nurse practitioners': [5.4].

88 *Voluntary Assisted Dying Act 2017* (Vic) s 46. The coordinating practitioner can, either at the person's request or on their own initiative, transfer the role of coordinating practitioner to a consulting practitioner who has assessed the person as eligible and who accepts the transfer of the role: *Voluntary Assisted Dying Act 2017* (Vic) ss 32–33.

89 *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'administering practitioner'), 54, 64. See the discussion of transfer of the role of administering practitioner in Chapter 10 above.

13.65 In Tasmania, the legislation creates the role of 'administering health practitioner'. The person's primary medical practitioner may choose to become the administering health practitioner or request the Voluntary Assisted Dying Commission to appoint another eligible medical practitioner or registered nurse to that role, who agrees to be appointed (the 'administering health practitioner').[90]

13.66 In Canada and New Zealand, nurse practitioners are permitted to administer the voluntary assisted dying substance.[91]

13.67 Including nurse practitioners and registered nurses as administering practitioners recognises that the skills and expertise required to undertake this role fall within their scope of practice. It also facilitates access to voluntary assisted dying, particularly in rural and remote locations, by increasing the number of practitioners who may be involved.[92]

MINIMUM QUALIFICATION AND EXPERIENCE REQUIREMENTS FOR COORDINATING PRACTITIONERS AND CONSULTING PRACTITIONERS

13.68 In Victoria, Western Australia and Tasmania, a medical practitioner must not accept a request or referral to be a coordinating practitioner (or, in Tasmania, a primary medical practitioner) or a consulting practitioner unless they meet the minimum qualification and experience requirements set out in the legislation.[93] This is to ensure that 'only registered medical practitioners with considerable experience and relevant expertise may undertake assessments against the eligibility criteria for access to voluntary assisted dying'.[94] The minimum qualification and experience requirements vary between the jurisdictions.

Victoria

13.69 In Victoria, the legislation requires that each coordinating practitioner and consulting practitioner must:[95]

(a) hold a fellowship with a specialist medical college;[96] or

(b) be a vocationally registered general practitioner.[97]

13.70 Additionally, the legislation requires that either the coordinating practitioner or the consulting practitioner must:[98]

90 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 5 (definition of 'AHP'), 61–65.

91 *Canada Criminal Code*, RSC 1985, c C-46, ss 241.1 (definitions of 'medical assistance in dying' and 'nurse practitioner'), 241.2(3); *End of Life Choice Act 2019* (NZ) ss 4 (definition of 'nurse practitioner'), 19–20. In New Zealand, under the instruction of a medical practitioner, nurse practitioners are permitted to write prescriptions for voluntary assisted dying substances, advise the Registrar of the scheduled time and date for administration, and administer a voluntary assisted dying substance upon receiving a person's final permission. In Canada, nurse practitioners can provide a person with medical assistance in dying, which includes assessing a person's eligibility, and prescribing and providing a substance to the person to self-administer, or administering the substance to the person. See also [13.63] above.

92 In Canada, including nurse practitioners as MAiD providers allayed some concerns expressed by members of rural communities related to access, given the lack of physicians practising in these areas. See, CJ Schiller, 'Medical Assistance in Dying in Canada: Focus on Rural Communities' (2017) 13 *Journal for Nurse Practitioners* 628.

93 *Voluntary Assisted Dying Act 2017* (Vic) ss 13(2), 23(2)–(6); *Voluntary Assisted Dying Act 2019* (WA) ss 17, 20(3), 31(3); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 9, 20(1), 40(1).

94 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 9. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 7, making a similar statement.

95 *Voluntary Assisted Dying Act 2017* (Vic) s 10(1).

96 To become a Fellow of a College, a medical practitioner must have completed a specialist qualification after they have become a registered medical practitioner: Vic Ministerial Advisory Panel Final Report (2017) 103.

97 'Vocationally registered general practitioner' has the same meaning as the definition of 'vocationally registered general practitioner' under the *Health Insurance Act 1973* (Cth): *Voluntary Assisted Dying Act 2017* (Vic) s 3(1); *Health Insurance Act 1973* (Cth) ss 3, 3F. To access the Medicare Benefits Schedule, doctors need to be a specialist general practitioner with vocational recognition or be participating in an approved placement under a program identified in s 3GA of the *Health Insurance Act 1973* (Cth), which currently includes the Australian College of Rural and Remote Medicine Fellowship Program, the Royal Australian College of General Practitioners Fellowship Program, and the More Doctors for Rural Australia Program: Department of Health (Cth), 'General practitioners (GPs)' (12 March 2021) <https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-pr-gp#Access%20to%20MBS>. See also, Quality Practice Accreditation, *Vocationally registered GPs* <https://files.gpa.net.au/resources/QPA_Vocationally_registered_GPs.pdf>.

98 *Voluntary Assisted Dying Act 2017* (Vic) s 10(2)–(3).

- have a minimum of five years of post-fellowship or postvocational registration practice experience; and
- have relevant expertise and experience in the disease, illness or medical condition expected to cause the person's death.

13.71 Those provisions generally implement the recommendations of the Victorian Panel. It explained that:[99]

> Given that voluntary assisted dying will be a new practice, the Panel recognises the importance of ensuring that only appropriately qualified medical practitioners are involved. This is why the Panel recommends that the two assessing medical practitioners must be Fellows of a College or be vocationally registered, and that at least one of the assessing medical practitioners has at least five years' of post-fellowship experience…
>
> The Panel also recommends that at least one of the assessing medical practitioners has expertise in the person's disease, illness or medical condition. The Panel is of the view that it is not appropriate to require a particular type of specialist expertise. This is because each person requesting voluntary assisted dying will have a different condition, different co-morbidities and different needs. Requiring at least one of the assessing medical practitioners to have expertise in the person's disease, illness or medical condition allows flexibility and recognises that other medical practitioners may have relevant expertise, for example in palliative care. To have expertise in the person's disease, illness or medical condition the assessing medical practitioner would be required to have experience in treating the disease, illness or medical condition, or similar conditions, and training relevant to the condition.

13.72 However, concern has been expressed that these requirements—in particular, the requirements mentioned at [13.70] above—adversely affect accessibility to voluntary assisted dying, especially in rural, regional and remote areas.[100] It was reported that '[t]here have been delays because of shortages of specialist doctors who have expressed willingness to participate… especially in key specialities in some rural areas'.[101]

13.73 The Victorian guidance for health practitioners explains, in relation to the requirements mentioned at [13.70] above, that 'one of the medical practitioners may fulfil both these requirements, or they may each fulfil one'. Additionally, to have expertise and experience in the medical condition expected to cause the person's death, the medical practitioner 'is required to be a medical specialist in the patient's medical condition'.[102] It has been noted that this interpretation means that palliative care specialists, geriatricians and general practitioners who are specialists in general practice are not categorised as specialists in patients with specific diseases, such as cancer.[103]

13.74 The Voluntary Assisted Dying Review Board reported that, in the first six months of

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99 Vic Ministerial Advisory Panel Final Report (2017) 103, Rec 14. The Panel observed that:

> a high level of expertise is required to have sensitive discussions about death and dying and to identify the person's preferences and values in relation to the end of their life. The assessing medical practitioner must also have the appropriate expertise to conduct a complex assessment and to make a considered prognosis.

The Panel also noted that medical practitioners already have professional obligations to act within their scope of practice and that it is part of standard medical practice for practitioners to assess whether they have the necessary skills to assist or treat patients and, if they do not, to refer them to an appropriate specialist.

100 R McDougall and B Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation (2020) 21 *BMC Medical Ethics,* Article 38 online <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5>, noting that the result of these requirements is that voluntary assisted dying 'is not equally accessible to eligible patients across the range of relevant medical conditions' and referring to unpublished data suggesting that 'there are only small numbers of willing doctors in the highly impacted specialties such as oncology and neurology'; H Platt, 'The Voluntary Assisted Dying Law in Victoria—A Good First Step But Many Problems Remain' (2020) 27 *Journal of Law and Medicine* 535, 542.

101 P Komesaroff et al, 'One year of voluntary assisted dying in Victoria: 400 have registered, despite obstacles', *The Conversation* (online, 30 June 2020) <https://theconversation.com/one-year-of-voluntary-assisted-dying-in-victoria-400-have-registered-despite-obstacles-141054>. See also Dr C McLaren, 'An Update on VAD: (Almost) A Year in Review', *Dying with Dignity Victoria* (16 June 2020) 2 <https://www.dwdv.org.au/news/an-update-on-vad-almost-a-year-in-review>, observing that 'the workload is outstripping the specialist workforce', and that 'keeping in mind that many of these patients are in the final stages of their life and are often house or even bed-bound, specialist physicians who are willing to do home visits have been exceedingly rare'.

102 Vic Guidance for Health Practitioners (2019) 5.

103 Platt, above n 100, 537; McLaren, above n 101.

operation, 134 medical practitioners had registered in the Voluntary Assisted Dying Portal and 33 per cent of trained practitioners were located outside of metropolitan Melbourne.[104] It recognised that some people 'found it difficult to find a medical practitioner who has undertaken the training and is willing to assist', but expected that 'access to trained medical practitioners will become easier in time' as more medical practitioners complete the training and choose to participate in the framework. It also noted that the Statewide Voluntary Assisted Dying Care Navigator Service, which connects people who wish to access voluntary assisted dying with participating medical practitioners, 'is expanding with a focus on developing regional networks'.[105]

13.75 In its report covering the period from July to December 2020, the Board reported that 455 medical practitioners had completed the training and 210 were registered in the portal. It also reported that more than one third (36 per cent) of medical practitioners were located in regional and rural Victoria.[106]

13.76 It reported that the number of trained medical practitioners registered in the portal by specialty area includes:[107]

- 122 with a specialty in general practice;
- 36 with a specialty in medical oncology;
- 10 with a specialty in neurology;
- 8 with a specialty in general medicine;
- 6 with a specialty in respiratory and sleep medicine;
- 6 with a specialty in haematology; and
- 5 with a specialty in palliative medicine.

13.77 The White and Willmott Model includes minimum qualification requirements in similar terms to the Victorian Act,[108] except for the requirement that one of the medical practitioners must have relevant expertise and experience in the person's disease, illness or medical condition.[109] The authors explained that:[110]

> The wording of clause 13(3) of the [White and Willmott Model] prescribing the required qualifications and experience of one of the registered medical practitioners is intentionally different from section 10(3) of the *Voluntary Assisted Dying Act 2017* (Vic). Under the Victorian Act, one of the registered medical practitioners must be a *medical specialist in the person's disease, illness or medical condition* (emphasis added). The interpretation of this provision is that General Practitioners and Palliative Care Physicians would not qualify as having this 'expertise and experience'. The proposed wording in [the White and Willmott Model] is instead that either of the registered medical practitioners 'must have relevant experience in treating or managing the medical condition expected to cause the death of the person being assessed'. While retaining the same policy goal that at least one of the registered medical practitioners

104 Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 7. Medical practitioners can register in the Voluntary Assisted Dying Portal once they have completed the mandatory assessment training. The portal was activated on 19 June 2019 for medical practitioners to submit online forms and permit requests on behalf of those people requesting voluntary assisted dying.

105 Ibid. See also Department of Health & Human Services (Vic), 'The Statewide Voluntary Assisted Dying Care Navigator Service' (September 2019) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying>.

106 Voluntary Assisted Dying Review Board Report of Operations July—December 2020 (2021) 6.

107 Ibid 7. 36 had other specialty areas (including anaesthesia, cardiology, intensive care medicine, and pain medicine), or do not have a specialty area listed on AHPRA. The specialty areas are reported in accordance with AHPRA. As a medical practitioner may have more than one specialty are listed with AHPRA, the total number of medical practitioners (229) exceeds the number of medical practitioners registered in the portal (210).

108 White and Willmott Model cl 13(1)–(2). Like Victoria, it requires that each of the first medical practitioner and second medical practitioner must hold a fellowship with a specialist medical college, or be a vocationally registered general practitioner, and that either the first medical practitioner or each second medical practitioner must have practised as a registered medical practitioner for at least five years after completing a fellowship with a specialist medical college or vocational registration (as the case requires).

109 White and Willmott Model cl 13(3). Unlike Victoria, it provides that either the first medical practitioner or each second medical practitioner must have 'relevant experience *in treating or managing* the medical condition expected to cause the death of the person being assessed' (emphasis added).

110 White and Willmott Model, Explanatory Notes 6.

> has particular experience with the person's medical condition, this wider wording is intended to reflect that General Practitioners and Palliative Care Physicians may have such experience.

Western Australia

13.78 The Western Australian Act provides that a medical practitioner is eligible to act as a coordinating practitioner or a consulting practitioner for a person if they:[111]

- hold specialist registration and have practised as a registered specialist for at least one year;
- hold general registration and have practised as a generally registered medical practitioner for at least ten years; or
- are an overseas-trained specialist who holds limited or provisional registration.

13.79 The medical practitioner must also meet any requirements approved by the CEO of the Department of Health, which must be published on the Department's website. As voluntary assisted dying is yet to be implemented in Western Australia, information about any additional approved requirements is not publicly available.[112]

13.80 Unlike Victoria, the Western Australian Act does not provide that either the coordinating practitioner or the consulting practitioner must have a minimum of five years post-fellowship or post-vocational training experience and that either one must 'have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed'. The coordinating practitioner, consulting practitioner, or both, can be general practitioners with general registration, provided they have practised for ten or more years.

13.81 Those legislative requirements reflect the recommendations of the Western Australian Panel.[113] The Panel considered adopting the Victorian minimum qualification and experience requirements. It noted that assessing eligibility for access to voluntary assisted dying 'is a significant responsibility' that is not appropriate 'to place on learning or inexperienced practitioners'.[114] At the same time, it noted that 'Western Australia differs significantly from Victoria in relation to geography [and] geographic distribution of the population',[115] and considered the need to 'ensure that there is appropriate access to voluntary assisted dying across the geographically diverse state of Western Australia'.[116]

13.82 The Panel concluded that minimum qualification and experience requirements such as in Victoria, including a requirement for one of either the coordinating practitioner or consulting practitioner to have practised for at least five years as a Fellow, 'would significantly reduce the number of medical practitioners available to undertake assessments, particularly in rural and remote areas'.[117] It also noted that:[118]

> senior doctors in country hospitals and [general practitioners] who do not hold a fellowship are already able to perform functions such as ceasing life sustaining treatment where it is assessed as futile. The Panel placed value on the enduring relationship that these medical practitioners may have with their communities and considered this as a factor when weighing up their decision.

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111 *Voluntary Assisted Dying Act 2019* (WA) s 17. Section 17(1) defines each of the four types of registration to mean: general registration, limited registration or provisional registration in the medical profession, or specialist registration in the medical profession in a recognised specialty, under the *Health Practitioner Regulation National Law (Western Australia)*. See also the discussion of regulation of health practitioners above.

112 It is expected that this information will be published closer to the time when voluntary assisted dying will become legally available in mid-2021: Department of Health (WA), 'Voluntary assisted dying' (3 April 2020) <https://ww2.health.wa.gov.au/voluntaryassisteddying>.

113 WA Ministerial Expert Panel Final Report (2019) Rec 15.

114 Ibid 58.

115 Ibid 57.

116 Ibid 60.

117 Ibid 58, noting that '[t]his access issue would be further compounded in smaller centres and towns if a sole practitioner had a conscientious objection to voluntary assisted dying'. See also Western Australia, Legislative Assembly, *Parliamentary Debates*, 5 September 2019, 6612 (RH Cook, Minister for Health).

118 WA Ministerial Expert Panel Final Report (2019) 58.

13.83 The Panel recommended that medical practitioners who may seek to become coordinating practitioners or consulting practitioners for the purposes of voluntary assisted dying must be:[119]

1. Medical practitioners who currently hold Specialist Registration with AHPRA and have practised as a registered specialist for at least one year; or
2. Medical practitioners who currently hold General Registration with AHPRA and have practised as a generally registered medical practitioner for ten or more years.

13.84 It further recommended that:[120]

> Given the unique circumstances that exist in Western Australia… that consideration be given to the following category of medical practitioners (below) where it has been demonstrated that no local provider meets the requirements above. This would need to be reviewed on a case by case basis for each applicant to assess suitability.
>
> 3. Internationally trained medical specialists who currently hold Limited or Provisional Registration for:
>
> (a) work in a gazetted Area of Need or as a sponsored provider within a health service in Western Australia; and,
>
> (b) who have undergone a formal assessment by the relevant Australian College; and,
>
> (c) for whom the relevant College has approved their specialist pathway and supervision program; and,
>
> (d) who have five years' experience as a specialist consultant; and,
>
> (e) have completed 12 months working in a supervised position within Western Australia.

Tasmania

13.85 In Tasmania, only 'authorised medical practitioners' are able to be a primary medical practitioner or a consulting medical practitioner. This means, among other things, that they must meet the following minimum qualification and experience requirements:[121]

- be a medical practitioner;[122] and
- have practised as a medical practitioner for at least five years after vocational registration as a general practitioner or after completing a fellowship with a specialist medical college; and
- have relevant experience in treating or managing the disease, illness, injury, or medical condition expected to cause a person's death.

Overseas jurisdictions

13.86 The legislation in most overseas jurisdictions does not require medical practitioners who participate in voluntary assisted dying to meet any minimum qualification or experience requirements, other than that they are qualified to practice medicine in their jurisdiction. However, in some jurisdictions, the legislation variously provides that the medical practitioner who conducts the second eligibility assessment must:

119 Ibid. The Panel also noted that the mandatory training on assessment is 'a significant factor in being able to undertake the voluntary assisted dying process well'.

120 Ibid 58–9.

121 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 9(a)–(c). They must also complete the approved training and meet the other requirements, discussed below.

122 'Medical practitioner' is defined to mean 'a person who is registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession (other than a student)': *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5.

- have held a practising certificate for at least the previous five years (New Zealand);[123]
- be competent in, or as to, the pathology concerned (Belgium and Luxembourg);[124] or
- be 'qualified by specialty or experience' to make a professional diagnosis and prognosis' regarding an individual's disease (state legislation in the United States).[125]

13.87 The federal legislation in Canada provides generally that medical assistance in dying 'must be provided with reasonable knowledge, care and skill'.[126]

Submissions

13.88 The Consultation Paper invited submissions about whether the draft legislation should set out minimum qualification and experience requirements that a medical practitioner must meet in order to act as a coordinating practitioner or a consulting practitioner and, if so, what those minimum qualification and experience requirements should be. We asked whether, for example, it should be a requirement that either the coordinating practitioner or the consulting practitioner must:[127]

(a) have practised as a medical specialist for at least five years (as in Victoria); and

(b) have relevant expertise and experience in the disease, illness or medical condition expected to case the death of the person being assessed (as in Victoria)?

13.89 Most respondents submitted that the legislation should provide minimum qualification and experience requirements for coordinating practitioners and consulting practitioners. However, respondents had differing views as to what those minimum qualification and experience requirements should be.

13.90 Generally, respondents considered that minimum qualification and experience requirements are necessary and must be sufficient to ensure that coordinating practitioners and consulting practitioners have the appropriate skills and expertise to act in these roles and undertake eligibility assessments.[128] Respondents also considered that this must be balanced against the need for voluntary assisted dying to be accessible, especially in rural, regional and remote areas. A registered nurse submitted that:

> It's essential that a high standard is maintained…However, it's vital to ensure that the threshold is not so high that it leads to the unintended consequence of having few remote and rural practitioners who can meet the legislated qualifications and experience. This would put people living in rural and remote communities at an unacceptable disadvantage.

13.91 The Clem Jones Group similarly submitted that:

> While minimum standards of qualification and experience are desirable and necessary

123 This may also be an equivalent certification from an overseas authority responsible for the registration or licensing of medical practitioners: *End of Life Choice Act 2019* (NZ) ss 4 (definition of 'independent medical practitioner'), 14. Cf the person's attending medical practitioner is required to hold a current practising certificate: s 4 (definitions of 'attending medical practitioner' and 'medical practitioner').

124 *Belgian Euthanasia Act 2002* art 3(2)(3); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(2)(3). 'Physician' is not defined.
In the Netherlands, the consulting physician in the 'vast majority of cases' is a physician that has been trained by the Royal Dutch Medical Association 'to make an independent, expert assessment in the context of a request for euthanasia'. These physicians can also 'offer support and provide information': Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) [3.6]; see also Vic Ministerial Advisory Panel Final Report (2017) 105.

125 See, eg, the definitions of 'attending physician' or 'physician', 'consulting physician' and 'medically confirmed', and other relevant provisions in *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.1(c), (f), (j), (m), 443.6; *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 2548102(2), (3), (9), (11), 107; *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7661.2(1), (3), (12), (14), 7-661.4(b); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L–1, 327L–5; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.2(B)(D), (H), (J), 2140.7; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann §§ 26:163, 26:167; *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.1.01(1), (4), (8), (10), 127.820.3.02; *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(2),(4), (8), (10), 70.245.050. A physician must be licensed to practice in the State. Cf *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann §§ 5281, 5283.

126 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(7).

127 QLRC Consultation Paper No 79 (2020) Q-36, Q-37.

128 For example, Palliative Care Nurses Australia Inc. submitted that the inclusion of minimum qualification and experience requirements for assessing practitioners is 'an important aspect [of] the rigour of assessments'.

> they…should not be set at a level that results in delays or roadblocks...For instance, requirements mandating levels of experience and qualification for medical specialists may cause such problems, especially in rural and remote areas in a large and decentralised state as Queensland even with the use of telehealth facilities.

13.92 Health Consumers Queensland submitted generally that:

> the needs across the [S]tate should be assessed to ensure that both safety and access [are] ensured for all Queenslanders…

13.93 Some respondents submitted that the draft legislation should include a requirement that either the coordinating practitioner or consulting practitioner must have practised as a medical specialist for at least five years, and have relevant expertise and experience in the disease, illness or medical condition expected to case the death of the person being assessed (as in Victoria).[129]

13.94 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld recognised that 'these minimum qualifications may impact the accessibility and availability of qualified and willing medical practitioners in regional and remote areas of Queensland'. However, they considered that:

> it is about weighing up the potential limitations in accessibility against a range of appropriate safeguards including ensuring suitably qualified people to undertake the assessment process, the appropriate level of experience required for such a significant undertaking and safeguarding vulnerable people.

13.95 Some respondents proposed solutions to the difficulties such requirements could pose in relation to accessibility in rural, regional and remote areas. Palliative Care Nurses Australia Inc. observed that telehealth could assist with access to specialists in rural, regional and remote areas. AMA Queensland submitted that, while these minimum requirements should be included in the draft legislation, there could be an exemption:

> for rural GPs and Rural Generalists who provide the bulk of medical care in rural and remote Queensland and are highly and broadly qualified. AMA Queensland considers this exemption may be necessary as delays were reported in rural and remote Victoria due to shortages of specialist doctors willing to participate in this scheme [in] rural Victoria.

13.96 A number of respondents supported a requirement that either the coordinating practitioner or the consulting practitioner have at least five years experience as a specialist but submitted that they should not be required to be a medical specialist in the patient's medical condition.

13.97 Some respondents submitted that a requirement for either the coordinating practitioner or consulting practitioner to be a specialist in the person's disease, illness or medical condition would cause difficulty and delay in accessing voluntary assisted dying, and would be a significant barrier to access in rural, regional and remote areas. Respondents noted that other specialists also have relevant expertise and experience to act as a coordinating practitioner or consulting practitioner, including palliative care specialists, geriatricians, or general practitioners who are Fellows. Some respondents submitted that it is not necessary for the coordinating practitioner or consulting practitioner to themselves be a specialist in the person's disease, illness or medical condition, as they will have access to the reports of those specialists.

13.98 A retired medical practitioner submitted that in Victoria the requirement for either the coordinating practitioner or consulting practitioner to be a specialist in the person's disease, illness or medical condition 'is a cause of considerable difficulty and delay':

129 Other respondents submitted that these requirements should be included but that a minimum of two years, as opposed to five years, of practice experience would be appropriate.

> Not only is there difficulty in finding relevant specialists, due to their relative scarcity in peripheral areas, it results in delays and long and difficult journeys for relatively immobile and dying people. The use of telehealth can eliminate much of this problem. It is even simpler for a reasonably contemporaneous specialist **report re diagnosis, prognosis and treatment** (rather than an assessment) to be sufficient. Almost every person approaching the end of life will have had a specialist assessment regarding these matters prior to any request for [voluntary assisted dying]. This matter is particularly relevant in such a large and diverse state as Queensland… (emphasis in original).

13.99 Professors White and Willmott continued to support the approach in the White and Willmott Model. They submitted that the interpretation of the requirement in Victoria that either the coordinating practitioner or consulting practitioner must be a medical specialist in the disease, illness or medical condition that will cause the person's death[130] means that:

> palliative care specialists, geriatricians and General Practitioners could never satisfy that legislative requirement… The practical consequence of this interpretation is that fewer doctors will be able to satisfy this requirement, with implications for the number of available medical professionals to facilitate [voluntary assisted dying].
>
> Clause 13 of the [White and Willmott Model] addresses this shortcoming in the Victorian legislation by expanding the requirement so that it is sufficient for the doctor to have 'relevant experience in treating or managing the medical condition'. This could not be interpreted as requiring the doctor to be a medical specialist in the patient's particular disease.

13.100 Go Gentle Australia submitted that:

> We agree that a medical practitioner is eligible to act as a coordinating practitioner or a consulting practitioner for a person if they hold specialist registration and have practised as a registered specialist for at least five years. We feel the 5-year experience is important to allow for additional experience in the field. We also feel it would be a big ask for someone who has had only 1 year in their vocation to be asked to participate.

13.101 A few respondents submitted that either or both practitioners should have relevant expertise and experience in the disease, illness or medical condition expected to cause a person's death, without necessarily supporting a requirement that they have five years' experience.

13.102 The Clem Jones Group submitted that minimum requirements 'relating to the number of years of practice by a medical practitioner be avoided'. It considered that:

> The imposition of minimum durations of experience or practice in the assessment of potential medical specialists may well aggravate the problem [of accessibility] if others who have qualified but may have practised for fewer than five years are available.

13.103 The Australian College of Nurse Practitioners submitted that assessing practitioners should simply have 'sufficient practice experience to prepare them for participation'.

13.104 In contrast, a member of the public submitted that 'the most senior only of medical practitioners should be able to participate' in voluntary assisted dying, and suggested a minimum of 20 years practice experience.

13.105 Some respondents submitted that both the coordinating practitioner and consulting practitioner could be general practitioners who hold general registration, provided they had a suitable level of experience. Dying with Dignity NSW submitted:

> We believe that an experienced general practitioner (GP), that is, one who has at least five years clinical experience is the appropriate level of qualifications and experience to

130 The Commission understands that this is a contentious interpretation of the actual requirement.

> be a [coordinating practitioner] or a [consulting practitioner]. A specialist could also be a [coordinating practitioner] or a [consulting practitioner] but they do not necessarily need to be a specialist in the underlying disease, they could be a palliative care specialist, a geriatrician or some other relevant specialty.
>
> We also believe that the [coordinating practitioner] and the [consulting practitioner] could both be general practitioners which might be a more effective approach in regional, rural and remote areas where it is very difficult for people to access specialists in a timely manner. They would naturally be relying on specialist reports about the person's illness and prognosis, but GPs with long experience would be well able to interpret such reports and perhaps more able to make assessments of decision-making capacity and freedom from coercion if they had known the patient for some time.

13.106 VALE Group similarly submitted that the minimum qualification and experience requirements for the role of coordinating practitioner and consulting practitioner should be five years of practice experience as a medical practitioner (and that it is not necessary that either medical practitioner is a medical specialist).

13.107 Avant Mutual Group Limited submitted that legislation in Queensland should follow the Western Australian model, which provides that a person may act as a coordinating practitioner or consulting practitioner if they hold specialist registration and have at least one year practice experience as a registered specialist, or hold general registration and have ten or more years experience, or are an overseas-trained specialist who holds limited or provisional registration. Unlike Victoria, both the coordinating practitioner and the consulting practitioner may be general practitioners with general registration (provided they have each practised for 10 or more years). It considered that:

> Queensland's geography and population spread are more akin to Western Australia than Victoria. Therefore, it should adopt similar provisions about the qualifications and training of health practitioners to ensure that access is not reduced, particularly in rural and remote areas of the state.

The Commission's view

13.108 Given the nature of voluntary assisted dying, inexperienced practitioners should not be eligible for the role of coordinating practitioner or consulting practitioner. Only practitioners who meet specified eligibility requirements, including minimum qualification and experience requirements, should be able to act in these roles.

13.109 The coordinating practitioner and consulting practitioner are each responsible for assessing the person's eligibility, against the criteria. This includes criteria about the person's diagnosis and prognosis.[131] The requirement for two independent assessments of the person's eligibility is a key safeguard. Practitioners who act in these roles must have appropriate skills and expertise to undertake these assessments.

13.110 In formulating the minimum eligibility requirements to act as a coordinating practitioner or consulting practitioner, the Commission had regard to the approach in Victoria and Western Australia. We also considered the large geographical area and decentralised population the scheme must accommodate and had regard to the health workforce in Queensland. The Commission has sought to ensure that practitioners who undertake eligibility assessments have appropriate skills and qualifications, and that these requirements are not a barrier to access voluntary assisted dying.

13.111 The draft Bill provides that a medical practitioner is eligible to act in the role of coordinating practitioner or consulting practitioner only if the medical practitioner:

- holds specialist registration and has practised for at least one year as the holder of that registration; or

131 See Chapter 7 above.

- holds general registration and has practised for at least five years as the holder of that registration; or
- holds specialist registration and has practised for at least five years as the holder of general registration; or
- is an overseas-trained specialist who holds limited registration or provisional registration.

13.112 A 'medical practitioner' is defined to mean 'a person registered under the Health Practitioner Regulation National Law (Queensland) in the medical profession, other than as a student. 'General registration', 'limited registration' and 'provisional registration' means, respectively, general, limited or provisional registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession. 'Specialist registration' means specialist registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession in a recognised specialty.

13.113 Coordinating practitioners and consulting practitioners must also meet any additional requirements approved for this purpose by the chief executive of the Department (the 'approved medical practitioner requirements'). The medical practitioner requirements must be made publicly available on the Department's website.

13.114 This is similar to the approach in Western Australia, which has comparable geographical challenges to Queensland. We consider that a requirement, as in Victoria, for either the coordinating practitioner or consulting practitioner to be a specialist with at least five years' experience, and for either one to be a specialist in the person's disease, illness or medical condition, would be a barrier to access, especially in rural, regional and remote areas.

13.115 Also, 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 balances the need for practitioners to meet specified eligibility requirements, including minimum qualification and experience requirements, and the need for access to the scheme, including in remote parts of Queensland far away from where most specialists in certain fields are based.

13.116 The inclusion of overseas-trained specialists with limited or provisional registration is intended to capture suitably qualified specialists, including in areas of need, to improve accessibility in rural, regional and remote areas. In order to hold limited or provisional registration, an overseas-trained specialist must be enrolled in a specialist pathway.[132] They must also meet the approved 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 of a coordinating practitioner or consulting practitioner. This could include requirements that overseas-trained specialists:

- work in a gazetted Area of Need or as a sponsored provider within a health service in Queensland;
- have undergone a formal assessment by the relevant Australian College;
- the relevant College has approved their specialist pathway and supervision program;
- meet any recency of clinical practice requirements;
- have five years' experience as a specialist consultant; and
- have completed 12 months working in a supervised position within Queensland.

13.117 The draft Bill sets out the minimum qualification and experience requirements for medical practitioners who may act in the role of coordinating practitioner or consulting practitioner and assess a person's eligibility to access voluntary assisted dying.

132 See [13.10] ff above.

However, all medical practitioners have professional obligations to work within the limits of their medical competence and scope of practice.[133]

13.118 The draft Bill also requires all coordinating practitioners and consulting practitioners to complete approved training before undertaking eligibility assessments, to enhance their knowledge about participating in voluntary assisted dying.[134]

13.119 The Commission considered whether nurse practitioners should be eligible to act in the role of coordinating practitioner or consulting practitioner and undertake eligibility assessments. We noted that their clinical expertise and experience has led to the introduction of nurse practitioner-led clinics, which make a substantial contribution to health service delivery, particularly in rural and remote areas of Queensland.

13.120 However, as voluntary assisted dying is a new scheme, we consider that responsibility for assessing whether a person meets the eligibility criteria should remain with medical practitioners. Whether nurse practitioners may be included as coordinating practitioners or consulting practitioners could be considered as part of the first review of Queensland's voluntary assisted dying scheme.

13.121 In the interim, nurse practitioners will continue to participate in multi-disciplinary teams providing high quality care to people at the end of life. Under the draft Bill, nurse practitioners are eligible to act in the role of administering practitioner.[135]

MINIMUM QUALIFICATION AND EXPERIENCE REQUIREMENTS FOR ADMINISTERING PRACTITIONERS

13.122 In Victoria, the coordinating practitioner has responsibility for administering the voluntary assisted dying substance under a practitioner administration permit.[136]

13.123 In Western Australia, the coordinating practitioner is responsible for administering the substance to the person if the person has made a practitioner administration decision, or may transfer this role to another eligible medical practitioner or nurse practitioner who accepts the role (in the capacity of an 'administering practitioner').[137] A person is eligible to act as an administering practitioner for a person if they are:[138]

- a medical practitioner who is eligible to act as a coordinating practitioner for the person; or
- a nurse practitioner who has practised the nursing profession for at least two years as a nurse practitioner, and meets the requirements approved by the CEO to administer the voluntary assisted dying substance.

13.124 As voluntary assisted dying is not yet operational in Western Australia, it is not known what additional requirements the CEO may approve. However, it was noted during the debate on the Bill in Parliament that 'ultimately, a nurse practitioner would be required to have had some experience in the area in which the patient is located and would obviously need to have the necessary clinical experience to fulfil the role of administering practitioner'.[139]

13.125 Administering practitioners in Western Australia are also required to complete the approved training to be eligible to act in this role.[140]

13.126 In Tasmania, the administering health practitioner may be either the person's primary medical practitioner or another suitably qualified and trained medical practitioner

133 See [13.31] above.
134 See the discussion of approved training below.
135 See [13.146] below.
136 *Voluntary Assisted Dying Act 2017* (Vic) s 46.
137 *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'administering practitioner'), 54, 63. See the discussion of transfer of the role of administering practitioner in Chapter 10 above.
138 *Voluntary Assisted Dying Act 2019* (WA) s 54(1)(a).
139 Western Australia, *Parliamentary Debates*, Legislative Assembly, 17 September 2019, 6791 (RH Cook, Minister for Health).
140 *Voluntary Assisted Dying Act 2019* (WA) s 54(1)(b).

or registered nurse who is appointed as the administering health practitioner by the Voluntary Assisted Dying Commission.[141] To be eligible for this role, a medical practitioner or registered nurse must, among other things, have 'the relevant experience', that is, at least 5 years' experience as, respectively, a medical practitioner or a registered nurse.[142]

13.127 During the Parliamentary debates on the Bill, an amendment was introduced to remove registered nurses from being able to act as an administering health practitioner. The amendment failed to pass.[143] In arguing against the amendment, the Bill's sponsor submitted that suitably qualified and trained registered nurses were capable of carrying out this role. It was noted that:[144]

> There may be an argument that nurses cannot diagnose and this is true; however, there is no requirement for the [administering health practitioner] whether a doctor, specialist, nurse practitioner or registered nurse to diagnose anything. The diagnosis and prognosis have been made long before an [administering health practitioner] is identified and engaged.

13.128 The New Zealand Act and the federal legislation in Canada permits nurse practitioners to administer a voluntary assisted dying substance. There are no additional minimum qualification or experience requirements that nurse practitioners must meet other than that they are qualified to practice as nurse practitioners in their jurisdiction.[145]

Submissions

13.129 Our Consultation Paper sought submissions on whether the draft legislation should provide that a voluntary assisted dying substance can be administered by:[146]

(a) the coordinating practitioner (as in Victoria and Western Australia);

(b) a medical practitioner who is eligible to act as a coordinating practitioner for the person (as in Western Australia); or

(c) a suitably qualified nurse practitioner (as in Western Australia).

13.130 Some respondents, including the Australian & New Zealand Society for Geriatric Medicine, Royal Australian College of General Practitioners Queensland and AMA Queensland, submitted that the voluntary assisted dying substance should be administered only by either a coordinating practitioner or another medical practitioner who meets the minimum qualification requirements of a coordinating practitioner.

13.131 In contrast, the Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that many of its members 'expressed discomfort with the role of a health practitioner actively administering a lethal dose of medication', and queried why, in a situation where the patient is unable to self-administer, it should be a medical practitioner who administers the medication.

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141 *End-of-Life (Voluntary Assisted Dying) Act 2021* (Tas) ss 61, 62. The medical practitioner or registered nurse must agree to be appointed: s 63(1)(a).

142 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 62(2), 63(1)(b)(iv), (2). The administering health practitioner must also complete the approved training and meet the other requirements, discussed below.

143 Tasmania, *Parliamentary Debates*, Legislative Council, 27 October 2020, 91–92.

144 Tasmania, *Parliamentary Debates*, Legislative Council, 27 October 2020, 58–59 (M Gaffney, Member for Mersey). In support of registered nurses acting as administering health practitioners, the Bill's sponsor also noted that the training required for administering health practitioners would include modules on voluntariness and decision-making capacity and that extending eligibility to nurses would increase the number of potential administering health practitioners: Tasmania, *Parliamentary Debates*, Legislative Council, 27 October 2020, 61 (M Gaffney, Member for Mersey).

145 *Canada Criminal Code*, RSC 1985, c C-46, ss 241.1 (definition of 'nurse practitioner'), 241.2(1)–(2), 241.2(3)(a); *End of Life Choice Act 2019* (NZ) ss 4 (definition of 'nurse practitioner'), 19-20.

In Canada, a 'nurse practitioner' is defined in s 241.1 to mean:

> a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner—or under an equivalent designation—and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.

In New Zealand, a nurse practitioner is defined to mean a health practitioner who holds a current practising certificate and who:

> is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the *Health Practitioners Competence Assurance Act 2003* (NZ) as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions.

146 QLRC Consultation Paper No 79 (2020) Q-38.

13.132 Many respondents submitted that coordinating practitioners, other medical practitioners who meet the requirements to be a coordinating practitioner, and suitably qualified nurse practitioners should be able to administer a voluntary assisted dying substance. Some respondents considered that this would improve patient access.

13.133 A member of the public observed that nurse practitioners are highly qualified and able to work autonomously.

13.134 Go Gentle Australia submitted that nurse practitioners should be permitted to administer the substance only in circumstances where:

> geographical distance and/or imminent death require, and only when the body overseeing [voluntary assisted dying] has confirmed that the person is eligible and that the nurse practitioner is qualified to administer the substance.

13.135 Palliative Care Nurses Australia Inc. submitted that nurse practitioners should be able to administer the substance 'if it improves access', but that it would be better if the coordinating practitioner was also involved 'to optimise continuity of care'.

13.136 Professors White and Willmott proposed modifying the White and Willmott Model to permit nurse practitioners to either administer the voluntary assisted dying substance to the person, or to supervise the person while the person self-administers the substance. They submitted:

> We consider that the inclusion of a nurse practitioner would not compromise safety and may help to address accessibility issues particularly in a State such as Queensland which is geographically vast.

13.137 In addition to nurse practitioners, several respondents submitted that suitably trained and experienced registered nurses should also be able to administer the voluntary assisted dying substance. Respondents considered that this is important to address accessibility issues, particularly in a state as geographically vast as Queensland.

13.138 Dying with Dignity Queensland submitted that appropriately trained registered nurses should be permitted to administer the substance under the direction of the coordinating practitioner.

13.139 Christians Supporting Choice for Voluntary Assisted Dying submitted that:

> Limiting who can administer may make access and the timing of administration for a patient in rural areas more difficult. The aim should be not to put up barriers for a patient who has qualified for [voluntary assisted dying] to prevent them from choosing when they wish to use the [voluntary assisted dying]. Including a Nurse Practitioner, or a Registered Nurse with appropriate experience and training, would then be a distinct advantage.

13.140 A registered nurse submitted that:

> Many small rural towns and remote areas have registered nurses working in the community and in hospitals/clinics, but they will not have a doctor or nurse practitioner. In addition, nurse practitioners are very rare in remote parts of the state.
>
> Registered nurses routinely administer all other medications, including (life-ending) terminal sedation medications and schedule-8 dangerous drugs, under authorisation of a doctor. [Voluntary assisted dying] medications should be treated no differently.

13.141 A retired nurse submitted that a registered nurse with at least five years post graduate experience in the field of 'End of Life Care/Palliative Care or Age Care', and who has completed voluntary assisted dying training, should be able to administer the substance. This respondent noted that:[147]

147 Referring to Nursing and Midwifery Board of Australia and AHPRA, *Nursing and Midwifery Board of Australia Registrant Data: 01 April 2020 to 30 June 2020* (30 June 2020) 9.

> Nurse Practitioners are also relatively few in numbers, 542 as per AHPRA statistics… particularly those with End of Life Care and Palliative Care experience. The majority of Nurse Practitioners are currently working in hospitals and major cities.
>
> In a State with such a vast geographic area such as [Western Australia] and Queensland, I believe it's essential to include appropriately trained Registered Nurses in the process of Voluntary Assisted Dying. (emphasis in original)

13.142 VALE Group submitted that registered nurses should be able to administer the voluntary assisted dying substance, but should have to meet the same requirements as under the Tasmanian Act. This includes that they must have at least five years' experience as a registered nurse and have completed approved training.

The Commission's view

13.143 The role of administering practitioner will be required only if the person makes a practitioner administration decision. The person's coordinating practitioner is responsible for prescribing the voluntary assisted dying substance and will also be responsible for administering the substance to the person, unless they transfer the role to another eligible health practitioner who accepts the transfer (in the capacity of administering practitioner).[148]

13.144 Under the draft Bill, if the person makes a practitioner administration decision, the administering practitioner is authorised to administer the voluntary assisted dying substance to the person, in the presence of a witness, if they are satisfied that, at the time of administration, the person has decision-making capacity in relation to voluntary assisted dying, and the person is acting voluntarily and without coercion. The administering practitioner is not required to undertake a formal eligibility assessment.

13.145 To be eligible to act in the role of administering practitioner, for the purposes of administering a voluntary assisted dying substance to the person, they must also have the skills and expertise required to carry out this role. Given the nature of voluntary assisted dying, only suitably qualified and trained practitioners should carry out the role of administering practitioner.

13.146 Accordingly, the draft Bill provides that a person is eligible to act as an administering practitioner if they are:

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

13.147 A 'nurse practitioner' is defined to mean 'a person registered under the Health Practitioner Regulation National Law (Queensland) to practise in the nursing profession, whose registration under that Law is endorsed as nurse practitioner'. It defines 'nurse' to mean 'a person registered under the Health Practitioner Regulation National Law (Queensland) to practise in the nursing profession, other than as a student' and 'in the registered nurses division of that profession'.

13.148 Nurse practitioners are highly qualified, skilled and experienced. They are authorised to autonomously manage complete episodes of care for people with a variety of health needs, in a range of healthcare settings.

13.149 As nurse practitioners already undertake these advanced practice roles, authorising them to act as an administering practitioner may facilitate access to voluntary assisted dying, particularly for those Queenslanders residing in rural and remote areas where there are fewer medical practitioners.

148 See the discussion of transfer of the role of administering practitioner in Chapter 10 above.

13.150 Research demonstrates that quality end of life care requires more than expert physical care. Effective communication, respectful and compassionate care are also essential.[149] Registered nurses in APN roles who care for patients at the end of life have experience and expertise in these areas,[150] and skills that are transferable to the provision of care for those people accessing voluntary assisted dying.

13.151 Queensland Health recognises that new nursing roles and titles are continuously being created in response to the rise in demand for healthcare and changes in practice.[151] This includes expanding a scope of practice by assuming responsibility for new activity beyond what is viewed as the established, contemporary scope of practice.[152]

13.152 Expanded scopes of practice for registered nurses have been envisaged for many years to transform health services and enable people to access the care they need.[153]

13.153 Expanding the practice of registered nurses to include the administration of a voluntary assisted dying substance to an eligible person who has made an administration decision will require formal processes for continuing education, assessment of competence and authorisation through credentialling.[154]

13.154 Administering practitioners must meet any additional requirements approved for this purpose by the chief executive of the Department and complete the approved training. The additional requirements will ensure that nurse practitioners and registered nurses who participate in voluntary assisted dying have relevant and current experience and expertise.

APPROVED TRAINING

Approved training for coordinating practitioners and consulting practitioners

13.155 In Victoria and Western Australia, the coordinating practitioner and consulting practitioner must complete the training approved under the voluntary assisted dying legislation before they can begin the assessment of the person's eligibility for access to voluntary assisted dying. The training is approved by the Secretary of the Department of Health and Human Services in Victoria and the CEO of the Department of Health in Western Australia.[155]

13.156 The inclusion of a legislative requirement for coordinating practitioners and consulting practitioners to complete approved training before commencing eligibility assessments was recommended by the Victorian Panel and Western Australian Panel.[156]

13.157 The Victorian Panel considered that this will ensure that medical practitioners understand their obligations under the voluntary assisted dying legislative framework and that they can undertake high quality assessments of a person's eligibility for voluntary assisted dying. It was also noted that training will promote consistency.[157]

149 C Virdun et al, 'Dying in the hospital setting: A systematic review of quantitative studies identifying the elements of end-of-life care that patients and their families rank as most important' (2015) 29(9) *Palliative Medicine* 774. See also, Australian Commission on Safety and Quality in Health Care, *National consensus statement: essential elements for safe and highquality endoflife care* (2015).

150 See, eg, Queensland Health, *Human Resources Policy: Nursing and midwifery classification evaluation methodology B7 (QH-POL-179)* (June 2020). Attachment Three — Simple Comparative Tables describe the practices of different classifications of nursing positions. Nurse Grade 6.2 and above work autonomously, function in more complex situations, demonstrate specialised knowledge and apply advanced clinical knowledge and skills.

151 Queensland Health, Clinical Excellence Division, *Framework for Lifelong Learning for Nurses and Midwives*, (June 2018) 28.

152 Ibid 70.

153 Queensland Health, *Registered Nurse Professional Practice in Queensland: Guidance for Practitioners, Employers and Consumers* (December 2013) 7.

154 Queensland Health, Clinical Excellence Division, *Framework for Lifelong Learning for Nurses and Midwives* (June 2018) 28.

155 *Voluntary Assisted Dying Act 2017* (Vic) ss 17, 26, 114; *Voluntary Assisted Dying Act 2019* (WA) ss 25, 36, 160.

156 Vic Ministerial Advisory Panel Final Report (2017) 104–6, Recs 15, 16; WA Ministerial Expert Panel Final Report (2019) 62–3, 96–100, Recs 17, 29.

157 Vic Ministerial Advisory Panel Final Report (2017) 104–6.

13.158 The Panel also recommended that the training should be able to be completed after the medical practitioner receives a request or referral, thus allowing the existing clinical relationship between the medical practitioner and patient to be maintained if the medical practitioner agrees to support them through the process. For this reason, it noted that the training should be readily accessible 'to ensure a person's assessment is not unduly delayed'.[158]

13.159 In Victoria, the training can be undertaken online and is reported to take an average of four hours to complete.[159] The training:[160]

> comprises nine modules including an assessment module. While the predominant focus of the modules is on law, they also contain some clinical components and links to further resources. Modules also contain videos, case studies and interactive exercises. The assessment consists of 30 questions, selected randomly from a question bank, with a pass mark of 90%.

13.160 The modules comprise of the following topics:[161]

1. Introduction (describing the nature of the [voluntary assisted dying] system and how it is different from other care provided at the end of life).
2. Conversations, a first request, and [medical practitioners] deciding whether to participate in [voluntary assisted dying].
3. Roles, qualifications and expertise of medical practitioners.
4. [Voluntary assisted dying] eligibility assessments by the co-ordinating medical practitioner and the consulting medical practitioner.
5. From assessments of eligibility for [voluntary assisted dying] to a [voluntary assisted dying] permit.
6. Prescribing or administering [voluntary assisted dying] medications and actions following the patient's death.
7. Protections [for medical practitioners and others] and oversight.
8. Assessment.
9. Self-care for medical practitioners, glossary and resources.

13.161 The Department of Health is currently working on the implementation of voluntary assisted dying in Western Australia.[162] The Government has indicated that the approved training will be available online and will take around six to eight hours to complete.[163] It has also indicated that the approved training will include information about: the voluntary assisted dying legislative scheme; the roles and responsibilities of coordinating practitioners, consulting practitioners and administering practitioners; the procedural requirements and safeguards, guidance about the eligibility assessments and the eligibility criteria; cultural competency training and training about how to have

158 Ibid 106. See also at 105, explaining that there was strong support for voluntary assisted dying processes to be:

> embedded in existing clinical practice and existing clinical relationships to help ensure people are given access to a full range of options. Requiring medical practitioners to be specifically trained prior to acting on a request for voluntary assisted dying may undermine this because the medical practitioners with whom a person has an existing relationship are unlikely to have undergone the specified training. Instead, there should be training readily available to medical practitioners who want to provide voluntary assisted dying when they receive a request.

159 Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 6; Department of Health & Human Services (Vic), 'Voluntary assisted dying training for medical practitioners' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/medical-practitioner-training>.

160 B White et al, 'Development of Voluntary Assisted Dying Training in Victoria, Australia: A model for consideration' (August 2020, online) *Journal of Palliative Care*, 2–3.

161 Ibid 8–9, referring to the module titles of the training modules.

162 Department of Health (WA), 'Voluntary assisted dying' (13 April 2020) <https://ww2.health.wa.gov.au/voluntaryassisteddying>. The approved training is being developed in consultation with the Department of Health (WA), the Royal Australian College of General Practitioners, key medical, nursing and allied health stakeholders, clinical, educational and regulatory experts, palliative care and end of life stakeholders and experts, cultural stakeholders and advisers for the Indigenous, and consumer and community representatives: Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6645 (JR Quigley, Attorney-General).

163 Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6645–46 (JR Quigley, AttorneyGeneral).

difficult conversations about end of life and choices at end of life; and medication management.[164]

13.162 The Western Australian Panel considered that the approved training should 'include more than assessment and functions of the legislation'.[165] The Panel noted that during its consultation it received feedback that 'there should also be an emphasis on communication training to ensure that the practitioner feels confident and is skilled in having difficult conversations about death and dying in a culturally competent manner', as well as 'support for the integration of competencies relating to working with people from culturally and linguistically diverse communities'.[166]

13.163 In Tasmania, only 'authorised medical practitioners' can act as a person's primary medical practitioner or consulting medical practitioner. They must have successfully completed an 'approved voluntary assisted dying training course'.[167] The training may be provided online and is to be approved by the Voluntary Assisted Dying Commission. The training must cover the functions and legal obligations of the different roles for medical practitioners under the Act, eligibility assessments and identifying whether a person may be subject to abuse or coercion when making a decision about voluntary assisted dying.[168]

13.164 The Parliamentary Committee recommended that any voluntary assisted dying framework in Queensland should require that:[169]

> health practitioners involved in administering or conducting assessments for voluntary assisted dying complete mandatory training developed by the Department of Health in conjunction with peak health professional bodies.

13.165 The White and Willmott Model provides that the coordinating practitioner and the consulting practitioner must not commence their assessment of eligibility for access to voluntary assisted dying unless that practitioner has completed approved assessment training.[170]

13.166 In contrast, the legislation in overseas jurisdictions does not include a requirement for health practitioners to complete mandatory assessment training before they can assess a person's eligibility for access to voluntary assisted dying.[171]

Approved training for administering practitioners

13.167 As discussed above, the Western Australian Act and Tasmanian Act creates a separate role for administering practitioners.[172]

13.168 In Western Australia, to be eligible to act as an administering practitioner, a medical practitioner or nurse practitioner must have completed the training approved under the legislation for these purposes.[173] The training for administering practitioners is approved by the CEO of the Department of Health in Western Australia.[174] As voluntary assisted dying is not yet operational in Western Australia, information of what may be included in this training is not yet publicly available.

13.169 In Tasmania, a medical practitioner or registered nurse must have completed an 'approved voluntary assisted dying course' within the previous five years to be eligible

164 WA, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6645 (JR Quigley).
165 WA Ministerial Expert Panel Final Report (2019) 63.
166 Ibid 96.
167 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 5 (definition of 'approved voluntary assisted dying training'), 20(1), 40(1), 63(b), 116.
168 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 116.
169 Qld Parliamentary Committee Report No 34 (2020) Rec 20.
170 White and Willmott Model cl 14.
171 However, see, for example, n 124 above as to training of consulting practitioners in the Netherlands.
172 See [13.64] above. In Victoria, the coordinating practitioner has responsibility for administering the substance to the person under a practitioner administration permit.
173 *Voluntary Assisted Dying Act 2019* (WA) s 54(1)(b).
174 *Voluntary Assisted Dying Act 2019* (WA) s 160.

to act as an administering health practitioner.[175] The course is to be approved by the Voluntary Assisted Dying Commission.[176]

Submissions

13.170 The Consultation Paper asked whether the draft legislation should require health practitioners to complete approved training before they can assess a person's eligibility for access to voluntary assisted dying.[177]

13.171 Most respondents submitted that the legislation should require health practitioners to undergo some form of approved training before assessing a person's eligibility to access voluntary assisted dying.

13.172 Avant Mutual Group Limited commented that:

> Robust training particularly in the area of eligibility will act as a safeguard for everybody involved. It will help ensure that the person is receiving the treatment they are eligible for and that the medical practitioner understands their legal obligations to their patient.

13.173 Go Gentle Australia submitted that approved training should be mandatory:

- To ensure that medical practitioners are equipped and confident to navigate the various stages of the [voluntary assisted dying] process and that they have access to all information and support.
- To ensure the process is undertaken appropriately and safely, and that both the person seeking [voluntary assisted dying] and participating medical practitioners are adequately safeguarded.

13.174 Professors White and Willmott, who along with others were engaged by the Victorian Government to design and provide the voluntary assisted dying training in Victoria, referred in their submission to an article they co-authored detailing the development and content of that training. The article notes that:[178]

> the process of State-endorsed formal training which provides standardized baseline levels of knowledge can enhance the quality and consistency of decision-making.

13.175 A number of respondents commented on the specific content of the training.

13.176 Some respondents submitted that, in particular, there should be training to assess decision-making capacity in the context of voluntary assisted dying. A few respondents noted that this would ensure there is consistency of approach.

13.177 In addition to providing training about the eligibility criteria and relevant skills to undertake assessments, respondents variously submitted that the training could also include: competency about the legal requirements under the Act and the voluntary assisted dying process itself (including receiving requests and the documentation required, and administering voluntary assisted dying medications); recognising vulnerability or coercion (including issues of elder abuse); palliative care and end of life care, communication skills training (particularly about discussions around end of life); cultural issues, disability rights and the needs of people with disabilities.

13.178 Some respondents noted that the Victorian model for training could be adopted and adapted for Queensland.

13.179 A few respondents considered that the training should not be limited to online. United Workers Union submitted that 'while there is a place for online training, it should not displace face-to-face learning'. MIGA submitted that the training:

175 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 63(1)(b).
176 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 5, 116.
177 QLRC Consultation Paper No 79 (2020) Q-39.
178 White et al, above n 157.

> should be provided through a single, government endorsed scheme, through face to face interactive workshops and provision of a range of material to participants covering key clinical, ethical, legal and practical issues. It should include hypothetical scenarios and case studies.

13.180 Some respondents observed that a lack of remuneration or compensation for mandatory training is an issue that needs to be addressed. An academic, Ms Jodhi Rutherford, reported the findings of a study on practitioner perspectives of voluntary assisted dying in Victoria. She noted that the training could be a disincentive to participating in voluntary assisted dying:

> Some participants note that the lack of compensation for six to eight hours of online training could serve as a disincentive…Incentives might need to be extended to doctors to participate in the mandatory training. Lack of remuneration could be offset by offering continuing professional education points, or by the Victorian Government providing some level of compensation for the time that doctors must take to complete the training.

13.181 Two academics jointly submitted that health practitioners should not be obligated to complete the training unless they have chosen to participate in voluntary assisted dying, noting that the right to conscientiously object should be preserved.

13.182 Some respondents specifically noted that, if the draft legislation enables a practitioner other than the coordinating practitioner to administer the voluntary assisted dying substance, the administering practitioner should also be required to complete approved training relevant to the administration of the substance.

The Commissions' view

13.183 The draft Bill provides the chief executive of the Department must approve training for coordinating practitioners, consulting practitioners and administering practitioners.

13.184 To ensure high quality, safe care, practitioners with key roles in voluntary assisted dying must be aware of their responsibilities under the Act.

13.185 The coordinating practitioner and any consulting practitioner may complete the approved training after they have accepted the request or referral. However, they must each complete the approved training before they can commence the assessment of a person's eligibility for access to voluntary assisted dying. This enables existing clinical relationships to be maintained. For example, if a medical practitioner receives a request from an existing patient and is willing to act as coordinating practitioner, but has not completed the approved training, they can accept the request. However, they must complete the approved training before undertaking the assessment.

13.186 The training may also be completed independent of any pre-existing clinical relationship if a practitioner contemplates participating in voluntary assisted dying in the future.

13.187 The draft Bill also provides that to be eligible to act in the role of administering practitioner, the practitioner must have completed the approved training. The practitioner must have completed the approved training before they accept a transfer of the role of administering practitioner.

13.188 The training is to be approved by the chief executive of the Department after careful consideration of what is to be included, what is assessed, and how it is delivered. Adequate time during the implementation phase should be provided to allow for the development and deployment of the training. The approved training should be accessible and delivered flexibly.

13.189 The training requirements should not be so onerous that they are a barrier to practitioners participating in voluntary assisted dying. For example, medical practitioners in private practice are not remunerated for the time taken to complete the training, so time spent completing it may have a financial impact. Also, medical practitioners with

specialist registration can only choose continuing professional development (CPD) activities set by their specialist medical college,[179] so the training may not count for this purpose. Given that these ancillary benefits are not available, the training requirements must be proportionate and manageable.

OTHER REQUIREMENTS

Independence of the practitioner from the person

13.190 The Western Australian Act provides that a health practitioner (or, as applicable, another person) is not eligible to act as the person's coordinating practitioner, consulting practitioner or administering practitioner, or to be a health practitioner (or other person) to whom the person is referred under the legislation, if they:[180]

- are a family member of the person; or
- know or believe that they are a beneficiary under a will of the person or may otherwise benefit financially or in any other material way from the person's death.[181]

13.191 Those requirements were not recommended by the Western Australian Panel or included in the Bill as introduced into Parliament. They were the subject of amendment during the Parliamentary debates, to ensure that medical practitioners providing voluntary assisted dying are independent of the person and reflect good medical practice.[182]

13.192 The Tasmanian Act provides that a medical practitioner is an authorised medical practitioner in relation to a person if they meet the qualification and training requirements provided in the legislation and if:[183]

> (e) the medical practitioner is not a member of the family of the person, and
>
> (f) the medical practitioner does not know or believe that he or she is likely to, either directly or indirectly, benefit from, or directly or indirectly receive a financial benefit as a result of, the death of the person, other than by receiving reasonable fees for the provision of services as the [primary medical practitioner], [consulting medical practitioner], or [administering health practitioner] of the person.

13.193 There are no equivalent requirements included in the Victorian Act. However, health practitioners are subject to professional obligations, including to recognise and resolve potential conflicts of interest that may arise in relation to initiating or continuing a professional relationship with a patient.[184]

13.194 In particular, health practitioners have professional obligations to avoid providing medical care to people with whom they have a close personal relationship:[185]

> **4.15 Providing care to those close to you**
>
> Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the patient and doctor.

179 Medical Board and AHPRA, *Registration Standard: Continuing Professional Development* (October 2016) 2.
180 *Voluntary Assisted Dying Act 2019* (WA) ss 17(2)(b)–(c), 37(5), 54(1)(c)–(d).
181 Other than by receiving reasonable fees for the provision of their services; for example, as the coordinating practitioner, consulting practitioner or administering practitioner for the person.
182 Western Australia, *Parliamentary Debates*, Legislative Assembly, 10 December 2019, 9961, 9975 (RH Cook, Minister for Health).
183 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 9(e)–(f), 20(1), 40(1). A medical practitioner or a registered nurse who is appointed as a person's administering practitioner must sign a statutory declaration stating that they meet those requirements: s 63(1)(b)(ii)–(iii).
184 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [10.12.1].
185 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.15]. Breach of professional obligations may result in disciplinary proceedings: see [13.3] above.

13.195 The White and Willmott Model does not include a provision expressly stating that a medical practitioner is not eligible to act as the person's first medical practitioner or second medical practitioner if they are a family member of the person, or if they know or believe that they are a beneficiary under a will of the person or may otherwise benefit financially or in any other material way from the person's death. Professors White and Willmott explained that their approach in drafting the Model was 'a preference for brevity' and that it does not include matters that are 'already adequately dealt with either by existing legislation or established protocols in the health system within which voluntary assisted dying will occur', or that may be dealt with in policies or guidelines.[186]

Submissions

13.196 In the Consultation Paper, we asked whether the draft legislation should provide (as in Western Australia) that the coordinating practitioner, consulting practitioner, any health practitioner (or other person) to whom the person is referred for determination of whether the person meets particular eligibility requirements, or the administering practitioner must not:[187]

> (a) be a family member of the person; or
>
> (b) know or believe that they are a beneficiary under a will of the person or may otherwise benefit financially or in any other material way from the person's death.

13.197 Most respondents who answered this question submitted that the legislation should include a provision in those terms.

13.198 Some respondents submitted that this provision reflects existing professional and ethical obligations.[188] Two academics jointly submitted that:[189]

> Both these situations are ethically problematic and are further contrary to the statement of ethical standards doctors practicing in Australia are required to adhere to…

13.199 The Office of the Health Ombudsman submitted that the inclusion of a provision in these terms 'should aid in avoiding conflicts of interest and encourage practitioners to ensure they comply with their professional obligations'.

13.200 Some respondents also submitted that, if such a provision is included, it should make it clear that 'benefitting financially' does not include the practitioner's right to remuneration for their services. Go Gentle Australia submitted that:

> 'benefitting financially' should not exclude a practitioner from charging any normally applicable fees.

13.201 MIGA submitted that:

> Such a provision will need to be framed carefully to ensure that practitioners who bill appropriately for their services provided during the voluntary assisted dying process are not considered as '*benefiting*' from a person's death.
>
> This could be done by way of a "*for avoidance of doubt*" provision indicating that such preclusions do not apply to remuneration for a practitioner's involvement in the process. (emphasis in original)

13.202 Professors White and Willmott continued to support the White and Willmott Model approach to these issues, which does not include a provision in these terms.

186 White and Willmott Model, Explanatory Notes 5–6.

187 QLRC Consultation Paper No 79 (2020) Q-24.

188 AMA Queensland submitted that this would 'reflect good medical practice'. Palliative Care Social Work Australia observed that this 'aligns with current ethical responsibilities of medical practitioners'.

189 Referring to MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020).

The Commission's view

13.203 The draft Bill provides that, to be eligible to act as the person's coordinating practitioner, consulting practitioner or administering practitioner, the practitioner:

- must not be a family member of the person requesting access to voluntary assisted dying; and
- must not know or believe that they—
  - are a beneficiary under a will of the person requesting access to voluntary assisted dying; or
  - may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services as the coordinating practitioner, consulting practitioner or administering practitioner for the person.

13.204 Those requirements also apply to a health practitioner or other person to whom the person requesting access to voluntary assisted dying is referred under the provisions in the draft Bill for the determination of particular eligibility criteria.[190]

13.205 For the purposes of the draft Bill, a 'family member' means the person's spouse, or the person's parent, grandparent, sibling, child or grandchild (or a person who is regarded as such under Aboriginal tradition or Torres Strait Island custom).

13.206 These provisions are consistent with existing professional obligations and ensure there is no conflict of interest between the practitioner and the person requesting access to voluntary assisted dying.

190 See the discussion of eligibility assessments and, in particular, requirements for referral of certain matters in Chapter 8 above.

RECOMMENDATIONS

Minimum qualification and experience requirements for coordinating practitioners and consulting practitioners

13-1 A medical practitioner should be eligible to act as a coordinating practitioner or a consulting practitioner for a person requesting access to voluntary assisted dying if:

(a) the medical practitioner:

(i) holds specialist registration and has practised for at least one year as the holder of that registration; or

(ii) holds general registration and has practised for at least five years as the holder of that registration; or

(ii) holds specialist registration and has practised for at least five years as the holder of general registration; or

(iii) is an overseas-trained specialist who holds limited registration or provisional registration; and

(b) the medical practitioner meets the approved medical practitioner requirements.

13-2 The chief executive must approve medical practitioner requirements and publish them on the Department's website.

13-3 The draft Bill provides that:

(a) 'general registration' means 'general registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession';

(b) 'limited registration' means 'limited registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession';

(c) 'provisional registration' means 'provisional registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession';

(d) 'specialist registration' means 'specialist registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession in a recognised specialty'.

Minimum qualification and experience requirements for administering practitioners

13-4 A person should be eligible to act as an administering practitioner if the person is:

(a) a medical practitioner who is eligible to act as a coordinating practitioner for the person requesting access to voluntary assisted dying; or

(b) a nurse practitioner who meets the approved nurse practitioner requirements; or

(c) a registered nurse who has practised in the nursing profession for at least five years and meets the approved nurse requirements.

13-5 The chief executive must approve nurse practitioner requirements and nurse requirements and publish them on the Department's website.

Approved training

13-6 The coordinating practitioner must not begin the first assessment, and the consulting practitioner must not begin the consulting assessment, unless the practitioner has completed approved training.

13-7 The administering practitioner must complete approved training to be eligible to act as an administering practitioner.

13-8 The chief executive must approve training and publish the approval on the Department's website.

Other requirements

13-9 The coordinating practitioner, consulting practitioner, administering practitioner, or another health practitioner or other person to whom the person is referred to determine certain eligibility matters:

(a) must not be a family member of the person requesting access to voluntary assisted dying; and

(b) must not know or believe that they—

(i) are a beneficiary under a will of the person requesting access to voluntary assisted dying; or

(ii) may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services as the coordinating practitioner, consulting practitioner or administering practitioner for the person, or in connection with the referral.

CHAPTER 14

Participation by individuals and conscientious objection

Chapter 14: Participation by individuals and conscientious objection

CHAPTER SUMMARY

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, an individual may be unable or unwilling to participate. For example, a health practitioner cannot be an assessing practitioner if they do not hold the required qualifications or have not completed the required 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 relating to voluntary assisted dying.[1]

A health practitioner's unwillingness to participate may be for personal reasons and may constitute a conscientious objection. Generally, a conscientious objection is 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.[2] A variety of concerns may prompt a conscientious objection by a practitioner to voluntary assisted dying. They include secular or professional reasons.[3]

Issues addressed in this chapter include:

- whether the legislation 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;
- be present at the time of the administration or self-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
- give the person:
  - information about a health practitioner, health service provider or service who, in the

1 Reasons why a practitioner may refuse a request to participate in the voluntary assisted dying process are discussed in Chapter 8 above in the context of refusal of a request or referral.

2 See, eg, AMA, *Position Statement: Conscientious Objection* (2019) [1.2]–[1.3]; Australian Nursing & Midwifery Federation, *Policy: Conscientious Objection* (November 2017) [1].

3 CM Haining, LA Keogh and LH Gillam, 'Understanding the Reasons Behind Healthcare Providers' Conscientious Objection to Voluntary Assisted Dying in Victoria, Australia' (February 2021, online) *Journal of Bioethical Inquiry*.

practitioner's belief, is likely to be able to assist the person; or

– the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person.

This does not necessarily require the health practitioner with 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 with 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.

Similar rights and requirements should exist for speech pathologists, who are not registered health practitioners. Those provisions should recognize 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 by the patient.

RELEVANT PRINCIPLES

14.1 Many of the principles discussed in Chapters 4 and 5 above arise in the context of participation by health practitioners and access to lawful end of life options. They include:

- a person's autonomy, including autonomy in respect of end of life choices, should be respected;
- access to voluntary assisted dying and other end of life choices should be available irrespective of where the person resides in Queensland;
- a person has the right to be supported in making informed decisions about end of life choices; and
- all persons, including health practitioners, have freedom of thought, conscience and belief.

14.2 As discussed in Chapter 4, these principles may sometimes conflict and must be reconciled and balanced. The individual rights of the patient are not absolute. Nor are the individual rights of the practitioner.

14.3 In Queensland, the HR Act recognises the right to 'freedom of thought, conscience, religion and belief', including 'the freedom to demonstrate the person's religion or belief in worship, observance, practice and teaching, either individually or as part of a community, in public or in private'.[4] This right may be subject under law to 'reasonable limits that can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom'.[5]

PROFESSIONAL ETHICS AND GOOD MEDICAL PRACTICE

14.4 The Commission is required to have regard to 'the legal and ethical obligations of treating health practitioners'.[6] As discussed in Chapter 4, four key principles are commonly recognised in medical ethics:[7]

- respect for autonomy—respecting and enabling an individual's right to hold views and make their own decisions based on their values and beliefs;
- beneficence—relieving or preventing harm and doing the best for the individual patient (or acting in the patient's best interests);

4 *Human Rights Act 2019* (Qld) s 20(1)(b).
5 *Human Rights Act 2019* (Qld) s 13.
6 Terms of reference para 4.
7 See [4.19] n 20 above and the sources cited there.

- non-maleficence—doing no harm, that is, avoiding acts that cause harm to the individual's interests and justifying any harmful actions; and
- justice—equity and the fair distribution of benefits, risks and costs, with a focus on the interests of the community as well as the individual patient.

14.5 Other core values of medical practice, which have particular significance in end of life care, include:[8]

- compassion and empathy, including relief of the patient's distress; and
- non-abandonment—the principle that the doctor-patient relationship involves an ongoing commitment by the doctor to care for the patient, and that a doctor should not abandon the patient without making or allowing time for other arrangements.

EXISTING PROVISIONS AND GUIDELINES ABOUT CONSCIENTIOUS OBJECTION

Guidelines

14.6 Conscientious objection is provided for in Australian codes of conduct and ethical standards for doctors, nurses, pharmacists and other health practitioners. Generally, these codes and standards recognise that a health practitioner may decline to provide or participate directly in a treatment or procedure to which the practitioner conscientiously objects. An objecting practitioner is required to inform their employer, colleagues and patients of their objection. They must ensure that a patient has alternative care options or that their access to care is not impeded, including by providing information to enable a patient to obtain services elsewhere.[9]

14.7 The MBA Code of Conduct for Doctors states:[10]

> **3.4 Decisions about access to medical care**
>
> Your decisions about patients' access to medical care must be free from bias and discrimination. Good medical practice involves:
>
> 3.4.1 Treating your patients with respect at all times.
>
> …
>
> 3.4.3 Upholding your duty to your patient and not discriminating against your patient on grounds such as race, religion, sex, gender identity, sexual orientation, disability or other grounds, as described in antidiscrimination legislation.
>
> …
>
> 3.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues of your objection, and not using your objection to impede access to treatments that are legal. In some jurisdictions, legislation mandates doctors who do not wish to participate in certain treatments, to refer on the patient.
>
> 3.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or directly participate in that care.

8 See [4.20] n 21 above and the sources cited there.

9 See MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.4.6]–[3.4.7]; AMA, *Code of Ethics* (2016) [2.1.13], [4.2.3]; AMA, *Position Statement: Conscientious Objection* (2019) [1.2][1.3], [2.2]–[2.3]; Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) [4.4](b); Australian Nursing & Midwifery Federation, *Policy: Conscientious Objection* (November 2017) [1]–[2], [4]; Australian Nursing & Midwifery Federation, *Position Statement: Voluntary assisted dying* (November 2019) [12](a); Pharmacy Board of Australia, *Code of Conduct for Pharmacists* (March 2014) [2.4](f), (g); Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists* (February 2017) 12, 18.

10 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.4].

14.8 The AMA Position Statement on conscientious objection states that:[11]

> A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients' access to care.

14.9 It also states that:[12]

> Doctors with conscientious objections should not be treated unfairly or discriminated against.

14.10 The AMA Position Statement goes on to provide:[13]

> 2.2 A doctor who invokes a conscientious objection to providing, or participating, in specific treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care and ensuing burden on colleagues and other health care professionals.
>
> 2.3 A doctor with a conscientious objection, should:
>
> - inform the patient of their objection, preferably in advance or as soon as practicable;
> - inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
> - take whatever steps are necessary to ensure the patient's access to care is not impeded;
> - continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking;
> - continue to provide other care to the patient, if they wish;
> - refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;
> - inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues.

14.11 In short, a practitioner may decline to provide or participate directly in a treatment or procedure to which they conscientiously object, but must:

- inform their employer, colleagues and patient of their objection; and
- ensure the patient's access to treatment or care is not impeded, including by providing information to enable a patient to obtain services elsewhere.

14.12 Clinical guidelines also recognise conscientious objection. For example, Queensland Health clinical guidelines about end of life care provide that in limited circumstances a medical practitioner may be excused from providing a patient with care that goes against their conscience. An objection must be 'declared as early as possible' so that the patient is not at risk of harm and their care can be appropriately handed over to another practitioner or treating team.[14]

An example of a statutory requirement to refer or to transfer care

14.13 An example of legislative recognition of a health practitioner's conscientious objection, coupled with a statutory obligation to refer the person elsewhere or transfer their

11 AMA, *Position Statement: Conscientious Objection* (2019) [1.5].
12 Ibid [1.7].
13 Ibid [2.2]–[2.3].
14 Queensland Health, Clinical Excellence Division, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*, Document No QHGDL-462:2019 (January 2018) [4.6].

care, appears in Queensland legislation about termination of pregnancy. It applies to registered health practitioners asked to give advice about a termination, decide if a termination should be performed in particular circumstances, or perform or assist in performing a termination.

14.14 Section 8 of the *Termination of Pregnancy Act 2018* provides:

> **8 Registered health practitioner with conscientious objection**
>
> (1) This section applies if—
>
> (a) a person asks a registered health practitioner to—
>
> (i) perform a termination on a woman; or
>
> (ii) assist in the performance of a termination on a woman; or
>
> (iii) make a decision under section 6 whether a termination on a woman should be performed; or
>
> (iv) advise the person about the performance of a termination on a woman; and
>
> (b) the practitioner has a conscientious objection to the performance of the termination.
>
> (2) The registered health practitioner must disclose the practitioner's conscientious objection to the person.
>
> (3) If the request is by a woman for the registered health practitioner to perform a termination on the woman, or to advise the woman about the performance of a termination on the woman, the practitioner must refer the woman, or transfer her care, to—
>
> (a) another registered health practitioner who, in the first practitioner's belief, can provide the requested service and does not have a conscientious objection to the performance of the termination; or
>
> (b) a health service provider at which, in the practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination.
>
> (4) This section does not limit any duty owed by a registered health practitioner to provide a service in an emergency.

Victoria and Western Australia

14.15 Participation in the voluntary assisted dying process by registered health practitioners is voluntary. A practitioner may choose not to participate because they have a conscientious objection, do not have the necessary skills or qualifications, are unavailable, or are 'unable or unwilling to perform the training and duties required'.[15] A health practitioner can also make decisions about their level of involvement, for example, by choosing to only give patients general information about voluntary assisted dying.[16]

14.16 In Victoria and Western Australia, a registered health practitioner who has a

15 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health). As to reasons why a practitioner may refuse a request to be involved in the voluntary assisted dying process, see also Chapter 8 above.

16 See, eg, Department of Health & Human Services (Vic) 'Health practitioner information' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information>. See generally Vic Guidance for Health Practitioners (2019) 8; Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health); Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 3; Department of Health (WA), 'Voluntary assisted dying' (26 February 2021) <https://ww2.health.wa.gov.au/voluntaryassisteddying>.

conscientious objection has the right to refuse to:[17]

- provide information about voluntary assisted dying (Victoria);
- participate in the request and assessment process (Victoria, Western Australia);
- apply for a voluntary assisted dying permit (Victoria);
- prescribe, supply or administer the substance (Victoria, Western Australia) or dispense a prescription for the substance (Victoria); or
- be present at the time of the administration of the substance (Victoria, Western Australia).

14.17 When a medical practitioner receives a request for access to voluntary assisted dying, the practitioner must inform the person whether they accept or refuse the request.[18] In Victoria, if the refusal is because of a conscientious objection, the practitioner must (within seven days) inform the person that they are refusing the request for that reason. In Western Australia, if the refusal is because of a conscientious objection, the practitioner must immediately inform the person that they are refusing the request.[19]

14.18 The Victorian Act does not legislate a duty on a practitioner to refer the person to another practitioner who is willing to be involved. Instead, that matter is the subject of guidelines. The Victorian Panel and the Minister for Health explained that a health practitioner's conscientious objection should not impede a person's access to voluntary assisted dying.[20]

14.19 Rather than recommend a legislative duty to refer, the Panel relied on existing obligations of medical practitioners under codes of conduct not to impede a person's access to legal treatment.[21] The Panel also recommended that guidelines be developed to ensure that 'there is a clear and consistent approach to managing requests for voluntary assisted dying' where a health practitioner has a conscientious objection.[22]

14.20 The 'absence of a specific legislative duty to refer' has been said to stand 'in stark contrast to the very detailed and prescriptive process outlined for other matters' in the Victorian Act.[23] Ms Rutherford, an academic who has researched and published in this field,[24] observed in her submission that the lack of a legal obligation to refer in the Victorian Act has arguably been 'walked back' in the Victorian health practitioner guidelines.

14.21 The Victorian guidelines explain that an objecting medical practitioner should inform the patient of their objection at the earliest opportunity, be aware of their obligation not to impede a person's access and, where possible, inform the organisation's 'voluntary assisted dying contact' so that they can assist the person. A practitioner may choose to refer a person to another practitioner or tell the person where they can get further information, such as a government website or a voluntary assisted dying care navigator.[25]

14.22 Health practitioners are also encouraged to inform their employer so that health services

17 *Voluntary Assisted Dying Act 2017* (Vic) s 7; *Voluntary Assisted Dying Act 2019* (WA) s 9(1). Section 9(1) of the Western Australian Act 'is not intended to limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in that subsection': s 9(2).

18 See further, as to acceptance or refusal of a request, Chapter 8 above.

19 *Voluntary Assisted Dying Act 2017* (Vic) s 13(1)(b)(i); *Voluntary Assisted Dying Act 2019* (WA) s 20(1), (2)(a), (5). See also, in similar terms, *Voluntary Assisted Dying Act 2017* (Vic) s 23(1)(b)(i); and *Voluntary Assisted Dying Act 2019* (WA) s 31(1), (2)(a), (5) on acceptance or refusal of a referral for a consulting assessment.

20 Vic Ministerial Advisory Panel Final Report (2017) 110; Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2947 (J Hennessy, Minister for Health). The Victorian Panel observed that there may be barriers to access in rural communities.

21 Vic Ministerial Advisory Panel Final Report (2017) 15, 110, citing MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014).

22 Vic Ministerial Advisory Panel Final Report (2017) 110.

23 BP White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 444.

24 See J Rutherford, 'Doctors and the Voluntary Assisted Dying Act 2017 (Vic): Knowledge and General Perspectives' (2020) 27(4) *Journal of Law and Medicine* 952. That author is based at the Australian Centre for Health Law Research.

25 Vic Guidance for Health Practitioners (2019) 21.

can understand the views of staff and manage patient access. Any referral must be made 'in a timely manner' so that a patient does not experience an unnecessary delay or adverse clinical outcome, 'such as a decline in decision-making capacity'.[26]

14.23 In Western Australia, a medical practitioner who refuses a request because of a conscientious objection is not required by the Act to refer the person elsewhere, but must give the person particular information.[27] It was explained that participation in the process by health practitioners is 'completely voluntary', but also that:[28]

> Health practitioners must still provide general information about voluntary assisted dying to the person who has requested access to voluntary assisted dying. After all, this person is still a patient to whom a duty is owed under the Western Australian healthcare system. A fundamental safeguard to the proposed model for voluntary assisted dying in Western Australia is that the person's decision is well informed throughout the process.

14.24 The Western Australian Panel recommended this requirement as an appropriate 'middle ground'. It expressed concern about a referral obligation because of 'deeply held objections' by parts of the community and some health practitioners. However, the Panel stated that 'it is not sufficient to simply not impede access' and that 'people should be provided with effective access to information'. It explained that government involvement would be required to effectively implement this approach, for example, by appointing care 'navigators' and developing a 'central information hub'.[29]

Tasmania

14.25 The Tasmanian Act recognises that a medical practitioner may refuse a first request for access to voluntary assisted dying, a referral for a second opinion or a request to be an administering practitioner for any reason, including that the practitioner has a conscientious objection. Similarly, a registered nurse may refuse a request to be an administering practitioner. The Act also recognises that a pharmacist may refuse to supply a voluntary assisted dying substance for any reason, including conscientious objection.[30]

14.26 A medical practitioner who refuses a first request must notify the person of their refusal as soon as reasonably practicable, but within seven days.[31] A medical practitioner or nurse who accepts or refuses a request may, but is not required, to give a reason for their acceptance or refusal.[32]

14.27 The Tasmanian Panel observed that a 'consequence of healthcare workers' rights not

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26 Ibid 8, 21. See also Department of Health & Human Services (Vic) 'Health practitioner information' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information>.
As to nurses and other allied health practitioners, see Department of Health & Human Services (Vic), 'Voluntary assisted dying: Information for nurses and allied health practitioners (September 2019) 2 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-information-for-nurses>.

27 *Voluntary Assisted Dying Act 2019* (WA) s 20(1), (2)(a), (5). Specifically, this is described as 'the information approved by the CEO for the purposes of this section': s 20(4)(b). The approved information will include information about voluntary assisted dying and contact details for the Western Australia Statewide Voluntary Assisted Dying Care Navigator Service: Information provided by Department of Health (WA), 19 March 2021. The service will be able to give information about voluntary assisted dying and support to the person, including help to locate a medical practitioner who is willing and eligible to participate: Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the Statewide Voluntary Assisted Dying Care Navigator Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Care-Navigator-Service.pdf>.

28 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health). It was stated that 'standardised information' will be developed and available to all health practitioners to give to patients who need information or make a request about voluntary assisted dying.

29 WA Ministerial Expert Panel Final Report (2019) 52–3, Rec 13. The Panel noted that there are 'known issues with health literacy and challenges faced by some population groups' and that people from some backgrounds may need additional help to access and understand information in a way that enables them to make informed choices.
See also WA Joint Select Committee on End of Life Choices Report (2018) 220–21 [7.66] ff, 228 [7.89], in which it was stated that a medical practitioner who has a conscientious objection should be required to offer to refer a person to another practitioner. That Committee also suggested a 'publicly available service so that people can directly access a doctor willing to provide assistance'.

30 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 20(2), 40(2), 64, 71(3).

31 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 20(3). The practitioner must also notify the Commission of the refusal and note on the person's medical records that the person made a first request and the medical practitioner refused the request: s 20(3)(b).

32 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 21, 41, 64.

to participate in [voluntary assisted dying] is that it will reduce access to the service, especially in regional settings'. The Panel considered that:[33]

> the access challenge may be exacerbated by the fact that those seeking [voluntary assisted dying] are likely to be very unwell, will require timely assistance, and may not be familiar with health systems and services. To balance the rights of doctors and patients, procedures for referring those seeking [voluntary assisted dying] to practitioners prepared to provide it are required.

14.28 The Panel noted that the Bill, in its then form, did 'not require practitioners exercising their right to conscientiously object to refer a person … to another provider or an organisation which can provide such information'. Instead, it 'place[d] the onus on the person (perhaps with the support of a Care Navigator) to find an alternative practitioner'.[34]

14.29 The Panel noted that '[m]andatory referral provisions are not a feature' of voluntary assisted dying laws in other Australian jurisdictions, which instead 'rely on policy guidelines and professional codes to ensure referral'. However, it noted the legislative requirement in most modern termination of pregnancy laws for doctors who have a conscientious objection to refer the person on.[35] The Panel considered that in contested areas of practice:[36]

> it can be helpful to individual practitioners and organisations to have an unambiguous legal requirement to undertake an action, rather than such a decision being based on the ethical deliberations of the individual doctor in the context of any employing organisation.

14.30 It added that this ensures 'a minimum standard' of care for all patients, 'rather than a different outcome depending upon which practitioner or service is approached'. For these reasons it suggested 'a legislative requirement for medical practitioners to provide an appropriate referral service' to people seeking voluntary assisted dying.[37]

14.31 An amendment to this effect was passed when the Tasmanian Bill was debated in the House of Assembly in early March 2021.[38] The Act states, in connection with the making of a first request, that if a person has 'clearly indicated to a medical practitioner that the person wishes to access voluntary assisted dying', the practitioner must give the person the contact details of the Voluntary Assisted Dying Commission. This applies whether or not the medical practitioner has a 'conscientious objection to providing assistance to the person to die' (and whether or not the practitioner accepts or refuses a request).[39]

14.32 The Tasmanian Panel also suggested it may be beneficial to include additional protection for health practitioners like that in the New Zealand Act, discussed immediately below. It stated such a provision 'would help ensure health practitioners do not incur detriment in their employment for their decision to participate in [voluntary assisted dying] or, conversely, not to participate on the grounds of conscientious objection'.[40] This suggestion was not taken up when the Bill was further considered in the Tasmanian Parliament in March 2021.

New Zealand

14.33 The New Zealand Act provides that a health practitioner 'is not under any obligation to assist any person who wishes to exercise the option of receiving assisted dying under this Act if the health practitioner has a conscientious objection to providing that

33 Tas Review Panel Report (2021) 74 [6.4.2].
34 Ibid.
35 Ibid 76 [6.4.2], citing the *Reproductive Health (Access to Terminations) Act 2013* (Tas).
36 Ibid.
37 Ibid.
38 See Tasmania, *Parliamentary Debates*, House of Assembly, 3 March 2021, 84–6.
39 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 18(1).
40 Tas Review Panel Report (2021) 74 [6.4.2], 84 [6.7.1].

assistance to the person'.[41] That provision is subject to the obligation in section 9(2), which applies if a person informs the medical practitioner they wish to receive assisted dying and the medical practitioner has a conscientious objection to providing that option. In that case, the medical practitioner must tell the person of:

- of their conscientious objection; and
- of the person's right to ask the Support and Consultation for End of Life in New Zealand Group for the name and contact details of a replacement medical practitioner.

14.34 Additionally, the New Zealand Act provides that an employer must not:[42]

> (a) deny to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit merely because the employee objects on the grounds of conscience to providing any assistance [to a person who wishes to exercise the option of receiving assisted dying]; or
>
> (b) provide or grant to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit conditional upon the employee providing or agreeing to provide any assistance [to a person who wishes to exercise the option of receiving assisted dying].

14.35 A person is entitled to recover damages for any loss resulting from a breach of that provision.[43]

Queensland

14.36 The Parliamentary Committee recommended that health practitioners with a conscientious objection should be able to choose not to participate in voluntary assisted dying 'provided that the rights of the patients to access the scheme are also protected'.[44] The White and Willmott Model includes a provision for conscientious objection in similar terms to Victoria and Western Australia which provides that a registered health practitioner who has a conscientious may refuse to do any of the things listed in the provision. The practitioner must also disclose their objection to the person seeking access to voluntary assisted dying.[45]

14.37 The Parliamentary Committee emphasised the importance of a voluntary assisted dying scheme being 'genuinely accessible' in circumstances where a registered medical practitioner has a conscientious objection, particularly for people living in rural or remote areas.[46]

14.38 The White and Willmott Model provides that a registered medical practitioner must disclose their objection and 'offer' to refer the person to 'another practitioner or entity'.[47] If requested, the medical practitioner must 'refer the person, or transfer their care', to:[48]

> (a) another registered medical practitioner who, in the referring registered medical practitioner's belief, does not have a conscientious objection to voluntary assisted dying; or
>
> (b) an entity at or through which, in the referring registered medical practitioner's belief, the person will have access to another registered medical practitioner

41 *End of Life Choice Act 2019* (NZ) s 8(1).
42 *End of Life Choice Act 2019* (NZ) s 8(3).
43 *End of Life Choice Act 2019* (NZ) s 8(4).
44 Qld Parliamentary Committee Report No 34 (2020) 144, Rec 17.
45 White and Willmott Model cl 38(1)–(2). The listed matters are: providing information about voluntary assisted dying; participating in any part of the request and assessment process for voluntary assisted dying; supplying, prescribing or administering voluntary assisted dying medication; and being present during voluntary assisted dying.
46 Qld Parliamentary Committee Report No 34 (2020) 144, Rec 18.
47 White and Willmott Model cl 38(2).
48 White and Willmott Model cl 38(3). It was explained that the intent of this provision is that a registered medical practitioner is required to offer to refer the person elsewhere. It was suggested that this is 'less onerous' than the *Termination of Pregnancy Act 2018* (Qld) s 8, which includes a duty to refer, because here 'it would be sufficient to provide information to enable someone to have access to that service': Evidence to the Parliamentary Committee, Brisbane, 5 July 2019, 12 (B White).

who does not have a conscientious objection to voluntary assisted dying.

Note—

Subsection (3)(b) provides for referral of a person requesting access to voluntary assisted dying to be to an entity through which the person will have access to another registered medical practitioner who does not have a conscientious objection to voluntary assisted dying. This would permit a registered medical practitioner to provide the person requesting access to voluntary assisted dying with contact details of an entity which can provide information that will facilitate access to voluntary assisted dying.

14.39 The approach of requiring a referral was said to 'reflect the balance normally struck in medicine that respects conscience but values autonomy and equality in ensuring a person still has effective access to a lawful health service'. The referral requirement was said to be intentionally broad, so that it can be satisfied by giving contact details of an entity that can give information to facilitate access to voluntary assisted dying. Some practitioners might consider this 'morally preferable'.[49]

14.40 Professors White and Willmott later observed that the absence of a legislative requirement to refer might 'impede access' to a lawful option, which would 'compromise the realisation of other important policy goals: respect for autonomous choices, alleviation of suffering and the provision of high-quality care'.[50]

OVERVIEW OF SUBMISSIONS

14.41 The Consultation Paper asked whether the draft legislation should provide that a registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following:[51]

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) if applicable, apply for a voluntary assisted dying permit;

(d) prescribe, supply, dispense or administer a voluntary assisted dying substance;

(e) be present at the time of the administration of a voluntary assisted dying substance; or

(f) some other thing (and, if so, what)?

14.42 It also asked whether a registered medical practitioner who has a conscientious objection to voluntary assisted dying should be required to refer a person elsewhere or to transfer their care.[52]

14.43 Respondents generally supported a legislative provision for conscientious objection by registered health practitioners.

14.44 There was widespread support for the draft legislation to provide that a registered health practitioner who has a conscientious objection has the right to refuse to:

- participate in the request and assessment process;

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49 White and Willmott Model, Explanatory Notes 4. See also Evidence to the Parliamentary Committee, Brisbane, 5 July 2019, 12–13 (B White).
The terms 'refer' and 'transfer of care' are not defined in the *Termination of Pregnancy Act 2018* (Qld). The QLRC explained that '[i]t will be for the objecting practitioner to determine how to appropriately refer a woman to another practitioner or service, and how and when to transfer a woman's care', and that '[a]n example of a referral could be giving a woman enough information to contact an alternative practitioner or health service provider about obtaining the requested service (for example, their name and contact details), or providing a written referral to another medical practitioner (for example, an obstetrician)': QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) [4.160]–[4.165].

50 White et al, above n 23, 444. See also R McDougall and B Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation' (2020) 21 *BMC Medical Ethics*, Article 38 online <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5>.

51 QLRC Consultation Paper No 79 (2020) Q40.

52 Ibid Q41.

- prescribe, supply or administer a voluntary assisted dying substance; or
- be present at the time of the administration of a voluntary assisted dying substance.

14.45 There was less support for a legislative right to refuse to provide information about voluntary assisted dying. This was on the basis that a health practitioner should be required to give basic information so that a patient is informed of their options and not impeded in accessing a lawful option. Some respondents noted that medical ethics require that a person's access to care is not impeded.

14.46 Other respondents considered that being required to provide any information at all about the option of voluntary assisted dying is inconsistent with a right to conscientiously object, and that practitioners should not have their speech compelled by law.

14.47 Of the respondents who supported a conscientious objection provision covering all matters listed in paragraphs (a) to (e) above, some suggested it should be described in similar but broader terms, or that it should simply apply to any involvement or participation in voluntary assisted dying.

14.48 Many respondents submitted that the right of a registered health practitioner to conscientiously object to voluntary assisted dying should be coupled with a requirement to:

- inform the person of their objection; and
- refer the person elsewhere (at least to a service, practitioner or entity that could provide information) or transfer the person's care.

14.49 Some respondents submitted that the need to protect health practitioners who have a conscientious objection must be balanced with the need to support patients who want to exercise their autonomy and access voluntary assisted dying. This includes people in remote, rural or regional areas, and people in other circumstances that may make it difficult to access an alternative health practitioner.

14.50 Other respondents submitted that practitioners who have a conscientious objection should not be required to refer a person elsewhere because this would impact on their right to object and amount to participation in voluntary assisted dying. Some submitted that the obligation of health practitioners who have a conscientious objection, consistent with the general obligation in health care, should be to inform a person of their objection and not impede access to lawful treatments.

14.51 A few respondents referred to the need to protect practitioners and others from harassment, pressure, discrimination or disadvantage because of their willingness or unwillingness to participate in voluntary assisted dying. Concerns included colleagues 'judging' one another and pressure on junior practitioners and nurses to participate. Other respondents submitted that there should not be any legal, administrative or disciplinary action for refusing or choosing to participate in voluntary assisted dying, or that the legislation should explicitly prohibit penalties, detriment or disadvantage based on conscientious objection.

14.52 Submissions about particular issues are summarised in more detail below.

ISSUES

14.53 The principal issues about participation by individuals and conscientious objection are:

1. Should the legislation provide that a health practitioner or other individual who has a conscientious objection to voluntary assisted dying has the right to refuse to participate?
2. To whom should provision about participation and conscientious objection apply?
3. Should any right to refuse be a right to refuse to participate in any way or should it be (as in Victoria and Western Australia) a right to refuse to do

certain things? If so, what should be the scope of any right of an individual to refuse to participate on the grounds of a conscientious objection?

4. Should the legislation prohibit penalties, detriment or other discrimination based on the person's willingness or unwillingness to participate in voluntary assisted dying?
5. Should any right to refuse to participate on the grounds of conscientious objection be subject to a requirement to:
   (a) inform the person that they are refusing the request for information or assistance because they have a conscientious objection to voluntary assisted dying; and
   (b) refer the person elsewhere or transfer their care?
6. What should be the consequences of non-compliance by a registered health practitioner with the conscientious objection provisions?

SUBMISSIONS ON PARTICIPATION AND CONSCIENTIOUS OBJECTION

14.54 This part considers the first four issues, which relate broadly to whether the draft legislation should provide for conscientious objection, the scope of any legislative provision and any associated prohibitions or protections.

Should the legislation include a conscientious objection provision?

14.55 There was general support for the legislation to include a conscientious objection provision. Some respondents submitted that a person should be permitted to conscientiously object to, or should not be required to participate in, voluntary assisted dying. Others supported a provision in similar terms to the question in the Consultation Paper as set out at [14.41] above.[53]

14.56 Some of those respondents, including the Queensland Nurses & Midwives' Union, Palliative Care Queensland and the Australian Lawyers Alliance supported a conscientious objection provision to recognise and respect the varying views, values, morals, ethics and beliefs of different people. For example, Palliative Care Queensland submitted that people should '[b]e supported to work within their own professional or personal ethical values, whilst continuing to provide safe, quality, compassionate care to people living with a life-limiting illness'.[54]

14.57 Several respondents submitted that the legislation should provide for conscientious objection because it would be consistent with the rights of individuals, particularly the right to freedom of conscience. One respondent emphasised 'religious freedom', submitting that the 'religion, conscience and beliefs' of practitioners must be protected and that, if practitioners were forced to act contrary to those beliefs, they may experience 'moral distress'.

14.58 Some respondents submitted that a conscientious objection provision would be consistent with the basic premise that access to voluntary assisted dying is voluntary and that there will be no compulsion on a person to participate.[55] A member of the public submitted that 'the word voluntary is significant' and it 'is important that people reluctant to participate should not feel any obligation to participate and should have their

53 As discussed later, several respondents supported a conscientious objection provision covering the matters in Q40(b)–(e), but not conferring a right to refuse to provide information about voluntary assisted dying as in Q40(a). A few respondents submitted there should be recognition that some people conscientiously participate in voluntary assisted dying.

54 This respondent noted that health professionals may make judgments about their participation in voluntary assisted dying based on their personal ethics and beliefs, as well as those of their employing organisation. Other respondents, such as Catholic Health Australia, also noted that an individual would be influenced or bound by the ethical frameworks of their employing organisation.

55 An academic submitted that support for voluntary assisted dying is not universal and people 'should be able to choose to be treated … by medical professionals who share their convictions' and 'not be discouraged from obtaining medical care due to fear of being subject to persuasion or advice to access a procedure [to] which they morally object'.

reluctance respected'.

14.59 Others observed that provision for conscientious objection would be consistent with:

- the approach taken in other jurisdictions, including Victoria and Western Australia;
- the recommendations made by the Parliamentary Committee and the White and Willmott Model;
- other legislation, such as the *Termination of Pregnancy Act 2018*; or
- codes of conduct and ethics applying to the medical profession or to particular health care organisations.

14.60 A medical defence organisation and professional indemnity insurer submitted that, due to the 'inevitable complexity' of a voluntary assisted dying framework, there should be '[b]road consistency' with other Australian jurisdictions and '[c]lear provisions for conscientious objection consistent with those operating generally in healthcare'. It identified that the obligations of an objecting medical practitioner should be consistent with those applying in a general health care context, as set out in the MBA Code of Conduct.[56]

14.61 One respondent submitted that a legislative provision about conscientious objection is unnecessary because it is provided for in the common law and medical ethics; but, observed that there is 'no harm' in including such a provision. Two academics jointly submitted that, instead of reliance on conscientious objection, practitioners could 'self-select' out of the voluntary assisted dying process by choosing not to complete the mandatory training.

14.62 In a recent study of Victorian medical practitioners' knowledge and perspectives of the Victorian Act, approximately half of those surveyed supported the conscientious objection provision. Their reasons included protecting practitioners who have a moral objection or do not want to be involved, and recognition that practitioners have biases and can 'influence … health care outcomes'. Some were 'generally supportive' of conscientious objection, but had concerns about its consistency with the 'obligation to relieve suffering' or the 'principle of nonabandonment'. Two practitioners were 'generally opposed' to the provision, including because patients have a right to seek lawful treatment.[57]

To whom should the conscientious objection provision apply?

14.63 Some respondents submitted that a provision about conscientious objection should apply to categories of persons such as 'registered health practitioners' or 'registered health professionals', 'health professionals', 'medical and health staff', 'clinical staff' or 'health staff'.[58] One respondent suggested that this should include 'all health care practitioners involved in the care of the patient or who would have direct role in the provision of [voluntary assisted dying] to the patient', and should apply equally in the public and private sectors. Some respondents submitted that any provision about conscientious objection should apply to 'medical practitioners' or 'doctors',[59] 'nurses' or 'pharmacists'.

14.64 Several respondents suggested that a provision should apply to a broader category of people that have a connection with health care. For example, this could include the 'interdisciplinary team treating the patient', 'allied health workers', employees of health and aged care services, 'care workers', volunteers, administrative employees and 'non-medical individuals within multidisciplinary teams'.

56 Citing MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.4.6], [3.4.7].

57 See Rutherford, above n 24, 960–61.

58 As mentioned earlier, numerous respondents supported a conscientious objection provision in similar terms to Q-40 of the Consultation Paper, which referred to 'registered health practitioners'.

59 Some respondents particularly noted the need for any conscientious objection provision to apply to medical practitioners, but did not suggest the provision be limited to those practitioners.

14.65 A few respondents considered that a legislative provision about conscientious objection should apply more broadly than to health care workers; for example, to family members or to any person. However, another respondent submitted that:

> it would be impracticable to extend [the right to conscientious objection] to those who are not directly involved in the provision of [voluntary assisted dying]—for example those involved in the logistics chain or bureaucracy. … Indirect conscientious objection in the case of [voluntary assisted dying] would be difficult to enforce and likely to deleteriously affect the health care system.

To what actions should the conscientious objection provision apply?

14.66 Some respondents submitted that a provision about conscientious objection should be broad in scope, and that a relevant person should be able to conscientiously object to any involvement or participation in voluntary assisted dying. For example, Queensland Baptists and the Royal Australian College of General Practitioners Queensland stated that a person should have 'uninhibited freedom' to refuse to participate, or should be able to 'refrain from involvement in accordance with their personal beliefs and values'.

14.67 Many respondents, including AMA Queensland, the Royal Australian College of General Practitioners Queensland, voluntary assisted dying advocacy groups, academics, medical practitioners and members of the public, submitted that any legislative provision should permit a person who has a conscientious objection to refuse to:[60]

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) if applicable, apply for a voluntary assisted dying permit;

(d) prescribe, supply or administer a voluntary assisted dying substance; or

(e) be present at the time of the administration of a voluntary assisted dying substance.[61]

14.68 One respondent submitted that a medical practitioner should have choice about the matters listed and, in particular, should be able to refuse to be present at the time of administration to avoid 'emotional harm'. It was also submitted that a medical practitioner should be able to exercise their autonomy by refusing to administer the substance.

14.69 A few respondents made similar suggestions. One respondent referred to the ability to refuse to participate in 'assessment, consultation, implementation, reporting or review' associated with voluntary assisted dying.

14.70 Some respondents, including Dying with Dignity NSW, Go Gentle Australia, the Australian College of Nurse Practitioners, a retired nurse and members of the public, submitted that the scope of any legislative provision should extend to permitting a relevant person who has a conscientious objection to refuse to do any of the matters listed at (b)–(e) above, but should not permit the person to refuse to provide information about voluntary assisted dying.[62]

14.71 It was submitted that people seeking access to voluntary assisted dying have a right to information and that giving patients information ensures they are aware of their options at the end of life. It was also submitted that health practitioners should not be able to refuse to give basic information about voluntary assisted dying, including where further information can be obtained. Some respondents noted that medical ethics require that a practitioner not impede a person's access to voluntary assisted dying.[63] An academic

60 This includes some respondents who also made more general statements about objection to any type of participation.

61 One respondent submitted that a person should be able to refuse to be present 'only if there is someone else able to support the patient'.

62 Catholic Health Australia submitted that, if the information to be provided is publicly available and pertains only to informing a patient of their legal rights, then 'this may be acceptable'.

63 One respondent observed that '[a]ll registered health practitioners should provide information about voluntary assisted dying'.

submitted that information should be provided 'to facilitate patient choice' and that '[p]atient autonomy and compassionate care should trump personal beliefs of a healthcare practitioner'.

14.72 Other respondents submitted that, where a practitioner has a conscientious objection, they should not be required to provide information about voluntary assisted dying. Some respondents submitted that in those circumstances a practitioner should provide a referral. A medical practitioner submitted that:

> The question with [voluntary assisted dying], as with other ethically contentious practices, is whether information can be 'provided' without in any way seeming to affirm or condone the practice. I think it can, within the private doctor-patient relationship, but the manner and content of providing information must not be 'specified' by legislation.
>
> It is normal practice for doctors to lay out all of a patient's options even if some are options that the doctor would not condone. …
>
> However, some doctors will feel that even raising the possibility of a grossly unethical practice like euthanasia is a violation of their ethic of care; in that case, those doctors should not have their speech compelled by law. …
>
> The manner and content of provision of information should be left to the doctor and the normal standards of professional care—we should not have the manner and content dictated by legislation.

14.73 Some respondents suggested that any provision should permit a practitioner with a conscientious objection to refuse to:

- initiate discussions about voluntary assisted dying;
- attend or provide training about voluntary assisted dying;
- develop clinical policies about the administration of voluntary assisted dying;
- work in a clinical area where voluntary assisted dying is practiced, even if the person is individually not required to participate;
- refer a person seeking access to voluntary assisted dying elsewhere;
- do any other action the practitioner considers is cooperation with voluntary assisted dying, or to be against their conscience.

14.74 The Royal Australasian College of Physicians observed that some practitioners may be willing to participate in voluntary assisted dying in limited ways, for example, 'in a limited range of cases' or 'in only providing a second opinion'.

Should the legislation contain additional protections for people who hold a conscientious objection?

14.75 Some respondents noted concerns about practitioners being 'judged' or not respected by colleagues or employers for choosing to participate or not participate in voluntary assisted dying. There were also concerns about junior medical practitioners, nurses or administrative employees being pressured to participate by colleagues, and practitioners being pressured to participate by patients or families.[64]

14.76 Some respondents suggested that the legislation should protect medical practitioners who have a conscientious objection from legal or disciplinary proceedings, abuse or adverse comments, censure, harassment, coercion or discrimination.[65] A few respondents submitted that there should also be protection for the privacy and confidentiality of employees.

64 One submission attached R McDougall et al, '"This is uncharted water for all of us": challenges anticipated by hospital clinicians when voluntary assisted dying becomes legal in Victoria' (2020) 44 *Australian Health Review* 399, 403.

65 It was also observed that some of these protections could apply to both those who conscientiously object to voluntary assisted dying, and those who choose to be involved in voluntary assisted dying.

14.77 Other respondents submitted that a person who chooses not to participate in voluntary assisted dying must not be subject to any penalty, detriment or disadvantage, or 'should not face any criminal, civil, administrative or disciplinary action for refusing to participate'.[66] Other respondents submitted that an employee should not be penalised, subject to disciplinary proceedings or dismissed.

14.78 A member of the public submitted that the New Zealand Act provisions that give protection to employees are insufficient. In their view, it is unclear to whom and how these provisions would apply due to a lack of information about how a person could know or prove that they had been denied employment or another thing, or had suffered a loss. An 'express bullying clause' was said to be required and that there should be 'a prohibition on the prospective employer asking the prospective employee about their position on assisted dying'.

14.79 A few respondents, including the United Workers Union, submitted that there should be penalties for persons who breach the rights or protections applying to people who have a conscientious objection.

THE COMMISSION'S VIEW

Should the legislation include a conscientious objection provision?

14.80 Recognition of the right of an individual to freedom of conscience and belief warrants a provision about an individual's conscientious objection to participating in voluntary assisted dying. The right to make such a conscientious objection is subject to other principles and other individual rights. These include a person's autonomy in end of life choices and the right to be supported in making informed decisions about those choices. It is subject, in the case of health practitioners, to ethical and professional standards. These include obligations to respect patient autonomy and a patient's right to make their own decisions based on their values and beliefs, and the principle of non-abandonment, including that a doctor should not abandon a patient without making other arrangements. The right of a health practitioner to conscientiously object to participating in voluntary assisted dying is subject to the qualification that the objection should not impede access to care and treatment that is lawful, including voluntary assisted dying.

14.81 Therefore, the right of an individual, including a health practitioner, to conscientiously object to participating in voluntary assisted dying should be subject to reasonable provisions that respect the rights of other individuals. These include the rights of an individual to access information about end of life choices, including voluntary assisted dying. The exercise of a right to refuse to participate should not hinder or deprive a person of their right to access a process that is lawful.

14.82 The right of a health practitioner to not participate in voluntary assisted dying on the grounds of a conscientious objection is reflected in the draft Bill, together with appropriate qualifications on that right discussed below.

To whom should the conscientious objection provision apply?

14.83 As explained, many submissions stated that provision about conscientious objection should apply to medical practitioners or registered health practitioners. Others suggested a broader application, such as to each person involved in a patient's care or treatment or to broader categories of people employed by a relevant health service. However, there were also observations about the impracticability of extending the right to those who are not involved in the provision of voluntary assisted dying.

14.84 This raises a similar issue to one considered by the Commission in the review of

66 Some of these respondents stated that this should also apply where a practitioner chooses to participate in voluntary assisted dying.

termination of pregnancy laws. The provision enacted in the *Termination of Pregnancy Act 2018*, set out at [14.14] above, applies to a registered health practitioner. To minimise barriers to access, it does not apply to 'administrative, managerial or other tasks that are ancillary to the provision of termination of pregnancy services', or to 'administrative, managerial staff or others' engaged in those ancillary tasks.[67]

14.85 The application of the conscientious objection provision to registered health practitioners would accord with the Victorian and Western Australian Acts, and the *Termination of Pregnancy Act 2018*.

14.86 The right to refuse to participate in the request and assessment process relates to requests made to, and assessments undertaken by, health practitioners. It is not necessary to extend the statutory right to refuse to do these things to employees who are not involved in dealing with a 'first request', an eligibility assessment or the administration of a substance. Therefore, it is unnecessary to extend the statutory right to refuse to participate to other employees who, for example, assist in providing food to a patient in hospital. The right to refuse to prescribe, supply or administer the substance similarly applies to registered health practitioners because other persons are not authorised to do those things.

14.87 More generally, the right of a health practitioner to refuse to participate in the assessment or administration processes on the grounds of a conscientious objection arises because, without such a right, the practitioner might have a professional or legal duty to provide the requested services.

14.88 Also, an employee who is not a registered health practitioner and receives a request by a patient for information about voluntary assisted dying would be expected to direct that request to an appropriate person, consistent with proper practice and the workplace's guidelines. If, for example, the request was made to an employee in the ward who was not a registered health practitioner, then the request would be passed on, irrespective of whether the employee had or did not have a conscientious objection. The request would be referred to someone trained to respond to it in accordance with the law and relevant practices. Therefore, we do not consider that it is necessary to extend the conscientious objection provision to all employees who assist in the wards. Nor should it apply to employees engaged in administrative, managerial or other tasks that are ancillary to the provision of services that include voluntary assisted dying.

14.89 To extend the right to refuse to a broad range of employees who are not directly involved in process would undermine practical access by persons to voluntary assisted dying.

14.90 The right to refuse to participate in voluntary assisted dying on the grounds of conscientious objection should apply to registered health practitioners, such as doctors and nurses, to whom requests are made and who might otherwise be expected to be involved in the assessment and administration processes.

14.91 As a general rule, issues concerning participation by other employees, who are not registered health practitioners, are best addressed by workplace agreements, codes of practice, and guidelines. For example, Palliative Care Australia's guideline states that care workers should be able to exercise their right to conscientiously object or conscientiously participate in any aspect of voluntary assisted dying.

14.92 Interpreters, who are not health practitioners, may be requested to provide services in connection with voluntary assisted dying. Certain accredited interpreters are subject to a code of ethics. In any case, we have been informed by Queensland Health that the recognised best practice is for an interpreter to be briefed before being engaged, at which time the interpreter might decline to accept the assignment on the grounds of a conscientious objection. Queensland Health and Hospital and Health Services

67 Explanatory Memorandum, Termination of Pregnancy Bill 2018 (Qld) 9, 20. See also QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) [4.147].

who regularly engage interpreters should be expected to embed such practices. This will respect the conscientious objections of interpreters, while facilitating access to interpreters who are willing to interpret patient-practitioner communications about voluntary assisted dying.

14.93 Special provision should be made for speech pathologists, who are allied health professionals, but not registered health practitioners. They may be asked to be involved in the request and assessment process, for example, to help a patient communicate a voluntary assisted dying request or to assist in patient-practitioner communications in the assessment process. They may be asked to assess a person's ability to swallow or to communicate.

14.94 Speech Pathology Australia submitted that because speech pathologists may be involved in the voluntary assisted dying process they should be afforded 'the same expectations and protections' as registered health practitioners and should be recognised in the legislation as part of a person's treating team.

14.95 Bodies representing health professionals, such as speech pathologists, who are not 'registered health practitioners' have developed standards to regulate their members.[68] Speech Pathology Australia has a code of ethics which binds its members to professional standards and ethical practice. The code does not specifically address conscientious objection. However, it recognises the ethical principles of respect for the rights of others to self-determination and to make free and informed decisions. It also includes the principle of 'beneficence'. Speech pathologists who are bound by the code must 'proactively anticipate, disclose and resolve any potential, perceived or actual conflicts of interest'.[69] The practical application of those principles might therefore be expected to align with the MBA and AMA standards on conscientious objection. As earlier noted, in general terms, these standards recognise that a practitioner may decline to provide or participate directly in a treatment or procedure to which they conscientiously object, but require the practitioner to:[70]

- inform their employer, colleagues and patients of their objection;
- ensure that a patient's access to treatment or care is not impeded, including by providing information to enable a patient to obtain services elsewhere.

14.96 In summary, we recommend that the right to refuse to participate in voluntary assisted dying on the grounds of conscientious objection should apply to registered health practitioners (such as doctors and nurses) and to speech pathologists.

To what actions should the conscientious objection provision apply?

14.97 As noted, respondents who supported a legislative conscientious objection provision generally considered that it should confer the right to refuse to participate in the request and assessment process, to prescribe, supply or administer the substance, or to be present at the time of the administration of the substance.

14.98 However, there was disagreement about whether there should be a right to refuse to give information about voluntary assisted dying. A few respondents considered the conscientious objection provision should apply broadly to any involvement or participation in voluntary assisted dying.

14.99 Possible legislative models include providing that a health practitioner who has a conscientious objection:

- is under no obligation to assist a person to access voluntary assisted dying (as in New Zealand); or

68 National Alliance of Self Regulating Health Professions, *Self Regulating Health Profession Peak Bodies Membership Standards* (2 December 2016).

69 Speech Pathology Australia, *Code of Ethics* (2020) 4, 8, [2.3].

70 See generally [14.6]–[14.12] above.

- has the right to refuse to do certain things (as in Victoria, Western Australia and the White and Willmott Model).

14.100 The Commission favours the latter approach. It is preferable to identify the things that a health practitioner may refuse to do because of a conscientious objection.

14.101 As to the specific things an objecting health practitioner may refuse to do, the Western Australian Act includes the three matters stated at [14.44] above. The draft legislation should also include those matters.

14.102 Unlike the Victorian Act and the White and Willmott Model, the Western Australian Act does not give a right to refuse to 'provide information about voluntary assisted dying'. The Western Australian Act addresses the provision of information in the context of a medical practitioner either accepting or refusing a first request. If the medical practitioner refuses the first request because of a conscientious objection, the practitioner must, immediately after the first request is made:[71]

- inform the patient that the practitioner refuses the request; and
- give the patient the information approved by the chief executive officer of the Department.

14.103 It is preferable that the draft Bill addresses the right of a health practitioner to refuse to give information about voluntary assisted dying based on a conscientious objection, along with any qualifications on that right. Also, that right and any qualifications on it should apply to health practitioners in general, not simply medical practitioners to whom a first request is made. This is consistent with the White and Willmott Model.

14.104 This approach has the advantage of making it clear whether the right to refuse to assist extends to giving information, subject to any requirement to advise where information may be obtained or to refer. We consider it preferable to address that issue in the legislation, rather than leave it to be determined by general codes which may be uncertain.

14.105 The legislation should address one other matter not specifically addressed by the Victorian and Western Australian Acts. It should include a right to refuse to 'participate in an administration decision'.

14.106 Accordingly, the draft Bill provides that a health practitioner who has a conscientious objection has the right to refuse to:

- provide information about voluntary assisted dying;
- participate in the request and assessment process;
- prescribe, supply[72] or administer the substance;
- participate in an administration decision; or
- be present at the time of the administration or self-administration of the substance.

14.107 Similarly, the draft Bill provides that a speech pathologist who conscientiously objects has a right to refuse to provide information about voluntary assisted dying, participate in the request and assessment process, participate in an administration decision, or be present at the time of the administration or self-administration of the substance.

Should the legislation contain additional protections for people who hold a conscientious objection?

14.108 A separate issue is whether the individual right to not participate should be reinforced by a provision that protects individuals from penalties, detriment or discrimination in the workplace based on the person's position on voluntary assisted dying. This issue

71 *Voluntary Assisted Dying Act 2019* (WA) s 20(2)(a), (4)(b), (5).
72 'Supply' includes 'dispense': see Chapter 11 above.

could apply to a practitioner who refuses to participate for any reason but might be of particular relevance to a practitioner whose refusal is due to conscientious objection.

14.109 Palliative Care Australia has developed guiding principles for those providing care to people living with a life-limiting illness. The guidelines include that '[p]eople living with a life-limiting illness are supported and respected whether or not they choose to explore or access voluntary assisted dying'. Another principle is that '[p]eople exploring voluntary assisted dying will not be abandoned'.[73]

14.110 Their guidelines state that:[74]

> In any setting where care is provided to people living with a life-limiting illness, there may be different views between health and care professionals about voluntary assisted dying and what options should or can be offered and accessed. There will also be decisions at the organisational level that will determine the extent of involvement in voluntary assisted dying within a specific setting.

14.111 Their guidelines also state that health professionals, care workers and volunteers should:[75]

> - Be supported to work within their own professional or personal ethical values, whilst continuing to provide safe, quality, compassionate care to people living with a life-limiting illness.
> - Be treated with mutual understanding and respect, facilitated by open and transparent communication.
> - Be able to exercise their right to conscientiously object or conscientiously participate in any aspect of voluntary assisted dying.
>
> …

14.112 The case for a legislative prohibition against certain conduct is that it provides practical support to the right of a health practitioner to refuse to participate in voluntary assisted dying.

14.113 The case against including such a provision is that:

- no such provision is contained in the Victorian or Western Australian Acts or the White and Willmott Model;
- no similar provision appears in the *Termination of Pregnancy Act 2018* which recognises conscientious objection;
- issues of this kind are best left to laws governing the workplace, antidiscrimination law, the HR Act[76] and guidelines within workplaces which give practical application to the statutory right to refuse, as well as the AMA Position Statement that doctors with conscientious objections should 'not be treated unfairly or discriminated against';[77] and
- the statutory right of a health practitioner to refuse to do certain things should be reflected in guidelines (as in Victoria) and workplace practices, rather than complicate a voluntary assisted dying statute.

14.114 The Commission is persuaded by these points. On balance, we consider that it is unnecessary to include a provision in the draft Bill to prohibit penalties, detriment or other discrimination based on the person's willingness or unwillingness to participate in voluntary assisted dying.

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73 Palliative Care Australia, *Voluntary Assisted Dying in Australia: Guiding Principles for those providing care to people living with a life-limiting illness* (June 2019).

74 Ibid.

75 Ibid.

76 It is not anticipated that any voluntary assisted dying legislation would supplant protections given by other legislation, or purport to be a complete statement of the rights and responsibilities of parties in the workplace.

77 AMA, *Position Statement: Conscientious Objection* (2019) [1.7], at [14.9] above.

14.115 Also, insofar as such a provision might be premised on the 'right of a health practitioner to participate in voluntary assisted dying', the draft Bill is concerned with the right of a health practitioner to *not* participate in voluntary assisted dying, including on the grounds of a conscientious objection. Any suggested right for a health practitioner to participate in voluntary assisted dying is contentious and is not provided for in the draft Bill. It raises complex issues about the suggested right of an employee or independent contractor to engage in conduct contrary to the terms of their engagement. As the guidelines of Palliative Care Australia note, decisions at an organisational level will determine the extent of involvement in voluntary assisted dying within a specific setting. More generally, both public and private health services have an interest in determining what services they will offer in general or at a certain facility, and are entitled to organise their workforce accordingly.

14.116 A qualified, statutory right to refuse to do certain things on the grounds of conscientious objection provides a sufficient foundation for a person who exercises that right to address conduct which is inconsistent with it.

REQUIREMENTS TO INFORM, TO REFER OR TO TRANSFER CARE

14.117 This part considers the fifth issue listed at [14.53] above—whether the draft Bill should require a registered health practitioner who refuses to participate in voluntary assisted dying on the grounds of conscientious objection to inform a person of the reason for their refusal, and to refer the person elsewhere or transfer their care.

Submissions

A requirement to inform a person of their conscientious objection

14.118 Many respondents submitted that a health practitioner who has a conscientious objection to voluntary assisted dying should be required to inform a person seeking access to voluntary assisted dying of their objection.[78] A medical defence organisation and professional indemnity insurer supported this because it would be consistent with the obligations in the MBA Code of Conduct.

14.119 Health Consumers Queensland stated that a medical practitioner should be 'transparent' about their beliefs, values and ability to support the patient's wishes, and that '[i]t is important that this not cause distress or delay to access'. Some respondents submitted that a practitioner should advise a patient of their conscientious objection 'early in the care relationship', so that a patient has the opportunity and time to develop a relationship with a different medical practitioner.

14.120 In contrast, two academics jointly submitted that a practitioner should not be required to disclose their conscientious objection because this:

> imposes an unwarranted burden and fear of being judged on the patient and potentially conflicts with their right to freedom of religious belief, while arbitrarily forcing the practitioner to choose between the demands of their conscience, and their right to privacy of religious belief.

14.121 A member of the public submitted that there should be no need for a person who conscientiously objects to provide a reason or explanation. A medical practitioner submitted that a health practitioner who has an objection should inform the person but 'should not have to explain or justify their stance'.

78 Many of these respondents also supported a requirement for the practitioner to refer the person elsewhere or transfer their care. One respondent suggested the patient could be informed 'in writing … or as a general disclosure'.

14.122 The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine suggested that medical practitioners who conscientiously object could 'register' their objection with a government body or could declare their objection when renewing their registration as a medical practitioner so that this information is publicly accessible.[79]

A requirement to refer a person elsewhere or transfer their care

14.123 Numerous respondents submitted that, if a registered medical practitioner has a conscientious objection, they should be required to refer a person elsewhere or to transfer their care.[80] Some respondents submitted that this requirement should be mandatory or included in legislation.

14.124 Some respondents supported a legislative requirement for referral or transfer of care to ensure that people have access to voluntary assisted dying or to 'quality choice of end of life care'. One respondent submitted that '[p]roviding for conscientious objections without the dual requirement for referral and transfer' would be 'in stark contrast to the guiding principles of the legislation'.

14.125 Several respondents, including Professors White and Willmott, the Australian Lawyers Alliance and Palliative Care Social Work Australia, noted that there must be a balance between respect for a practitioner's conscientious objection and respect for an individual's rights, autonomy and ability to access lawful end of life options, including voluntary assisted dying. Professors White and Willmott submitted that:

> a [conscientious objection] by a health practitioner should not be able to block the ability of a person to pursue [voluntary assisted dying] if they so choose. We therefore consider the legislation should contain a mechanism to facilitate such access. Such a mechanism would reflect the balance normally struck in medicine that respects conscience but values autonomy and equality in ensuring a person still has effective access to a lawful health service.

14.126 Others, including VALE Group and Health Consumers Queensland, submitted that a requirement to refer a person or to transfer their care is consistent with the protection of human rights or patient rights, including autonomy, access to (and choice of) services and continuity of care. One respondent stated that 'enabling the person's choice and supporting them is key'.

14.127 Several respondents, including the Australian Lawyers Alliance and a medical practitioner, observed that a requirement to refer a person elsewhere or transfer their care would be consistent with good medical practice, as set out in codes of conduct and ethics, or with a practitioner's duty of care. Some respondents considered that it is also consistent with the principle of non-abandonment. The End of Life Choice Society New Zealand Inc, consistently with the position of the New Zealand Medical Association, submitted that 'a right to conscientiously object does not constitute a right to obstruct services or treatment'.[81]

14.128 A medical practitioner submitted that an objecting practitioner should be required to refer a person elsewhere or transfer their care, not only when a person makes a request about voluntary assisted dying but also when a person makes a 'general inquiry' about end of life options. It was submitted that this aligns with the MBA Code of Conduct, including the requirement for a practitioner to ensure their personal views do not adversely affect their patient's access to care or the referrals made by the practitioner.[82]

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79 See also [14.145] below, and further n 95 as to privacy concerns.

80 Q-41 of the Consultation Paper was directed to registered medical practitioners rather than the broader category of registered health practitioners.

81 Citing New Zealand Medical Association, *Position Statement: Objection on the Grounds of Freedom of Conscience (Conscientious Objection)* (December 2019).

82 Citing MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [2.1], [3.2.14], [3.4.6].

14.129 Some respondents submitted that a requirement to refer a person elsewhere or transfer their care is necessary to ensure a person is connected with an alternative medical practitioner. An academic, Ms Rutherford, observed that:[83]

> Conscientious objection provisions can create an access barrier to [voluntary assisted dying], with 'a potential for injustice because similar patients with similar diseases and life expectancies may find a wide variation in the availability of prescribers.' International studies describe the difficulty in finding alternative providers when faced with another doctor's conscientious objection. (notes omitted)

14.130 Some respondents observed that a requirement to refer or to transfer care could be of particular relevance in remote, rural or regional areas or in some types of care facilities, or for people with specific cultural or linguistic needs. Those categories of people may have limited access to alternative medical practitioners. Another respondent submitted that it is important to balance protection of practitioners with support for patients in remote and regional areas, and to ensure than an objection does not deny access to a person in such a situation. The Australian Psychological Society stated:

> Dying people may be at the limit of their mental, physical and economic resources and find it very difficult to locate another health practitioner who does support assisted dying. This is particularly true for individuals living in rural and remote areas, as well as those in residential aged care or palliative care facilities (where patients are entirely dependent on visiting medical practitioners who attend to them). Finding an alternative medical practitioner oneself in these circumstances may be excessively onerous or impossible.

14.131 One respondent submitted that a requirement for an objecting medical practitioner to refer a person elsewhere and transfer their care does not result in the practitioner 'participating' in voluntary assisted dying. In their view, it appropriately balances the practitioner's preferences with the patient's right to be referred to care where they can explore lawful options without having to 'start a new medical consultation process … while seriously unwell'.[84]

14.132 Other respondents considered that a medical practitioner who has a conscientious objection to voluntary assisted dying should not be required to refer a person elsewhere or transfer their care.

14.133 Numerous respondents, including the Royal Australasian College of Physicians, Catholic Health Australia, medical practitioners and academics, opposed a requirement for referral or transfer of care because it would impact on a medical practitioner's morals or right to conscientious objection, where their objection extends to referring a person elsewhere to access a service. Several respondents explained that referral would be considered a form of participation in voluntary assisted dying.[85] For example, an academic submitted that:[86]

> Imposing an obligation on registered health professional[s] to refer … is inappropriate. It imposes an obligation which some registered health professionals will consider to be participation in an immoral act. … Obligations to refer of this kind seriously undermine freedom of conscience and belief and elevate the legislative objectives set out [at [8.14]

83 Citing HM Chochinov and C Frazee, 'Finding a balance: Canada's law on medical assistance in dying' (2016) 388 *The Lancet* 543; and SM Harman and D Magnus, 'Early Experience With the California End of Life Option Act: Balancing Institutional Participation and Physician Conscientious Objection' (2017) 177(7) *JAMA Internal Medicine* 907. Ms Rutherford also submitted that, at minimum, an objecting health practitioner should be required to refer a person to an alternate source of information.

84 Another respondent supported a requirement to refer a person to another medical practitioner, but observed that there may be difficulties in compelling some practitioners to comply because they 'will consider such a referral to be a violation of their personal values'.

85 One respondent observed that this might discourage people with a 'religious or conscientious conviction' from becoming medical practitioners.

86 Citing Australian Bahái Community, Submission No 1914 to Australian Human Rights Commission, *Freedom of Religion and Belief in the 21st Century* (2010) 5.

> of the Consultation Paper][87] over the protection of that fundamental human right. It is an example of the 'tendency to treat the right to freedom of religion or belief as less important' and as 'a "second class citizen" in the sphere of human rights'. (note omitted; note added)

14.134 A medical practitioner explained that a requirement to refer 'in effect denies the practitioner the right to remove themselves from this process' and that '[t]he act of referral may make the medical practitioner feel complicit in a process to which they are opposed'. Another medical practitioner submitted that:

> There should be no 'requirement to refer' as that is the state compelling collaboration with an act the practitioner considers unethical. [Regarding] 'transfer of care', however, it is normal practice for any condition that we 'transfer care' at the request of the patient to whichever practitioner they choose. That does not imply collaboration. That does not require specification in any law.

14.135 One respondent acknowledged that there may be difficulties accessing a medical practitioner who does not have a conscientious objection, or limited access to medical practitioners in rural or remote areas, but submitted that 'this is a process and resource issue that should not impede on the rights of an individual' to conscientiously object.[88]

14.136 A few respondents variously observed that an objecting practitioner should not hinder patients from accessing voluntary assisted dying services, should ensure there are arrangements for the person's broader ongoing care, or should maintain a therapeutic relationship with the person by continuing to offer other care.

14.137 Some respondents, including two medical defence organisations and professional indemnity insurers, submitted that there should not be a legislative requirement for an objecting medical practitioner to refer a person elsewhere or transfer their care. They preferred that this be dealt with by ethical or practice guidelines.[89] One of those organisations submitted that current ethical guidelines are 'sufficient to guide practitioners about their ethical obligations [toward a patient] where they hold a conscientious objection'.

14.138 The other organisation opposed an obligation going beyond the requirements in the MBA Code of Conduct, such as an obligation to refer. It considered '[t]his would be inconsistent with usual professional expectations, may place the practitioner or others in a position of moral conflict and may be impractical'. It submitted that a preferable approach would be the development of guidance about 'a range of options' for how a practitioner could 'ensure they do not impede' a person's access to voluntary assisted dying.[90]

14.139 However, as noted, Ms Rutherford, an academic in this field, observed that the lack of a legal obligation to refer in the Victorian Act has arguably been 'walked back' in the Victorian health practitioner guidelines.

14.140 The AMA Queensland submitted:[91]

> In accordance with the AMA Federal position on conscientious objection, AMA Queensland believes that a doctor with a conscientious objection should inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right, and … take whatever steps

87 Specifically, QLRC Consultation Paper No 79 (2020) [8.14] states: 'Elsewhere, it was observed that the absence of a legislative requirement to refer might "impede access" to a lawful option, which would "compromise the realisation of other important policy goals: respect for autonomous choices, alleviation of suffering and the provision of high-quality care"'. (notes omitted)

88 Another respondent submitted more generally that '[t]he remote location should never be an excuse to override conscientious objection'.

89 One respondent submitted, in response to the White and Willmott Model and its referral requirement, that 'this principle is enshrined in traditional medical practice and bodies (Medical Boards) that oversee medical practice, and in common law'. They also noted that other areas of law related to end of life, particularly palliative care, are not as stringently regulated: see R Syme, 'A Response to White and Willmott' (2020) 8(1) *Griffith Journal of Human Law and Dignity* 1, 4.

90 This respondent did not support the approach in the White and Willmott Model because '[t]his is effectively a duty to refer that goes beyond the general expectations' on medical practitioners.

91 Citing AMA, *Position Statement: Conscientious Objection* (2019).

> are necessary to ensure the patient's access to care is not impeded. AMA Queensland members support that practitioners who are conscientious objectors should refer a person elsewhere or … transfer their care. (note omitted)

14.141 A few respondents suggested that, instead of a requirement to refer or to transfer care, a 'central information source' should be established, which can assist patients to access voluntary assisted dying. The Uniting Church and entities associated with it submitted that access to voluntary assisted dying is not urgent and the State should establish a service that can provide information and facilitate access.[92] It submitted that the individual can then take responsibility for obtaining access without impeding on another's conscience.[93]

14.142 Health Consumers Queensland observed that if a voluntary assisted dying care navigator role is established, it would support patients and families and improve access and equity, including by alleviating 'reliance on a single point of contact with the health practitioner should they conscientiously object'.[94]

14.143 A few respondents suggested that the person seeking access to voluntary assisted dying should be required to find an alternative medical practitioner. One submitted that this 'will show the genuineness of the patient's inquiry, and reduce the scope of coercion'.

The timing of a requirement to refer or transfer care

14.144 Several respondents submitted that the person should be informed of a registered health practitioner's conscientious objection at the time of their request or soon after (for example, within one hour), and that a referral should take place within 24 hours. Other respondents submitted that a referral or transfer of care should be 'timely' or should occur 'promptly', 'immediately' or as soon as or as quickly 'as possible'. The Australian College of Nurse Practitioners explained that a patient should be informed and referred elsewhere at the time of the request to avoid prolonging the patient's suffering.

14.145 A few respondents observed that a register of willing practitioners, as is maintained in Victoria, would help ensure that requests for access can be referred or completed in a reasonable time.[95]

14.146 One respondent, opposed to a requirement to refer or to transfer care, submitted that, as in Victoria, a health practitioner should respond to a request for access to voluntary assisted dying within seven days.[96]

14.147 A few respondents also submitted that a person should be referred or have their care transferred to the most geographically proximate location. One stated that a referral should be 'timely and feasible for the consumer to access' because they may be 'suffering significant pain and distress'. Another respondent suggested that there should be legislative guidance for situations where an objecting medical practitioner is 'the sole practitioner in a rural or remote community', or where there is not another practitioner in a community to whom a person can be referred.

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92 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld.

93 A medical defence organisation and professional indemnity insurer (which opposed a requirement to refer or transfer care) agreed with the Victorian Panel position that there are key differences between termination of pregnancy and voluntary assisted dying. That Panel noted, for example, that there is 'not the same level of urgency' for voluntary assisted dying as for termination of pregnancy: Vic Ministerial Advisory Panel Final Report (2017) 110. However, another respondent observed that it is 'inappropriate' to state that voluntary assisted dying is not an emergency procedure and rely on that statement to justify delays or procedural complexities, because for the person seeking access 'it may be just that'.

94 This respondent observed that this role might be similar to the existing nurse navigator role in Queensland Health.

95 Some respondents observed that a register may raise 'privacy issues'. A few suggested that it should be forbidden to publicly identify practitioners who do or do not participate in the voluntary assisted dying process, or that protections should be available for practitioners who do not want to be identified, for example, because they have concerns about stigmatisation or compromising patient care.

96 It was also submitted that, like Victoria, the practitioner should not be required to provide information about the voluntary assisted dying process if they do not wish to do so.

Where or to whom a person should be referred or their care transferred

14.148 The White and Willmott Model provides that an objecting medical practitioner must (if requested) refer the person or transfer their care to another medical practitioner who does not conscientiously object or an entity through which the person can access such a practitioner.[97] In their submission, Professors White and Willmott reinforced their support for this clause and their view that it is broad enough to permit an objecting practitioner to give a person 'contact details of an entity which can provide information that will facilitate that access' (provided such an entity exists). They noted that some practitioners might consider this 'morally preferable'.

14.149 Some other respondents, including Dying with Dignity Queensland, supported the White and Willmott Model.[98] The Queensland Law Society submitted that existing guidelines requiring that an objecting practitioner not impede a person's health care 'should be reflected in the legislation as an obligation upon the objecting practitioner to provide referral details … of an entity that either provides access to [voluntary assisted dying], or will provide information to facilitate that access', and submitted that the White and Willmott Model 'is appropriately drafted to achieve this objective'.

14.150 Some respondents, including the Clem Jones Group, Dying with Dignity Queensland, Dying with Dignity NSW, STEP Queensland, the Anglican Bishop of North Queensland, a registered nurse and academics, submitted that an objecting medical practitioner should be required to refer or to transfer the care of a person to another registered medical practitioner, or to either another practitioner or a service or entity, such as an institution or facility or a voluntary assisted dying care navigator service.

14.151 Many of those respondents stated that referral should be to a practitioner who does not have a conscientious objection, or to a practitioner, service or entity that can provide the person with information about, or assistance to access, voluntary assisted dying. Another respondent considered that, at the least, an objecting practitioner 'should be prevented from referring the person to another medical practitioner that they know has a conscientious objection'.

14.152 Some respondents suggested that a register of participating practitioners could assist in referring a person elsewhere. The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that a medical practitioner could register their objection with a government body and then 'refer the patient request' to that body for information about an alternative practitioner, adding that '[t]his need not constitute a formal referral, but should provide access to a pathway'.

14.153 The Australian Lawyers Alliance observed that it might be 'onerous' to require referral to another practitioner known to not have a conscientious objection, stating that '[t]his information may not be in the medical practitioner's means of knowledge unless a central database of medical practitioners available to participate in the … scheme is accessible'.

14.154 Other respondents, such as the End of Life Choice Society New Zealand Inc and Go Gentle Australia, submitted that an objecting medical practitioner should be required to refer a person to an information source, such as care navigator service or a government body.[99] They observed that such a service or body could in turn give the person the details of an alternative medical practitioner, which would avoid an objecting practitioner having to make a direct referral.[100] Christians Supporting Choice for Voluntary Assisted

97 White and Willmott Model cl 38(3).

98 In contrast, an academic who opposed a requirement for referral or transfer of care, submitted that the approach in the White and Willmott Model is not 'intentionally broad', because it requires a practitioner to have knowledge of practitioners or entities through which voluntary assisted dying is accessible.

99 The Royal Australian College of General Practitioners Queensland submitted that a person should be given information of 'a general or specific nature' about 'where to access voluntary assisted dying services'.

100 Two respondents jointly submitted that referral to a care navigator service would be beneficial for objecting medical practitioners who do not wish to provide information about voluntary assisted dying.

Dying submitted that '[i]deally the patient would be referred to another doctor' but that it 'may help the "conscience" of the objecting doctor if the patient could be referred to [a] Care Navigator' instead.

14.155 In contrast, a member of the public described the requirement in New Zealand to tell a person of their right to contact the relevant government body as 'arguably a referral', and as something that a medical practitioner may not wish to do.

14.156 Ms Rutherford, a researcher in this field, submitted that, at a minimum, an objecting practitioner 'should be required to refer a person who enquires about [voluntary assisted dying] onto another information source'. Drawing on the perspectives of medical practitioners about the Victorian Act, she observed that:[101]

> The conscientious objection protections … support doctors who decide to not participate …, but some participants are concerned that this compromises the level of care available to a person who might seek [voluntary assisted dying] because there is no coincident legal obligation to refer on. Extending support to those persons who might not be able to find a participating doctor would address this access barrier. At a minimum, participants suggest this support could include a centralised referral service (utilising the existing [voluntary assisted dying] state-wide navigators) for which doctors could legally be required to supply details. Alternatively, participants suggest that the requirement to refer could be legislated. There is some precedent for this in Victorian law, with the provisions of the … *Abortion Law Reform Act 2008* (Vic). (note omitted)

14.157 Several respondents, including Dying with Dignity Queensland, Dying with Dignity NSW and an academic, suggested that referral to a care navigator service could be the minimum requirement for an objecting practitioner, or could be another option that sits alongside referral to a different medical practitioner or to a service or entity. The Australian College of Nurse Practitioners suggested that a person should be referred to a source of information, such as a website, and a health practitioner that can assist the person.

14.158 A few respondents, including Go Gentle Australia, submitted that a medical practitioner who has a conscientious objection should have to transfer the person's medical records and patient history, as required.

The Commission's view

Disclosure to patient of refusal to participate on grounds of conscientious objection

14.159 The requirement for a medical practitioner to advise a patient that they accept or refuse a first request for access to voluntary assisted dying or a referral for a consulting assessment is discussed in Chapter 8 above.

14.160 Generally, a health practitioner who refuses to assist a patient should promptly advise the person of their refusal and give a reason for that refusal. Doing so makes it clear to the person that the practitioner's refusal to assist is not because voluntary assisted dying is unlawful or because they are ineligible to access it. The reason is particular to that practitioner, not the person.

14.161 The Victorian Act requires a medical practitioner who refuses the person's first request because of a conscientious objection to inform the person that their request has been refused for that reason.[102] The White and Willmott Model requires a medical practitioner exercising a conscientious objection to disclose 'the practitioner's conscientious

101 Another academic submitted that, if a practitioner's objection extends to referring a person to another practitioner, they should be required to refer to an advisory body established by government.

102 See [14.17] above and the discussion in Chapter 8 above. The Victorian Act also provides for refusal of a request on other grounds, such as unavailability. Similar provisions apply to a request for a consulting assessment. See *Voluntary Assisted Dying Act 2017* (Vic) ss 13(1)(b), 23(1)(b).

objection to the person and offer to refer the person to another practitioner or entity'.[103]

14.162 Consistent with the Victorian Act and the White and Willmott Model, there is no reason in principle why a practitioner who exercises a conscientious objection in response to a request for information about, or assistance to access, voluntary assisted dying should not be required to inform the person of that conscientious objection. The MBA Code of Conduct and the AMA Position Statement on conscientious objection require a practitioner to disclose the conscientious objection to the patient.

14.163 A requirement for a practitioner to inform the person of their conscientious objection appropriately balances the right of the person to access the end of life options that are available to them, including voluntary assisted dying, and the right of the practitioner to conscientiously object. A practitioner would not be required to explain the reasons behind their objection; only to inform the person that they are refusing to provide the requested service because they have a conscientious objection.

14.164 Chapter 8 above discusses in detail the process that should apply when a medical practitioner refuses a first request for access to voluntary assisted dying, or a request for a consulting assessment. In summary, we conclude that a medical practitioner should be required to inform the person of their refusal and of the reason for their refusal within two business days, or immediately if the reason is that the practitioner has a conscientious objection to voluntary assisted dying. The Commission agrees with the position adopted in Western Australia that a medical practitioner who has a conscientious objection does not require a length of time to consider whether they are available to provide the service, so should be required to refuse immediately.

14.165 There may be other points in the voluntary assisted dying process where a medical practitioner's conscientious objection becomes relevant, and causes them to decide to refuse to do something. For example, it may be at the stage of an initial request for information and advice, before a formal first request. A practitioner may be willing to be a coordinating practitioner but have a conscientious objection to administering the substance. If the patient later chooses practitioner administration, then the practitioner may wish to conscientiously object part way through the process. In those circumstances, we consider that the medical practitioner should be subject to a similar requirement to immediately inform the person that they have a conscientious objection.

14.166 Also, there may be circumstances where a registered health practitioner other than a medical practitioner receives a request from a patient about voluntary assisted dying. For example, a patient may ask a registered nurse, who is providing palliative care services, for information about voluntary assisted dying. We consider that other registered health practitioners should be subject to a similar requirement to immediately advise the person that they have a conscientious objection and cannot help with their request.

A requirement to provide information or to refer

14.167 Many submissions were made on this issue. Numerous respondents supported a requirement that a health practitioner who has a conscientious objection refer a person elsewhere or to transfer their care. They considered this appropriately balances the rights of practitioners and individuals, assists in ensuring that individuals can access voluntary assisted dying (including in remote and regional areas), and is consistent with good medical practice.

14.168 Other respondents opposed any requirement to refer, submitting that referral is a form of participation that affects the right to object or undermines freedom of conscience and belief, and that the matter is adequately addressed by ethical guidelines. Some respondents suggested that, rather than a requirement to refer, there should be a central information source to assist patient access.

103 White and Willmott Model cl 38(2).

14.169 If, as suggested, the right of a practitioner with a conscientious objection extends to a right to refuse to provide information or other assistance, then that right should be qualified in some respects. It should be subject to reasonable provisions that respect the rights of other individuals. These include the right of an individual to access information about end of life choices, including voluntary assisted dying.

14.170 Respondents had different views about the specifics of any referral. There was support for referral to another practitioner or facility that will give the person information about, or assistance to access, voluntary assisted dying, or referral to an information source such as a care navigator service, or a combination of these options. Some respondents observed that referral to an information source might be preferred by doctors who object to transferring care to another practitioner.

14.171 One possible formulation would be a requirement:

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

14.172 The Commission observes that this formulation requires only the giving of information and does not impose a requirement 'to refer'. It is less demanding than the requirement to refer or to transfer care in the *Termination of Pregnancy Act 2018*. Also, it is less protective of a right of access to voluntary assisted dying than the position urged by many respondents for a requirement 'to refer a person elsewhere or to transfer their care'.

14.173 The MBA Code of Conduct and the AMA Position Statement do not impose a requirement 'to refer'. Instead, the MBA Code of Conduct says that a doctor should not use their objection 'to impede access to treatments that are legal', and notes that in some jurisdictions legislation mandates doctors who do not wish to participate in certain treatments to refer on the patient.[104] The AMA Position Statement does not use the word 'refer'. Instead, it states that a doctor with a conscientious objection should 'take whatever steps are necessary to ensure the patient's access to care is not impeded'. It might be said to contemplate a referral, and refers to an obligation to 'continue to provide other care to the patient, if they wish'.[105]

14.174 The Victorian Act does not impose a requirement to refer. Referral is addressed in guidelines which state:[106]

> Medical practitioners may also choose to refer patients to another medical practitioner to whom the patient can make a request. The referral must be made in a timely manner to ensure the patient does not experience unnecessary delays or adverse clinical outcomes (such as a decline in decision-making capacity). If the medical practitioner is not comfortable referring the patient they can inform the patient about where they can get further information on voluntary assisted dying, such as from the Department of Health and Human Services end-of-life care website or from a voluntary assisted dying care navigator.

104 See [14.7] above.
105 See [14.10] above.
106 Vic Guidance for Health Practitioners (2019) 21.

14.175 The White and Willmott Model does not go quite so far as to impose a requirement to refer in all cases. Instead, it obliges a registered medical practitioner to 'offer to refer' the person to another practitioner or entity. If the referral is requested, then it triggers the obligation to refer or transfer care.[107]

14.176 The Western Australian Panel considered the issue of referral and stated that it was 'guided by the core principle that the person should be fully informed about voluntary assisted dying and all other options before formally requesting voluntary assisted dying'.[108] In seeking to achieve a balance it concluded that practitioners who have a conscientious objection 'have an obligation to provide information to people seeking voluntary assisted dying but are not obliged to refer on'.[109] It noted that this was contrary to the recommendation of the Western Australian Joint Select Committee which recommended that practitioners should be obliged to offer to make a referral. The Panel was influenced by the example in Victoria of how information can be provided through central government agencies such as a care navigator service and a central information hub.[110]

14.177 The Panel recommended that a health practitioner or a health service that is unwilling to be involved in the process must provide enough information to enable the person to access information about voluntary assisted dying.[111]

14.178 We have reached a similar view about the appropriate balance between a practitioner's right to refuse to do certain things on the grounds of a conscientious objection and the right of a person to access voluntary assisted dying and be informed about it and other lawful end of life options.

14.179 A registered health practitioner who refuses to do one of the things stated in the conscientious objection provision in response to a request from a person for information about, or assistance to access, voluntary assisted dying should be required:

(a) to inform the person that other health practitioners, health service providers or services may be able to assist them; and

(b) to give the person:

(i) information about a health practitioner, health service provider or service who, in the first practitioner's belief, is likely to be able to assist the person; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person.

14.180 This requirement does not require a health practitioner with a conscientious objection to provide the person with information about another health practitioner, health service provider or service. Requirements (b)(i) and (ii) above are alternatives and provide flexibility. In some circumstances, the health practitioner will find it convenient to provide the person with 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 a voluntary assisted dying care navigator service.

14.181 It is appropriate that this requirement to inform the person of these matters and to give information applies to all registered health practitioners.

14.182 A medical practitioner will already be required, if accepting or refusing a first request or a referral for a consulting assessment, to inform the person of their acceptance or

107 White and Willmott Model cl 38(2)–(3).
108 WA Ministerial Expert Panel Final Report (2019) 52.
109 Ibid.
110 Ibid 53.
111 Ibid Rec 13.

refusal and to give the person certain information.[112] However, that requirement would not necessarily apply if a medical practitioner were approached by a person in other circumstances; for example, where a person seeks general information about voluntary assisted dying. In those circumstances, there should be a similar requirement to inform the person of their objection and to give that person information.

14.183 Other registered health practitioners do not have a similar obligation about the acceptance or refusal of a request or referral. However, there are circumstances in which they might be approached by a person for information about voluntary assisted dying. For example, a person receiving palliative care services from a registered nurse might ask that nurse to give them advice about voluntary assisted dying. Again, we consider that, in such circumstances, it is appropriate for a registered health practitioner to inform the person of their objection and give them at least certain information.

14.184 Some respondents who opposed a requirement to refer suggested that a preferable requirement would be that a practitioner not impede the person's access to lawful voluntary assisted dying. The proposed requirement reflects an appropriate reconciliation of the practitioner's right to conscientiously object (or otherwise not participate) and the patient's right to access voluntary assisted dying, including being supported in making informed decisions about end of life choices.

14.185 Also, it seems unnecessary to impose a statutory requirement upon a practitioner to not impede access by a person to voluntary assisted dying. Those matters are the subject of ethical standards and codes of conduct. There may be an argument that the obligation in the MBA Code of Conduct to not use a conscientious objection 'to impede access to treatments that are legal' does not apply to voluntary assisted dying which, on one view, is not a treatment. However, it is unnecessary to resolve that issue because our preferred model imposes a requirement upon a medical practitioner to give certain information. The information should enable a person to contact another health practitioner if they wish to do so. Therefore, it is unnecessary to impose an additional requirement to not impede.

14.186 It is preferable to deal with the rights and obligations of a health practitioner who exercises a conscientious objection in the draft Bill rather than in regulation (as in Western Australia).[113]

14.187 The information to be given, which balances the interests of the person and the interests of the practitioner, should not be determined by an official, who from time to time may alter that balance by imposing more or less demanding requirements.

14.188 The requirement to give information deals with a request from a person to a health practitioner. It does not address a request from one health practitioner to another. This may occur in a wide variety of circumstances, for example, a doctor seeking the assistance of a nurse or a more senior or junior doctor. Given the multiplicity of circumstances, this should be worked out between health professionals in accordance with their duties and codes of practice. It makes little sense to prescribe in legislation that a nurse should tell a doctor about a care navigator service or that another nurse could assist.

14.189 The proposed provision at [14.179](b)(i) above requires the practitioner to give the person 'information about a health practitioner, health service provider or service who, in the first practitioner's belief, is likely to be able to assist the person'.

14.190 The Commission had considered, but ultimately rejected, a slightly different form of words, namely, to give the person information about a health practitioner, health service provider or service who, in the first practitioner's belief:

112 See Chapter 8 above.

113 In Western Australia a medical practitioner who refuses to accept a first request because of a conscientious objection must give the patient 'information approved by the CEO': *Voluntary Assisted Dying Act 2019* (WA) s 20(4)(b), (5).

(a) does not have a conscientious objection to voluntary assisted dying; and

(b) is likely to be able to provide the requested information or assistance.

14.191 The words in paragraph (a) above are similar section 8(3) of the *Termination of Pregnancy Act 2018*. However, these additional words seem unnecessary. If the practitioner is aware that the other health practitioner, health service provider or service has a conscientious objection, the practitioner will not believe that they are likely to be able to assist the person. Also, the simpler form of words aligns with the provision about refusal of a first request, whether on the grounds of conscientious objection or otherwise.

14.192 Finally, it should be emphasised that the requirement proposed is a minimum requirement. Many practitioners may choose to give additional information about voluntary assisted dying and alternative sources of information and assistance. Some will choose to refer a patient elsewhere for assistance. The proposed provision does not prevent this from occurring. Many practitioners, while not wishing to give the requested information or other assistance, may decide to do more for the patient than the minimum required.

Transfer of care

14.193 The issue of a requirement to transfer care is potentially complex. Not every situation may warrant a requirement to transfer care. For example, a patient may simply want information about voluntary assisted dying which the practitioner has a conscientious objection to providing. The patient may not be extremely ill or even, at that stage, eligible for voluntary assisted dying. The patient may be happy to continue their therapeutic relationship with that practitioner, but simply want general information about the option of voluntary assisted dying. The patient's interests or wishes may not necessitate a transfer of their care. In other circumstances, the patient's interests or wishes and the health practitioner's professional obligation may require that care be transferred.

14.194 We consider transfer of care is best addressed by:

- duties of care and ethical obligations when the practitioner cannot provide all the advice or assistance the patient requires; and
- working out the process, in practice, for the person to contact another practitioner who arranges for transfer of care and of any records.

14.195 Neither the Victorian Act nor the Western Australian Act deals with transfer of care. The White and Willmott Model simply states that, if requested, a medical practitioner must 'refer the person, or transfer their care' to another practitioner or an entity that meets certain requirements.

14.196 As noted, the AMA Position Statement envisages that a doctor with a conscientious objection should continue to provide 'other care to the patient, if they wish'. The use of the word 'other' suggests that care in respect of end of life choices, including voluntary assisted dying, is transferred elsewhere.

14.197 A freestanding obligation to transfer care may have unfortunate consequences. For example, requiring a doctor to transfer the care of a patient elsewhere when the patient might want only general information about voluntary assisted dying or be in a position to go elsewhere for an assessment.

14.198 Therefore, we do not recommend a requirement to transfer care. Instead, transfer of care should be worked out through the process of giving information and the ethical and legal duties imposed on a practitioner to transfer care in certain circumstances.

The separate position of speech pathologists

14.199 For the reasons earlier given, a speech pathologist should have a similar right to a registered health practitioner to refuse to do certain things on the grounds of conscientious objection. However, the issue of referring a patient elsewhere does not

arise in the same way for a speech pathologist. A speech pathologist will typically be asked to provide services by a medical practitioner or a health service provider, not directly by the patient.

14.200 The requirement on a speech pathologist who refuses to participate on the grounds of conscientious objection should reflect accepted obligations that apply to health professionals who exercise a conscientious objection. They should be required to:

- inform their employer or the other person who requested their services of their conscientious objection;
- inform that party of another speech pathologist or speech pathology service who, in their opinion, is likely to be able to assist in providing the requested speech pathology services; and
- not intentionally impede a person's access to speech pathology services in relation to voluntary assisted dying.

14.201 In addition, and consistently with the kind of obligation which the AMA Position Statement imposes on a doctor with a conscientious objection,[114] a speech pathologist who is employed or otherwise engaged by a health service that provides, or is likely to provide, access to voluntary assisted dying should be required, after being employed or engaged, to inform their employer or the service of their conscientious objection. This will enable them to discuss how they can practice in accordance with their beliefs without placing a burden on their colleagues or compromising a person's access to a lawful end of life option.

14.202 It might be said that this requirement imposes different obligations on a speech pathologist than those imposed by the draft Bill on a registered health practitioner, and that the requirements on all health professionals should be the same. However, there are at least two reasons for the different requirement.

14.203 First, medical practitioners are subject to a code of conduct which requires them to disclose their conscientious objection to patients and, if relevant, colleagues, and to not deny a patient access to the relevant service. Many speech pathologists may feel that, as health professionals, they are subject to a similar ethical or professional duty. However, there is no such requirement in any code governing them. Therefore, the requirement should be made explicit as a condition of a speech pathologist's statutory right to refuse to provide services on the grounds of a conscientious objection.

14.204 Second, and as previewed above, a speech pathologist is likely to act as an intermediary between a medical practitioner and a patient and will not be engaged by the patient directly. It seems inapposite for a speech pathologist to be required to inform the patient about health practitioners, health service providers or services who may be able to assist them or to provide details of a care navigator service. Instead, if the request for speech pathology services is refused on the grounds of conscientious objection, the speech pathologist should ensure that the person making the request (typically the health service or health practitioner who sought to engage their services) is assisted to find someone else to provide the services. This will ensure that a person's access to information and assistance about a lawful end of life option is not denied or impeded.

Consequences of non-compliance

14.205 Elsewhere, the Commission discusses the professional and legal consequences for health practitioners contravening a provision of the draft Bill. They include referral of a matter for investigation and possible disciplinary proceedings.[115]

114 See final dot point quoted at [14.10] above.
115 See Chapter 17 below.

14.206 A failure by a registered health practitioner to comply with a requirement discussed in this chapter should be the subject of those general compliance provisions.

14.207 We do not recommend any specific penalty for failure to comply with the requirements associated with the conscientious objection provisions. This is consistent with the approach taken elsewhere in the draft Bill, and with the *Termination of Pregnancy Act 2018*.

14.208 A breach by a speech pathologist of the requirements discussed in this chapter is likely to be addressed by an employer, a body such as Speech Pathology Australia's Ethics Board, or by complaint to the Health Ombudsman.[116]

RECOMMENDATIONS

14-1 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:

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) participate in an administration decision;

(d) prescribe, supply or administer a voluntary assisted dying substance;

(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

14-2 A registered health practitioner who, because of a conscientious objection, refuses to do any of those things for a person seeking information or assistance about voluntary assisted dying should be required to:

(a) inform the person that other health practitioners, health service providers or services may be able to assist them; and

(b) give the person:

(i) information about a health practitioner, health service provider or service who, in the first practitioner's belief, is likely to be able to assist the person; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person.

116 See *Health Ombudsman Act 2013* (Qld) s 288, discussed in Chapter 17 below.

14-3 A speech pathologist who is requested to assist a person to access voluntary assisted dying and who has a conscientious objection to voluntary assisted dying should have the right to refuse to do any of the following:

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) participate in an administration decision;

(d) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

14-4 A speech pathologist who refuses on the grounds of conscientious objection to do any of those things should be required to:

(a) inform their employer or the other person who requested their services of their conscientious objection;

(b) inform that party of another speech pathologist or speech pathology service who, in their belief, is likely to be able to assist in providing the requested speech pathology services; and

(c) not intentionally impede the person's access to speech pathology services in relation to voluntary assisted dying.

14-5 A speech pathologist who is employed or otherwise engaged by a health service provider that they know (or ought reasonably to know) provides, or is likely to provide, services relating to voluntary assisted dying should be required to:

(a) inform the health service provider of their conscientious objection; and

(b) discuss with the health service provider how they can practice in accordance with their beliefs without placing a burden on their colleagues or compromising a person's access to voluntary assisted dying.

CHAPTER 15

Participation by entities

Chapter 15: Participation by entities

CHAPTER SUMMARY

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 not be prepared 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.

It is convenient to 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 the person's life may be inconsistent with the person's legal right of residence at the entity's facility.

The term 'entity' is used in this chapter 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.[1] 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 have been addressed in the previous chapter.

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

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.

THE RIGHTS AND INTERESTS OF INDIVIDUALS

15.1 The rights and interests of individuals in this context include:

- access to information and advice about a lawful end of life option;
- individual autonomy; and
- access to high quality care and treatment to minimise the person's suffering and maximise their quality of life.

15.2 The rights and interests will also include rights enjoyed as consumers not to be misled about the availability of services and rights as persons to whom a duty of care in law is owed by the relevant entity. The entity may have responsibilities imposed by statute by virtue of its status as an entity providing health care or aged care. The entity may be vicariously responsible for a breach of professional standards and the duty of care owed by health practitioners employed by it. The various duties imposed upon the entity to care for the individual give rise to corresponding rights in the individual by virtue of the general law, contract law or statute law. In some circumstances a person at a facility will have certain rights as a resident. That situation may be likened to a tenant who, subject to the terms of a lease, is entitled to occupy that place of residence and undertake lawful activities there.

THE RIGHTS AND INTERESTS OF ENTITIES

15.3 The rights and interests of entities derive from property rights and the general law, subject to statutory qualifications on those rights. The principle of freedom of contract entitles an entity to make decisions about the services it offers. For example, a private hospital may choose to not offer certain kinds of services such as neurosurgery. Decisions about the services it offers may be based on an entity's policy, financial considerations or available resources. The entity may be required to provide certain services as a term of its contractual and legal arrangements with governments that fund it. Absent such an obligation, the entity is free to not offer those services.

15.4 An entity may have rights as a property owner or occupier to control access by individuals to its premises. It also may credential only some health practitioners to provide services on its premises.

15.5 If an entity is not obliged to provide certain services at its facility, then the occasion to

1 In this regard, cl 39(1) of the White and Willmott Model applies to 'an entity, other than a natural person, who provides a health service, residential service or professional care service'.

object to providing those services does not arise. It is simply a case of choosing not to provide certain services at its facility. For example, a private hospital does not need to 'object' to providing obstetric and gynaecological services at its facility. It may simply choose not to do so.

INSTITUTIONAL CONSCIENTIOUS OBJECTIONS

15.6 As noted, there may be pragmatic reasons for an entity not providing certain services at a facility it operates.

15.7 The previous chapter discusses the concept of an individual's conscientious objection. A health practitioner may decline to provide or participate in a lawful treatment or procedure because it conflicts with the individual's personal beliefs, values or moral concerns. The HR Act recognises an individual's right to 'freedom of thought, conscience, religion and belief'.

15.8 A more contentious issue is whether an institution itself can have a 'conscientious objection'.[2] Some argue that there is no basis for an institution to have a conscientious objection because it cannot have moral beliefs as people do.[3] Others consider that an entity which provides care may be regarded as a group of people organised to deliver a social good and may have a distinctive mission or ethos which should permit it to have a conscientious objection.[4] A different position is that while institutions do not possess a conscience as individuals do, they may be entitled to refuse to provide a service on the basis of their identity and integrity. On this approach, institutions still have obligations to prevent harm to patients, promote health and respect autonomy which can outweigh claims to refuse a service based on their identity and integrity.[5]

THE JUSTIFICATION FOR REGULATION

15.9 Whether styled 'institutional conscientious objection' or, more broadly, as the right of an entity to not participate, there is scope for confusion about the competing interests of individuals seeking to obtain information about, or access, voluntary assisted dying, and the interests of an entity which does not wish to participate in such a scheme.

15.10 Those competing interests must be reconciled to resolve potential conflict. This may be achieved by regulating the process by which an individual may seek access to voluntary assisted dying in the face of an institutional objection.

15.11 Without regulation which establishes a process to ensure that a person's access to voluntary assisted dying is not unreasonably denied where institutional objections occur, confusion and uncertainty will prevail.

15.12 If the position is taken that an entity should not be required to provide access to voluntary assisted dying at its facility by providing services, then questions will remain. These include:

- whether an entity has a right to prevent access to an aged care facility by a qualified health practitioner who has been requested by a resident to attend to provide information or to conduct an assessment?
- whether an entity has a right to hinder access to voluntary assisted dying in a facility operated by it?

2 BP White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).

3 Ibid at ft 21, citing D Gilbert, 'Faith and/in Medicine: Religious and Conscientious Objections to MAiD' (2020) 43(2) *Dalhousie Law Journal* 657 1, 38; GJ Annas, 'Transferring the Ethical Hot Potato' (1987) 17 *Hastings Center Report* 20, 21.

4 Ibid at ft 23, citing C Flynn and RF Wilson, 'Institutional Conscience and Access to Services: Can We Have Both?' (2013) 15(3) *American Medical Association Journal of Ethics* 226, 227; D Sulmasy, 'What is Conscience and Why is Respect for it So Important?' (2008) 29 *Theoretical Medicine and Bioethics* 135; K Wildes, 'Institutional Identity, Integrity, and Conscience' (1997) 7 *Kennedy Institute of Ethics Journal* 413, 416.

5 Ibid at ft 24, citing MR Wicclair, 'Conscientious Refusals by Hospitals and Emergency Contraception' (2011) 20 *Cambridge Quarterly of Healthcare Ethics* 130.

- whether an entity has a right to hinder lawful self-administration of medication by an individual in their own home, over which they enjoy security of tenure, when that home is located in a facility operated by the entity?
- is an entity which objects to voluntary assisted dying obliged to inform the public of that objection and the services it will not provide so that potential patients or residents who might seek those services in the future can obtain them elsewhere?
- if an entity declines to itself provide access to voluntary assisted dying within its facility, should the entity be required:
  - to refer the person to a service, entity or health practitioner who may be expected to provide information and advice about voluntary assisted dying;
  - to allow access to a voluntary assisted dying care navigator who can provide the person with information;
  - to allow access to a health practitioner who can provide information or receive a first request;
  - to allow a suitably qualified health practitioner to conduct an eligibility assessment on its premises;
  - alternatively, and if this is feasible, to facilitate a transfer of care to enable an eligibility assessment to be conducted at another facility or place; or
  - if transfer is not feasible, to allow a suitably qualified practitioner to access its premises to administer the substance or assist a person to self-administer.

15.13 These issues illustrate the range of practical problems that arise and which may warrant regulation. Some relate simply to access to information. Allowing a patient to access information, in the sense of not hindering that person obtaining information from another source, is materially different to requiring an entity to itself provide access to voluntary assisted dying at its premises.

15.14 Another issue is permitting, in the sense of not hindering, access by qualified health practitioners who are asked to visit a patient or resident at a facility.

15.15 An important issue is whether an entity which objects to providing access to voluntary assisted dying at its premises, by providing services or facilitating the provision of it by others at its premises, should be required to facilitate the transfer of the patient or resident off-site where this is possible. This involves practical considerations depending on whether the transfer is short-term to enable the person to obtain information and an assessment, or the transfer is longer term which may, in the case of a hospice or aged-care facility, involve a change to the person's place of residence.

15.16 In some cases, the person may not be in a physical condition to be able to be moved without great pain and discomfort. An alternative place simply may not be available. In such a case is the resolution of competing rights best accommodated by allowing a health practitioner to visit the person, either to assess their eligibility or provide authorised voluntary assisted dying?

EXISTING POSITION

15.17 The Victorian, Western Australian and Tasmanian Acts do not address the issue of institutional objection.

Victoria

15.18 The Victorian Parliamentary Committee recognised the right of health services to conscientiously object,[6] but the Victorian Ministerial Advisory Panel recommended that this be limited to health practitioners:[7]

6 Vic Parliamentary Committee Final Report (2016) [8.4.2].
7 Vic Ministerial Advisory Panel Final Report (2017) 110–11.

> This is because health services do not have the same professional obligations as health practitioners and do not conscientiously object to providing medical treatment. Instead, a health service will assess which medical treatments it can safely provide, and will make decisions, as an organisation, about whether to provide these medical treatments. A health service may choose not to provide voluntary assisted dying, in the same way that neurosurgery is not performed at many health services. If voluntary assisted dying is legalised, health services will be able to determine the extent of their involvement in voluntary assisted dying in accordance with the capabilities of the health service.

15.19 Information about the Victorian Act states that a health service may determine if it wants to participate in voluntary assisted dying, taking into consideration its capacity to provide the service, the skill and expertise of its staff and 'whether participation aligns with the values of the health service'. A service that does not participate is not obliged to refer a person elsewhere. However, the service should not inhibit a person's access to treatment. A medical practitioner at the service may refer a person to another practitioner or service that is willing and able to assist the person to obtain information about, or access to, voluntary assisted dying. The document also states that the service which has chosen not to provide voluntary assisted dying should provide people who are seeking information about, or access to, it with information and support.[8]

15.20 The 'Voluntary Assisted Dying Model of Care Pathways for Health Services' developed in partnership with the Victorian Healthcare Association provides guidance for a health service that has chosen not to provide voluntary assisted dying. It states that such a service should provide an information and support service. In particular, such a health service should ensure that staff:[9]

- have access to information about voluntary assisted dying;
- know how to respond to preliminary inquiries about it;
- know where to direct patients to information sources;
- know how to respond if a patient brings the voluntary assisted dying medication into the service; and
- are aware of options to connect patients to either:
  - medical or other health practitioners who will further assist; or
  - the end of life care advisory line or voluntary assisted dying care navigator.

15.21 The Health service policy guidance for voluntary assisted dying states that:[10]

> A medical practitioner at the health service may also refer the person to a general practitioner or another health service that is willing and able to assist the person to access information about, or access to, voluntary assisted dying.

8 Department of Health & Human Services (Vic), 'Health practitioner information' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information>; Department of Health & Human Services (Vic), 'Health services information' (2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-services-information>; Department of Health & Human Services (Vic), 'Health service participation in voluntary assisted dying' (August 2018) 1 <https://www2.health.vic.gov.au/Api/downloadmedia/%7BDAECC49E-7775-4127-A963-1B12EF23A3AD%7D>; Department of Health & Human Services (Vic), '*Voluntary Assisted Dying Model of Care Pathways for Health Services*' (January 2019) 9, 13 <https://www2.health.vic.gov.au/Api/downloadmedia/%7B38D6AD67-02C1-4A97-A240-9D726C5D9D6A%7D>; Department of Health & Human Services (Vic), 'Health service policy guidance for voluntary assisted dying' (April 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-service-policy-guidance-for-voluntary-assisted-dying>. See also Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3347, 3431 (J Hennessy, Minister for Health).

See generally R McDougall and B Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation' (2020) 21 *BMC Medical Ethics*, Article 38 online <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5>.

9 Department of Health & Human Services (Vic), '*Voluntary Assisted Dying Model of Care Pathways for Health Services*' (January 2019) <https://www2.health.vic.gov.au/Api/downloadmedia/%7B38D6AD67-02C1-4A97-A240-9D726C5D9D6A%7D>

10 Department of Health & Human Services (Vic), 'Health service policy guidance for voluntary assisted dying' (April 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-service-policy-guidance-for-voluntary-assisted-dying>

Western Australia

15.22 The Western Australian Joint Select Committee stated that when a person is an inpatient at a health service that is unwilling to provide voluntary assisted dying, the health service must facilitate the patient's transfer to a different service in a timely manner.[11] The Western Australian Ministerial Expert Panel recommended that a practitioner or service that has a conscientious objection should be required to provide information, but not to make a referral.[12] However, as noted, the Western Australian Act does not address the issue of institutional objection.

15.23 Instead of regulating the matter in its Act, the Western Australian Government is developing a policy that applies to all health service providers in Western Australia about the management of voluntary assisted dying in their services. The Commission understands that health service providers will be expected to establish policies and protocols, and that the Statewide Care Navigator Service will assist patients and residents in facilities operated by entities that object to providing access to voluntary assisted dying.

Tasmania

15.24 During debates in the Tasmanian Legislative Council, some members expressed concern about the barriers to access for individuals who were approaching the end of their lives, suffering intolerably and seeking access to voluntary assisted dying. There were particular concerns about residential aged care facilities. Some parliamentarians expressed surprise that institutions could prevent health professionals from entering facilities to enable persons to obtain information and services in relation to voluntary assisted dying.

15.25 An amendment was proposed in the Tasmanian Legislative Council on 30 October 2020 which would have required institutions which object to voluntary assisted dying to transfer a patient to a health care facility that did not object.[13] However, some considered that regulating the issue might be seen as implicit recognition of institutional objections and conscience rights.[14]

15.26 In November 2020, the Tasmanian Government asked the University of Tasmania to undertake an independent review of the Bill. The Independent Review's Report released in February 2021 noted that the issue of organisational non-participation had come on to the legislative agenda for a number of reasons. It reported:[15]

> There is a concern that, in practice, organisational non-participation may restrict access to [voluntary assisted dying] (especially in regional settings) or, in cases where people have to be transferred between organisations in order to access [voluntary assisted dying], that it may increase the suffering of those persons. Also, some hospitals and care organisations are seeking greater clarity in relation to their obligations with respect to the provision of services which are inconsistent with their organisational ethos.

15.27 The Independent Review considered submissions and possible approaches to 'organisational non-participation'. It noted advocacy for a legislative approach to clarify the extent to which organisations can opt not to participate in voluntary assisted dying. Such a legislative model was said to seek to establish a balance between 'an organisation's decision to not provide or support [voluntary assisted dying], with the need to ensure access to [voluntary assisted dying] for all persons, and to respect

11 WA Joint Select Committee on End of Life Choices Report (2018) [7.89]. The Committee also suggested a 'publicly available service so that people can directly access a doctor willing to provide assistance': [7.67], see also [7.70].

12 WA Ministerial Expert Panel Final Report (2019) 53. See generally, Western Australia, *Parliamentary Debates*, Legislative Council, 23 October 2019, 8165, 8178 (S Dawson, Minister for Environment).

13 Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 1 (B Seidel, Member for Huon); Tasmania, *Votes and Proceedings* (No 78), Legislative Council, 30 October 2020, 497.

14 Ibid 10 (M Webb, Member for Nelson).

15 Tas Review Panel Report (2021) 14, 80, [6.5.4].

persons' autonomy in seeking [voluntary assisted dying]'. This 'compromise or reasonable accommodation' model was said to involve the following features:[16]

- Establishing legislative obligations of non-participating organisations should they choose not to provide or allow access to [voluntary assisted dying] services. Legislation would not grant organisations a positive right to refuse to provide access to [voluntary assisted dying], (reflecting the concern of Members in the Tasmanian Legislative Council with respect to implicitly recognising or even inducing such objection);
- Requiring that non-participating organisations provide persons with information about [voluntary assisted dying] and ensure appropriate referral, including to services such as [Voluntary Assisted Dying] Care Navigator networks;
- Setting out a process which institutions must follow should they not wish to participate in [voluntary assisted dying];
- Developing and applying a list of relevant considerations to a determination about whether the person should be transferred to another facility, or remain at the facility with support to leave for [voluntary assisted dying]-related appointments; and
- Where it is determined that the person should remain at the objecting institution, the facility will be obligated to permit the person to access [voluntary assisted dying].

15.28 The Independent Review noted that providing information, as well as referral and transfer services, would enable patients and residents at non-participating organisations to access voluntary assisted dying, although in some cases transfer may be impractical and may make it difficult to maintain the therapeutic relationships between a person and their health practitioner.

15.29 The Independent Review described the issue of 'organisational non-participation' as one of the most complex issues considered by it. Its conclusions were:[17]

- No organisation or entity should be compelled to participate in or provide [voluntary assisted dying] even though non-participation limits access, may compromise therapeutic relationships and, where transfers are required, may exacerbate suffering.
- Whether the right to organisational non-participation should be enshrined in legislation is an open question. It is unnecessary in that no organisation is compelled to participate and there are few precedents for it (Oregon is an exception). However, some academic research and submissions to this Review argue that an organisation's obligations to a patient, should they decide not to support [voluntary assisted dying], should be set out in legislation.
- In practice, policies and procedures should be developed for referral and transfer procedures from non-participating organisations to facilities which provide [voluntary assisted dying] services. Evidence suggests the effectiveness of these services depends on access to well-resourced Care Navigators.
- The most challenging scenario is providing options for people who are seeking [voluntary assisted dying] in non-participating organisations who cannot be transferred without subjecting them to additional suffering.

15.30 A further consideration noted by the Independent Review was whether the rights and obligations identified by it 'should be codified in legislation or be allowed to evolve in policy and practice over time'.

15.31 An amendment was proposed in the Tasmanian House of Assembly on 2 March 2021,

16 Ibid.
17 Ibid 81, [6.5.7].

to the effect that health service providers which conscientiously object must provide a person seeking access with 'prescribed information' and transfer the person to a health service provider that can provide access to voluntary assisted dying.[18] There was support for this amendment because it was considered necessary to clarify the obligations of non-participating entities. However, the amendment was opposed on the basis that many entities receive public funding, that such a provision could be discriminatory and restrict choices and access to voluntary assisted dying for some people, and that the result of such a provision may be to give an entity to the capacity to object to voluntary assisted dying and to transfer a person from a place that they consider to be their home. The proposed amendment was ultimately unsuccessful.[19]

15.32 The Tasmanian Bill returned to the Legislative Council, was passed on 2 March 2021 and was assented to on 22 April 2021.

New Zealand

15.33 The New Zealand Act does not recognise 'institutional conscientious objection' nor seek to regulate it. Therefore, it does not contain provisions for referral, transfer or access to a facility when transfer is impractical.

15.34 An amendment to the Act was proposed to the effect that an organisation providing services to a person who wants to exercise assisted dying (for example, health, aged care or palliative care services) is not obliged to assist the person, and could promote itself as having a conscientious objection and require that employees and health practitioners be bound by a prohibition on providing assisted dying. The amendment also provided that an organisation could not be denied, or offered, funding because of their position on assisted dying services. The amendment was supported as reinforcing that no one is required to participate in assisted dying but opposed on the basis that it was unnecessary because no institution is required to participate. The amendment was not passed.[20]

15.35 Hospice New Zealand applied to the High Court of New Zealand for declarations about the scope of conscientious objection rights in the New Zealand Act. Among other things, it sought a declaration about whether organisations such as hospices could, consistent with their core values, conscientiously object to assisted dying and explicitly operate a 'euthanasia-free' service without exposing its health practitioners to criminal prosecution.[21]

15.36 In considering these issues, it was accepted 'that an organisation may well have an entrenched moral ethos through which it operates' and that 'so far as is practicable, an organisation should have the benefit of the right to freedom of conscience and to hold its opinions free of interference'.[22] The Court held that the Act does not require organisations to provide assisted dying services. It does not prevent an organisation from excluding assisted dying from its services or from the work of health practitioners employed by the service, as long as practitioners can also comply with their obligations

18 Tasmania, *Parliamentary Debates*, House of Assembly, 2 March 2021, 44-45 (M Ogilvie, Member for Clark); Tasmania, *Votes and Proceedings* (No 83), House of Assembly, 2 March 2021, 6–8.

19 Tasmania, *Parliamentary Debates*, House of Assembly, 2 March 2021, 44–69. During the course of the debates it became apparent that the application of this clause to residential providers such as aged care or disability care facilities, where the facility becomes a person's 'home', was a particular issue. Leave was sought for the clause to be withdrawn and reconsidered, to take into account those issues and to seek the perspectives of those health service providers. Leave was refused, and the clause was voted on and negatived.

20 New Zealand, House of Representatives, Supplementary Order Paper 295, 6 August 2019; New Zealand, *Parliamentary Debates*, House of Representatives, 21 August 2019, 13237 ff. See also *Hospice New Zealand v Attorney General* [2020] NZHC 1356, [58]–[61], [115].

21 *Hospice New Zealand v Attorney General* [2020] NZHC 1356, [5], [89]. Hospice NZ also considered that the legislation was unclear about whether organisations that exercised a conscientious objection could be denied Crown funding for the services they do provide. There were also issues raised about interactions between the obligations of a health practitioner under this legislation and other relevant legislation, and about the scope of a health practitioner's conscientious objection: [5].
Hospice NZ is a national organisation that represents 33 independently operating hospice services in New Zealand: [10].

22 Ibid [103]. In this respect, the AMA position statement on conscientious objection was noted: AMA, *Position Statement: Conscientious Objection* (2019) [3.1]–[3.2].

under the Act.[23] It was observed that it may be possible to put into place guidelines about this matter.[24]

15.37 The Court added:[25]

> Hospices or other organisations that choose not to offer assisted dying services may employ or engage health practitioners on the basis that these services are not provided by the hospices or organisations, but it will also be necessary to have arrangements for how health practitioners can comply with their objections (sic) under the End of Life Choice Act if a request is made of them by a person in the hospice or organisation's care.

United States of America

15.38 In the United States, legislation in some states extends provisions about conscientious objection to entities.

15.39 In California, legislation provides that participation in the medical aid-in-dying scheme is 'voluntary' and that 'a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorised [by the legislation] is not required to take any action in support of an individual's decision'.[26] In Colorado, the District of Columbia, Hawaii, Maine, New Jersey, Oregon and Washington, a health care facility may choose whether to participate, or is not required to participate, in providing medical aid-in-dying.[27]

15.40 Also, legislation in some states provides generally that a provider or facility may prohibit participation by other providers on its premises. In California and Maine, the legislation provides that:[28]

> a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

15.41 Generally, the concept of 'participating in activities' refers to performing the duties of a practitioner as specified in the Act, dispensing or delivering a prescription for the medication, or being present when a person takes the medication. It does not include providing a patient with information about the scheme, referring a patient elsewhere for the purposes of participation in the scheme, making a diagnosis of terminal disease or determining a patient's capacity.

15.42 The laws in the District of Columbia, Hawaii, Oregon and Washington take a similar approach.[29]

23 Ibid [106].
24 Ibid [114], [116].
25 Ibid [214].
26 *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.14(2)(e)(1).
27 *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25-48-102(4), 25-48-117(1); *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7–661.01(8), 7–661.10(a); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L–19(a)(4); *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.2(F), 2140.21; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:2H-5.33(b)(2); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.1.01(6), 127.885.4.01(4); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(6), 70.245.190(1)(d). In New Jersey, this provision states that any participation by a health care facility 'shall be voluntary on the part of the facility'.
28 *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.15; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140.22.
29 *District of Columbia Death with Dignity Act 2016*, DC Code § 7–661.10(c), (e); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L–19(b),(e); *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.885.4.01(5); *Washington Death with Dignity Act 2008*, RCW § 70.245.190(2).

15.43 In Colorado and Vermont, a health care facility may prohibit a physician from prescribing the medication to a person who intends to use it on the facility's premises. In Colorado, a facility must give written notice of its policy about medical aid-in-dying to patients, and is not entitled to enforce the policy if they fail to give such notice.[30]

Canada

15.44 In Canada, federal legislation states that an individual is not compelled to provide or assist in providing medical assistance in dying,[31] but is silent as to the position of an entity. Participation by individuals or entities is sometimes addressed in policy documents.

15.45 For example, Alberta Health Services policy states that it will facilitate referrals for people seeking access and 'accommodate requests for timely patient transfers from health care settings opting not to deliver medical assistance in dying to an appropriate [Alberta Health Services] setting or other non-objecting setting'.[32] The policy provides that a physician or nurse practitioner who elects not to participate shall provide information about a person seeking access to the 'Care Coordination Service', which will give the person information and resources to facilitate access to a physician or nurse practitioner who is willing to provide the service.[33] In some circumstances, a health care site that is not participating might also contact the Care Coordination Service, and in those circumstances the patient would need to be transferred.[34]

15.46 In Quebec, a relevant institution (such as an institution operating a hospital centre or a residential and long-term care centre) must offer end of life care, which includes palliative care and medical aid in dying. Generally, institutions and palliative care hospices must adopt a policy about end of life care, which must be made known to persons practicing within the institution, and to patients and their close relations.[35]

15.47 If a person requests medical aid in dying and:

- their request is refused by a physician practicing in a centre operated by an institution, for a reason other than the person not meeting the eligibility criteria or other requirements of the Act; or
- the physician receiving the request practices in a private health facility and does not provide medical assistance in dying,

then the physician must notify the relevant executive director (or another designated person) of the request. The executive director 'must then take the necessary steps to find, as soon as possible, another physician willing to deal with the request' or notify the executive director of the local authority that serves the territory in which the patient resides.[36]

The White and Willmott Model

15.48 The White and Willmott Model includes a clause stating that an entity (other than a natural person) which provides a health, residential or professional care service may 'refuse access to voluntary assisted dying, including assessments related to voluntary assisted dying, within its facility'. Where a person requests access and is residing or

30 *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-118(1), (3); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5286.

31 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(9).

32 Alberta Health Services, *Policy: Medical Assistance in Dying*, Document No HCS-165-01 (26 March 2021) [7.2] (e), (g).

33 Ibid [9.4].

34 Alberta Health Services, *Medical Assistance in Dying Process—Phase Three: Determination Phase* (26 August 2016). See also, generally, Alberta Health Services, 'Health Professionals: Medical Assistance in Dying' (2021) <https://www.albertahealthservices.ca/info/Page14381.aspx>.

35 *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, ss 3(1), (2),(3), 7, 8, 14. An institution 'must offer end-of-life care', and palliative care hospices 'determine the end-of-life care provided in their premises': ss 7, 13.

36 *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, s 31.

being cared for in a facility of an entity that refuses access, the entity must:[37]

(a) inform the person of the entity's decision to refuse access to voluntary assisted dying within its facility;

(b) offer to arrange a transfer of the care or residence of the person to an entity at which, in the entity's belief, access to voluntary assisted dying can be provided by a registered medical practitioner who does not have a conscientious objection to voluntary assisted dying; and

(c) take reasonable steps to facilitate that transfer.

15.49 This clause is intended to apply broadly to 'health service providers' and to other service providers through which a person might seek access to voluntary assisted dying, including residential aged care facilities, disability care facilities and supported housing. It establishes a process for transferring the care or residence of a person who is eligible for voluntary assisted dying in circumstances where an 'institution' has refused access. It aims to balance the 'significant potential implications' for access to voluntary assisted dying with respect for institutional positions.

15.50 Professors White and Willmott have suggested that:[38]

> The added clarity of legislative recognition … would help avoid instances where access … is denied or delayed because a transfer is not provided or supported, or there is confusion and uncertainty about whether it is required and the process that is to be followed.

Modified proposals by Professors White and Willmott

15.51 In their submission to the Commission, Professors White and Willmott suggested a modification to clause 39 of the White and Willmott Model. This modification was in response to experiences in other jurisdictions where voluntary assisted dying has been 'effectively blocked or caused harm to individuals seeking [voluntary assisted dying] as a result of the stance taken by entities'. Professors White and Willmott cited evidence emerging from Canada that transfer to a non-objecting facility is not always feasible because of a patient's condition. The patient may be so sick that travel is traumatic and painful, the transfer may require pain medication that renders the person incapable of later making a final request. Also, there may not be another service available to provide voluntary assisted dying. Professors White and Willmott submit that where transfer is not possible for these or other reasons 'the entity must be required to allow entry to other health professionals to undertake assessment of the patient and if eligible, provide [voluntary assisted dying]'.

15.52 Professors White and Willmott advised the Commission that they would also modify clause 4(e) of the White and Willmott Model to delete reference to enabling entities to refuse to participate in voluntary assisted dying without incurring liability.

15.53 The current position of Professors White and Willmott is more fully outlined in a recent article 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' which was co-authored with Dr Eliana Close and Professor Jocelyn Downie.[39] The article discusses possible models of legal regulation and considers the work of scholars in relation to institutional conscientious objection. They identify that at the heart of the matter is 'how best to weigh an individual's ability to access [voluntary

37 White and Willmott Model cl 39.
In the United States, legislation in some jurisdictions provides generally that a provider or facility may prohibit participation by other providers on its premises: *District of Columbia Death with Dignity Act 2016*, DC Code § 7–661.10(c); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat 27L–19(5)(b)–(c); *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140.22; *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.885.4.01(5); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5286; *Washington Death with Dignity Act 2008*, RCW § 70.245.190(2). See also Death with Dignity Bill 2016 (SA) cl 19(3) (not passed); *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, ch 3 div 1, ch 4 div 2.

38 Correspondence from Professors Ben White and Lindy Willmott, 31 August 2020.

39 BP White et al 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).

assisted dying] against an institution's desire not to permit access to [voluntary assisted dying] within its facility'.

15.54 They favour a 'compromise or reasonable accommodation' model for institutional objection. This approach aims to regulate institutional objections to ensure as little impact as possible on the person seeking voluntary assisted dying. While permitting some degree of institutional objection, this approach does not imply legislative endorsement of it. Instead, it focuses on creating processes to facilitate a person's access to voluntary assisted dying where objections occur. Under this model, the legislation does not create new rights for institutions. It seeks to ensure that a person's access is not unreasonably denied. The authors suggest that the legislation provide that 'Nothing in this section creates a right for an institution to refuse to provide access to voluntary assisted dying'. This is said to address concerns raised in the Tasmanian debates that legislatively regulating the issue might be seen as implicit recognition of institutional objections and conscience rights. They suggest that the legislation could state 'An institution wishing to refuse a person's request to access voluntary assisted dying within a facility must follow the process outlined in this section'.

15.55 While recognising that there are various compromise models that could be designed, Professors White and Willmott and their co-authors contend that all compromise models should, at a minimum, require institutions to provide information about voluntary assisted dying, and facilitate effective referral to a voluntary assisted dying provider. Such an obligation is said to not require an objecting institution to endorse voluntary assisted dying, or to be involved in its assessment or administration. As for the suggestion that providing information or referring a person to a provider would make an institution complicit in the activity to which it objects, a workable alternative is said to be to connect individuals with a central co-ordination service such as the Voluntary Assisted Dying Care Navigators in Victoria. This position has been adopted in some Canadian provinces.[40]

15.56 As to institutional objections to conduct eligibility assessments and administration, the authors identify that one way to accommodate both an institution's objections and a person's desire to access voluntary assisted dying is for assessments and administration to occur outside the facility. This might occur by transferring a person's care or residence to another non-objecting institution. Also, it might occur without a formal transfer. For example, a person in a residential aged care facility might remain living there but, if well enough to do so, leave the facility for the purpose of an assessment. However, it will be necessary to have criteria to assess when this is reasonable. The suggested criteria could include that it is not appropriate for an institution to refuse access to voluntary assisted dying where:[41]

- transfer would cause harm to the person (for example, pain or a deterioration of their condition from the required transfer);
- transfer would prejudice a person's access to voluntary assisted dying (for example, the transfer logistics to another institution mean a person is likely to lose capacity or die first; or pain medication required to manage the transfer means they are likely to lose capacity);
- transfer would cause undue delay (and thereby extended intolerable suffering) in accessing voluntary assisted dying; or
- access to voluntary assisted dying is not reasonably possible at another institution (for example, another institution will not accept a transfer or the institution is the only facility in the district that could manage the patient in their condition).

40 D Gilbert, 'Faith and/in Medicine: Religious and Conscientious Objections to MAiD' (2020) 43(2) *Dalhousie Law Journal* 657 1, 9.

41 BP White et al 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).

15.57 Given that the criteria are medical in nature or at least involve navigating the health system, the authors consider it appropriate for a doctor to determine whether the criteria are met. They propose a doctor chosen by or acceptable to the patient, since a doctor employed by an objecting institution may not be free to adopt a position contrary to it. However, a patient might choose to nominate a doctor working at an objecting institution if they consider that doctor is independent. Allowing a doctor to access the facility in order to assess the criteria is submitted to be required in order to 'appropriately balance the institutional and individual interests', since failing to allow access could preclude a person's access to voluntary assisted dying altogether.

15.58 Professors White and Willmott and their co-authors propose that where the criteria mean that access to voluntary assisted dying will occur outside the objecting institution, the institution must offer and take reasonable steps to facilitate this access. This may require supporting a transfer of the care or residence of the person to a place at which voluntary assisted dying can be accessed or provided by a doctor who does not have a conscientious objection. They also propose that a person must not experience financial detriment because of such a transfer, which could 'in some instances have financial implications for a person so serious as to create an unconscionable or insurmountable barrier'. The detriments could range from the cost of transport between institutions through to costs due to complex financial arrangements associated with entry into and exit from a residential aged care facility. The authors argue that because the need for a transfer arises from the institution's objection, the legislation should provide that no financial detriment will occur as a result.

15.59 Where the criteria mean that access to voluntary assisted dying will occur inside the objecting institution, the authors submit that the legislation should provide that access must be permitted by the institution. This is based on the view that a person's claim to access voluntary assisted dying outweighs an institution's objection when both outcomes cannot be achieved. Unless this approach is taken, the authors argue that it would effectively mean that 'a person who is unable to be reasonably transferred or leave the institution for periods to access [voluntary assisted dying] would be prevented from accessing [voluntary assisted dying] by an institution that is objecting'.

15.60 Therefore, they propose that legislation should state that, where transfer is not possible or unduly harms the person's interests, an objecting institution will be required to permit a person to access voluntary assisted dying within the institution and will take reasonable steps to allow this. This may include permitting existing staff who are willing to be involved in conducting assessments or administering the medication to the person or allowing other doctors to visit the person and provide the assistance required. In addition, the institution would not be allowed to impede a person self-administering the medication when its administration is authorised by the legislation.

AMA Position

15.61 In its position statement on conscientious objection, the AMA notes that some health care facilities may refuse to provide particular services due to an 'institutional conscientious objection'. In that situation, the institution should inform the public of this (for example, by putting information on their website or in brochures, or by having signage at their facility) so that patients can seek care elsewhere. Where an inpatient requests access to a treatment or procedure that the institution does not provide because of a conscientious objection, 'doctors should be allowed to refer patients seeking such a service to another doctor outside the facility'.[42]

42 AMA, *Position Statement: Conscientious Objection* (2019) [3.1]–[3.2].

SUBMISSIONS

15.62 Our Consultation Paper asked whether the draft Bill should provide for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility. We also asked whether an entity that refuses access should be required to:[43]

(a) refer the person to another entity or a medical practitioner who may be expected to provide information and advice about voluntary assisted dying; and

(b) facilitate any subsequent transfer of care.

Legislating for refusal of access to voluntary assisted dying

15.63 Many respondents submitted that the draft Bill should provide for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility, or more generally that an entity should not be required to participate or be involved in voluntary assisted dying.[44]

15.64 AMA Queensland reinforced the AMA's position statement about conscientious objection, which recognises that some facilities may not provide particular services due to an 'institutional conscientious objection'.[45] Another respondent observed that Victorian guidelines about voluntary assisted dying recognise that some entities refuse access to it.

15.65 Queensland Nurses and Midwives Union submitted that one of the elements of a voluntary assisted dying framework should be that '[n]o individual, group or organisation is compelled against their will to either participate or not participate'.[46] Palliative Care Queensland submitted that 'health service entities should be provided with legislative protection to ensure they are not required to undertake any acts which conflict with their personal or professional values'.[47]

15.66 One respondent considered that having legislative provision about this topic 'will provide clarity and certainty for [the] community and health care providers' and strengthen recognition of the fact that some providers have clearly stated positions that oppose voluntary assisted dying.

15.67 Several respondents supported such a provision because recognition should be given to the ethics, morals, standards and beliefs (including religious beliefs) on which an entity is founded, and that a lack of recognition might impact on the operation of some entities within the community.

15.68 In relation to religious beliefs, an academic explained that:

> In manifesting their religious beliefs, religious believers in some religious traditions, have established entities which carry out works such as … the provision of palliative or aged care or hospitals. These entities founded by religious believers are a communal demonstration of religious faith and service and a manifestation of that faith in their own right. They are also seen by others as representative of a religious faith. The religious objects or mission of an entity may preclude that organisation from enabling acts contrary to the teachings of that faith to be performed on premises owned or operated by that entity. The institutional beliefs [of] such entities warrant protection.

43 QLRC Consultation Paper No 79 (2020) Q-42.

44 Some respondents did not engage with the threshold question of whether the draft legislation should make provision for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility, but did make submissions about any requirement for an entity that does not permit access to voluntary assisted dying to refer a person elsewhere and facilitate any transfer of care.

45 Citing AMA, *Position Statement: Conscientious Objection* (2019) [3].

46 Similarly, ANZCA submitted that '[p]articipation by medical practitioners and health services in [voluntary assisted dying] should be voluntary with no need for any objection to be qualified'.

47 The same submission was also made in respect of 'health professionals'.

15.69 This respondent also noted that there are links between the religious freedom of individuals and 'the protection of the autonomy of the collective church'.[48] Accordingly, this respondent recommended that the AMA's position regarding 'institutional conscientious objection' should be adopted in the draft Bill, with religious entities not obliged to participate. This approach is said to be 'an appropriate recognition of the importance of religious organisations … [which] are a key aspect of the respect for diversity and difference in Australia and a visible demonstration of pluralism'.

15.70 Catholic Health Australia explained that entities—and health practitioners working within those entities—are bound by ethical codes and frameworks (including codes specific to Catholic health services), and that participation in voluntary assisted dying is incompatible with them. It submitted that entities should be able to choose not to offer voluntary assisted dying on the basis that it is inconsistent with their 'ethic of care', and should be permitted to decide what services they can provide and continue to offer care within their ethical framework.[49]

15.71 The Anglican Bishop of North Queensland considered that institutions should not be forced to compromise their defining moral values, because doing so may cause the institution to become 'incapable of fulfilling its mission'.[50] A member of the public submitted that 'legislation should not trample over moral beliefs'.

15.72 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Queensland ('Uniting Church') jointly submitted that one of the guiding principles of the draft Bill should be that respect for diversity of views, values and beliefs is extended to entities. This approach 'recognises that the legislation has the potential to significantly impact on entities providing community and health services across Queensland'.

15.73 In summarising this issue, an academic submitted that:

> In a multi-faith, plural society respect for difference and diversity ought be demonstrated by recognizing that individuals and entities are different and not all can or ought be obliged to participate in every practice which the State has determined to make lawful.

15.74 Some of these respondents also considered the impact that voluntary assisted dying might have on the provision of services by entities with an ethical, moral or religious basis, or on the acceptance of services by members of the public.

15.75 An academic submitted that facilities and practitioners should not be required to provide voluntary assisted dying because that could discourage people with 'religious or conscientious convictions' from becoming medical practitioners, and discourage facilities operated by religious organisations from providing services. This respondent observed that:[51]

> Given the number of organisations of this kind operated by the Catholic Church, for example, the withdrawal of the operations of those providers would be deeply problematic for the State and for patients wishing to access other health services.

15.76 The Anglican Bishop of North Queensland submitted that institutions should be able to 'opt out' of participation when it conflicts with the institution's basic values, mission and public image for pragmatic reasons, including that 'many people will boycott institutions such as aged care facilities where they know [voluntary assisted dying] is being carried

48 Citing *Iliafi v Church of Jesus Christ of Latter Day Saints Australia* (2014) 311 ALR 354; *Metropolitan Church of Bessarabia v Moldova* (2002) 35 EHHR 13.

49 This respondent also observed that if health practitioners cannot object to participation in any aspect of voluntary assisted dying this would infringe upon the right to freedom of thought, conscience, religion and belief, and submitted that '[i]f healthcare and aged care services whose ethos prohibit participation and cooperation in any form with [voluntary assisted dying] processes are not excluded from participation in [voluntary assisted dying] this will constitute a violation of these rights'.

50 The Bishop made particular reference to 'non-profit institutions', submitting that it is in the public interest to allow those institutions to determine their own moral values, rather than having them imposed by legislation.

51 This respondent also submitted that the same arguments apply in relation to a legislative requirement to refer a person seeking access to voluntary assisted dying elsewhere.

out with deleterious impacts on the delivery of services at those facilities and in the broader community'.[52] The Bishop also suggested that requiring entities to participate when it is inconsistent with their values 'is not in the public interest', because of the damage caused to the institution and their ability to provide for the public good.

15.77 Catholic Health Australia submitted that, to protect autonomy, the safeguards in a voluntary assisted dying scheme should include ensuring that people can access institutions providing health and aged care services 'where they are guaranteed that they will not be offered or pressured into [voluntary assisted dying]', and that for this reason all of its members 'should be exempt from facilitating access to or providing [voluntary assisted dying]'.[53]

15.78 Similarly, an academic submitted that support for voluntary assisted dying is not universal and people 'should be able to choose to be treated at hospitals and by medical professionals who share their convictions', and should 'not be discouraged from obtaining medical care due to fear of being subject to persuasion or advice to access a procedure [to] which they morally object'.

15.79 The Queensland Law Society submitted that:

> This is a complex issue requiring careful consideration to ensure that the legislation strikes an appropriate balance between the ability of an entity to reject [voluntary assisted dying], if it considers the practice to be in conflict with its established doctrine or tenets, and with the right of an individual to access healthcare in accordance with established common law principles, including autonomy, equality, self-determination, and reducing suffering.

15.80 As noted, Professors White and Willmott have considered this issue in a recent substantial article.[54] They also submitted that an entity's policy position should not block an individual's ability to pursue voluntary assisted dying, and for that reason supported legislative regulation to ensure that people have a means of obtaining access.[55] Their submission proposes a process to aid an individual to access voluntary assisted dying, while respecting the choice of an entity to not provide it.[56]

15.81 Professors White and Willmott also consider that legislation is preferable to a policy-based approach because the 'stronger normative and coercive force of law' is likely necessary where institutions have 'deeply-held views' and individuals are seeking to compel those institutions to comply with requirements that may conflict with those views.[57]

15.82 The Queensland Law Society and Professors White and Willmott supported a modified version of the White and Willmott Model so as to permit access in circumstances where a person's care cannot be transferred.[58]

15.83 The Uniting Church, which provides health and aged care services, stated that they were aware of potential difficulties in accessing practitioners who do not have a conscientious objection, and of the limited access to practitioners in rural and remote areas, but submitted that 'this is a process and resource issue that should not impede on the rights of an individual or … entities to conscientiously object'.

15.84 A few respondents submitted that an entity which refuses to participate in voluntary assisted dying should not be subject to penalties, legal proceedings or other consequences.

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52 The Bishop also added that 'there are strong commercial arguments in favour of allowing private and non-profit institutions to opt out' of voluntary assisted dying.

53 It was also submitted that this approach will assist in securing the right to life.

54 See also, for detailed discussion of cl 39 of the White and Willmott Model and the views of these respondents, [15.137] ff below.

55 See also [15.137] ff below.

56 See also BP White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).

57 Ibid.

58 See also [15.137] ff below, where cl 39 of the White and Willmott Model and these submissions are discussed in greater detail.

15.85 Other respondents, including Christians Supporting Choice for Voluntary Assisted Dying, Dying with Dignity Queensland, Dying with Dignity NSW, a registered nurse, academics and members of the public, submitted that the draft Bill should not include provision for an entity to refuse access to voluntary assisted dying within its facility, or more generally to refuse to participate or be involved in the process.[59]

15.86 A number of these respondents observed that, following the passing of legislation, voluntary assisted dying would be a lawful 'medical procedure' or 'health service'. A registered nurse submitted that '[t]he right of citizens to access lawful medical procedures should be protected under legislation'.

15.87 Several respondents submitted that, unlike individuals, entities do not or should not have human rights.[60] Dying with Dignity Queensland stated that it 'accepts freedom of choice for voluntary assisted dying as a human right and conscientious objection to voluntary assisted dying as a human right', but that it 'does not accept that an entity can have either human [rights] or be able to deny those human rights to an individual'. Similarly, a registered nurse observed that the underlying principle of voluntary assisted dying legislation is an individual's right to have freedom of choice, and stated that '[i]individual practitioners must always have the right to conscientiously object to [participation] in the provision of [voluntary assisted dying] services – but this right should not extend as a blanket exemption to entities'.

15.88 A member of the public submitted that:[61]

> While natural persons hold conscience, institutions do not. The natural person harbours intuitive and deliberative cognitive capacities … and affective capacities that, in various combinations, guide their evaluation of and response to ethical questions.
>
> Institutions (e.g. companies, associations) are contrivances of 'personhood' in law. They do not hold cognitive or affective capacities of their own: they do not have consciences. Rather, they have rules that merely masquerade as 'conscience', and the reliability of those rules is questionable.

15.89 Several respondents also observed that an entity's position about voluntary assisted dying may not represent the position of its employees, and that there may be health practitioners employed by an entity opposed to voluntary assisted dying who are individually willing to participate in some way in the provision of those services. One member of the public noted the position of the Catholic Church that voluntary assisted dying will not be provided on the premises of Catholic-based institutions or by doctors employed by those institutions. This respondent submitted that this is 'at serious odds with actual consciences' because there is support for voluntary assisted dying among Australian people of the Catholic faith.

15.90 A number of respondents considered that it is relevant whether an entity receives government funding. For example, Christians Supporting Choice for Voluntary Assisted Dying submitted that an entity should not be permitted to refuse access to voluntary assisted dying, particularly if they receive public or government funding. Dying with Dignity Queensland submitted that if an entity receives government funding, or has a 'privileged' taxation or financial status, then the entity 'should provide health services in line with community expectations'.

15.91 A registered nurse stated that privately operated facilitates receive government funding and are 'providing an essential public service to the people of Queensland'. This respondent submitted:

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59 One respondent submitted more broadly that '[i]deally an entity should not be permitted to refuse any medical treatment to be carried out on their premises'.

60 One respondent submitted that there is a difference between an individual having the right to refuse to be involved and an entity requiring a person to go elsewhere because the person has requested access to a lawful procedure.

61 Citing R Smalling and U Schuklenk, 'Against the accommodation of subjective healthcare provider beliefs in medicine: counteracting supporters of conscientious objector accommodation arguments' (2017) 43(4) *Journal of Medical Ethics* 253.

> As taxpayers, all citizens help fund these private facilities. It would be a gross injustice for citizens to have to fund these facilities – yet, for the facility to be allowed to refuse to provide them with a lawful medical procedure.

15.92 A few respondents submitted that it would be discriminatory for an entity to refuse access to a person seeking voluntary assisted dying. One respondent stated that there is 'no reason' why a publicly or privately owned entity that is open to the public should have the right to refuse access to a person who is seeking voluntary assisted dying, any more so than the entity should be able to refuse admission or treatment to a person on the basis of their race, religion or sexual orientation.

15.93 In various ways respondents addressed the impact on both individuals and the community if entities were permitted to refuse access to voluntary assisted dying in their facilities.

15.94 Several respondents observed that a significant proportion of relevant facilities or services, including hospitals, nursing homes and aged care services, are operated by private or religious-based entities. They submitted, therefore, that refusal by those entities to provide access would have significant practical effects. Dying with Dignity NSW submitted that the availability of voluntary assisted dying would be 'greatly diminished'.[62] A registered nurse submitted that if all these entities required a person be transferred to a public facility to access voluntary assisted dying, this would place an 'unacceptable burden' on:

1. The person seeking [voluntary assisted dying] (who may be in very poor medical condition and unfit to travel).
2. The public hospitals and aged care facilities [that] would be accepting these transfers.
3. The ambulance service ([which] would be diverting emergency paramedics to transfer these people).

15.95 A few respondents also observed that for some people, particularly those in residential aged care facilities, a facility is effectively their home, and some have lived there for many years. Respondents submitted that in those circumstances, an entity should not operate in a way that is inconsistent with 'community needs and expectations', and that 'it would be a gross injustice to force these people out of their own (new) home to access [voluntary assisted dying]'.[63]

15.96 Similarly, VALE Group observed that individuals diagnosed with an incurable or life-limiting illness will become 'part of' a health care facility or entity, and also observed that some specialist health practitioners will only provide services from specific health care facilities or entities and an individual will generally simply attend at whichever facility can deliver the care they require. It submitted that to permit an entity to refuse access to voluntary assisted dying within its facility, and therefore require an individual who is so unwell that they are seeking access to voluntary assisted dying to find a new specialist and health care team, 'is appalling' and 'would cause immense distress'.

15.97 Some respondents specifically addressed access to services in regional, rural or remote areas, or areas with limited health services. Health Consumers Queensland explained that:

> refusal from an entity to provide access to voluntary assisted dying within the facility poses risks of access and equity as well as continuity of care. This is especially a risk for rural and remote communities where there are reduced facilities.

62 VALE Group submitted, in similar but more general terms, that '[t]he majority of health-care facilities [or] entities in Queensland operate their business … under … mission-based religious values' and that '[i]t is unacceptable for … control to be exercised which is detrimental to those who would seek to access voluntary assisted dying … but cannot do so'.

63 One respondent also observed that residents of private aged care facilities pay large sums of money to live at the facility.

15.98 Dying with Dignity Queensland submitted that entities with a 'monopoly status in regard to geographical locality' should not be able to disadvantage a community by withholding services for reasons that are misaligned with the community's needs and expectations. A registered nurse observed that if the only relevant entity in a geographic area can refuse to provide such services, then people may have to travel long distances to secure access to voluntary assisted dying.

Scope of provision about refusal of access to voluntary assisted dying

15.99 Some respondents made submissions about the scope of any legislative provision for an entity to refuse access to voluntary assisted dying within its facility. These included submissions about the entities that should be able to rely on the provision, and the circumstances in which the provision should apply.

Relevant entities

15.100 Respondents used various terms to describe the entities that, in their view, should be able to refuse access to voluntary assisted dying within their facility.

15.101 Some respondents adopted the term 'entities'. The White and Willmott Model proposes that the provision apply to an entity (other than a natural person) which provides a health, residential or professional care service.[64] This clause is intended to apply broadly to 'health service providers' and to other service providers through which a person might seek access to voluntary assisted dying, including residential aged care facilities, disability care facilities and supported housing.[65]

15.102 Other respondents used similar general terms to describe the relevant entities. For example:

- facilities, or more specifically healthcare (or health) facilities, care facilities or medical facilities;
- services, or more specifically healthcare (or health) services, community services and aged care services;
- institutions, or more specifically medical institutions;
- organisations, or more specifically healthcare organisations.

15.103 Some respondents noted particular types of entities to which they considered that a provision about refusal of access should apply, including aged care facilities, disability care facilities, hospices, hospitals or private hospitals and nonprofit health care providers. Some respondents also made specific mention of entities that were founded by or associated with a church or a religion.

15.104 A member of the public submitted that any provision should apply only to 'privately owned and non-government funded' entities. Another respondent did not suggest any limitation on the types of entities to which a provision might apply, but submitted that '[f]or these provisions to apply, an entity should have a clear position in opposition to participating in voluntary assisted dying based on their values, principles, belief or mission'.[66]

Relevant circumstances

15.105 As explained, some respondents submitted that a relevant entity should be able to refuse access to voluntary assisted dying within its facility or should not be required to participate or be involved in the process.

15.106 Some respondents considered that any provision about entities should apply broadly.

64 White and Willmott Model cl 39.

65 Correspondence from Professors Ben White and Lindy Willmott, 31 August 2020.

66 It was also suggested that '[t]his will strengthen the legislation to recognise that large health and community service providers in Queensland such as UnitingCare, Catholic Healthcare, Catholic Health Australia and Southern Cross Care have clearly stated positions in opposition to voluntary assisted dying'.

For example, a member of the public submitted that an entity should be able to refuse to be involved in voluntary assisted dying 'in any way', and Queensland Baptists and the Australian Christian Lobby submitted that relevant entities should be able 'to refuse to participate … for any reason'.

15.107 The Lutheran Church of Australia and the Uniting Church submitted that the same protections and provisions applying to conscientious objection by individuals should also apply to entities other than natural persons. Specifically, it was submitted that entities should be able to refuse to do any of the matters listed in the conscientious objection provisions in the other legislation,[67] as well as being able to refuse to have their property used for voluntary assisted dying. The Lutheran Church of Australia submitted that this approach is consistent with the HR Act and the International Covenant on Civil and Political Rights.

Informing the person

15.108 Some respondents submitted that where an entity refuses access to voluntary assisted dying within its facility, there should be a requirement to inform the person of the entity's position.

15.109 Some respondents, including academics and voluntary assisted dying advocacy groups, considered that such a requirement should be part of a requirement to refer a person elsewhere or to facilitate the transfer of their care.[68] There was also support from respondents, including several faith-based respondents and the AMA Queensland, for a broader requirement that an entity which refuses to permit access in its facility must make its policies and positions clear to the community, and to current and prospective patients or residents.[69]

15.110 AMA Queensland reinforced the AMA's position statement about conscientious objection,[70] to the effect that where a facility refuses to provide particular services due to an 'institutional conscientious objection' they should 'inform the public of this so that patients can seek care elsewhere'.

15.111 Go Gentle Australia supported both a requirement for an entity to make their policies clear to individuals who may be admitted to the facility and a requirement to inform a person who has requested voluntary assisted dying of the entity's position. It recommended:[71]

> that any institution that refuses to allow [voluntary assisted dying] on its premises must inform potential patients/residents of this policy prior to admission of the person. … [T]heir position should also be part of any published literature (print, digital, or other) where they advertise, or inform people about, their services. This is to avoid a potentially harmful situation if a patient should ever wish to apply for [voluntary assisted dying].
>
> An institution that is religiously or philosophically opposed to [voluntary assisted dying], if requested by a person in their care to provide [voluntary assisted dying], must immediately respond, informing them they cannot support that request. They must then facilitate transfer to a suitable facility in a timely and professional manner.

67 This includes refusing to provide information about voluntary assisted dying, participate in the request and assessment process, prescribe, supply or administer a voluntary assisted dying substance, or be present at the time of administration of a voluntary assisted dying substance.

68 See also [15.137] ff below. A requirement to inform a person of the entity's position is included in cl 39 of the White and Willmott Model.

69 See also R Syme, 'A Response to White and Willmott' (2020) 8(1) *Griffith Journal of Human Law and Dignity* 1, 9. Some respondents also noted that this is consistent with the position of the AMA. See also BP White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).
A member of the public submitted that advising incoming patients or residents 'has particular relevance within the Aged Care industry'.

70 AMA, *Position Statement: Conscientious Objection* (2019) [3].

71 See also [15.131] below, as to its submission about referral and transfer of care.

15.112 A member of the public submitted that there should not be a requirement to provide a reason or explanation for an entity's refusal.

Referral and transfer of care

15.113 Many respondents, including the Clem Jones Group, academics and members of the public, submitted that if an entity refuses a person access to voluntary assisted dying within its facility, it should be required to refer the person elsewhere and facilitate any transfer of care.[72] Other respondents were opposed to a legislative provision for an entity to refuse access but submitted that, if there was such a provision, then there should also be requirements about referral and transfer of care.[73]

15.114 Some respondents contended that requirements for referral or transfer of care to be mandatory and included in legislation.

15.115 The Clem Jones Group explained that a requirement to refer a person to a different practitioner or facility 'might not be necessary if the patient assumes responsibility for seeking out another medical practitioner, but … can help ensure no patient is left without [voluntary assisted dying] at least as an option to consider'. It also noted that a requirement to refer facilitates access to services, particularly because of the size and geographic diversity of Queensland.

15.116 The United Workers Union submitted that:

> [an] obligation to refer and transfer care must also apply to those healthcare services that do not allow or provide for [voluntary assisted dying] in its facilities. For example, where private providers of health care, such as private hospitals and aged care facilities, refuse [voluntary assisted dying] on religious grounds. Despite their own internal standards, providers should be obliged under [voluntary assisted dying] legislation to on-refer and facilitate transfer of care without discrimination.
>
> Providing for conscientious objections without the dual requirement for referral and transfer will deny individuals the right to access quality choice of end of life care and is in stark contrast to the guiding principles of the legislation.

15.117 Professors White and Willmott submitted that an entity's policy position 'should not have the effect of blocking the ability of a person to pursue [voluntary assisted dying]', and therefore that there should be a legislative mechanism to 'regulate processes' and provide for a patient's transfer of care so that the patient can explore and access voluntary assisted dying.[74] Similarly, the Australian College of Nurse Practitioners submitted that practitioners or entities do not 'have the right to prevent access to care' and that 'refusal should not result in a barrier to access', but might result in a transfer of care.

15.118 Dying with Dignity Queensland submitted that an obligation to refer a person elsewhere should apply in situations where an entity does not offer voluntary assisted dying.

15.119 Other respondents did not support a requirement that an entity that refuses access within its facility must refer the person elsewhere or facilitate a transfer of care.[75]

15.120 Catholic Health Australia submitted that '[s]ome healthcare and aged care institutions are bound by codes of ethics which prohibit cooperation in any way with [voluntary assisted dying]' and that '[r]eferral is a form of cooperation'. Similarly, a medical practitioner submitted than an entity should not be required to refer a person elsewhere

72 Some respondents expressed support for a requirement to refer a person elsewhere and facilitate any transfer of care, but did not engage with the threshold question of whether there should be any legislative provision for an entity to refuse access to voluntary assisted dying within its facility.

73 One respondent supported a legislative provision applying to only some entities.

74 In their submission, Professors White and Willmott expressed support for cl 39 of the White and Willmott Model, with some modifications to permit access in circumstances where a person's care cannot be transferred.

75 Two respondents (one supportive of a requirement to refer a person elsewhere, the other opposed to it but supportive of providing a person with information about their legal rights) observed that there is tension between a suggested requirement to facilitate a transfer of care and existing standards or principles about patient-centred care, continuity of care and nonabandonment.

because that is 'compelling collaboration with an act that violates that entity's ethic of care'. However, that respondent also observed that it is 'normal practice' to transfer a patient's care at their request, and that this does not 'imply collaboration' or 'require specification in any law'.

15.121 An academic submitted that a requirement to provide a referral would 'be a positive discouragement to hospitals, aged care facilities and hospices operated by religious organisations which consider assisted dying to be immoral, from beginning or continuing to provide those services'. This respondent submitted that:[76]

> it would be appropriate for entities with an "institutional conscientious objection" to voluntary assisted dying to make … it clear by signage at their facilities, on their websites and in other promotional materials that they are unable to provide or participate in that activity. This will obviate the need for referral or transfer of patients in such facilities who wish to seek voluntary assisted dying and enable patients wishing to be treated in facilities which do not engage in voluntary assisted dying to be treated in a facility which shares their position.

15.122 The Lutheran Church of Australia Queensland District and the Uniting Church[77] submitted that an entity that refuses to permit access to voluntary assisted dying should be required to:

- inform the person of the entity's position;
- not impede a transfer of the person's care or residence; and
- take steps to support the transfer and minimise the person's suffering, such as transferring records to enable continuity of care.

15.123 The Uniting Church explained that:[78]

> The institution or entity should seek to facilitate and not impede any transfer of care within what is reasonable and appropriate to compassionately support the person in their decision and minimise suffering. However, the ultimate responsibility for arranging access to voluntary assisted dying belongs with the individual seeking the service. …
>
> We believe that the ethical issue is the balance between respecting the conscience and individual autonomy. The solution is not in a 'middle ground' that seeks to compromise an individual's conscience. Rather, it is a process and resource solution in which the State makes provision to a service that facilitates access to voluntary assisted dying and has clear information readily available online for people to easily access. Performing voluntary assisted dying is not a medical emergency or a circumstance that has a timeframe urgency that would result in immediate harm if immediate action is not undertaken. The ethical obligation for accessing the service is on the individual, and for the State to facilitate an effective process to access this service, without impeding on the conscience of individuals or institutions/entities.

15.124 Some respondents opposed a requirement to refer a person elsewhere but supported a requirement to provide information. For example, a medical practitioner submitted that the entity should 'inform the person of alternate facilities where voluntary assisted dying can be carried out'. Catholic Health Australia in its original submission contended that an entity should only be required to give a person information about their legal rights and about publicly available information. Its recent supplementary submission, discussed below, developed its position.

15.125 A medical defence organisation and professional indemnity insurer submitted that obligations for entities should be consistent with those of natural persons, because '[t]o do otherwise raises significant issues of inconsistency and difficulties in implementation'.

76 Another academic submitted that relevant entities 'should only be required to make their position clear to the community [and] persons they serve'.

77 The Uniting Church Synod together with Wesley Mission Queensland and UnitingCare Qld.

78 In contrast, the Lutheran Church of Australia Queensland Division described the requirement as 'while not facilitating, neither impede nor hinder the resident transferring to another environment'.

It supported an approach, consistent with the AMA position, whereby an entity should disclose their position to the community and should '[n]ot preclude doctors practicing within the institution [from] refer[ring] or transfer[ring] patients under the care of the institution elsewhere'.

15.126 A member of the public submitted that referral should be optional and that the person or their family should make any alternate arrangements. This respondent submitted that relevant facilities would include those with a religious basis, and 'anyone who enters such a facility can be expected to know … the views of that religion'.

The scope and operation of a requirement to refer and to transfer care

15.127 Some respondents made submissions about the details of a requirement to refer or to transfer care.

15.128 A few respondents submitted that any referral or transfer of care should be 'prompt' or 'timely', or that a person should be informed immediately and referred elsewhere within 24 hours.

15.129 There were different suggestions about to where a person seeking access to voluntary assisted dying should be referred or transferred. Some respondents submitted that an entity refusing access to voluntary assisted dying within its facility should be required to refer the person to another entity or a medical practitioner who may be expected to provide information and advice about voluntary assisted dying, and facilitate any subsequent transfer of care.[79]

15.130 Some respondents, such as the Clem Jones Group and Dying with Dignity NSW, submitted that an entity should be required to facilitate a referral and transfer of the person's care to 'a practitioner or facility willing to assist their application and assessment' or 'a service which will facilitate their access to the [voluntary assisted dying] scheme'. Dying with Dignity Queensland considered that referral could be to 'an institution where voluntary assisted dying is provided' or to a government-run navigation service. VALE Group suggested that consideration be given to establishing new facilities to provide access to voluntary assisted dying, and that entities refusing access within their own facility should be required to facilitate a transfer of care to those new facilities.

15.131 Go Gentle Australia submitted that an entity refusing access should refer a person to an information source, like the Victorian Care Navigator Service or a government body that could provide the person with a referral. The entity should also facilitate a transfer of care, and:[80]

> Until such transfer can be arranged, no institution should be allowed to block access to the person making the request of: either the coordinating or consulting practitioner; the care navigators; the pharmacist; or anyone else involved in that person's legal right to access [voluntary assisted dying].

15.132 Christians Supporting Choice for Voluntary Assisted Dying supported a navigation service (as in Victoria), and submitted that this service should maintain a list of entities that do and do not permit access to voluntary assisted dying on their premises. It also submitted that, where an entity refuses access to voluntary assisted dying, a transfer of care should be facilitated appropriately (for example, via ambulance if required) and at no cost to the person, and that any associated transfer of a bond or similar should occur promptly and without penalty to the person.[81]

15.133 The Lutheran Church of Australia Queensland District observed that consideration may need to be given to amendment of the application of security of tenure obligations

79 Another respondent expressed support for a provision in these terms, except that it should not include the option of referral to a medical practitioner.

80 It also submitted that any efforts to block access should be punishable by a fine.

81 An obligation on the entity to bear the costs associated with transfer is also supported by Professors White and Willmott and their co-authors in their article discussed below.

under the *Aged Care Act 1997* (Cth) ('the Aged Care Act') where an entity's refusal to provide access in its facility results in the person's transfer to a different facility.[82] It also submitted that an entity should not be required to facilitate a transfer of care, but should 'neither impede nor hinder the resident transferring to another environment'.

A recent proposal by Catholic Health Australia

15.134 In a recent supplementary submission dated 11 April 2021, Catholic Health Australia reiterated its support for statutory recognition for the right of a health service to refuse to offer or to facilitate voluntary assisted dying processes within its premises on the grounds of conscientious objection. It also emphasised the right of a prospective resident in an aged care home to choose a place in which they will be cared for based on that institution's values, and on an informed choice of knowing whether voluntary assisted dying is offered by a particular service. Catholic Health Australia envisaged that a patient may choose to reside in a Catholic Health facility, knowing that voluntary assisted dying is not offered there, but then seek to access it. This was said to raise a question of how the patient's choice and autonomy may be reasonably accommodated.

15.135 It submitted that an entity's statutory right to refuse to authorise or permit the voluntary assisted dying process on its premises should not prevent a patient from having access to voluntary assisted dying elsewhere. It proposed formalising, either in law or in regulation, protocols facilitating the transfer of patients or residents in its members' care to facilities that offer voluntary assisted dying.

15.136 Catholic Health Australia proposed a provision that would apply if the person advised the service that they wished to access voluntary assisted dying. In that event, the relevant service provider would be required to ensure that:

(a) the person is advised of the relevant service provider's refusal to authorise or permit the carrying out at a health service establishment owned or occupied by the relevant service provider of any part of the voluntary assisted dying process; and

(b) arrangements are in place whereby the patient or resident may be transferred to another health service establishment at which, in the opinion of the relevant service provider, a medical practitioner who does not have a conscientious objection to voluntary assisted dying is likely to be able to ensure the person is able, if the person indicates that the person wishes to do so, to make a request under this Act; and

(c) reasonable steps are taken to facilitate the transfer referred to in paragraph (b).

The White and Willmott Model

15.137 Professors White and Willmott propose a legislative approach to regulate the process where an entity refuses access to voluntary assisted dying within its facility, including provision for transfer of a person's care.

15.138 In their submission to this review, and in an article co-authored with two other academics, Professors White and Willmott advance a new proposal for transfer or access where transfer is not feasible. Considering practical difficulties experienced in other jurisdictions, they suggest a provision to address scenarios where transfer is not feasible, or where it would not be appropriate for an entity to refuse access to voluntary assisted dying. This might include where:[83]

- transfer would cause harm to the person;
- transfer would prejudice a person's access to voluntary assisted dying;

82 Other respondents observed more generally that there is a need to consider the compatibility of State voluntary assisted dying legislation and the *Aged Care Act 1997* (Cth).

83 BP White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming), and see the examples quoted in the article.

- transfer would cause undue delay, and thereby extended intolerable suffering, in accessing voluntary assisted dying; or
- access to voluntary assisted dying is not reasonably possible at another institution.

15.139 Professors White and Willmott submitted that '[w]here transfer is not feasible for these (or other) reasons, the entity must be required to allow entry to other health professionals to undertake assessment of the patient and, if eligible, provide [voluntary assisted dying].' It was explained that this approach 'prioritises the interests of an individual seeking [voluntary assisted dying] over the interests of an institution seeking to conscientiously object in circumstances where the position of both cannot be accommodated'.

15.140 The Queensland Law Society supported a similarly modified version of the White and Willmott Model. However, it was concerned about the 'practical implications' of such a provision, particularly for people 'in remote or regional areas and for whom obtaining access to the [voluntary assisted dying] process may impose significant travel, financial, physical or emotional burdens'. It submitted that a transfer to a different facility will sometimes cause additional pain and trauma and could result in the person being separated from their family and community, and in those circumstances 'an authority to refuse will not align with common societal expectation(s) that laws should reduce suffering, in accordance with community values and established legal principles'.

15.141 The Queensland Law Society also raised concerns about compatibility with the HR Act where an entity refuses access within its facility and requires a person to 'undertake painful, traumatic or difficult travel' to an alternative facility, noting that clause 39 'create[s] a risk whereby in some cases an individual's rights will be unreasonably limited'. It submitted that some entities that may refuse access could be 'public entities' under the HR Act, and therefore required to act and make decisions in a way that is compatible with human rights.[84] It also submitted that circumstances in which access to voluntary assisted dying is refused and care is transferred might engage the rights to health services without discrimination, equality, privacy, and family, the cultural rights of Aboriginal and Torres Strait Islander peoples and, in severe case, protection from cruel, inhuman or degrading treatment.[85]

15.142 Ultimately, the Queensland Law Society submitted that clause 39 of the White and Willmott Model should be included in the draft Bill 'with amendments to ensure that access to [voluntary assisted dying] is equitable irrespective of an eligible person's condition, location and accommodation'. Specifically, it submitted that the clause should require an entity to permit other health professionals to enter, and to carry out assessments and administer voluntary assisted dying, where transfer is not feasible, for example because travel would cause additional trauma or pain medication required might impact a person's eligibility for voluntary assisted dying.

15.143 More generally, Dying with Dignity Queensland considered that there should be 'legislative protection against any unreasonable delay in implementing a referral', and that if a transfer of care is not possible because the person is too unwell or there is no alternative facility available, then other practitioners must be permitted to enter and to assess the person and (if eligible) provide voluntary assisted dying.

84 See, in particular, HR Act (Qld) ss 9, 10, 58.

85 See, in particular, HR Act (Qld) ss 15, 17, 25, 26, 28, 37.
The Queensland Law Society also noted that entities do not have rights under the HR Act, but that the people working in those entitles will have rights, including the right to freedom of thought, conscience, religion and belief. The Queensland Law Society observed that it was unclear how clause 39 of the White and Willmott Model would provide any greater protection than is already given by clause 38 (which relates to conscientious objection by health practitioners), but noted that '[it] may be that there are employees of such entities who would not fall into the definition of a registered health practitioner under clause 38'.

ADDITIONAL INFORMATION ABOUT RELEVANT ISSUES

15.144 The submissions about participation by entities prompted the Commission to engage in further consultation, in particular to clarify issues related to problems of practical access to voluntary assisted dying (especially in rural and regional areas), the feasibility or otherwise of transferring a person to another facility or place, the regulation of residential aged care facilities, credentialing of health practitioners and transfer of clinical care.

15.145 The Commission consulted with:

- participants in the voluntary assisted dying schemes in Victoria and Western Australia;
- entities which have chosen to not participate in the scheme in Victoria;
- Associate Professor Mark Boughey, Director of Palliative Medicine at St Vincent's Hospital, Melbourne, about practices in Victoria including the response of Catholic Health Australia and other entities;
- the Voluntary Assisted Dying Review Board in Victoria; and
- persons involved in the implementation of the schemes in Victoria and Western Australia.

15.146 The Commission was also briefed by Queensland Health about the regulation of residential aged care facilities, credentialing of health practitioners and transfer of clinical care. Parts of the following sections draws upon that information.

STATE REGULATION OF HOSPITALS AND HEALTH SERVICES

15.147 In Queensland, public and private hospitals are regulated by different, although sometimes overlapping, legislative schemes.

15.148 The *Hospital and Health Boards Act 2011* provides for the establishment of a public sector health system to deliver hospital and health services in Queensland. It also provides for the management of that system, including service agreements, funding arrangements and performance management.[86]

15.149 The *Private Health Facilities Act 1999* establishes a system of licensing for the operation of 'private health facilities', namely private hospitals and day hospitals, and includes requirements about accreditation and compliance with standards. It is intended to provide a framework for the protection of the health and wellbeing of patients receiving health services at these facilities.[87]

15.150 Public hospitals and licenced private health facilities must comply with the Clinical Services Capability Framework for Public and Licensed Private Health Facilities (the 'CSCF').[88] The CSCF sets out 'the minimum support services, staffing, safety standards and other requirements' that apply to those facilities in Queensland,[89]

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86 *Hospital and Health Boards Act 2011* (Qld) ss 5(1), 8–9, pts 2–4. Hospital and Health Services are statutory bodies established under this Act. They are the 'principal providers of public sector health services' and their primary function is to deliver, as per a service agreement with Queensland's Department of Health, hospital, health, teaching, research and other services: ss 7, 16, 19. A 'health service' is defined as 'a service for maintaining, improving, restoring or managing people's health and wellbeing' and includes such a service provided to a person at a hospital, residential care facility, community health facility or other place: s 15. See also, as to the provision of public services at Mater hospitals: *Mater Public Health Services Act 2008* (Qld).

87 *Private Health Facilities Act 2005* (Qld) ss 3, 4, 8, pts 4–6.
A 'private hospital' is a facility at which people are provided with health services and discharged on a day other than the day of their admission. It does not include a hospital operated by the State, or a nursing home, hostel or other facility at which accommodation and nursing or personal care are provided to people with a permanent need for such care. A 'health service' is defined as 'a service provided to a person for maintaining, improving or restoring the person's health and wellbeing': ss 7, 9.
A 'day hospital' is a facility at which people are provided with a limited range of 'day hospital health services', and are admitted and discharged on the same day: s 10.

88 Queensland Health, C*linical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) [1], [6.1]; Queensland Health, *Clinical services capability framework: About the CSCF* (31 May 2016) <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/about>.

89 Queensland Health, *Clinical services capability framework* (26 July 2019) (22 May 2017) <https://www.health.qld.gov.au/system-governance/licences/private-health/cscf>. See also Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) 3.

including for the delivery of palliative care services, geriatric services, and services connected with conditions that could be associated with voluntary assisted dying, such as cancer.

15.151 The CSCF categorises clinical services into six service levels, which reflect increasing levels of patient complexity.[90] Services can only be provided by a hospital or facility with a certain service level. While a level one palliative care service provides low-complexity care to patients living in the community, a level five or six service provides inpatient care and can manage clinically complex issues or symptoms.[91]

AGED CARE FACILITIES

15.152 Generally, the Australian aged care system is funded and regulated by the Commonwealth Government through the Aged Care Act, the *Aged Care Quality and Safety Commission Act 2018* (Cth) and associated legislative instruments.[92]

15.153 The Aged Care Quality and Safety Commission ('the Commission') has the role of assessing and approving aged care providers to provide services under the Aged Care Act. If a provider is approved then they can receive government subsidies, which increases their affordability and accessibility to eligible care recipients.[93]

15.154 However, aged care providers can also operate as 'private providers', which means they do not need to be approved by the Commission to provide services and do not receive government funding. Aged care homes that do, and do not, receive government funding are similar: both provide accommodation and care services, but private providers 'are not regulated or subsidised by the Australian Government'.[94]

Aged Care Quality Standards

15.155 A Commonwealth Government approved aged care provider must be able to demonstrate that it meets the Aged Care Quality Standards. These are:[95]

1. Consumer dignity and choice;
2. Ongoing assessment and planning with consumers;
3. Personal care and clinical care;
4. Services and supports for daily living;
5. Organisation's service environment;
6. Feedback and complaints;
7. Human resources; and
8. Organisational governance.

15.156 Some of these standards may be relevant to voluntary assisted dying.

Dignity and choice

15.157 'Consumer dignity and choice' requires that a consumer is 'treated with dignity and respect' and 'can make informed choices about [their] care and services, and live the

90 Queensland Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) [7].

91 Department of Health, *Palliative Care Services*, (version 3.2, CSCF, 2015).

92 The regulation of aged care in Australia has been the subject of a recent report of the Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, released on 1 March 2021 <https://agedcare.royalcommission.gov.au/publications/final-report>.

93 Aged Care Quality and Safety Commission (Cth), 'Becoming an approved aged care provider' (January 2021) <https://www.agedcarequality.gov.au/providers/becoming-approved-aged-care-provider>.

94 Aged Care Quality and Safety Commission (Cth), 'Becoming an approved aged care provider' (6 January 2021) <https://www.agedcarequality.gov.au/providers/becoming-approved-aged-care-provider>; My Aged Care, Australian Government, 'Non government-funded providers' <https://www.myagedcare.gov.au/non-government-funded-providers>. See also: Aged Care Guide, 'What are your non-Government funded aged care alternatives?' <https://www.agedcareguide.com.au/information/what-are-your-non-government-funded-aged-care-alternatives>.

95 Aged Care Quality and Safety Commission (Cth), 'Quality Standards: Introduction' (20 December 2019) <https://www.agedcarequality.gov.au/standards/guidance-introduction>; *Quality of Care Principles 2014* (Cth) pt 5, sch 2.

life [they] choose'. An organisation must support consumers to 'exercise choice and independence'. In relation to 'choice', it is explained that:[96]

> **Choice**—The consumer's right to make informed choices, to understand their options, and to be as independent as they want, all affect quality of life. The organisation needs to provide genuine options that support choice. The workforce needs to involve, listen to and respect the consumer's views and communicate with the consumer about their choices.
>
> Consumers who need support to make decisions are expected to be provided with access to the support they need to make, communicate and take part in decisions that affect their lives. …
>
> Providing choice also includes care and services that the organisation might not provide itself, that it could help the consumer to access. These services could be from other specialist providers or individuals, or they could be services from other organisations that are better placed to support the consumer's needs.
>
> The location or environment may limit access to particular care and services. There may also be situations where consumers won't be able to have unlimited choice, such as if their choice negatively affects other people. In these situations, it's expected that the organisation will take reasonable steps to find alternatives that can help meet the consumer's needs and preferences.

15.158 This standard recognises that for consumers to make an informed choice, they must be given information in a timely way and in a form and language that they can understand. Among other things, '[o]rganisations are expected to address barriers to effectively communicating information, taking into account health status, cognitive or sensory ability, and language'.

15.159 This standard may support arguments that a consumer should be able to access information about voluntary assisted dying, and that an approved provider should assist a consumer who wishes to explore or access it. The standard also recognises that a person's location may limit their access to particular services and that in those circumstances an alternative may need to be found.

Health care planning

15.160 The standard of 'ongoing assessment and planning with consumers' requires that care and services are assessed and planned for in partnership with the consumer, and that there is 'a focus on optimising health and well-being in accordance with the consumer's needs, goals and preferences'.[97] This can include advance care planning and end of life planning.

15.161 This standard provides that:

> If an organisation can't meet a consumer's preferences for care and services, they will need to explain why, so the consumer can understand the reasons and look at other options. This allows the consumer to make an informed decision about their care and services.

15.162 This standard could require an aged care facility to inform people, at an early opportunity, of their position in relation to voluntary assisted dying.

Personal and clinical care

15.163 'Personal and clinical care' can include assistance with personal hygiene, mobility or communication, the provision of nursing services or the provision of specialised therapy services. The standard requires consideration being given to the delivery of personal

96 Aged Care Quality and Safety Commission (Cth), 'Standard 1. Consumer dignity and choice' (4 April 2021) <https://www.agedcarequality.gov.au/providers/standards/standard-1>.

97 Aged Care Quality and Safety Commission (Cth), 'Standard 2. Ongoing assessment and planning with consumers' (20 January 2020) <https://www.agedcarequality.gov.au/providers/standards/standard-2>.

and clinical care at end of life to maximise a person's comfort, maintain their dignity and prevent or relieve suffering. How an organisation does this will depend on the setting, the consumer's needs and their access to specialist resources. An organisation should consider how it can work with others outside the service (for example, palliative care specialists) to improve a person's end of life care.[98]

15.164 This standard supports transfer of information between organisations responsible for a consumer's care to improve outcomes for a consumer. This might be relevant if a consumer goes to hospital for specialist treatment, or if their needs, goals or preferences have changed.

15.165 This standard also states that a provider should, when necessary, refer a consumer elsewhere in a timely and appropriate way to meet their needs:

> Organisations that provide care and services are expected to consult with the consumer and make appropriate referrals to other individuals, organisations or providers that can provide care and services that meets the consumer's needs. This is to make sure that the care and services meet the consumer's needs, goals and preferences and improves their health and well-being.
>
> After finding out what a consumer's needs, goals and preferences are for independence, health and well-being, an organisation may decide that specialist providers will be better able to give the consumer the particular care they need. Specialist services can include allied health, hearing, dental, medical or psychiatric services or other specialised therapy services.

15.166 This standard may require an organisation to refer a person seeking access to voluntary assisted dying to an alternative provider and to take steps to facilitate that person's transfer of care.

Charter of Aged Care Rights

15.167 The Aged Care Quality Standards are supported by the Charter of Aged Care Rights. The Charter states that residents of an approved provider of aged care services have the right to:[99]

- safe and high-quality care and services;
- be treated with dignity and respect;

…

- be informed about [their] care and services in a way [they] understand;
- access all information about [themselves], including information about their rights, care and services;
- have control over and make choices about [their] care, and personal and social life, including where the choices involve personal risk;
- have control over, and make decisions about, the personal aspects of [their] daily life, financial affairs and possessions;
- [their] independence;
- be listened to and understood;

…

- exercise [their] rights without it adversely affecting the way [they] are treated.

98 Aged Care Quality and Safety Commission (Cth), 'Standard 3. Personal care and clinical care' (17 December 2020) <https://www.agedcarequality.gov.au/providers/standards/standard-3>.

99 *User Rights Principles 2014* (Cth) sch 1. See also, in relation to residential care, ss 9, 11.

Quality of Care Principles

15.168 The *Quality of Care Principles 2014* (Cth) set out the care and services that an approved provider of residential aged care services must provide. A care or service must be provided in a way that complies with the Aged Care Quality Standards.[100]

15.169 These are set out to reflect the general care or service that must be provided, and then the more specific content of that care or service. They include:[101]

> **Care or service**: Assistance in obtaining health practitioner services
>
> **Content**: Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit care recipients, whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients, or are made direct with a health practitioner.

15.170 Notably, 'care or service' includes assistance in obtaining health practitioner services. Arrangements might be made directly with a health practitioner by the care or service recipient, or a relative or another person representing their interests. This suggests that the organisation should assist the resident to obtain services from a health practitioner of the person's choice who will provide information to the person, and, if requested, assess the person's eligibility to access voluntary assisted dying.

15.171 A resident agreement between a care recipient and an approved provider of aged care services must specify the care and services that the approved provider has the capacity to provide.[102]

User Rights Principles

15.172 The *User Rights Principles 2014* (Cth) set out the responsibilities of an approved provider of residential aged care service in relation to security of tenure. Under those principles, an approved provider of residential aged care services can ask a care recipient to leave a residential care service only if:[103]

- the service is closing;
- the accommodation and care provided by the service no longer suits the care recipient's assessed long-term needs;
- the care recipient has been assessed as no longer needing the care provided;
- the care recipient was receiving care under a specialist dementia care agreement, and it has been determined that they are no longer suitable to continue receiving that care;
- the care recipient has not paid their agreed fees within 42 days of the due date, for a reason within their control;
- the care recipient intentionally caused serious damage to the service or serious injury to staff or another resident; or
- the care recipient is away from the residential care service for a continuous period of seven days, for a reason other than one which is permitted by the Act or an emergency.[104]

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100 *Quality of Care Principles 2014* (Cth) s 7.

101 See generally *Quality of Care Principles 2014* (Cth) sch 1 pt 2 items 2.4, 2.7, 2.8.

102 *Aged Care Act 1997* (Cth) s 59-1(1)(b).

103 *User Rights Principles 2014* (Cth) s 6(2);

104 Generally, a resident can take leave from a residential aged care service for various reasons. Taking leave does not affect a person's right to services because their place is secured, but might affect the subsidy payable by the government and the fees that can be charged by a service. Residents can take unlimited leave if they go into hospital or into transition care after being in hospital. Residents can take up to 52 days of social leave (or more, but in those circumstances the subsidy will not be paid by the Government). A resident may also take emergency leave. See generally Department of Health (Cth), 'Managing temporary leave for residential aged care' (July 2020) <https://www.health.gov.au/initiatives-and-programs/residential-aged-care/managing-residential-aged-care-services/managing-temporary-leave-for-residential-aged-care >.

Security of tenure

15.173 An approved provider of residential care services must not take action to make a care recipient leave the service, or imply that the care recipient must leave the service, before suitable alternative accommodation is available that meets the care recipient's assessed long-terms needs and is affordable by the care recipient.[105] A care recipient must be given at least 14 days' notice that they are being asked to leave the residential service.[106]

15.174 A resident agreement between a care recipient and an approved provider of residential aged care services must specify the circumstances in which a care recipient may be asked to depart from the residential service. However, an agreement must not contain a provision that would have the effect that a care recipient would be treated less favourably in relation to any matter than they would otherwise be treated, under any Commonwealth law, in relation to that matter.[107]

15.175 It is not apparent that the grounds on which a person could be asked to leave a residential care service would extend to where a resident had requested information about or access to voluntary assisted dying.

15.176 A residential service might contend that, in those circumstances, the accommodation and care provided by the service no longer suits the recipient's assessed long-term needs. However, a person's long-term needs are the ones assessed by either an ACAT team or two medical practitioners. It is unclear how this assessment might take into account a person's expressed wish to explore voluntary assisted dying, noting that the person may ultimately be ineligible or decide not to continue with the process.

15.177 If state legislation provided that a facility that does not provide voluntary assisted dying may take steps that prompt a person seeking access to it to transfer their care, this might conflict with the limitations on taking action to make a person leave, or imply that they must leave, before alternative accommodation is found. The requisite 14-day notice period may also operate as a barrier.

15.178 Given that a resident agreement cannot result in a recipient of services being treated less favourably than they would be treated under Commonwealth law, it is questionable whether an agreement could specify that a person could be asked to depart from the service if they made a decision to seek information about, apply for access to, or proceed with accessing, voluntary assisted dying.

15.179 Even if a resident agreement could provide for the future that a person is not permitted to access voluntary assisted dying while receiving services from a residential service, or that a person could be asked to leave if they seek access to it, this would not address the situation for a person already receiving services.

Private providers of aged and other care services

15.180 As noted, some aged care service providers operate as 'private providers' and are not subject to the above regulatory framework. Instead they are generally regulated by state legislation. In Queensland, relevant legislation includes the *Residential Tenancies and Rooming Accommodation Act 2008* and the *Residential Services (Accreditation) Act 2002*.

15.181 Other types of care services, such as supported accommodation for people with a disability or a medical condition, might also be subject to those laws or other laws specific to disability or housing services.

15.182 Some services may be registered providers under the National Disability Insurance Scheme.

105 *User Rights Principles 2014* (Cth) s 6(3).
106 *User Rights Principles 2014* (Cth) s 7(1)-(2).
107 *Aged Care Act 1997* (Cth) s 59-1(1)(e), (3); see also *User Rights Principles 2014* (Cth) s 6(1), note.

Palliative care for young person in aged care facilities

15.183 Persons entering a residential aged care facility on a palliative pathway can include 'young people in care', who are under 65 years of age. Care is often accessed through aged care due to the limited number of other options available.

Access by health practitioners to residential care facilities operated by Queensland Health

15.184 Access to residential aged care facilities by health practitioners for the purpose of responding to a request for information, receiving a first request, conducting an eligibility assessment, or administering the substance depends on the legal requirements imposed by laws such as the Aged Care Act. It also depends on the position of the entity operating the facility.

15.185 Queensland Health is an approved provider of public aged care services at 16 residential aged care facilities and 34 multi-purpose health services. Those 16 residential aged care facilities represent a very small percentage of residential aged care places in Queensland. Queensland Health's position is that it will facilitate access to health practitioners for the resident and family, including:

- organising to discuss with a general practitioner, psychologist, psychiatrist, geriatrician, social worker and any other steps as required by voluntary assisted dying laws;
- documenting those processes; and
- facilitating access by other persons of the resident's choice, such as pastoral care services.

CREDENTIALING

15.186 Both public and private health facilities conduct a system of credentialing. A health practitioner providing health care in a Queensland Health facility must be credentialed. Private entities, such as private hospitals, also adopt a system of credentialing and have processes to verify a health practitioner's credentials and to decide who enters their premises to providing health care.

15.187 Generally, as part of an organisation's quality and risk management system,[108] health practitioners must undergo a process of credentialing and their scope of clinical practice must be defined.

15.188 The term 'credentialing' means:[109]

> the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.

108 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 10, Actions 1.23 and 1.24. Queensland Health has also developed a series of documents regarding the credentialing and defining of the scope of clinical practice of health professionals in hospitals and health services: see, eg, Queensland Health, *Department of Health Guideline QHGDL39011:2017, Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 58. See also *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1; Chief Health Officer, *Credentials and Clinical Privileges Standard* (Version 5) (May 2019), in relation to licensed private health facilities.

109 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 70 (definition of 'credentialing'). See also Queensland Health, *Department of Health Guideline QH-GDL-390-1-1:2017, Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 53 (definition of 'credentialing').

15.189 The term 'scope of clinical practice' means:[110]

> the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.

15.190 Generally, a health practitioner providing a health service within an organisation, such as a hospital or a private health facility, must be credentialed to provide that service and must be acting within their defined scope of clinical practice.

15.191 Queensland Hospital and Health Services ('HHS'), require registered medical practitioners, nurse practitioners and nurses to be credentialled and have a defined scope of clinical practice.[111] Some practitioners can be credentialled to provide services at multiple locations within Queensland Health.[112] A practitioner may be credentialled as a 'visiting medical officer' to provide specialty services at some facilities, including those in rural and regional areas.[113]

15.192 Private health facilities must also comply with an accreditation scheme for safety and quality, as prescribed by relevant regulations. The prescribed scheme is the Australian Health Service Safety and Quality Accreditation Scheme.[114] Queensland Health advises that each private facility may have their own processes of credentialing a practitioner and determining their scope of clinical practice.

15.193 A practitioner's scope of clinical practice is informed by the needs and service capabilities of the organisation within which they are practicing. An organisation's service level under the CSCF may impact a clinician's scope of clinical practice.

15.194 In some circumstances, a practitioner may be easily able to visit a patient at a facility, such as a residential aged care service. In other circumstances, strict credentialing requirements at certain facilities might make consultation with an external practitioner difficult.

TRANSFER OF CARE

Hospital and Health Services

15.195 Queensland Health protocols address patient access to emergency care and public health services, including the management of 'interhospital transfers', within Hospital and Health Services (HHS) facilities.[115]

15.196 An inter-hospital transfer may occur within a single HHS facility or between HHS facilities, depending on the patient's clinical needs and access to specialised services. Each HHS must have formalised arrangements and appropriate staffing arrangements to ensure bed management and the transfer of critically ill patients.[116]

15.197 Before a transfer takes place, the referring and accepting facilities must agree to the transfer and a bed or treatment area must be available. However, the transfer of a

110 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 75 (definition of 'scope of clinical practice'). See also Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 55 (definition of 'scope of clinical practice').

111 *Queensland Government, Directive QH-HSD-034:2014*, *Credentialing and Defining the Scope of Clinical Practice* (19 May 2020) 1-3; Queensland Health, Department of Health Policy QH-POL-390: 2015, *Credentialing and Defining the Scope of Clinical Practice* (19 May 2020) 1-2.

112 Queensland Government, Directive QH-HSD-034:2014, *Credentialing and Defining the Scope of Clinical Practice* (19 May 2020) 4-5; Queensland Health, Department of Health Policy QH-POL-390: 2015, *Credentialing and Defining the Scope of Clinical Practice* (19 May 2020) 6-7.

113 Queensland Health, *Visiting Medical Officers* (20 September 2018) <https://www.health.qld.gov.au/employment/work-for-us/clinical/medical/vmo>; Queensland Health, *Visiting Medical Officers: Employment framework*, Health Employee Directive No 05/18 (3 October 2018); Queensland Government, *Visiting Medical Officer Contract of Employment*, Queensland Health (16 April 2019) <https://www.health.qld.gov.au/employment/conditions/contracts/medical>.

114 *Private Health Facilities Act 1999* (Qld) s 48(1)(b); *Private Health Facilities Regulation 2016* (Qld) s 8.

115 Queensland Health, *Protocol for Patient Access to Queensland public hospitals*, Health Service Directive Protocol QH-HSDPTL-025-1: 2015 (16 December 2019) 2–4.

116 Ibid 2–3.

critically ill patient should not be delayed because of bed availability. The decision to transfer 'must be based on an appropriate clinical risk assessment'. In addition:[117]

> [inter-hospital transfer] negotiations between accepting and referring hospitals shall always include an agreement by the referring hospital to receive the patient back once the services at the accepting hospital are no longer required or indicated.

15.198 The appropriate level of clinical escort must be arranged for the patient, and the patient must generally be transported directly to an available inpatient bed.[118]

Residential aged care facilities

15.199 Queensland Health has advised that in the context of a resident in a residential aged care facility, the term 'transfer of care' or 'transition of care' refers to a transfer of clinical governance from one healthcare provider to another. A transfer may involve:

- a physical transfer of a person from one place to another; for example, transferring a person from a residential aged care facility to a hospital; or
- a transfer of 'medical governance'; for example, a person could remain a resident of a residential aged care facility, which would be responsible for their accommodation, daily routines and nursing care, but an emergency department or a substitutive hospital service[119] would provide the person's medical governance and clinical care.

15.200 Effective transfer of a person's care generally requires:

- a clinical handover of relevant information from the transferring service;
- consent from the person or another appropriate decision-maker;
- if there is a physical transfer, arrangements for safe transport (generally by ambulance); and
- if there is a transfer of medical governance, consent from the person's general practitioner and the clinical manager of the residential aged care facility.

15.201 A person in a residential aged care facility might seek to be transferred to a different place, such as another aged care facility, a hospital or hospice, a 'hospital in the home' arrangement or a family home. There may be funding implications for a permanent transfer to a different care setting. In some instances, rather than transfer care, it may be possible for a resident to take a 'leave of absence' from a residential aged care facility.

15.202 Where a person is transferring to a Queensland Health facility and their transfer does not relate to an emergency, there must be an available bed and a consultant to accept the transfer.

General practitioners

15.203 The AMA has developed a position statement about transfer of care arrangement between hospitals and general practitioners. A referral by a general practitioner to a hospital should be comprehensive and any transfer of care back from a hospital should include 'clear and appropriate information to support safe and meaningful clinical handover of patient care'.[120]

Issues related to transfers from a residential aged care facility to a hospital to access voluntary assisted dying

15.204 One suggested approach is for a patient or resident of a facility which does not provide voluntary assisted dying to be transferred elsewhere to make a 'first request' or to have

117 Ibid 3.
118 Ibid.
119 For example, a Residential Aged Care Acute Support Service or the Hospital in the Home service.
120 AMA, *Position Statement: General Practice/Hospitals Transfer of Care Arrangements* (2018) 3.

an eligibility assessment. This raises questions about the reasonableness of requiring such a transfer, considering the person's circumstances such as frailty. It also assumes the availability of an alternative place in which a person, who may be close to death, can be transferred and accommodated while the assessment is undertaken, and possibly for a longer period after the assessment.

15.205 The Parliamentary Committee identified that funding for palliative care services in Queensland is constrained, and recommended (among other things) that both the Australian Government and the Queensland Government provide increased funding for palliative care.[121] The Queensland Government has made commitments to 'increase investment in the delivery of end-of-life and palliative care [services] across Queensland'.[122] However, transferring people from private facilities to public hospitals to make a 'first request' or undergo an eligibility assessment are likely to place additional strains on the public hospital system through increased bed occupancy. Increased demand for bed spaces may impact access to acute care for Queenslanders in general.

15.206 To avoid such a scenario, greater public resources will be required to address the demand on public hospitals and health services to provide end of life treatment, palliative care and voluntary assisted dying. However, even with increased resources, it should not be assumed that an alternative place within the public system will be readily available, or even reasonably available, where a transfer is contemplated from a non-participating facility to make a 'first request' or undergo an assessment. This problem of availability is likely to be acute in regional, rural and remote areas of Queensland.

15.207 The cost, both personal and to the health system in general, of transfers for a person to make a 'first request' or have an eligibility assessment are significant. This does not mean that an entity which objects to providing voluntary assisted dying should be compelled, against its wishes, to participate in the request and assessment process, let alone in the administration process. It does, however, prompt consideration of whether the interests of entities, and the interests of patients and residents are best accommodated by allowing qualified health practitioners to access the facility, on reasonable notice, to receive a 'first request' or undertake an eligibility assessment.

PARTICIPATION BY PUBLIC ENTITIES

15.208 Many of the issues considered in this chapter concern non-participation by private entities. As noted, entities may not be prepared to provide access to voluntary assisted dying for a variety of reasons. Their reasons may be pragmatic, based on the non-availability of qualified staff, or may be based on an objection in principle to providing or promoting voluntary assisted dying.

15.209 If Queensland Health provides access to voluntary assisted dying through Hospital and Health Services, it will need to consider the staff and resources required to do so. It must also ensure that the provision of resources for voluntary assisted dying does not come at the expense of palliative care or other services.

15.210 As in Victoria and Western Australia, it will be necessary to develop policies to guide health services' participation in voluntary assisted dying. The policies should include what happens if a public health service decides not to provide access because of resource constraints or the absence of suitably qualified staff. The policies should outline how a health service will be supported if it does provide voluntary assisted dying.

15.211 The Commission initially assumed that the issue of non-participation by certain public hospitals related to small hospitals in regional, rural and remote areas. We were

121 Qld Parliamentary Committee Report No 33 (2020) 340–44, Recs 53–56.

122 Queensland Government, *Queensland Government Response—Report No 33: Aged care, end-of-life and palliative care* (Final Response, tabled 24 September 2020) <https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2020/5620T1686.pdf> 5–7; Queensland Labour, 'More palliative care funding for Queenslanders and the Wish Ambulance' (Media Release, 18 October 2020) <https://annastaciapalaszczuk.com.au/media-releases/more-palliative-care-funding-for-queenslanders-and-the-wish-ambulance/>.

interested to learn that at least one major public hospital in Melbourne does not provide access to voluntary assisted dying. The Commission also was informed that in one instance this was because of the personal position of the head of the palliative care unit in that public hospital.

15.212 The conscientious objection of such a medical practitioner to personally provide voluntary assisted dying should be respected. However, it should not determine the practical access of patients in a government-operated, public hospital to voluntary assisted dying if other practitioners are qualified, available and willing to provide it.

15.213 Queensland Health has advised us that its position in relation to voluntary assisted dying is:

- All Queenslanders, including those seeking voluntary assisted dying, should be entitled to quality palliative and end of life care, which relieves pain and suffering and supports family, friends and carers.
- Queensland is a signatory to the National Palliative Care Strategy 2018 and in 2021 will begin the process to develop a Queensland Palliative Care Strategy. When developed, the Queensland Strategy should address the relationship between palliative care and voluntary assisted dying.
- Voluntary assisted dying should be clearly defined in Queensland legislation to be a form of healthcare. Equally, seeking information about voluntary assisted dying, including applying to receive voluntary assisted dying, should be clearly defined as accessing healthcare.
- From a human rights perspective, equity of access to voluntary assisted dying as a form of healthcare is entirely consistent with the HR Act. The right to seek information about, apply for and access voluntary assisted dying, as a form of health care is also consistent with the *Aged Care Quality Standards* (Cth) and *Charter of Aged Care Rights* (Cth), which recognise an individual's right to dignity and choice.

15.214 Queensland Health accepts that it will need to address the extent to which public entities, such as those that operate hospitals and health services, are obliged to offer access to voluntary assisted dying, and how that obligation is implemented.

THE COMMISSION'S VIEW

15.215 The starting point for our consideration of participation and non-participation by entities is general principle and the need to reconcile competing interests. It is then necessary to consider how those interests should be reconciled in various circumstances and at the different times an individual might seek information, advice or assistance in relation to voluntary assisted dying.

General principles

15.216 Issues about participation and non-participation by entities in voluntary assisted dying apply to both public and private entities, including entities which operate hospitals. An entity can make operational or policy decisions about the services it will provide at its facility.

15.217 Absent some undertaking by it to do so, possibly as a condition of funding, an entity is not obliged to provide or participate in voluntary assisted dying. Therefore, the occasion for it to object to doing so, either on the grounds of an 'institutional conscientious objection' or otherwise, does not arise. To date, Australian and New Zealand legislatures have not seen the need to confer or confirm in legislation the right of an entity to refuse to provide voluntary assisted dying.

15.218 The rights of individuals include the right to access information and advice about a lawful end of life option and to access high quality care and treatment to minimise the person's suffering and maximise their quality of life. Views differ as to whether

voluntary assisted dying is health care. It is an end of life option governed by medical assessments and prescriptions by medical practitioners and designed to minimise suffering and maximise quality of life. In that context, many, including Queensland Health, consider it to be a form of health care. In that regard, section 37 of the HR Act provides that every person 'has a right to access health services without discrimination'. In any case, voluntary assisted dying aims to reduce a person's suffering and maximise their quality of life. Others take an entirely different view, including various entities, some palliative care specialists, other health practitioners and individuals from many walks of life. They fundamentally object to voluntary assisted dying on ethical, health policy or other grounds. The right of individuals and entities to take these different views should be respected.

15.219 The interests of individuals seeking information and assistance about a lawful end of life option and the interests of an entity that does not wish to provide that option must be reconciled. Without a form of regulation which establishes a process to ensure that a person's access to voluntary assisted dying is not unreasonably denied where institutional objections occur, confusion and uncertainty will prevail.

15.220 That regulation might be in the form of policy guidelines (as in Victoria) or legislation. Regulation at a policy level provides greater flexibility. However, legislation would make the reconciliation of competing rights clear to all concerned and as a matter of law. Absent such clarity, individuals and their families may insist that an entity must provide a service or assist in facilitating access to voluntary assisted dying, and the entity will dispute that it is. These kinds of disputes, especially when a person is in the final days and weeks of their life, should be avoided.

15.221 We have informed ourselves about how the system operates in Victoria where the rights and responsibilities of non-participating entities are addressed in guidelines.

15.222 It might be said that it should not matter whether the process is regulated by law, by regulation or by guidelines and policies so long as they are clear and fairly reconcile competing rights and interests. However, there is a practical difference between processes that are enforceable and those that are not.

15.223 On balance, we favour a legislative approach to clarifying the rights of individuals and entities when an entity chooses not to provide, or facilitate access to, voluntary assisted dying.

15.224 Any legislated regulation of the rights of individuals and entities should be supported by guidelines and policies developed by Queensland Health and the entities themselves. The policies must be suited to the circumstances of individuals and to the services and facilities provided by the entity. Examples are the *Health Service Policy Guidelines for Voluntary Assisted Dying* produced by the Victorian Health and Human Services Department, and the more detailed *Voluntary Assisted Dying Model of Care Pathways for Health Services* developed by that department in partnership with the Victorian Health Care Association. The Commission has had the benefit of briefings and information from different participants in Victoria, including by entities and organisations which do not consider that voluntary assisted dying is or should be a part of end of life care. The policy of these organisations is to neither provide nor facilitate voluntary assisted dying. Nevertheless, they have developed systems to respond to questions about voluntary assisted dying and to co-ordinate transfer of care to other providers. Although these entities decline, as a matter of principle or policy, to provide voluntary assisted dying, they state that they will not impede access to its provision by others.

15.225 Many entities in Queensland which will choose not to provide voluntary assisted dying might be expected to develop similar processes in accordance with guidelines. However, a legislative regulation of the rights and interests of individuals and entities has the advantage of clarifying processes and encouraging entities, both public and private, to develop workable practices.

15.226 We consider that the optimal regulatory response is by way of legislation, rather than policy.[123] Legislation, supported by more detailed policy statements, informs individuals and entities of the basic ground rules by which their respective rights and interests are reconciled and the process which applies. An individual can rely on such a legislative statement to compel an entity to respect the individual's rights. Equally, an entity can rely on the law to explain its rights and obligations if a patient or resident insists on being provided with services that the entity is not obliged by law to provide.

Diverse circumstances

15.227 While certain general principles should govern the regulation of the rights and interests of individuals and entities when entities choose to not participate in voluntary assisted dying, those principles must be applied in a wide variety of circumstances.

15.228 Any law or policies that regulate the interests of individuals and entities must take account of the variety of facilities, which include hospitals, hospices, nursing homes, aged care facilities, disability care facilities, and supported housing.

15.229 They must also take account of the vastly different circumstances of individuals. An individual may seek information and assistance in their own homes, for example, in a residential aged care facility in which they have security of tenure by virtue of the Aged Care Act. An individual may choose to enter a privately operated facility, such as a hospital or a hospice, and know at that time that the facility does not provide or facilitate voluntary assisted dying. An individual may enter a residential aged care facility when their demise and the option of seeking voluntary assisted dying is not on their mind, or even a lawful option. Many current residents of aged care facilities in Queensland will fall into this category. There are many other examples.

15.230 As for personal circumstances, some individuals will be located 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. Others, 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 facility, if a place is available there, may cause significant pain and distress, and deny them, in a practical sense, access to voluntary assisted dying.

15.231 When devising a form of regulation to address the wide variety of circumstances of individuals and entities, voluntary assisted dying should not be treated as a seamless process. It may be inappropriate to have one rule which applies to all stages of the process. Different considerations may apply to:

- access to information;
- a first request or further request;
- an eligibility assessment; and
- the administration of the substance.

15.232 It is convenient to address the application of the general principles to each of those stages.

Access to information

15.233 It is difficult to justify denying, on the grounds of an entity's institutional objection, an individual's access to information and advice about voluntary assisted dying. Allowing an official care navigator service or a health practitioner to provide the patient or resident with information cannot be equated with the entity condoning voluntary assisted dying. It is notable that organisations like Catholic Health Australia, whose policy is to neither provide nor facilitate voluntary assisted dying, have developed

123 BP White et al 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).

processes in Victoria by which requests for information about voluntary assisted dying are communicated to services or entities which can provide it. This may involve an employee of an official voluntary assisted dying care navigator, the person's general practitioner or another health practitioner visiting the person.

15.234 The right of a person to obtain requested information about voluntary assisted dying and to receive visits from an official navigator care service or a registered health practitioner who is prepared to provide information and advice should be confirmed. An entity which objects to providing access to voluntary assisted dying should not hinder access by a person to information about it and not hinder such visits. An entity which chooses not to provide voluntary assisted dying should be required to allow reasonable access by a registered health practitioner or a trained member of the staff of an official voluntary assisted dying care navigator services to an individuals who requests information that the entity is not willing or able to provide.

Receiving a first or further request and conducting eligibility assessments

Receiving a first request

15.235 In some instances, a 'first request' might be made to a health practitioner at the same time as the practitioner provides information. In other cases, it will not be. An entity may not wish to be involved in receiving and recording a 'first request'. In such circumstances, it is hard to see why a patient or resident who is dying should be put to the trouble of being transferred outside of a facility to make a 'first request' to a practitioner who is qualified and willing to receive it.

15.236 Instead, there should be a requirement to allow reasonable access to the person at the facility by a registered health practitioner who is qualified and willing to receive a 'first request' and whose presence is requested for that purpose by the person or the person's agent.

15.237 If such a practitioner is not available to attend to receive the request at the facility, then reasonable steps should be taken to facilitate the transfer of the patient or resident to a place at which the request may be made, and their return thereafter to the facility.

15.238 The same accommodation of interests should apply to further requests or declarations required by the draft Bill.

Eligibility assessments

15.239 Eligibility assessments by qualified and trained health practitioners may occur in many different circumstances. A resident of an aged care facility, who enjoys security of tenure, may invite the practitioner into the person's home to conduct the assessment. The person may be a patient in an acute care ward of a public hospital operated by a private entity. The health practitioner who is requested to undertake the assessment may be the person's general practitioner or the specialist who has cared for and treated the person for a substantial period. The person's treating doctor may be entitled to visit the facility to see their patient in accordance with the facility's rules or because the person, as a resident of a residential aged care facility, has the right to see their doctor in accordance with the Charter of Aged Care Rights. In other cases, the practitioner requested to undertake the eligibility assessment will not be 'credentialed' at the facility. An example is a specialist who is not credentialed at the private hospital in question.

15.240 Therefore, in some circumstances access by a qualified practitioner to complete an eligibility assessment will depend upon the policy of the entity.

15.241 The current issue concerns assessment, not administration. An assessment may result in a finding that the person is not eligible for voluntary assisted dying, and the process will go no further. If, however, the person is found to be eligible, they may choose not to procced to administration, or may die before administration is possible. Therefore,

access for the purpose of receiving a 'first request' or for assessment should not be confused with access for the purpose of administration.

15.242 Although the transfer of care from one facility to another is reasonably common, transfers come at a human and financial cost. The person may be so ill that the transfer would be traumatic or painful. The transfer may require pain medication that affects the person's decision-making capacity and renders them ineligible for voluntary assisted dying. Financial costs may be incurred. Continuity of care may be affected. After being transferred to another facility for an assessment, continuity of care or the person's wishes may necessitate another transfer back to the original facility.

15.243 In some cases, the person requesting the assessment will not be able to be transferred to another facility because of their frail condition or because a suitable place at another facility is not available.

15.244 An issue then arises as to the appropriate reconciliation of the individual's right to access continuing care and treatment at the non-participating entity's facility to minimise the individual's suffering and to access a lawful end of life option, and the entity's right to control access by individuals to its premises.

15.245 Allowing access to a qualified and willing health practitioner to undertake an eligibility assessment where a transfer is not feasible does not amount to requiring the entity to provide voluntary assisted dying. The visiting health practitioner is not engaged or invited by the entity. The entity would not be asked to endorse the assessment. Instead, the requirement might be to allow reasonable access onto its premises by a registered health practitioner who is qualified and willing to undertake an eligibility assessment and whose presence is requested by the person or the person's authorised agent.

15.246 On one view, such a requirement appropriately reconciles the competing rights and interests. It would not compel the entity to provide assistance. Hospital staff would not be compelled to provide assistance to the visiting practitioner. Any right of the patient to access records would be governed by the general law. In substance, the requirement upon the entity would be to not hinder reasonable access onto its premises of a qualified practitioner who attends at the person's request to receive a 'first request' or conduct an eligibility assessment.

15.247 However, providing such access might be unnecessary in some circumstances, such as where it was reasonable for the patient to be transferred to another facility for the purpose of assessment and then returned to the original facility. In those circumstances it may be appropriate to qualify in some respects what would be a right of reasonable access for the purposes of assessment by the assessing health practitioner. To recognise the diversity of circumstances of individuals seeking an assessment and the variety of facilities in which they might be located, an appropriate accommodation would be to provide that the requirement to permit reasonable access to a health practitioner would not apply where it is reasonable to transfer the person elsewhere for the purpose of undertaking the assessment.

15.248 The legislation, regulations or guidelines might provide that transfer will not be reasonable where:

- the transfer would cause serious harm to the person;
- the transfer would prejudice a person's access to voluntary assisted dying;
- the transfer would cause undue delay; or
- access to voluntary assisted dying is not reasonably possible at another facility.

15.249 The reasonableness of the transfer would be decided by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity.

15.250 The position recently advanced by Professors White and Willmott and their co-authors is that an entity which objects to a voluntary assisted dying assessment being

conducted within its facility should be responsible for the costs caused by the transfer, such that if the transfer arises from the entity's objection the person will not suffer financial detriment as a result.

15.251 We are not inclined to recommend such a requirement. As previously noted, the circumstances in which a person may come to be transferred are many and varied. In some circumstances, it would seem reasonable for the entity whose objection has necessitated the transfer to be responsible for the financial costs incurred as a result. In other circumstances, it would seem unreasonable. An example is where the person knew of the facility's objection to voluntary assisted dying at the time they entered the facility and contemplated the possibility of seeking access to voluntary assisted dying at that time. Because of the variety of circumstances, we do not recommend a statutory requirement that the facility be responsible for the costs caused by any transfer.

The Commission's conclusion: requests and eligibility assessments

15.252 Subject to what follows about a patient or resident who wishes to make a 'first request' or have an eligibility assessment undertaken in their own home, in which they enjoy security of tenure by virtue of the Aged Care Act or on some other basis, the Commission considers that the following process should govern the reconciliation of the rights and interests of an individual seeking to access voluntary assisted dying and the rights and interests of an entity which does not wish to provide it at its facility.

15.253 An entity which does not wish to provide access to voluntary assisted dying should not be required to do so.

15.254 A patient or resident at a facility operated by such an entity should have reasonable access to qualified health practitioners in order to make a 'first request' or to undertake an eligibility assessment. If the entity does not allow health practitioners engaged or employed by it to receive such requests or undertake such assessments at its facility, then the entity should not hinder the patient or resident making a first request or undergoing such an assessment.

First request and any further request

15.255 If a patient or resident wishes to make a 'first request', the relevant entity should allow reasonable access to its facility by a registered health practitioner who is qualified and willing to receive a 'first request' and whose presence is requested by the person or the person's agent for that purpose.

15.256 If such a practitioner is not available to attend to receive the request at the facility, then reasonable steps should be taken to facilitate the transfer of the patient or resident to a place at which the request may be made, and their return thereafter to the facility.

15.257 The same process should apply to the making of any further request or declaration under the draft Bill if the person is a patient or resident at that time.

Eligibility assessments

15.258 An entity which does not provide access to voluntary assisted dying (in particular to the request and assessment process at its facility), should be required to:

- take reasonable steps to facilitate the person's transfer 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 a health practitioner who is qualified to conduct the assessment when transfer to a place outside the facility for the purpose of assessment would not be reasonable.

15.259 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 may 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; and
- the person would incur financial loss or costs because of the proposed transfer.

15.260 The reasonableness of the proposed transfer should be decided by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity to decide its reasonableness.

15.261 If a patient or resident wishes to have an eligibility assessment in their own home, in which they enjoy security of tenure by virtue of the Aged Care Act or on some other basis, the entity should allow reasonable access to the facility by a registered health practitioner who is qualified and willing to undertake an eligibility assessment and whose presence is requested by the person or the person's agent for that purpose.

15.262 If such a practitioner is not available to attend to undertake the assessment at the facility, then reasonable steps should be taken to facilitate the transfer of the patient or resident to a place at which the eligibility assessment may be undertaken, and their return thereafter to the facility.

15.263 Similar provisions should apply to access by, or transfer to, a coordinating practitioner for the purpose of making an 'administration decision' (between self-administration decision or practitioner administration, after which steps are taken in relation to prescription, dispensing and supply of the substance).

Administration

15.264 On one view, the position reached in relation to eligibility assessments should apply equally to administration. This is the approach Professors White and Willmott and their co-authors took in their article. There may, however, be reasons to distinguish between assessment and administration. Assessment is a necessary antecedent to voluntary assisted dying and an integral part of the process. For that reason, practitioners and entities who object to voluntary assisted dying do not wish to provide eligibility assessments. We do not suggest that they should be required to do so. However, an eligibility assessment does not in any real or immediate sense cause the death. The person may be found to be ineligible to access voluntary assisted dying. If they are assessed to be eligible, they may make a different end of life choice and choose not to proceed to the administration stage. An assessment does not cause death. Administration of the substance does.

15.265 That difference may justify greater weight being accorded to the entity's objection (and to its rights and interests) at the administration stage than at the assessment stage.

15.266 Another difference between administration and assessment arises in the context of transfers. A transfer for the purpose of assessment may require the person to occupy a place at another facility for some time while their condition stabilises and they undergo assessment, before returning to the original facility. Time may be required at the assessing facility for the person to regain capacity, be assessed by two independent doctors and make the formal declaration required by law. Such a process of transfer and return may prove harmful, increase the person's suffering, and not be reasonable in all

the circumstances to accommodate the legitimate interests of the parties.

15.267 By comparison, a transfer from a hospital or hospice operated by an entity which objects to voluntary assisted dying to the person's home or the home of a family member or friend for the purpose of self-administration may be possible and reasonable to undertake shortly before the anticipated date or time of self-administration.

15.268 Again, reconciliation of rights and interests may be different in a residential aged care facility to an acute care ward of a hospital. The former is, for all intents and purposes, the person's home. The person should be able to access a lawful end of life option in the privacy of their own home unless they have agreed otherwise, for example in the terms of any lease or similar binding contract. Being required to go somewhere else, and away from one's home, seems a harsh thing to require in those circumstances. It is also inconsistent with the inclination of many people to be able to die in their home, if that is possible.

15.269 If, however, the person is not in their home, and has no home reasonably available to them to transfer to for the purpose of administration, then consideration is required of the provision of facilities, operated by the state or by private entities which do not object to voluntary assisted dying, where administration might occur.

15.270 We anticipate that, in the event voluntary assisted dying legislation is passed, important decisions will need to be made by the State Government, and by Queensland Health in particular, about whether voluntary assisted dying is embedded within regular wards and units of hospitals, and its relationship with palliative care services. In any event, places should be created by state hospital and health services to accommodate persons wishing to access any lawful system of voluntary assisted dying. Those places should be available for patients and residents of public facilities, and for persons who can reasonably transfer from a facility which does not provide voluntary assisted dying for the purpose of administration.

The Commission's conclusion: administration of substance

15.271 Subject to what follows about a patient or resident who wishes to self-administer or receive authorised practitioner administration in their own home, in which they enjoy security of tenure by virtue of the Aged Care Act or on some other basis, we consider that the following process should govern the reconciliation of the interests of an individual seeking access to voluntary assisted dying and the interests of an entity which does not provide it at a facility.

15.272 An entity which does not wish to provide access to voluntary assisted dying should not be required to do so.

15.273 A person wishing to self-administer or receive administration should transfer from the facility for the purpose of administration, unless transfer is unreasonable.

15.274 An entity which does not provide access to voluntary assisted dying (in particular, access to administration of voluntary assisted dying substance at its facility) should be required to:

- take reasonable steps to facilitate the person's transfer to a suitable place outside the entity's facility for the purpose of administration; or
- where transfer to a place outside the facility for the purpose of administration would not be reasonable:
  - allow reasonable access to the facility by a registered health practitioner who is authorised and willing to undertake practitioner administration (together with an eligible witness); and
  - not hinder access by the person to the substance required for self-administration.

15.275 In determining whether or not it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of administration, regard may 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 their 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, thereby rendering them ineligible for authorised practitioner administration; and
- there is no reasonably available place at which the person might self-administer or receive practitioner administration (if authorised).

15.276 The reasonableness of the proposed transfer should be decided by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity to decide its reasonableness.

15.277 If a patient or resident wishes to undergo administration in their own home, in which they enjoy security of tenure by virtue of the Aged Care Act or on some other basis, the entity should:

- allow reasonable access to the entity's facility by a registered health practitioner who is qualified, authorised and willing to undertake practitioner administration, together with any person whose presence is required to witness the administration; and
- not hinder access by the patient or resident to the substance required for self-administration.

Notice to the public of an entity's position on voluntary assisted dying

15.278 As earlier noted, the AMA's position is that where a health care facility refuses to provide particular services due to an 'institutional conscientious objection', it should inform the public of this (for example, by putting information on their website or in brochures, or by having signage at their facility) so that patients can seek care elsewhere. In their recent consideration of institutional objection, Professors White and Willmott, Dr Close and Professor Downie state that regardless of whether a legislative or policy response is adopted, 'it should require organisations to disclose their objections publicly.'[124] Such a provision may avoid a person finding out after their admission, or taking up residence, that the facility objects to voluntary assisted dying.

15.279 Therefore, we recommend that if an entity does not provide access to voluntary assisted dying[125] at a facility it should:

- inform the public, including persons that use the facility or may use the facility in the future, that the entity does not provide access to those services at the facility; and
- do so in a way that is likely to be brought to the attention of consumers or potential consumers of its services by, for example, placing the information on its website, in brochures and on signage at the facility.

The form of regulation

15.280 The Tasmanian Independent Review described the issue of 'organisational non-participation' as one of the most complex issues that it was required to consider.[126] The Commission shares this view. The length of this chapter confirms the complexity.

124 BP White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' *University of New South Wales Law Journal* (forthcoming).

125 More precisely, services associated with voluntary assisted dying, such as access to the request and assessment process, access to the administration of a voluntary assisted dying substance, or both.

126 Tas Review Panel Report (2021).

15.281 However, the complexity of the issue is not a reason to avoid regulation of processes by legislation. Rather, it is a reason to not leave processes uncertain, governed only by non-enforceable policies. On balance, 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.

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

15.283 It is unnecessary, and would further complicate an already complex area, for the draft Bill to declare:

- that an individual has a right to access voluntary assisted dying in the face of an entity's choice to not to provide it; and
- that an entity has a right to refuse to provide access to voluntary assisted dying in the face of an individual's request to access it.

15.284 Little, other than confusion, would be gained by declaring rights that conflict with each other. Instead, the draft Bill proposes a process by which an entity which chooses not to provide voluntary assisted dying (whether on the grounds of 'institutional conscientious objection' or a broader entitlement to not participate) is required to address a person's request to access it. The draft Bill regulates the processes by which such a person may access information, make requests, undergo eligibility assessments and, if eligible, seek administration. It aims to do so by requiring the entity to follow certain processes, while respecting the entity's choice to not itself provide voluntary assisted dying.

The need for regulations and guidelines to support the processes

15.285 As noted, any legislated regulation of the process should be supported by guidelines and policies that are developed by Queensland Health and the entities themselves, and that are suited to the circumstances of individuals and to the facility and the services provided at it by the entity.

15.286 Guidelines developed by authorities and entities in Victoria and Western Australia will be an essential point of reference if voluntary assisted dying legislation is enacted in Queensland.

RECOMMENDATIONS

Form of regulation

15-1 Legislation should include provisions about the process that must be followed in circumstances where an entity does not provide access to voluntary assisted dying at its facility.

15-2 In simple terms, an 'entity' is a non-natural person which owns, occupies or operates a facility that provides a health service, residential aged care or a personal care service (as defined in the draft Bill).

Access to information

15-3 Where a person receiving relevant services from a relevant entity at a facility asks the entity for information about voluntary assisted dying, and the entity does not provide at the facility the requested information, the entity (and any other entity that owns or occupies the facility) must:

(a) not hinder the person's access at the facility to information about voluntary assisted dying; and

(b) allow reasonable access by a registered health practitioner or a staff member of an official voluntary assisted dying care navigator service to provide the requested information to the person.

Making a first request and later requests

15-4 Where a person receiving relevant services from a relevant entity at a facility wishes to make a 'first request' for access to voluntary assisted dying and the entity does not provide access to the request and assessment process at the facility:

(a) the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by a registered health practitioner who is qualified and willing to receive a 'first request' under the legislation and whose presence for that purpose is requested by the person or the person's agent; or

(b) if such a practitioner is not available to attend to receive a first request at the facility, then the relevant entity must take reasonable steps to facilitate the transfer of the person to a place at which the request may be made, and their return thereafter to the facility.

15-5 Similar provisions should apply to any later request or declaration required by the legislation.

Eligibility assessments

15-6 Where a person receiving relevant services from a relevant entity at a facility wishes to undergo an assessment of their eligibility to access voluntary assisted dying and the entity does not provide access to the request and assessment process at the facility:

(a) if the person is a permanent resident of the facility—

(i) the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by a registered health practitioner who is qualified and willing to

undertake an eligibility assessment and whose presence for that purpose is requested by the person or the person's agent; or

(ii) if the relevant practitioner is not available to attend to undertake the assessment at the facility, the relevant entity must take reasonable steps to facilitate the transfer of the person to a place at which the eligibility assessment may be undertaken, and their return thereafter to the facility.

(b) if the person is not a permanent resident of the facility—

(i) the relevant entity must take reasonable steps to facilitate 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

(ii) in circumstances where transfer to a place outside the facility for the purpose of assessment would not be reasonable, the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by a registered health practitioner who is qualified and willing to conduct the assessment.

15-7 For the purpose of these provisions the term 'permanent resident':

(a) refers to a person who resides at the facility as their settled and usual place of abode, being the place where the person regularly or customarily lives;

(b) includes the resident of an aged care facility who has security of tenure by virtue of the *Aged Care Act 1997* (Cth) or on some other basis; and

(c) does not include a person who resides at the facility as a temporary resident, for example as an in-patient at a hospital or the resident of a hospice.

15-8 In determining whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of undergoing an eligibility assessment, regard must be had to whether:

(a) the transfer would be likely to cause serious harm to the person, for example, significant pain or a significant deterioration in their condition;

(b) the transfer would be likely to adversely affect the person's access to voluntary assisted dying; 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;

(c) the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

(d) there is an alternative place reasonably available; for example, whether another facility within a reasonable distance has a suitable

place to which to admit the person and can provide the level of care required by the person for the relevant period;

(e) the person would incur financial loss or costs because of the transfer.

15-9 The determination of whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of undergoing an eligibility assessment should be made by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity to decide the reasonableness of the proposed transfer.

15-10 Similar provisions should apply to access to the person's coordinating practitioner when the person wishes to make an administration decision.

Administration of the voluntary assisted dying substance

15-11 Where a person receiving relevant services from an entity at a facility wishes to self-administer or have an authorised practitioner administer a voluntary assisted dying substance and the entity does not provide access to administration of a voluntary assisted dying substance at the facility:

(a) if the person is a permanent resident of the facility, the entity (and any other entity that owns or occupies the facility) must:

(i) allow reasonable access to the facility, by the administering practitioner to undertake practitioner administration, together with any person whose presence is required to witness the practitioner administration; and

(ii) not hinder access by the person to the substance required for self-administration.

(b) if the person is not a permanent resident of the facility—

(i) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place outside the entity's facility for the purpose of administration of the voluntary assisted dying substance; or

(ii) in circumstances where transfer to a place outside the facility for the purpose of administration would not be reasonable, the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by the administering practitioner, together with any person whose presence is required to witness the practitioner administration, and not hinder access by the person to the substance required for self-administration.

15-12 In determining whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of administration of the voluntary assisted dying substance, regard must be had to whether:

(a) the transfer would be likely to cause serious harm to the person, for example, significant pain or a significant deterioration in their condition;

(b) the transfer would be likely to adversely affect the person's access to voluntary assisted dying; 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, thereby rendering the person ineligible for authorised practitioner administration;

(c) there is an alternative place reasonably available at which the person can self-administer or receive practitioner administration of the voluntary assisted dying substance.

15-13 The determination of whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of administration of the voluntary assisted dying substance should be made by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity to decide the reasonableness of the proposed transfer.

Notice that an entity does not provide access to voluntary assisted dying

15-14 A relevant entity that does not provide services associated with access to voluntary assisted dying, such as access to the request and assessment process or access to administration of a voluntary assisted dying substance, at a facility which it operates must:

(a) inform the public, including persons that use the facility or may use the facility in the future, that it does not provide services associated with access to voluntary assisted dying (such as access to the request and assessment process, access to the administration of a voluntary assisted dying substance, or both) at the facility; and

(b) do so in a way that is likely to be brought to the attention of consumers or potential consumers of its services at the facility by, for example, placing the information on its website, in brochures and on signage at the facility.

CHAPTER 16

Review of certain decisions by QCAT

Chapter 16: Review of certain decisions by QCAT

CHAPTER SUMMARY

This chapter considers whether there should be a right of review to the Queensland Civil and Administrative Tribunal ('QCAT' or 'the tribunal') for certain decisions about a person's eligibility.[1]

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 decision should not be a routine part of the request and assessment process.

Decisions that should be reviewable

The eligibility criteria[2] 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 below, 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 a review application

1 This is part of considering the process for granting or denying access to voluntary assisted dying and the need for appropriate safeguards: see terms of reference paras 3 and 5.

2 See Chapter 7 above.

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

This chapter 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 any tribunal hearing a challenge to a decision about decision-making capacity with a tribunal member with experience in that field. Hearings would be in private.

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

QUEENSLAND

The Parliamentary Committee

16.1 The Parliamentary Committee did not specifically comment on this issue, apart from expressing general support for the White and Willmott Model.[3]

The White and Willmott Model

16.2 The White and Willmott Model does not include a provision for tribunal review of decisions or assessments, although it suggests this may be appropriate 'in relation to decision-making capacity':[4]

> This Bill does not include specific provisions about intervention in voluntary assisted dying decisions by the courts or tribunals. This is because these are primarily clinical matters for the first and second medical practitioner to assess. An exception is in relation to decision-making capacity. Depending on local legislation, guardianship or civil and administrative tribunals may have jurisdiction to adjudicate a person's decision-making capacity, and if not, it may be appropriate to specifically grant such jurisdiction to a tribunal in relation to capacity.

16.3 Professors White and Willmott observed that, in 'exceptional circumstances', declaratory relief might be sought from the Supreme Court in the exercise of its inherent jurisdiction:[5]

> Finally, should exceptional circumstances warrant wider judicial scrutiny, Supreme Courts have been willing to consider end-of-life issues in appropriate circumstances when approached for guidance.[6] (note omitted; note added)

3 Qld Parliamentary Committee Report No 34 (2020) 105, Rec 1.

4 White and Willmott Model, Explanatory Notes 7.

5 Ibid.

6 Citing *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84; *H Ltd v J* (2010) 107 SASR 352. Both of those cases, where declaratory relief was sought from the court, involved a competent adult's withdrawal of consent to nutrition and hydration and, in the former case, consent to palliative treatment.

QCAT's jurisdiction

16.4 QCAT is an independent tribunal established under its own legislation[7] with jurisdiction for a range of specialist civil and administrative matters.

16.5 The tribunal has original jurisdiction to decide particular matters, as well as jurisdiction to review decisions made by other entities.[8]

Original jurisdiction to decide matters in the first instance

16.6 An 'enabling Act' may confer jurisdiction on the tribunal 'to decide a matter in the first instance'.[9] This may be exercised when a person has applied, or has referred a matter, to the tribunal to exercise the jurisdiction.[10]

16.7 In exercising original jurisdiction under an enabling Act, the tribunal may perform the functions conferred on it by the QCAT Act or the enabling Act.[11]

16.8 For example, under the *Guardianship and Administration Act 2000* the tribunal is given various functions, including 'making declarations about the capacity of an adult, guardian, administrator or attorney for a matter'.[12] That Act is focused on 'adults with impaired capacity'[13] and applies with respect to defined matters.[14]

Review jurisdiction

16.9 An enabling Act may confer jurisdiction on the tribunal to review a decision (a 'reviewable decision') made by another entity (a 'decision-maker') under the Act.[15] This may be exercised when a person has applied to the tribunal to exercise the jurisdiction.[16]

16.10 For example, under the *Health Ombudsman Act 2013* a health practitioner may apply to QCAT for the review of a decision by the Health Ombudsman to suspend or impose conditions on the practitioner's registration, or to prohibit or restrict the practitioner's provision of health services.[17]

16.11 In exercising its review jurisdiction, the tribunal:[18]

- must decide the review in accordance with the QCAT Act and the enabling Act;
- may perform the functions conferred on the tribunal by the QCAT Act or the enabling Act; and

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7 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) (the 'QCAT Act') ch 4 pt 1. See also *Queensland Civil and Administrative Tribunal Rules 2009* (Qld) made under that Act.

8 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 9(1), (2)(a)–(b). The tribunal also has an appeal jurisdiction: s 9(2)(c).

9 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 10(1)(b). An 'enabling Act' is an Act, other than the QCAT Act, that confers original, review or appeal jurisdiction on the tribunal, or subordinate legislation, other than under the QCAT Act, that confers review jurisdiction on the tribunal: s 6(2).

10 *Queensland Civil and Administrative Tribunal Act 2009 (Qld)* s 15. As to making an application or referring a matter see ss 33(1)–(2), 34.
An application or referral under an enabling Act is to be made in the approved form, filed in the registry, and include payment of the prescribed fee, if any: *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 33(1)–(2), 38(1); *Queensland Civil and Administrative Tribunal Rules* (Qld) rr 7, 9. Presently, the prescribed fee for making an application or referral is $352, except for applications under particular Acts such as the *Guardianship and Administration Act 2000* (Qld) for which there is no fee: *Queensland Civil and Administrative Tribunal Regulation 2019* (Qld) s 8(1), (2)(a), (c), sch 2.

11 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 16.

12 *Guardianship and Administration Act 2000* (Qld) s 81(1)(a).

13 *Guardianship and Administration Act 2000* (Qld) s 11A(1). Together with the *Powers of Attorney Act 1998*, that Act is intended to provide 'a comprehensive scheme to facilitate the exercise of power for financial matters and personal matters' by or for adults with impaired capacity and, among other things, 'confers jurisdiction on the tribunal to administer particular aspects of the scheme': s 7(b), (e).

14 See *Guardianship and Administration Act 2000* (Qld) sch 2 (Types of matters), which include 'financial matters', 'personal matters', and 'health matters'. Some matters are excluded—this includes 'special personal matters' such as the making or revoking of a will, a power of attorney, an enduring power of attorney or an advance health directive; consenting to adoption of a child; consenting to marriage or entering or terminating a civil partnership; and entering a plea on a criminal charge.
In Chapter 19 below, the Commission recommends an amendment to the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) to provide that voluntary assisted dying is not a matter to which those Acts apply.

15 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 17.

16 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 18(1).

17 *Health Ombudsman Act 2013* (Qld) ss 63, 74, 90N.
See also, eg, *Disability Services Act 2006* (Qld) ss 138ZW, 178(9); *Legal Profession Act 2007* (Qld) ss 26(4), 51(9), 54(2), 61(3), 69(3), 87(5); *Retirement Villages Act 1999* (Qld) ss 29, 41A, 41K, 113J.

18 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 19.

- has all the functions of the decision-maker for the reviewable decision being reviewed.

16.12 The purpose of the review 'is to produce the correct and preferable decision', and the tribunal must hear and decide the review 'by way of a fresh hearing on the merits'.[19] This means the tribunal 'stands in the shoes of the decision maker and makes its own decision on the merits of the case about how the legislation applies in the person's circumstances'.[20]

16.13 In reviewing the decision, the tribunal may:[21]

- confirm or amend the decision;
- set aside the decision and substitute its own decision; or
- set aside the decision and return the matter for reconsideration to the decision-maker, with any directions the tribunal considers appropriate.[22]

16.14 Where the tribunal confirms, amends or substitutes its own decision, it has effect as if it were, and from the same time as, the decision made by the original decision-maker.[23]

16.15 The enabling Act may, however, state the specific functions of the tribunal in its review jurisdiction, which may add to, otherwise vary or exclude the functions stated in the QCAT Act.[24]

General powers and procedural matters

16.16 The QCAT Act confers general procedural powers on the tribunal. For example, the tribunal has power to make an interim order it considers appropriate in the interests of justice, or to grant an interim or other injunction in a proceeding if it is just and convenient to do so.[25] It also has power to make non-publication orders in particular circumstances.[26]

16.17 The tribunal may be empowered by an enabling Act to conduct an expedited hearing,[27] and has power to dismiss or otherwise deal with proceedings that are vexatious or lacking in substance.[28]

16.18 The QCAT Act also contains provisions of general application about requirements for applications, the conduct of proceedings, and the enforcement of tribunal decisions.[29]

19 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 20.

20 QCAT, 'QCAT review jurisdiction' (Fact Sheet, 27 January 2021) <https://www.qcat.qld.gov.au/__data/assets/pdf_file/0009/101304/review-jurisdiction.pdf>.

21 *Queensland Civil and Administrative Tribunal Act 2009 (Qld) s 24(1).*

22 Also, at any time during a proceeding for review of a decision, the tribunal may invite the decision-maker to reconsider the decision: *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 23(1). This gives the decision-maker 28 days to reconsider and either confirm or amend the decision, or substitute a new decision: s 23(2). The confirmed, amended or new decision then becomes the decision under review by the tribunal: s 23(3)–(4).

23 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 24(2): where the tribunal confirms, amends or substitutes its own decision, the tribunal's decision 'is taken to be a decision of the decision-maker for the reviewable decision' and 'subject to any contrary order of the tribunal, has effect from when the reviewable decision takes or took effect'.

24 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 6(4). 'Function' includes power: s 8 sch 3 (definition of 'function'). The modifying provision in an enabling Act prevails over the provisions of the QCAT Act to the extent of any inconsistency, and the QCAT Act must be read, with necessary changes, as if the modifying provision were a part of the Act: s 7(1)–(3). An enabling Act may also expressly state how the QCAT Act applies in relation to the modifying provision, including, for example, by stating that stated provisions of QCAT Act do not apply or apply subject to stated variations: s 7(5).

25 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 58, 59.

26 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 66.

27 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 94. See also *Queensland Civil and Administrative Tribunal Rules 2009* (Qld) r 82.

28 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 47. See also s 48.

29 See generally *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ch 2 pts 2–8.

16.19 An enabling Act that confers jurisdiction on the tribunal may include provisions about those matters that may add to, otherwise vary, or exclude those provisions.[30] For example, an enabling Act may include provisions about the period within which an application must be made, persons who must be notified of a proceeding or the tribunal's decision in a proceeding, additional persons who are a party to a proceeding, and hearings that must be held in private.[31]

OTHER JURISDICTIONS

Victoria and Western Australia

16.20 The legislation in Victoria and Western Australia provides that 'eligible applicants' may apply to the relevant civil and administrative tribunal for review of a decision of a coordinating medical practitioner or consulting medical practitioner.

16.21 The civil and administrative tribunals in those jurisdictions have a similar review jurisdiction to QCAT.[32]

16.22 The right to apply for review of a decision under the voluntary assisted dying legislation applies to particular decisions only, namely, a decision by a coordinating practitioner or a consulting practitioner that the requesting person:[33]

- is or is not ordinarily resident in the State (Victoria);
- at the time of making the first request, was or was not ordinarily resident in the State for a period of at least 12 months (Victoria and Western Australia);
- has or does not have decision-making capacity in relation to voluntary assisted dying (Victoria and Western Australia); or
- is or is not acting voluntarily and without coercion (Western Australia).

16.23 An application for review may be made by the person who is the subject of the decision, the person's agent, or another person who the tribunal is satisfied has a special interest in the medical care and treatment of the person.[34]

16.24 If an application for review is made, the request and assessment process is suspended, and no further step is to be taken while the review application is on foot.[35]

16.25 Provisions are also included about what the tribunal may decide on an application for review, the effect of a tribunal's decision on the voluntary assisted dying process, and other matters such as notice requirements.[36]

16.26 These provisions modify provisions of the *Victorian Civil and Administrative Tribunal Act 1998 (Vic)* and the *State Administrative Tribunal Act 2004* (WA), respectively.

Tasmania

16.27 Tasmania does not have a civil and administrative tribunal with review jurisdiction similar to QCAT or its equivalents in Victoria and Western Australia.[37]

16.28 The Tasmanian Act establishes a Voluntary Assisted Dying Commission with a broad range of functions and roles.[38] This includes oversight functions similar to the Boards in

30 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 6(7)–(8). As to the effect of a modifying provision, see n 24 above.
31 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 6(7)(a)–(b), examples.
32 See generally *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 42, pt 3 div 3; *State Administrative Tribunal Act 2004* (WA) s 14, pt 3 div 3.
33 *Voluntary Assisted Dying Act 2017* (Vic) s 68(1); *Voluntary Assisted Dying Act 2019* (WA) s 84(1).
34 *Voluntary Assisted Dying Act 2017* (Vic) s 68(2); *Voluntary Assisted Dying Act 2019* (WA) s 83 (definition of 'eligible applicant'). The person who is the subject of the decision is a party to the proceeding, whether or not they are an applicant for the review: *Voluntary Assisted Dying Act 2017* (Vic) s 68(3); Voluntary Assisted Dying Act 2019 (WA) s 84(2).
35 *Voluntary Assisted Dying Act 2017* (Vic) s 70; *Voluntary Assisted Dying Act 2019* (WA) s 86.
36 See generally *Voluntary Assisted Dying Act 2017* (Vic) pt 6; *Voluntary Assisted Dying Act 2019* (WA) pt 5.
37 Tasmania has several tribunals conferred with jurisdiction to adjudicate disputes in specific areas, including the Anti-Discrimination Tribunal and the Health Practitioners Tribunal: see generally Courts and Tribunals Tasmania, 'Tribunals' (15 May 2019) <https://www.courts.tas.gov.au/>.
38 See generally *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 110(1), 114.

Victoria and Western Australia,[39] information functions similar to the navigator services in Victoria and Western Australia[40] and review functions similar to those of the tribunals in Victoria and Western Australia.[41]

16.29 Like Victoria and Western Australia, the Tasmanian Act provides for:[42]

- a person who is the subject of the decision;
- an agent of such a person; or
- any other person who the review body is satisfied has a special interest in the medical treatment and care of such a person

to apply for review of a decision of a primary medical practitioner, consulting medical practitioner or administering health practitioner that the requesting person:

- meets, or does not meet, the residency requirements;
- has, or does not have, decision-making capacity; or
- is, or is not, acting voluntarily.

16.30 If an application for review is made, no further action in the voluntary assisted dying process is to be taken until the application is determined, withdrawn or dismissed.[43]

16.31 The Commission is to 'reach the correct and proper decision' and 'is to conduct a hearing, or to obtain evidence, or both, so as to be able to make a fresh decision, on the evidence before the Commission, in substitution for the relevant decision'.[44] However, if the Commission decides, contrary to the practitioner, that the person has decision-making capacity or is acting voluntarily, the practitioner may (but is not required) to adopt that decision.[45]

SUBMISSIONS

16.32 The Consultation Paper asked whether a person should be able to apply to QCAT for review of a coordinating practitioner's or consulting practitioner's decision that a requesting person:[46]

- is or is not ordinarily resident in the State or, at the time of making the first request, was or was not ordinarily resident in the State for the minimum time required (if any);
- has or does not have decision-making capacity in relation to voluntary assisted dying; or
- is or is not acting voluntarily and without coercion.

16.33 We also sought submissions about the persons who should have standing to apply for review of such a decision.[47]

Should decisions be reviewable by QCAT?

16.34 Most respondents who addressed this issue agreed that an eligible person should be able to apply to QCAT for review of certain decisions of the coordinating practitioner or consulting practitioner.

39 See generally Chapter 18 below.
40 See the discussion of navigator care services in Chapter 21 below.
41 See *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) pt 15.
42 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 94 (definition of 'eligible applicant'), 95(1). The Commission must prepare and issue guidelines for the purposes of the definition of an 'eligible applicant' in s 94 which must be considered in deciding whether a person has a 'special interest' within the meaning of that definition: see ss 94 (definition of 'eligible applicant', para (c)), 118(1).
43 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 96.
44 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 99.
45 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 103(6). Cf the effect of the tribunal's decision in Western Australia: *Voluntary Assisted Dying Act 2019* (WA) ss 89–90.
46 QLRC Consultation Paper No 79 (2020) Q-25.
47 Ibid Q-26.

16.35 Palliative Care Social Work Australia commented, for example, that '[i]t is essential to have a tribunal review cases so concerns/conflicts can be scrutinized in an independent thorough manner'.

16.36 Similarly, the Anglican Bishop of North Queensland expressed the view that '[t]here is certainly a need for a Tribunal, to provide for a quick and informal way of reviewing decisions'. This respondent submitted that:

> the Tribunal itself should act in an informal way and should have the authority to mediate or resolve an issue in the interests of the well being of the patient. Its membership should include an independent health care practitioner, a solicitor or barrister, and a lay person.

16.37 AMA Queensland submitted that 'review should be conducted by QCAT [so] as to remain consistent with the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*'.[48]

16.38 Professors White and Willmott commented that '[t]here is merit to the fast and accessible justice such tribunals can provide to resolve disputes', but noted the potential for a review process to be 'used by parties to unreasonably or vexatiously delay' access to voluntary assisted dying:

> Caution is needed though to ensure these processes are not used by parties to unreasonably or vexatiously delay or deprive a person of access to [voluntary assisted dying]. By definition, persons who are eligible for [voluntary assisted dying] are suffering and have a medical condition that will cause death, and potentially with a specific time prognosis to death (depending on what eligibility criteria are adopted). Although noting the different legal context in Canada, there has been recent litigation about [voluntary assisted dying] access in Canada, with suggestions that one objective of this litigation was to delay access to [voluntary assisted dying] so that the person seeking it would lose capacity and no longer be eligible. We do note that tribunals have existing powers which could be used to address litigation motivated by such reasons.

16.39 The Clem Jones Group supported a review process but 'urge[d] that any statutory process … ensure rapid decision-making is undertaken by the imposition of short but workable deadlines for decisions'. A member of the public similarly commented that 'the potential for this process to be a lengthy one and thus increase suffering for the person awaiting a decision should be addressed in the legislation'.

16.40 The President of QCAT submitted that:

> This would be a new jurisdiction for QCAT. Investing QCAT with this jurisdiction would have obvious and immediate resourcing implications. QCAT is not adequately resourced to deal promptly and efficiently with its current jurisdictional workload. Any proposal to invest QCAT with this further jurisdiction would need to be accompanied by an appropriate resourcing and funding model.

16.41 A few others did not support a right of review to QCAT, either at all or in relation to particular decisions. For example, a member of the public submitted that:

> A tribunal is a 'sledge hammers and walnuts' strategy, appropriate for marital disputes and inappropriate for [voluntary assisted dying]. The simplest and safest solution is to allow practitioners to withdraw if they smell something fishy and for patients to seek a more suitable practitioner if they encounter someone unsuitable.

Which decisions should be reviewable?

16.42 Most respondents who addressed this question considered the following decisions of a coordinating practitioner or consulting practitioner should be reviewable:

48 Matters heard by QCAT under the *Guardianship and Administration Act 2000* (Qld) and *Powers of Attorney Act 1998* (Qld) fall within QCAT's original jurisdiction.

- that the requesting person is, or is not, ordinarily resident in the State;
- that, at the time of making the first request, the requesting person was or was not ordinarily resident in the State for a specified minimum period;
- that the requesting person has or does not have decision-making capacity in relation to voluntary assisted dying;
- that the requesting person is or is not acting voluntarily and without coercion.

16.43 As for the residency requirements, STEP Queensland commented, for example, that:

> If the draft legislation contains the residency requirements (which we believe is a policy decision for the Government and we make no submission in that respect), then the draft legislation should include the ability for an eligible applicant to apply to the Tribunal for a review of these decisions.

16.44 In contrast, some other respondents considered that a decision whether the requesting person meets the residency requirements should not be reviewable.[49] An academic submitted, for example, that:

> This should not require referral to the Tribunal; as with other 'proof of residence' issues, providing relevant documents should be sufficient. Why make it unnecessarily bureaucratic?

16.45 As to a decision whether the requesting person has decision-making capacity in relation to voluntary assisted dying, the Public Advocate supported review by QCAT, submitting that:[50]

> This will provide an additional safeguard when determining the critical question of capacity in this process. QCAT already has the jurisdiction to determine decision-making capacity, and such reviews could conceivably be undertaken using that provision without requiring further amendments to the *Guardianship and Administration Act.* This is especially so if the definition of capacity adopted for voluntary assisted dying is the same as that under the *Guardianship and Administration Act.* (note omitted)

16.46 The Public Advocate further submitted that it should not be assumed that a medical practitioner's assessment of capacity is equivalent to a legal determination of capacity:

> It is important to make the point here, that the draft legislation should not assume, or be drafted in a way that suggests that a finding by a medical practitioner regarding a person's decision-making capacity, amounts to a legal determination of capacity. There is already a level of confusion in the community about the status of a medical assessment of capacity, versus a determination by QCAT.

16.47 The Queensland Law Society expressed the view that '[n]either the draft bill nor any other legislation should disallow an individual who is seeking access to [voluntary assisted dying] from bringing an application to the Tribunal for review'. In its view, express provision to allow an application for review in relation to decision-making capacity is not needed in the voluntary assisted dying legislation. It suggested that amendments be made to the QCAT Act:

> to clarify that the Tribunal has authority to hear a matter relating to 'decision-making capacity', which as discussed above, is distinct from 'capacity' as defined by the *Guardianship Act* and the *[Powers of Attorney* Act].
>
> Further amendments to the QCAT Act should clarify whether decisions relating to eligibility requirements of [voluntary assisted dying], such as residency and decision-

49 Some of these respondents opposed the inclusion of particular residency requirements as part of the eligibility criteria: see Chapter 7 above.

50 Under s 146 of the *Guardianship and Administration Act 2000* (Qld), the tribunal may make a declaration about the capacity of an adult, guardian, administrator or attorney for a matter, on its own initiative or on the application of the individual or another interested person. (The tribunal's power to make a declaration under this provision falls within the tribunal's original jurisdiction, rather than its review jurisdiction.) See also the discussion of decision-making capacity in Chapter 7 above.

> making capacity, are 'special health matters' or otherwise.[51] (note added)

16.48 Other respondents considered that provision should not be made for QCAT to review a practitioner's decision about the requesting person's decision-making capacity. A member of the public expressed the view that this 'is a mental health issue to be decided by a proper authority', not by the tribunal.

16.49 That respondent expressed a similar view in relation to a decision whether the person is acting voluntarily and without coercion. Go Gentle Australia also opposed the review of such a decision, 'as there have already been assessments by two independent doctors'. A member of the public submitted in this respect that:

> [Reviews] should be focused on qualifying details like residency. Tribunals should exercise the strongest possible caution in overturning a physician's ruling that an individual was being coerced. We know from experience in the United States and other countries that coercers will simply keep trying until they get the decision they want.

16.50 On the other hand, several respondents supported any decision denying a person's request for access to voluntary assisted dying, or any decision in a practitioner's eligibility assessment, to be reviewable.

16.51 For example, Australian Lawyers Alliance submitted that:

> Eligible applicants should be able to apply to QCAT if they consider a person does not meet eligibility requirements. Alternatively, a person should be able to apply to QCAT if their request to participate in the [voluntary assisted dying] scheme is denied.

16.52 Dying with Dignity NSW considered that there should be a right of review 'if a [voluntary assisted dying request] is rejected', commenting that [a]nything that maximises the rights of the patient should be available'. A member of the public expressed concern that, without the ability to seek review in those circumstances, 'there is a risk [that] practitioners who are morally opposed to [voluntary assisted dying] may use their power to block applications'.

16.53 Another member of the public submitted that '[a]ll stages of the assessment and all aspects of the assessment should be referable to the QCAT'. Additionally, in their view:

> QCAT must be given authority to undo assessments of medical practitioners. If it is not, then this reference out will be praised and cited as a safeguard but it will be of no practical merit.

16.54 A medical defence organisation and professional indemnity insurer considered the tribunal should have a broad jurisdiction:

> Given the wide range of situations and complexities involved in the voluntary assisted dying process, it is prudent to provide QCAT with a relatively broad jurisdiction to consider both eligibility and compelling cases for departures from prescribed requirements.

16.55 The Anglican Bishop of North Queensland commented that:

> A request to grant [voluntary assisted dying] would not normally require review by Tribunal, except if there is reason to believe that coercion of the patient took place or that the patient was not eligible. However the distress caused by this could be considerable and should be limited to practitioners involved in assessing or caring for the patient. It is anticipated that most requests for review would come where a request for [voluntary assisted dying] was denied, and is likely to come from the patient or their family.

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51 The *Guardianship and Administration Act 2000* (Qld) deals with decisions for an adult with impaired capacity about particular matters including 'financial matters', 'personal matters', 'health matters', and 'special health matters'. 'Special health matters' include sterilisation, termination of pregnancy, and electroconvulsive therapy. Decisions about special health care for an adult with impaired capacity may be made only under the adult's advance health directive or, if that does not apply, by an entity authorised to deal with the matter or, if that does not apply, by the tribunal. The tribunal may consent to special health care for an adult in particular circumstances. See *Guardianship and Administration Act 2000* (Qld) ss 65, 68, sch 2 pt 2 items 6, 7.

Who should be able to apply for review of a decision?

16.56 All respondents who addressed this question considered that the person who is the subject of the decision should be eligible to make an application for review.

16.57 Many respondents also considered that an application should be able to be made by:

- an agent of the person who is the subject of the decision; or
- another person who the tribunal is satisfied has a special interest in the medical care and treatment of the person.

16.58 Some respondents supported the inclusion of an agent provided the agent is appointed by the person who is the subject of the decision. The Queensland Law Society submitted that:

> An 'agent' who is nominated by the applicant should have standing to make an application. A definition of who is an 'agent' should be provided for clarity—for example, if the term includes a person with a power of attorney or other legally appointed representative. The term is not defined in the Victorian Act or the [Western Australian] Act, or in the *Acts Interpretation Act 1954* (Qld).

16.59 On the other hand, a medical defence organisation and professional indemnity insurer expressed concern that '[t]he concept of an agent is potentially confusing and should not be used'. Instead, they submitted that '[t]he standing of those purporting to act on behalf of the relevant person is best determined by QCAT using a "sufficient interest" test'.

16.60 Similarly, some respondents expressed concern or queried the meaning of the term 'special interest' or considered that it should be qualified or modified in some way.

16.61 For example, one respondent supported the inclusion of this category of person 'provided that special interest is grounded in concerns for the particular patient's safety and welfare, rather than abstract opposition to [voluntary assisted dying] per se'.

16.62 The Public Advocate submitted that:

> consideration should be given to adopting the definition of 'interested person' in the *Guardianship and Administration Act,* which is defined as a person who has a 'sufficient and continuing interest in the other person' the subject of the application. This definition would provide flexibility for QCAT to determine the suitability of other people making the application, while also having precedents to guide these determinations. (note omitted)

16.63 The Queensland Law Society observed that '[i]t is not clear what is to be demonstrated in order to constitute having a "special interest"' and that the term is not defined in the Victorian or Western Australian legislation. It noted the term 'interested person' in the *Guardianship and Administration Act 2000* but preferred a different approach:

> With respect to the issues raised by our members regarding the need for a robust process which seeks to avert vexatious review applications, we do not support using the terminology from the Guardianship Act. Instead, a definition of 'special interest' which requires a person to demonstrate a direct, personal and relevant interest with the [voluntary assisted dying] applicant should be developed and included in the QCAT Act.

16.64 Go Gentle Australia opposed standing for a category of persons with a 'special interest' in the person, submitting that:

> we feel this leaves the door open to allow frustration of the process by people who may disagree with the option of [voluntary assisted dying], such as family members, or even health professionals, who may not share the same world view as the patient.

16.65 Similar views were expressed by some other respondents.

16.66 In contrast, a member of the public expressed the view that, in addition to the person themselves, an application should be able to be made by the person's spouse or other

family members, the person's 'usual health practitioner if that person was not included in the assisted dying process', a police officer, a friend of the person, or 'any person who has or may have knowledge of any facts, matters or circumstances which may prove the patient has not met any requirement for eligibility' to access voluntary assisted dying.

16.67 Dying with Dignity NSW submitted that '[n]o danger is posed by a person other than the patient making an application because the ultimate decision lies with QCAT'.

16.68 Other respondents supported provision for potential applicants other than the person who is the subject of the decision, but noted that the person who is the subject of the decision 'must be a party to the application to ensure that their interests are protected', and that the review body 'should have the ability to decide against hearing vexatious applications'.

THE COMMISSION'S VIEW

The review of certain decisions by QCAT

A review mechanism

16.69 The draft Bill should include a review mechanism for certain non-clinical decisions made by a coordinating practitioner or consulting practitioner in the request and assessment process.

16.70 Any review mechanism should be timely and accessible, with appropriate limits to minimise unnecessary distress and delay. It should have the features set out in this chapter.

16.71 The Commission considers that, assuming adequate resources, QCAT is best suited to this mechanism. This has the advantage of adopting existing provisions of the QCAT Act with modifications as needed in the present context. The tribunal's procedures are flexible, and it is required to deal with matters in a way that is 'accessible, fair, just, economical, informal and quick'.[52] It may, for example, deal with matters on the papers or by remote conferencing.[53]

16.72 QCAT should be given the additional resources that are needed to ensure the effective operation of the recommended new jurisdiction under the draft Bill.

First instance referral

16.73 Consideration was given to whether the draft Bill should allow an assessing practitioner to refer a decision about the eligibility criteria to the tribunal for determination in the first instance. Such a mechanism might assist in unusual cases in which the assessing practitioner is unsure whether the person meets the residency requirements or other eligibility criteria. Determination by QCAT would provide a clear answer in such cases.

16.74 On balance, however, the Commission considers this is unnecessary and could have unintended consequences.

16.75 The eligibility criteria are a key safeguard. If an assessing practitioner is so uncertain that they cannot be satisfied the person meets the relevant eligibility criterion, the person should be assessed as ineligible. If the requesting person (or another eligible person) wishes to formally challenge that decision, an application for review of the decision may be made to the tribunal under the recommended review mechanism. This achieves the same results as a referral of the matter to QCAT in the first instance.

16.76 The draft Bill addresses the possibility of an assessing practitioner's uncertainty in other ways. It provides for an assessing practitioner to refer particular matters, including the question of decision-making capacity, to another health practitioner with appropriate

52 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 3(b). See also s 4, ch 2 pt 2, pt 6 div 1.
53 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 32.

skills and training for their determination. Also, if satisfaction of the residency criteria is problematic, there is provision for the requesting person to seek an exemption from those requirements from the Director-General of the Department.

16.77 There is little need for an additional provision to refer eligibility assessment decisions to QCAT for determination. It would risk unintended consequences. Overly cautious assessing practitioners may seek the comfort of a tribunal determination in cases where it is unnecessary to do so. The voluntary assisted dying process is built upon the premise that eligibility assessment should, and can, be determined by appropriately trained and qualified medical practitioners. The involvement of the tribunal should be as a last resort, where there is genuine disagreement with a decision made in such an assessment.

16.78 The Commission's approach is pragmatic and consistent with the aim of developing compassionate, safe and practical legislation.

The decisions that should be reviewable

16.79 It is not desirable to leave every decision of an assessing practitioner open to review by the tribunal. To do so would add an unnecessary layer of complexity to the process and cause uncertainty and delay. As noted in Chapter 18 below, a contemporaneous ruling by an external oversight body about the legality of particular cases has the potential to cause significant undue distress.

16.80 Safeguards exist. Access to the scheme requires a person to be assessed as eligible by two qualified practitioners. The draft Bill provides for an assessing practitioner to refer certain matters to another health practitioner with appropriate skills and training for their determination.[54]

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

16.82 The eligibility criteria[55] that are assessed by the practitioner involve varying degrees of judgment and questions of fact. Some are more appropriate for review than others.

Age

16.83 The requesting person's age is a question of fact: the person either meets that criterion or not. There is no need for review by the tribunal.

Residency

16.84 It is also a question of fact whether the requesting person meets the two elements of the residency requirement. However, some aspects of those criteria, involve judgment in the particular circumstances, namely, whether the person has been 'ordinarily resident' for the required time. These are not matters of medical assessment and may involve differing interpretations. Therefore, it is appropriate for decisions about the 'ordinarily resident' criterion to be reviewable by the tribunal.

Disease, illness or medical condition

16.85 In contrast, the eligibility criteria about the person's disease, illness or medical condition are matters of clinical judgment that are best determined by a medical practitioner, rather than an administrative body. In the Commission's view, they should not be subject to review by the tribunal. As noted in the discussion of the role of the oversight body, the assessment of eligibility is a matter for clinical judgment within a therapeutic relationship.[56]

16.86 The requirement for a requesting person to be assessed as eligible by two qualified practitioners is a central safeguard in the legislation. If the assessing practitioner is

54 See the referral requirements in Chapter 8 above.
55 See Chapter 7 above.
56 See Chapter 18 below.

uncertain, there is provision in the draft Bill for referral to another health practitioner for determination. Further, if the assessing practitioner considers a requesting person does not meet these criteria, the requesting person may choose to start a new request and assessment process with a different practitioner.

Decision-making capacity

16.87 A practitioner's assessment of whether the requesting person has the required decision-making capacity may involve aspects of clinical judgment and judgment in the application of the legislative definition of 'decision-making capacity'. These are evaluations that medical practitioners routinely make. It would be expected that, in many cases, where the practitioner is in an ongoing therapeutic relationship with the person, the practitioner will be well placed to make this assessment. In the case of uncertainty, provision is also made in the draft Bill for referral of this question to another health practitioner.

16.88 This criterion is, however, a key feature and major safeguard in the draft Bill. It is therefore important that, in exceptional circumstances, genuine disagreement with a practitioner's assessment of this issue can be addressed through an independent review mechanism. QCAT already has jurisdiction under the guardianship legislation to make declarations about an adult's capacity for particular matters. It has a body of expertise upon which to draw in this context, especially given that the draft Bill defines 'decision-making capacity' consistently with the guardianship legislation.[57]

Voluntariness

16.89 Similarly, the criterion that the requesting person is acting voluntarily and without coercion is a major safeguard and feature of the draft legislation. In the Commission's view, the assessing practitioner's decision in this respect should be reviewable by the tribunal. Assessment of this matter requires consideration of a range of factors, some of which might be subtle or, depending on the circumstances, unknown to the practitioner. There could be situations where there is a genuine concern about the influence of another person on the voluntariness of the requesting person's choice; for example, a family member, carer or medical practitioner (including an assessing practitioner).

Conclusion

16.90 Therefore, we consider that the draft legislation 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:[58]

- 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**.

16.91 The reference to a decision 'in an assessment' or 'in a final review' means that a decision is reviewable once the assessment or final review is completed by the practitioner.

16.92 This is consistent with the approach in the Victorian, Western Australian and Tasmanian legislation.

57 See Chapter 7 above.

58 In the case of a final review, this would apply to a decision of a coordinating practitioner about the last two of those four matters: see the discussion of final review in Chapter 8 above.

Decisions of an administering practitioner

16.93 We have 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. At the time of administration, an administering practitioner must be satisfied of various matters, including that the requesting person has decision-making capacity in relation to voluntary assisted dying. If the administering practitioner is not satisfied, they are not authorised to administer the substance.[59]

16.94 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.

16.95 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.[60]

16.96 In practice, if capacity, for example, is fluctuating and not irretrievably lost, the process can be managed by determining the best time for the proposed administration to take place. This might be relevant, for example, where the person's capacity is temporarily affected by the effect of medication or sleep. This is a matter for consideration by the practitioner, the person and (if relevant) other members of the person's care team in the context of the therapeutic relationship.

16.97 If necessary, there is provision in the draft Bill for the role of the administering practitioner to be transferred to another practitioner.[61] Ultimately, if an administering practitioner is not satisfied of the relevant matters, they should not administer the substance. Additionally, all cases will be retrospectively reviewed by the Board to ascertain compliance with the legislation, with any identified issues to be referred by the Board to the relevant agency, such as the Health Ombudsman, the coroner or the police.[62]

16.98 Therefore, we conclude that it is neither necessary nor desirable for the QCAT review mechanism to apply to 'decisions' of an administering practitioner.

Notice of the reviewable decision

16.99 As part of the request and assessment process, the requesting person is to be informed of the outcome of the coordinating practitioner's and consulting practitioner's assessments and given a copy of the completed assessment record form (which is also to be submitted to the Board). The requesting person will also be made aware of the outcome of the coordinating practitioner's assessment in the final review.[63]

16.100 The completed assessment record form will contain both the assessing practitioner's decisions with respect to the eligibility criteria, as well as any attached supporting documents. The Commission considers this is a sufficient statement of the 'reasons' for the decision, and that any further obligation would impose an additional burden with little benefit or advantage.

16.101 It is sufficient for the draft Bill to require that the requesting person be notified of the outcome of the assessment, rather than imposing a statutory obligation on the

59 See the practitioner administration requirements in Chapter 10 above.

60 See *Voluntary Assisted Dying Act 2017* (Vic) ss 64(1), (5), 66(1), 68(1); *Voluntary Assisted Dying Act 2019* (WA) ss 59(5), 61(2)(b), 84(1). (A different approach is taken under the Tasmanian Act, which requires the administering health practitioner to be satisfied of the relevant matters within 48 hours before the person gives the final permission, rather than at the time of administration: see *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 78, 95(1)).

61 See Chapter 10 above.

62 See generally Chapter 18 below.

63 See the discussion of reporting requirements in Chapter 8 above.

assessing practitioner to inform other persons of the outcome. Respect for autonomy and privacy suggests that it is ordinarily a matter for the requesting person to choose the extent to which others are informed, including family members. It is expected that such matters, including information sharing with other members of the person's care team as needed, would be appropriately addressed as a matter of clinical practice in accordance with professional standards.[64]

16.102 Accordingly, the Commission does not consider it necessary or desirable for additional formal requirements for the provision of notice or reasons to apply in this context. As such, the provisions in the draft Bill exclude sections 157 to 160 of the QCAT Act, which deal with the usual requirements for notice of, and reasons for, reviewable decisions.[65]

16.103 The Commission is concerned to ensure that the review mechanism remains streamlined, expedient and aligned to clinical practice, without imposing additional obligations that may needlessly delay the process. The purpose of the review mechanism is to ensure that, as a last resort, a person can seek a decision from the tribunal—not to provide an additional formalised process for obtaining further explanation of the assessing practitioner's reasons.

Applications for review

Who may apply for review?

16.104 The primary focus of a decision is the person making the request for voluntary assisted dying. 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 in the context of voluntary assisted dying. This might include, for example, another member of the person's health care team, a spouse or other close family member, or carer.

16.105 The review mechanism is needed for those exceptional cases where there is genuine disagreement or concern. However, the Commission is concerned to ensure that it does not become a means of unjustified interference or delay.

16.106 For these reasons, the range of potential applicants should be kept small.

16.107 Accordingly, the draft legislation should provide that an application for review of a decision may be made by:

- the person who is the subject of the decision ('the person'); or
- an agent of the person.

16.108 This is consistent with the approach in the other jurisdictions.

16.109 Recognising that the requesting person is dying and suffering, the provision for an agent to apply on their behalf is a practical necessity. The Commission does not consider it necessary to define the term 'agent' for this purpose.[66] It is anticipated that the tribunal would require, through the application form, some supporting statement or information that the applicant is acting on the requesting person's behalf. The QCAT Act also has procedures to address the concern that a person may not be authorised to make the application.[67]

64 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.3], [4.4.1]–[4.4.4], [4.10.2], [6.2.1]. See also the recommended confidentiality provision in Chapter 17 below, under which personal information may be disclosed for a purpose under the legislation or with the person's consent.

65 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(4), (7)(a)–(b), 7.

66 In ordinary usage, 'agent' means 'a person acting on behalf of another': *Macquarie Dictionary* (online at 16 February 2021) 'agent'. In the law of agency, an agent is a person with an authority or capacity to create or affect legal relations between a principal and third parties: see, eg, *International Harvester Co of Australia Pty Ltd v Carrigan's Hazeldene Pastoral Co* (1958) 100 CLR 644, 652. See generally S Fisher, *Agency Law* (Butterworths, 2000) [2.1.1], [2.1.4], [2.2.2].
Submissions to a review of the Tasmanian Bill suggested that 'the concept of an "agent" … is confusing' and that, '[i]nstead a "sufficient interest test" should be used': Tas Review Panel Report (2021) 65.

67 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 35, especially s 35(3)(a). An application may be accepted on conditions or rejected because the application is made by a person who is not authorised to make it.

16.110 Additionally, we consider that the draft Bill should provide that an application for review may be made by:

- any other person who has a sufficient and genuine interest in the rights and interests of the person in relation to voluntary assisted dying.

16.111 This adopts a different wording to the legislation in the other jurisdictions, which refers to 'any other person who the Tribunal is satisfied has a special interest in the medical care and treatment of a patient [who is the subject of the decision]'.[68]

16.112 Voluntary assisted dying is an end of life choice. The relevant concern might be whether the person has the requisite decision-making capacity or is acting voluntarily and without coercion. These are matters directly related to voluntary assisted dying but are not necessarily about medical care or treatment. As noted above, the Commission considers the relevant interest is in upholding the requesting person's rights and interests in relation to voluntary assisted dying.

16.113 This category of applicant should also be confined to those persons who have a special interest over and above members of the community, including those who hold a general belief in favour of or against voluntary assisted dying. It should reflect a particular proximity or connection between the applicant and the requesting person in relation to the subject matter. This is consistent with the general approach to standing for review of administrative decisions.[69]

16.114 The Commission sees merit in adopting a similar formulation to that used in Queensland's guardianship legislation. Under that legislation, applications to the tribunal may be made by the adult concerned or another 'interested person', defined to mean 'a person who has a sufficient and genuine concern for the rights and interests of the other person'.[70]

16.115 That formulation has the advantage of referring both to a 'sufficient' and 'genuine' concern, as well as referring to the 'rights and interests' of the other person. Those concepts align well with the present context.

16.116 However, we consider that some modifications to that formulation are appropriate to ensure this category of potential applicants remains narrowly confined to those who have an interest (rather than a mere concern) which is not only sufficient (that is, direct and relevant) and genuine (that is, real and of substance) but which relates to the particular subject matter at hand, namely, voluntary assisted dying.

16.117 For this reason, we favour the formulation above, namely, a 'sufficient and genuine interest' in the person's 'rights and interests in relation to voluntary assisted dying'.

16.118 As in other jurisdictions, it is intended that simply being a member of the person's family will not, by itself, entitle a person to bring an application.[71] Whether a family member, health practitioner or other person has a sufficient and genuine interest that meets this test will depend on the individual circumstances.

68 *Voluntary Assisted Dying Act 2019* (WA) s 83 (definition of 'eligible applicant', para (c)). See, in virtually the same terms, *Voluntary Assisted Dying Act 2017* (Vic) s 68(2)(c); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 94 (definition of 'eligible applicant', para (c)). Submissions on the Tasmanian provision suggested that it should 'more clearly determine', for example, 'whether family members or health professionals who disagree could apply in order to frustrate the process': Tas Review Panel Report (2021) 65.

69 As to standing for a person with a 'special interest' to apply for judicial review of an administrative decision, see generally Westlaw AU, *Laws of Australia* [2.6.240]–[2.6.310] (1 March 2014); *Australian Conservation Foundation Inc v Commonwealth* (1979) 146 CLR 493; *Onus v Alcoa of Australia Ltd* (1981) 149 CLR 27. Whether a person has a special interest varies according to the nature of the subject matter and the circumstances of the case.

70 See *Guardianship and Administration Act 2000 (Qld)* ss 3, 115(2), sch 4 (definition of 'interested person'). The same definition of 'interested person' is used in the *Powers of Attorney Act 1998* (Qld) s 3 sch 3 and *Public Guardian Act 2014* (Qld) s 3 sch 1.

71 See, eg, Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 28; Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 25.

16.119 Under the QCAT Act, the tribunal is also empowered to order a proceeding, or part of it, to be dismissed or struck out if it considers it is 'frivolous, vexatious or misconceived', 'lacking in substance' or 'otherwise an abuse of process'.[72]

The time within which an application for review may be made

16.120 The draft Bill provides that an application for review must be made within five business days after the applicant was notified under the provisions mentioned above, or became aware, of the decision. Accordingly, section 33(3)–(4) of the QCAT Act should not apply.[73]

16.121 Under the QCAT Act, the default time limit for an application for review is 28 days,[74] although the tribunal has a general power to extend or shorten this time.[75] The Commission considers that a significantly shorter time limit should apply in the context of voluntary assisted dying. It is not preferable to rely on the exercise by the tribunal in every case of its power to shorten the time.

16.122 A shorter time limit will give greater certainty without the possibility of an application for review being made late in the voluntary assisted dying process. This is consistent with the compassionate and practical aim of the legislation.

16.123 The tribunal would retain its power to extend or shorten the time limit of five business days, provided it would not cause prejudice or detriment to a party.

The effect of an application for review

16.124 The Western Australian Act specifies the effect of an application for review on the voluntary assisted dying process. It provides that:[76]

- if the request and assessment process is not completed when the application for review is made, the process is 'suspended and no further step' in the process is to be taken 'until the review application is determined or otherwise disposed of'; and
- if the request and assessment process is completed when the application for review is made, the process for accessing voluntary assisted dying is 'suspended and no further step' in that regard is to be taken until the review application is determined or otherwise disposed of, including the prescription, supply or administration of a voluntary assisted dying substance.

16.125 Similar provision is made in the Victorian Act, with some differences to reflect the additional permit application process in that jurisdiction,[77] and in the Tasmanian Act.[78] The provisions were included to make it clear what consequences arise from the making of an application.[79]

16.126 The request and assessment process established by the draft Bill defines the roles and responsibilities of participating practitioners, and the steps they must take to comply with the legislation. A legislative statement in the draft Bill would make it clear how that process is impacted by an application for review.

16.127 It should not be necessary to rely on the tribunal to order a stay of the decision under review.[80] Instead, the draft Bill includes provision to the general effect that an application

72 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 47(1)–(2)(a). The tribunal may do so on its own initiative or on application of a party to the proceeding: s 47(3). This power is exercisable only by the tribunal as constituted for the proceeding or by a legally qualified member or an adjudicator: s 47(4). See also s 48.

73 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(7)(a), 7.

74 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 33(3), (4).

75 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 61(1)(a)–(b), (4). The tribunal's power to extend or shorten a time limit is exercisable only by the tribunal as constituted for the proceeding or a legally qualified member, an adjudicator or the principal registrar: s 61(5). The tribunal must not extend or shorten a time limit 'if to do so would cause prejudice or detriment, not able to be remedied by an appropriate order for costs or damages, to a party or potential party to a proceeding': s 61(3).

76 *Voluntary Assisted Dying Act 2019* (WA) s 86. This modifies s 25 of the *State Administrative Tribunal Act 2004* (WA).

77 *Voluntary Assisted Dying Act 2017* (Vic) s 70.

78 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 96.

79 In Victoria, see Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 25.

80 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 22(2)(b), (3)–(4).

for review suspends the voluntary assisted dying process, at whatever stage it has reached, and no further step in the process may be taken until the application is finalised (for example, by being withdrawn, dismissed or decided). Accordingly, section 22 of the QCAT Act should not apply.[81]

What the tribunal may decide and the effect of a tribunal decision

The tribunal's decision

16.128 As provided in the QCAT Act, the tribunal's functions on an application for review should be to hear and decide the review by way of a fresh hearing on the merits with the purpose of producing the correct and preferable decision. In doing so, the tribunal would have all the functions of the assessing practitioner who made the decision under review.[82]

16.129 The draft Bill provides that in a proceeding for a review the tribunal may decide, relevantly, that:

(a) the person:

(i) was ordinarily resident in Australia for at least three years immediately before making the first request; or

(ii) was ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request; or

(iii) has decision-making capacity in relation to voluntary assisted dying; or

(iv) is acting voluntarily and without coercion; or

(b) the person:

(i) was not ordinarily resident in Australia for at least three years immediately before making the first request; or

(ii) was not ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request; or

(iii) does not have decision-making capacity in relation to voluntary assisted dying; or

(iv) is not acting voluntarily and without coercion.

16.130 This corresponds to the decisions that are reviewable under the draft Bill and is consistent with the approach in other jurisdictions. It is not intended that the tribunal would refer a decision back to the assessing practitioner for reconsideration, as this could create unnecessary delay.[83] The process must be expedient and provide certainty. The application should be heard and decided by the tribunal as quickly as is reasonable in all the circumstances.

16.131 Sections 23 and 24(1) of the QCAT Act should not apply.[84]

The effect of a tribunal decision

16.132 The draft Bill should deal with the effect of the tribunal's decision on the voluntary assisted dying process. This will provide clarity and 'close the loop' on the effect of the application for review on the process. The effect of the tribunal's decision will differ depending whether it is a decision that the relevant eligibility criterion is, or is not, met.

81 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(8), 7, 22(2)(a).
82 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 17(1), 18(1), 19, 20.
83 Cf *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 24(1)(c). See also s 23.
84 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(4), 7.

16.133 The draft Bill includes provisions to the general effect that:

- if the tribunal makes a decision referred to in [16.129](a) above and does not also, in the same proceeding, make a decision referred to in [16.129](b) above:
  - the voluntary assisted dying process is no longer suspended; and
  - the tribunal's decision is taken to be the decision made by the coordinating practitioner or consulting practitioner, as the case may be, for the relevant assessment; and
- if the tribunal makes a decision referred to in [16.129](b) above:
  - the person is taken to be ineligible for access to voluntary assisted dying for the purposes of the request and assessment process; and
  - the voluntary assisted dying process, at whatever stage it has reached, ends and no further step in that process for requesting or accessing voluntary assisted dying is to be taken.

16.134 Section 24(2) of the QCAT Act should not apply.[85]

16.135 Similar provisions are included in the Western Australian and Tasmanian legislation.[86]

Refusal of a coordinating practitioner to continue

16.136 The Commission recognises that, where the tribunal makes a different decision about the person's decision-making capacity or voluntariness, the coordinating practitioner may feel compromised about continuing in that role.

16.137 To address this situation and avoid delay, the draft legislation should provide that:

- if the tribunal's decision is substituted for that of the coordinating practitioner, and the decision is about whether the person has, or does not have, the required decision-making capacity or is, or is not, acting voluntarily and without coercion;
- the coordinating practitioner may refuse to continue in that role; and
- if they do so, must transfer that role to the consulting practitioner for the person or, if there is no consulting practitioner for the person, to another medical practitioner who is eligible to act as a coordinating practitioner.

16.138 Similar provision is included in the Victorian and Western Australian legislation.[87]

16.139 It is not necessary to provide for the refusal and transfer of the role of a consulting practitioner in these same circumstances. Unlike the coordinating practitioner, the consulting practitioner does not have a continuing role once the consulting assessment is complete.[88]

16.140 If the tribunal sets aside the consulting practitioner's decision, the assessment will take effect as if the tribunal's decision were that of the practitioner. If the effect is that the person is assessed as eligible, the process can proceed to the next stage, which does not involve a consulting practitioner. If the effect is that the person is assessed as ineligible, the process ends.[89]

85 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(4), 7.

86 *Voluntary Assisted Dying Act 2019* (WA) ss 89, 90; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 103(3), (6). Under the Tasmanian Act, the decision of the Commission in some circumstances may, but need not, be adopted as the decision of the practitioner: s 103(6).

87 See *Voluntary Assisted Dying Act 2017* (Vic) s 73(1), (3); *Voluntary Assisted Dying Act 2019* (WA) s 91.

88 A consulting practitioner's decision is reviewable once the assessment is complete: see [16.91] above.

89 See [16.133] above.

Other procedural provisions

The parties to the proceeding

16.141 The parties to the proceeding on an application for review should include the applicant and the decision-maker for the decision under review.[90] The draft Bill specifies that the following persons are parties to the proceeding:

- if the person who is the subject of the decision is not the applicant for review—the person; and
- if the decision-maker was the consulting practitioner—the coordinating practitioner for the person.

16.142 This is consistent with the Tasmanian Act.[91] It is also consistent with the Victorian and Western Australian Acts,[92] except that it clarifies that, if the decision under review is that of a consulting practitioner, the coordinating practitioner will also be a party. This will ensure that the person's coordinating practitioner is a party to any application for review.

16.143 This modifies section 40 of the QCAT Act,[93] and applies in addition to the other persons who may be a party under that section.[94]

Notice of proceedings and tribunal decisions

16.144 The draft legislation should provide that the principal registrar must, within two business days after receiving an application for review that is accepted, give a copy of the application to:

- each party to the proceeding;
- if there is a consulting practitioner for the person and the consulting practitioner is not a party to the proceeding—the consulting practitioner; and
- any other person the tribunal directs.

16.145 Similarly, the tribunal's decision on an application for review should be given to each of those persons. Under the QCAT Act, the tribunal must give its final decision to each party to the proceeding and any other person it reasonably considers should be given notice of the decision.[95] The draft legislation should additionally provide for the decision to be given, as soon as reasonably practicable, to the consulting practitioner for the person, if there is one and they are not a party to the proceeding.

16.146 Those provisions modify sections 37 and 121 of the QCAT Act.[96]

16.147 The requesting person, who is dying and suffering, should not have the task of providing copies of the application. Instead, this should be done by the principal registrar of the tribunal. This is consistent with the approach taken in QCAT's guardianship jurisdiction.[97]

16.148 Unlike the approaches in Victoria and Western Australia,[98] the Commission does not consider it necessary to require a copy of the application or the tribunal's decision to be given to the Department or the Board.

90 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 40(1)(a)–(b).
91 See *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 97(1).
92 See *Voluntary Assisted Dying Act 2017 (Vic)* s 68(3); *Voluntary Assisted Dying Act 2019* (WA) s 84(2).
93 See *Queensland Civil and Administrative Tribunal Act 2009 (Qld)* ss 6(7)(b), 7, 40(1)(e).
94 In particular, a party includes a person who intervenes in the proceeding (that is, the Attorney-General or another person with the tribunal's leave), and a person joined by the tribunal as a party in particular circumstances: see *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 40(1)(c)–(d).
95 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 121(1)(a), (d).
96 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(7)(b), 7, 37(2)(b), 121(1)(b).
97 See *Guardianship and Administration Act 2000* (Qld) s 118; *Queensland Civil and Administrative Tribunal Rules 2009* (Qld) rr 20, 21 (which apply, among other things, to certain applications under the *Public Guardian Act 2014 (Qld)* and applications under the *Guardianship and Administration Act 2000* (Qld)).
98 See *Voluntary Assisted Dying Act 2017* (Vic) s 69(b)–(c); *Voluntary Assisted Dying Act 2019* (WA) s 94(1)(d)(e). In Western Australia, notice of the application and the tribunal's decision is also to be given to an administering practitioner to whom that role has been transferred: *Voluntary Assisted Dying Act 2019* (WA) s 94(1)(c).

16.149 However, we consider that the coordinating practitioner for the person (who will be a party to the proceeding) should be required to submit a copy of the tribunal's final decision to the Board within two business days after receiving the decision from the tribunal. This is consistent with the role of the coordinating practitioner and their obligations to submit relevant documents to the Board at key stages of the voluntary assisted dying process. It will ensure that the Board has an accurate record of the relevant assessment outcome, for the purpose of its retrospective review of cases.

16.150 Notice of an application and of the tribunal's decision must be provided expeditiously. It should be possible do this electronically.[99] It is to be expected that the application form would include standard information, written in an accessible way, about the effect of an application, the tribunal's functions on the review, and the obligation of the decision-maker and coordinating practitioner to give relevant documents to the tribunal. Similarly, it is anticipated that standard information, written in an accessible way, would be included with a copy of the decision about the effect of a tribunal decision under the voluntary assisted dying legislation.

Coordinating practitioner or consulting practitioner to assist the tribunal

16.151 The draft legislation should provide that, if a coordinating practitioner or consulting practitioner is given a copy of an application for review by the principal registrar,[100] the principal registrar must also give the practitioner a notice requiring them to give the tribunal any documents in their possession or under their control that are relevant to the review of the decision. The practitioner should be required to comply with the notice within two business days after receiving it.

16.152 This would have the effect that such assistance is to be provided by:

- the coordinating practitioner, whether or not they are the decision-maker for the reviewable decision; and
- the consulting practitioner, if there is one and they are the decision-maker for the reviewable decision (or the tribunal has otherwise directed a copy of the application to be given to them).

16.153 The documents to be provided would include, for example, the completed assessment record form along with any accompanying supporting documents or the completed final review form. It is unnecessary to require the decision-maker to provide an additional statement of reasons.[101] The tribunal's functions are not to assess the decision-maker's reasons, but to make the correct and preferable decision itself.

16.154 A short time limit for this obligation is justified. The draft Bill requires the practitioner to provide the documents within two business days after being given a copy of the application for review by the principal registrar.

16.155 Therefore, section 21(2) and (4) of the QCAT Act should not apply.[102]

16.156 The tribunal would retain its power to extend or shorten the time limit, provided it would not cause prejudice or detriment to a party.[103] It would also retain its general powers to require the decision-maker, or a person who is not a party to the proceeding, to provide additional documents that may be relevant within a stated period.[104]

16.157 The recommended provisions are similar to those in the Western Australian Act, but with some differences as to scope and time.[105]

99 As to giving documents by electronic means, see *Queensland Civil and Administrative Tribunal Rules 2009* (Qld) r 39(1)(c)–(e).
100 See [16.144] above for the persons who must be given a copy of an application.
101 See also [16.100] above.
102 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(7)(b), 7.
103 See n 75 above.
104 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 21(3), (5), 63.
105 See *Voluntary Assisted Dying Act 2019 (WA)* s 95, which modifies the *State Administrative Tribunal Act 2004* (WA) ss 24, 35.

The constitution of the tribunal

16.158 The QCAT Act provides that the President is to choose one, two or three members, or an adjudicator, to constitute the tribunal for a particular matter.[106] In doing so, the President is to consider: the nature, importance and complexity of the matter; the need for the tribunal hearing the matter to have special knowledge, expertise or experience relating to the matter; any provision of the QCAT Act, the enabling Act or the rules that may be relevant; and any other matter the President considers relevant.[107]

16.159 The QCAT Act provides for the appointment of senior members, ordinary members, supplementary members and adjudicators. It also confers certain functions and powers on judicial members and legally qualified members. Each class of member has different qualifications.[108]

16.160 The Western Australian Act provides that the tribunal 'must be constituted by, or so as to include, a judicial member' when exercising its review jurisdiction.[109]

16.161 In comparison, the tribunal is to be constituted for a hearing under the *Guardianship and Administration Act 2000* by three members, unless the President considers it appropriate for the matter to be heard by two members or a single member.[110]

16.162 On balance and taking into account the seriousness of the subject matter and the need for expedition, the Commission considers that the draft legislation should provide for the tribunal to be constituted by at least one legally qualified member. This will retain the President's discretion about how the tribunal is constituted but will ensure that an application for review is heard by at least one member who is an Australian lawyer of at least six years standing or is a Magistrate or a judicial member.[111] It will also ensure that the tribunal is able, if appropriate, to exercise those powers exercisable only by a legally qualified member, such as to make declarations or consolidate two or more proceedings.[112]

16.163 This modifies section 167 of the QCAT Act.[113]

Hearings to be in private

16.164 The QCAT Act provides that, unless the enabling Act provides otherwise, a hearing of a proceeding must be held in public. The tribunal may, however, direct a hearing or part of a hearing to be held in private if the tribunal considers it necessary:[114]

(a) to avoid interfering with the proper administration of justice; or

(b) to avoid endangering the physical or mental health or safety of a person; or

(c) to avoid offending public decency or morality; or

106 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 165(1).

107 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 167(1). For the review of a reviewable decision, a person who is, or was at the time the reviewable decision was made, an employee or officer of the entity in which the reviewable decision was made, cannot be chosen to constitute the tribunal: s 167(2).

108 See generally *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ch 4 pts 3, 4, ss 171(2), 183, 192, 198, sch 3 Dictionary.

109 *Voluntary Assisted Dying Act 2019* (WA) s 92(1). That Act also provides that 'a person who is a public sector employee may be appointed to be a non-judicial member in respect of matters in the Tribunal's review jurisdiction': s 92(2).

110 *Guardianship and Administration Act 2000* (Qld) s 102.

111 A 'legally qualified member' is a judicial member; an ordinary member or supplementary member who is a magistrate; or a senior member or ordinary member who is an Australian lawyer of at least six years standing: *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 8 sch 3 Dictionary (definition of 'legally qualified member'). A 'judicial member' is the president; the deputy president; or a supplementary member who is a Supreme Court judge or District Court judge: s 8 sch 3 Dictionary (definition of 'judicial member').

112 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 54(2), 60(5).

113 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(7), 7, 167(1)(c), (4). If an enabling Act that is an Act provides that the tribunal is to be constituted for a particular matter in a particular way, the president must ensure the tribunal is constituted in that way: s 167(4).

114 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 90(1)–(2). The tribunal may make directions about the persons who may attend a hearing or a part of a hearing to be held in private: s 90(3). The tribunal may exercise its power under s 90 on application of a party or on its own initiative: s 90(4).

(d) to avoid the publication of confidential information or information whose publication would be contrary to the public interest; or

(e) for another reason in the interests of justice

16.165 The Western Australian Act provides that hearings of the tribunal for a review application must be held in private, and that the tribunal may give direction as to the persons who may be present at a hearing.[115]

16.166 In recognising the private and potentially sensitive nature of the subject matter, the Commission considers it appropriate for the draft Bill to provide that a hearing of the tribunal for an application for review must be held in private. The tribunal should retain its power to make directions, on its own initiative or on the application of a party, about the persons who may attend a hearing or a part of a hearing.[116]

16.167 This modifies section 90 of the QCAT Act.[117]

Withdrawal of an application if the person dies

16.168 The QCAT Act provides that the applicant may withdraw the application before the matter is heard and decided by the tribunal. Some applications require leave of the tribunal to be withdrawn.[118]

16.169 The Victorian, Western Australian and Tasmanian Acts provide that an application for review of a decision is 'taken to be withdrawn' if the person who is the subject of the decision dies.[119]

16.170 For practical reasons, provision to the same effect should be included in the draft legislation. Once the person who is the subject of the decision has died, there is no reason for the application for review to proceed.

16.171 If the person who is the subject of the decision dies the application should be taken to be withdrawn and the principal registrar should, as soon as reasonably practicable after becoming aware the person has died, give notice of the withdrawal to each person who received a copy of the application for review and any other person the tribunal directs.

16.172 This modifies section 46 of the QCAT Act.[120]

115 *Voluntary Assisted Dying Act 2019* (WA) s 93.
116 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 90(3)–(4).
117 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(7)(b), 7, 90(1).
118 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 46(1)–(2). See also *Queensland Civil and Administrative Tribunal Rules 2009* (Qld) rr 57A–59.
119 *Voluntary Assisted Dying Act 2017* (Vic) s 71; *Voluntary Assisted Dying Act 2019* (WA) s 87; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 98(3).
120 See *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 6(7)(a)–(b), 7.

RECOMMENDATIONS

The review of certain decisions by QCAT

16-1 QCAT should be given jurisdiction to review, on the application of particular persons, a decision of the coordinating practitioner (in a first assessment or final review) or of a consulting practitioner (in a consulting assessment) that the requesting person:

(a) was—or was not—ordinarily resident in Australia for at least three years immediately before making the first request;

(b) was—or was not—ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request;

(c) has—or does not have—decision-making capacity in relation to voluntary assisted dying; or

(d) is—or is not—acting voluntarily and without coercion.

The mechanism for review of decisions by QCAT should have the other features set out in this chapter and included in the draft Bill about making an application for review, the effect of an application for review, what the tribunal may decide and the effect of a tribunal decision, and other procedural matters.

16-2 QCAT should be given the additional resources that are needed to ensure the effective operation of the proposed new jurisdiction under the draft Bill.

CHAPTER 17

Compliance and protection from liability

Chapter 17: Compliance and protection from liability

CHAPTER SUMMARY

The Commission must have regard to compliance monitoring and 'appropriate safeguards and protections, including for treating health practitioners'.[1]

This chapter 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 and is not 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.

CURRENT LAW AND REGULATION

Offences under the Criminal Code

17.1 Attempting suicide is not an offence in Queensland.[2]

17.2 However, a person who does not cause another person's death but assists that other person to cause their own death is guilty of aiding suicide, and a person who intentionally causes the death of another person, even with their consent, is guilty of murder.[3]

17.3 It is a crime to procure, counsel or aid another person to commit suicide. Section 311 of the Criminal Code provides:

> **Aiding suicide**
>
> Any person who—
>
> (a) procures another to kill himself or herself; or
>
> (b) counsels another to kill himself or herself and thereby induces the other person to do so; or
>
> (c) aids another in killing himself or herself;
>
> is guilty of a crime, and is liable to imprisonment for life.

1 Terms of reference para 5.

2 The former misdemeanour of 'attempting suicide' in the Criminal Code (Qld) s 312 was repealed by the *Criminal Law Amendment Act 1979* (Qld) s 4, consistently with a recommendation of the National Health and Medical Research Council: see Queensland, *Parliamentary Debates*, Legislative Assembly, 3 April 1979, 3819 (WD Lickiss, Minister for Justice and Attorney-General).

3 See Carter v Attorney-General (Qld) [2014] 1 Qd R 111, 124 [36], 127 [48]–[51] (White JA; Atkinson and Martin JJ agreeing). See also Criminal Code (Qld) s 7(1) as to the persons who are deemed to have taken part in committing an offence and to be guilty of the offence.

17.4 It is also a crime to unlawfully kill a person,[4] whether or not that person consents.[5]

17.5 The Criminal Code provides that 'any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person'.[6] Additionally, under section 296, a person 'who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause' is also deemed to have killed that other person.

17.6 A killing is unlawful unless it is 'authorised or justified or excused by law'.[7] Relevantly, under section 302, a person who unlawfully kills another person intending to cause the other person's death is guilty of murder, punishable (under section 305) by imprisonment for life. Under Chapter 28 of the Criminal Code, 'manslaughter', 'attempt to murder', 'accessory after the fact to murder' and 'conspiring to murder' are also crimes.[8]

17.7 Section 284 states that '[c]onsent by a person to the causing of the person's own death does not affect the criminal responsibility of any person by whom such death is caused'. Accordingly, consent of the person killed does not authorise, justify or excuse the killing.

17.8 The Criminal Code includes limited defences for medical practitioners.

17.9 Section 282(1) provides that a person is not criminally responsible 'for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment' of a person 'if performing the operation or providing the treatment is reasonable, having regard to all the circumstances of the case'.

17.10 Section 282A also provides that, in certain circumstances, a doctor or a person acting under a doctor's written order is not criminally responsible for the reasonable provision of 'palliative care' to another person, in good faith and with reasonable care and skill, 'even if an incidental effect of providing the palliative care is to hasten the other person's death'.[9] However, it provides that:[10]

> nothing in this section authorises, justifies or excuses—
>
> (a) an act done or omission made with intent to kill another person; or
>
> (b) aiding another person to kill himself or herself.

Health practitioners' duties

17.11 A medical or other health practitioner who undertakes to care for a patient has a duty to exercise reasonable care and skill in advising and treating the patient,[11] and may be civilly[12] or criminally[13] responsible for harm that results from a failure to do so.[14] Additionally, a health practitioner who does not obtain the required consent of the patient to medical treatment may be criminally responsible for assault.[15]

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4 Criminal Code (Qld) s 300. See also ss 291, 293, 300, 302, 303, 305, 310.

5 Criminal Code (Qld) s 284.

6 Criminal Code (Qld) s 293.

7 Criminal Code (Qld) s 291.

8 See Criminal Code (Qld) ss 300, 303 (and 310), 306, 307, 309, which are punishable by up to life imprisonment or, in the case of conspiring to murder, up to 14 years imprisonment. See also s 308 (Threats to murder in document), which is punishable by up to seven years imprisonment.

9 Criminal Code (Qld) ss 282A(1)–(2). Section 282A(5) defines 'palliative care' to mean 'care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering'.

10 Criminal Code (Qld) s 282A(3).

11 See generally *Rogers v Whitaker* (1992) 175 CLR 479, 483.

12 See, eg, *Mules v Ferguson* [2015] QCA 5. See also *Civil Liability Act 2003* (Qld) ch 2 pt 1 (especially div 5).

13 See Criminal Code (Qld) s 288; *Patel v The Queen* (2012) 247 CLR 531.

14 See generally LexisNexis Australia, *Halsbury's Laws of Australia* [280-2025] ff (26 August 2016); L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 3rd ed, 2008) [2.46] ff, [7.10] ff; and KJ Breen, SM Cordner and CJH Thomson, *Good Medical Practice: Professionalism, Ethics and Law* (Australian Medical Council, 4th ed, 2016) ch 9.

15 See, eg, *Secretary, Department of Health and Community Services v JWB and SMB ('Marion's Case')* (1992) 175 CLR 218, 232, 234. As to the requirement to obtain consent, see, eg, *Rogers v Whitaker* (1992) 175 CLR 479, 489; Re T (*Adult: Refusal of Treatment*) [1993] Fam 95, 102103. See generally LexisNexis Australia, *Halsbury's Laws of Australia* [280–3000] (10 February 2016); and Breen et al, above n 14, ch 6.

17.12 As a general rule, there is no legal obligation on a health professional to assist a third party who is not their patient. However, medical practitioners and professional rescuers such as paramedics and ambulance officers may owe a duty, when requested in their professional capacity, to provide aid or assistance in an emergency in some circumstances.[16] Rendering such assistance must be done with reasonable care and skill.[17] Limited circumstances are recognised in which an ambulance officer may withhold commencement of resuscitation; for example, where the patient has given a lawful direction to withhold or withdraw such treatment.[18] A medical practitioner, nurse or ambulance officer who provides aid in an emergency is protected from legal liability in limited circumstances.[19]

17.13 A failure by a public health service to obtain consent, or provide access, to medical treatment may be a ground for complaint under the HR Act.[20]

Health practitioner regulation

17.14 Health practitioners in Australia are governed under the National Health Practitioner Regulation Law in force in each Australian state and territory (the 'National Law'). The National Law is administered by AHPRA together with the relevant professional boards for each health profession (the 'National Boards'), such as the MBA.[21] In Queensland, aspects of the National Law are also administered by the Health Ombudsman.[22]

17.15 The health professions regulated under the National Law, and for which there are National Boards, include the medical, nursing, paramedicine, pharmacy, and psychology professions (and recognised specialities within those professions).[23]

17.16 The National Law deals with the registration and accreditation of health practitioners, to ensure that only those practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. It also deals with complaints and concerns about the health, performance and conduct of individual health practitioners who are, or were, registered. The primary consideration under the National Law is the health and safety of the public. The aim is to manage risks and protect the public, rather than to punish practitioners.[24]

17.17 One obligation of a registered health practitioner under the National Law is to comply with professional standards, including codes of ethics and conduct.[25] This includes the MBA's code of conduct for doctors which sets out core standards for good medical

16 See M Eburn, *Emergency Law: Rights, liabilities and duties of emergency workers and volunteers* (Federation Press, 4th ed, 2013) 61–2, 74, 77–80; J Teng, 'A Positive Duty to Rescue and Medical Practitioners: A Review of the Current Position in Australia and a Comparison with International Models' (2017) 24 *Journal of Law and Medicine* 695. See *Lowns v Woods* (1996) Aust Torts Reports ¶81-376; Kent v Griffiths [2001] QB 36.

A duty to provide aid may also arise where the duty is assumed by initiating such aid: G Dingwall and AA Gillespie, 'Reconsidering the Good Samaritan: A Duty to Rescue?' (2008) 39(1) *Cambrian Law Review* 26, 30; and Criminal Code (Qld) s 290.

17 Eburn, above n 16, 62–3. See, eg, *Neal v Ambulance Service NSW* (2008) Aust Torts Reports ¶81-988. An ambulance officer may be empowered to administer life support procedures to protect persons from danger in an emergency: see *Ambulance Service Act 1991* (Qld) s 38(1)(a), (2)(h).

18 See generally Queensland Ambulance Service, *Clinical Practice Guidelines: Resuscitation/General guidelines* (April 2018) 214–17; and see, eg, *Powers of Attorney Act 199*8 (Qld) ss 35–36. See also Queensland Health, Clinical Excellence Division, 'Acute Resuscitation Plan (for adults)' (6 July 2020) <https://clinicalexcellence.qld.gov.au/resources/arp>.

19 See *Law Reform Act 1995* (Qld) ss 15–16 (for services performed by a medical practitioner or nurse 'without fee or reward or expectation of fee or reward'); *Civil Liability Act 2003* (Qld) ss 25–26 and *Civil Liability Regulation 2014* (Qld) sch 1 (for aid provided by a person 'while performing duties to enhance public safety' for a prescribed entity, such as the Queensland Ambulance Service). See also *Ambulance Service Act 1991* (Qld) s 39, which confirms that the State is to indemnify a service officer.

20 See *Human Rights Act 2019* (Qld) ss 17(c), 37, 63–64. A complaint under that Act may only be made about an alleged contravention by a 'public entity' as defined in s 9, such as a public health service. See also s 10(3)(b)(ii).

21 See generally AHPRA & National Boards, 'What we do' (10 March 2021) <https://www.ahpra.gov.au/About-AHPRA/What-We-Do.aspx>.

22 See Health Practitioner Regulation National Law (Queensland) s 146; *Health Ombudsman Act 2013* (Qld) pt 3 div 3. See generally Office of the Health Ombudsman, 'Make a notification' <https://oho.qld.gov.au/for-providers/make-a-notification>.

23 Health Practitioner Regulation National Law (Queensland) ss 5 (definitions of 'health profession' and 'National Board'), 31; Health Practitioner Regulation National Law Regulation 2018 (Qld) s 4. See generally AHPRA & National Boards, 'National Boards' (5 January 2021) <https://www.ahpra.gov.au/National-Boards.aspx>.

24 See generally AHPRA & National Boards, 'Regulatory principles for the National Scheme' (5 October 2020) <https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>.

25 See Health Practitioner Regulation National Law (Queensland) pt 5 div 3, pt 6.

practice.[26] The code recognises that good medical practice includes compliance with the law. It states that the code 'is not a substitute for the provisions of legislation and case law' and '[i]f there is any conflict between this code and the law, the law takes precedence'.[27] Similar provisions are included in the codes of other health professions.[28]

17.18 Non-compliance with professional standards may result in a finding that a practitioner's conduct is unsatisfactory or unprofessional. In turn, this may result in disciplinary action such as cautioning or reprimanding the practitioner, or suspending, cancelling or imposing conditions on the practitioner's registration.[29]

17.19 In Queensland, the Health Ombudsman deals with concerns about registered health practitioners that are notified or referred to it under the National Law.[30] The Health Ombudsman's functions also include dealing with complaints about health services and health service providers in Queensland, including registered and unregistered health practitioners, and identifying and reporting on systemic issues in the health system in Queensland.[31] In dealing with a complaint, the Health Ombudsman may take a range of actions, including prohibiting or restricting a health practitioner from providing particular health services.[32]

17.20 Health care workers who are not required to be registered under the National Law are subject to the *National Code of Conduct for Health Care Workers (Queensland)*. The code sets minimum standards of conduct for health care workers, including that health services are to be provided in a safe and ethical manner and may be considered by the Health Ombudsman in dealing with a complaint.[33]

CRIMINAL OFFENCES UNDER VOLUNTARY ASSISTED DYING LEGISLATION

Other jurisdictions

17.21 The approaches taken in other jurisdictions fall into two main categories.

Netherlands, Belgium and Luxembourg

17.22 One approach is to treat voluntary assisted dying as an exception to existing criminal offences that prohibit euthanasia or assisted suicide. A medical practitioner who provides voluntary assisted dying in compliance with specific requirements will not commit an offence. However, the criminal offences of euthanasia or assisted suicide will continue to apply where the legislative requirements are not followed. This is the model

26 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [1.1]. See also AMA, Code of Ethics (2016).

27 See MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [1.3]. Other parts of the code recognise particular obligations that may apply under legislation, for example, in relation to patient referrals, non-discrimination in patient access to medical care, organ and tissue donation, minimising risk to patient safety, advertising and research: [3.1.4], [3.4.3], [3.4.6], [4.13.12], [8.3.1], [10.7], [13.1].

28 See, eg, Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) 4, 5 [1]; Paramedicine Board of Australia, *Code of Conduct (interim)* (June 2018) [1.1]; and Pharmacy Board of Australia, *Code of Conduct for Pharmacists* (March 2014) [1.1].

29 See Health Practitioner Regulation National Law (Queensland) s 5 (definitions of 'professional misconduct', 'unprofessional conduct' and 'unsatisfactory professional performance'), pt 8 divs 1012; *Health Ombudsman Act 2013* (Qld) s 107.

30 See *Health Ombudsman Act 2013* (Qld) ss 36, 37(1)(a)(i); Health Practitioner Regulation National Law (Queensland) s 146, pt 8 div 12. See further [17.175]–[17.176] below.

31 See *Health Ombudsman Act 2013* (Qld) ss 11, 25. A complaint may be made 'about a health service or other service provided by a health service provider': s 31 (emphasis added). A health service is 'a service that is, or purports to be, a service for maintaining, improving, restoring or *managing people's health and wellbeing*': s 7(1) (emphasis added). A health service provider is a health practitioner under the National Law or another individual or entity 'who provides a health service': s 8(1). See generally Office of the Health Ombudsman, 'About us' <https://www.oho.qld.gov.au/about-us>. The definitions in ss 7(2), 8(1) and 31 of that Act are sufficiently wide to cover services provided, or purported to be provided, by a health practitioner or other health service provider under the draft Bill.

32 *Health Ombudsman Act 2013* (Qld) pt 7 div 2, pt 8A. As to other actions that may be taken, see generally s 38.

33 *Health Ombudsman Act 2013* (Qld) s 288; *Health Ombudsman Regulation 2014* (Qld) s 5(c); COAG Health Council, *National Code of Conduct for Health Care Workers (Queensland)* (1 October 2015). The code also applies to registered health practitioners who provide health services unrelated to their registration.

Among other things, the code provides that a health care worker must not provide health care of a type that is outside their experience or training or that they are not qualified to provide; and must report concerns to the Health Ombudsman about conduct of other health care workers that may place clients at serious risk: COAG Health Council, *National Code of Conduct for Health Care Workers (Queensland)* cll 1(1), (2)(a)–(b), 4.

adopted in the Netherlands, Belgium and Luxembourg.[34]

17.23 For example, in the Netherlands it is explained that:[35]

> Under articles 293 and 294 of the Criminal Code, euthanasia is prohibited in the Netherlands. The entry into force of the [Termination of Life on Request and Assisted Suicide (Review Procedures)] Act did not change that. The Criminal Code makes an exception for physicians only. Euthanasia performed by a physician who has complied with all the due care criteria set out in the Act and has notified the municipal pathologist is not a criminal offence …

17.24 Similarly, the approach in Luxembourg is described as 'conditional decriminalisation':[36]

> The Law [on euthanasia and assisted suicide] makes a conditional decriminalisation which aims to protect the doctor who proves to have shown all the stringency required by the Law. The Law decriminalises provided the euthanasia or assisted suicide is performed by the patient's doctor within the conditions of the Law. Only in that case is the act not subject to criminal sanction and may not give rise to a civil action for damages. A specific ground for the exclusion of criminal proceedings was thus inserted to that end in the Criminal Code.
>
> Given that the Law does not provide for pure and simple decriminalisation, euthanasia and assisted suicide remain punishable outside the legal framework of the Law of 16 March 2009. The existence of this Law does not mean that anybody can help to kill another person who might have made such a request of them.

Other overseas jurisdictions and Australia

17.25 The second approach is similar to the first but also creates criminal offences for specific conduct under the voluntary assisted dying legislation. This is the approach in most other jurisdictions, including Canada, New Zealand, Victoria, Western Australia and Tasmania.

17.26 The types of offences (and the penalties for them) vary. They relate to:

- altering, forging, falsifying, destroying, or making a false statement in a document or form about a person's request for voluntary assisted dying;[37]
- coercing or exerting undue influence on a person to induce the person to request voluntary assisted dying or to self-administer a voluntary assisted dying substance;[38]
- failing to provide the required documents, forms or information to the oversight body;[39]
- in some jurisdictions, failing to return any unused voluntary assisted dying substance as specified;[40] and

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34 See *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2.1; The Netherlands Criminal Code ss 293(2), 294(2); *Belgian Euthanasia Act 2002* art 3(1); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* arts 2, 14. A somewhat similar approach is taken in Vermont: *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a), (b).

35 Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review procedures in practice* (April 2018) 8.

36 Ministry of Health et al (Luxembourg), *Euthanasia and assisted suicide: Law of 16 March 2009—25 questions 25 answers* (June 2010) 12.

37 See, eg, *End of Life Choice Act 2019* (NZ) s 39(2), (3) (three months imprisonment or $10 000); *Canada Criminal Code*, RSC 1985, c C-46, s 241.4 (five years imprisonment); *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.890.4.02; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 127–128 (two years imprisonment or 200 penalty units or both); *Voluntary Assisted Dying Act 2017* (Vic) ss 87–88 (five years imprisonment or 600 penalty units or both, or 2400 penalty units for a body corporate); *Voluntary Assisted Dying Act 2019* (WA) s 102 (seven years imprisonment, or up to three years and $36 000 on summary conviction).

38 See, eg, *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.890.4.02; *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.17; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 124(a)–(b), 129 (five years imprisonment or 200 penalty units or both); *Voluntary Assisted Dying Act 2017* (Vic) ss 85–86 (five years imprisonment or 600 penalty units or both, or 2400 penalty units for a body corporate); *Voluntary Assisted Dying Act 2019* (WA) ss 100 (seven years imprisonment, or up to three years and $36 000 on summary conviction), 101 (life imprisonment).

39 See, eg, *Canada Criminal Code*, RSC 1985, c C-46, s 241.31(4)–(5) (two years imprisonment); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 130 (50 penalty units); *Voluntary Assisted Dying Act 2017* (Vic) s 90 (60 penalty units); *Voluntary Assisted Dying Act 2019* (WA) s 108 ($10 000).

40 See, eg, *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 131 (100 penalty units); *Voluntary Assisted Dying Act 2017* (Vic) s 89 (12 months imprisonment or 120 penalty units or both); *Voluntary Assisted Dying Act 2019* (WA) s 105 (12 months imprisonment).

- in some jurisdictions, disclosing or publishing personal or other specified information obtained under the legislation.[41]

17.27 As outlined below, some jurisdictions also include offences for a participating practitioner who 'fails to comply' with the legislative requirements or a person who administers a voluntary assisted dying substance without authorisation. The scope of the offences vary. They apply in addition to any relevant general criminal offence of unlawful killing or aiding suicide.

17.28 The position in these jurisdictions is also influenced by the scope of any provisions in the legislation that protect a person from criminal liability for unlawful killing or assisted suicide.

New Zealand

17.29 The New Zealand Act includes an offence relating to forgery, alteration or destruction of an approved form,[42] and prohibits the publication of particular information 'in respect of a death that was, or appears to be, the result of assisted dying' under the legislation.[43]

17.30 It also contains an offence of wilful non-compliance by a participating health practitioner with the requirements of the Act:[44]

> A person who is a medical practitioner, nurse practitioner, or psychiatrist commits an offence if the medical practitioner, nurse practitioner, or psychiatrist wilfully fails to comply with any requirement of this Act.

17.31 The maximum penalty for this offence is three months imprisonment or $10 000.

17.32 When the Bill was first introduced into the New Zealand Parliament, the proposed offence of wilful non-compliance was drafted more broadly to apply to any person who wilfully fails to comply with a requirement in the Act.[45] The Parliamentary Justice Committee recommended that the scope of the offence be narrowed:[46]

> We note that clause 27(1) is very wide. It would apply to every actor mentioned in the bill, including the patient, the various health professionals, and administrative bodies including the registrar, the Director-General of Health, and the Minister of Health. This is unusual for an offence provision. We do not consider it necessary to make all of these people liable for failing to comply with a requirement in the bill. We recommend narrowing clause 27(1)(a) so that it would cover only the attending medical practitioner, the independent medical practitioner, and the specialist.

Canada

17.33 In Canada, the federal Criminal Code includes a small number of specific offences relating to falsification of documents and failure to provide specific information.[47] It also includes a separate offence for a participating practitioner to knowingly fail to comply with the specified safeguards in the legislation for medical assistance in dying:[48]

> A medical practitioner or nurse practitioner who, in providing medical assistance in dying, knowingly fails to comply, subject to subsection 241.2(3.2), with all of the requirements set out in paragraphs 241.2(3)(b) to (h) or paragraphs 241.2(3.1)(b) to (k), as the case may be, and with subsection 241.2(8) is guilty of:

41 See *Voluntary Assisted Dying Act 2019* (WA) s 106 (12 months imprisonment); *End of Life Choice Act 2019* (NZ) s 36 ($5000, or $20 000 for a body corporate).
42 *End of Life Choice Act 2019* (NZ) s 39(2), (3).
43 *End of Life Choice Act 2019* (NZ) s 36 ($5000, or $20 000 for a body corporate). The offence applies to publication of the method by which the medication was administered, the place where the medication was administered, or the name of the person who administered the medication (or the name of their employer). There is an exception in respect of court or tribunal proceedings.
44 *End of Life Choice Act 2019* (NZ) s 39(1), (3) (three months imprisonment or $10 000).
45 End of Life Choice Bill 269–1 (NZ) cl 27(1)(a), as introduced 8 June 2017.
46 Justice Committee, Parliament of New Zealand, End of Life Choice Bill (April 2019) 8.
47 See *Canada Criminal Code*, RSC 1985, c C-46, ss 241.4, 241.31(4)–(5).
48 *Canada Criminal Code*, RSC 1985, c C-46, s 241.3.

(a) an indictable offence and liable to imprisonment for a term of not more than five years; or

(b) an offence punishable on summary conviction.

The United States of America

17.34 Most of the states with voluntary assisted dying legislation in the United States include specific offences relating to falsification of documents, and coercion or undue influence.[49] Those offences do not preclude criminal penalties applicable under other law for conduct that is inconsistent with the requirements of the legislation.[50]

Tasmania

17.35 The Tasmanian Act creates specific offences relating to falsification of records, making false statements, and dishonest inducement.[51] It does not include a separate offence for unauthorised administration of a voluntary assisted dying substance.

Victoria

17.36 The Victorian Panel noted that existing criminal offences would continue to apply:[52]

> the crimes of murder and aiding and abetting suicide will continue to apply to those who act outside of the framework provided for in the legislation. In addition, it is already a criminal offence to possess prescription medication without authorisation.

17.37 However, it considered that additional offences were warranted given the new instruments and roles created by the legislation, as this would 'provide a strong deterrent and ensure there are harsh penalties for anyone who intentionally attempts to act outside the scope of the legislation'. It recommended offences for:[53]

- inducing a person, through dishonesty or undue influence, to request voluntary assisted dying;
- inducing a person, through dishonesty or undue influence, to self-administer the lethal dose of medication;
- falsifying records related to voluntary assisted dying; and
- administering a lethal dose of medication to a person who does not have decision-making capacity.

17.38 The Victorian Act includes offences of failing to report as required to the oversight body, providing false or misleading information, falsifying a form or record, and inducing a person by dishonesty or undue influence to request voluntary assisted dying or to self-administer the substance.

17.39 The Act also includes two offences relating to unauthorised administration of a voluntary assisted dying substance, where:

- a coordinating medical practitioner, intending to cause the person's death, knowingly administers the substance other than as authorised by, and in accordance with, a practitioner administration permit;[54] or

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49 See, eg, *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.890.4.02. See similar provisions in *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.17; *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-119; *District of Columbia Death with Dignity Act 2016*, DC Code § 7–661.13; *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L–20; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:16-18; *Washington Death with Dignity Act 2008*, RCW § 70.245.200. There are variations as to whether the offences apply to 'wilful' or 'knowing' conduct or conduct without authorisation or consent. Cf Vermont: see n 34 above.

50 Provision to this effect applies in California, Colorado, Hawaii, New Jersey, Oregon and Washington: see the Acts cited in n 49 above.

51 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 124(a)–(b), 127–131 (up to five years imprisonment or 200 penalty units or both).

52 Vic Ministerial Advisory Panel Final Report (July 2017) 179.

53 Ibid 179–80, Rec 57.

54 *Voluntary Assisted Dying Act 2017* (Vic) s 83 (life imprisonment or imprisonment for such other term as is fixed by the court). Practitioner administration requirements are discussed in Chapter 10 above.

- a person knowingly administers to another person the substance that is dispensed in accordance with a self-administration permit.[55]

17.40 It was explained that the second of those offences:[56]

> recognises that just because a voluntary assisted dying substance has been dispensed in accordance with the Bill, it cannot be administered by others. The voluntary assisted dying substance dispensed in accordance with a self-administration permit may only ever be self-administered by the person named in the permit.

17.41 Failure to give copies of the required forms to the Board is punishable by a fine of up to 60 penalty units (presently $9913); the inducement offences are punishable by up to five years imprisonment or 600 penalty units (presently $99 132) or both;[57] and unauthorised administration of the substance is punishable by imprisonment for life or such other term fixed by the court.[58]

Western Australia

17.42 The Western Australian Act takes a generally similar approach to Victoria, but there are some differences.

Offences under the legislation	Vic	WA
Failing to give copies of forms to the Board as required under the legislation	s 90	s 108
Making a statement or giving information in a report or form about a person who requests access to voluntary assisted dying (Vic) or for any other purpose under the legislation (WA) that the person knows is false or misleading in a material particular	s 88	s 102
Falsifying a form or record required to be made under the legislation	s 87	—
Administering a voluntary assisted dying substance to a person when not authorised to do so.	ss 83, 84	s 99
Inducing a person, by dishonesty, undue influence or (in WA) coercion, to request access to voluntary assisted dying or (in WA) to access voluntary assisted dying	s 85	s 100
Inducing a person, by dishonesty, undue influence or (in WA) coercion, to self-administer the substance	s 86	s 101
The contact person failing to return unused or remaining substance within 15 days after the person's death (Vic) / as soon as practicable and in any event within 14 days after the person's death (WA)	s 89	s 105(2)
The contact person failing to return the substance supplied in accordance with a self-administration decision as soon as practicable and in any event within 14 days after the self-administration decision is revoked	—	s 105(1)
Advertising a Schedule 4 poison or Schedule 8 poison as a voluntary assisted dying substance	—	s 103
Recording, using or disclosing personal information obtained by the person because of a function the person has or had under the legislation except as permitted (eg, for the purpose of performing a function under the legislation, if required by another Act, or under a court order)	—	s 106

17.43 The Act includes offences for failure to give the required forms to the Board (punishable by up to $10 000), making false statements (punishable by up to seven years imprisonment),[59] and inducing a person to request voluntary assisted dying (punishable by up to seven years imprisonment). It also prohibits a person who performs a function under the Act from recording, using or disclosing personal

55 *Voluntary Assisted Dying Act 2017* (Vic) s 84 (life imprisonment or imprisonment for such other term as is fixed by the court).
56 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 29.
57 Or, in the case of a body corporate, 2400 penalty units (presently $396 528): *Voluntary Assisted Dying Act 2017* (Vic) ss 85(1), 86.
58 The value of a penalty unit in Victoria from 1 July 2020 to 30 June 2021 is $165.22: Department of Treasury and Finance (Vic), 'Indexation of Fees and Penalties' (28 April 2020) <https://www.dtf.vic.gov.au/financial-management-government/indexation-fees-and-penalties>.
59 Or, three years imprisonment and $36 000 on summary conviction: *Voluntary Assisted Dying Act 2019* (WA) s 102(1).

information obtained under the legislation, except in permitted circumstances (punishable by up to 12 months imprisonment).[60]

17.44 It is also an offence to administer a prescribed substance to a person when not authorised to do so under the practitioner administration provisions.[61] It was explained that this offence has the following consequences:[62]

- If an administering practitioner is not satisfied of the matters referred to [in section 59(5)][63] at the time of administration but nonetheless administers the prescribed substance to the patient, the [administering] practitioner may commit a crime under this clause.
- If an administering practitioner administers a prescribed substance to the patient, without a witness being present, the administering practitioner may commit a crime under this clause.
- If an administering practitioner administers a prescribed substance to someone other than the patient, the administering practitioner may commit a crime under this clause.
- If the patient administers a prescribed substance to someone other than themselves, the patient may commit a crime under this clause.
- If a person (other than the administering practitioner) administers a prescribed substance to the patient or another person, that person may commit a crime under this clause. (note added)

17.45 The maximum penalty for this offence is life imprisonment, reflecting the seriousness of administering the substance without authority.[64]

Queensland

17.46 The Parliamentary Committee did not make any specific recommendations about possible offences.

17.47 The White and Willmott Model includes the following as 'illustrative of the standard type of offences' in other voluntary assisted dying legislation, noting that '[o]ther offences may be added or the below proposed offences modified depending on how the criminal law is regulated by jurisdiction':[65]

> **44 Inducing another person to request access to voluntary assisted dying**
>
> A person who, by dishonesty or undue influence, induces another to make a request for access to voluntary assisted dying is guilty of a crime.
>
> Maximum penalty—[insert]
>
> **45 Inducing another person to access voluntary assisted dying**
>
> A person who, by dishonesty or undue influence, induces another to self-administer voluntary assisted dying medication or induces another to request that a registered medical practitioner administer that medication is guilty of a crime.
>
> Maximum penalty—[insert]
>
> **46 False or misleading statements**
>
> A person who knowingly makes a false or misleading statement in, or in relation to, a request for access to voluntary assisted dying is guilty of a crime.

60 *Voluntary Assisted Dying Act 2019* (WA) s 106(1)–(2). The prohibition does not apply to statistical or other information that is not personal information: s 106(3).

61 *Voluntary Assisted Dying Act 2019* (WA) s 99 (life imprisonment).

62 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 33.

63 The matters in s 59(5) of the Western Australian Act are that the patient has decision-making capacity and is acting voluntarily and without coercion and that the patient's request for voluntary assisted dying is enduring. See Chapter 10 above.

64 See, eg, Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5139 (RH Cook, Minister for Health).

65 White and Willmott Model pt 8, cll 44–47.

> Maximum penalty—[insert]
>
> **47 Failing to report to Board**
>
> A registered medical practitioner who fails to report to the Board as required by this Act is guilty of a crime.
>
> Maximum penalty—[insert]

17.48 The White and Willmott Model suggests that consideration also be given to legislating 'confidentiality duties for those with access to personal information in the course of administering the Act'. It does not include draft provisions, noting that the approach may vary between jurisdictions.[66]

17.49 The White and Willmott Model does not include any offences relating to unauthorised administration of a substance or other conduct falling outside the requirements of the legislation. Neither does it suggest what penalties should attach to the specific offences included.

Submissions

17.50 The Consultation Paper asked whether the draft legislation should include specific criminal offences similar to those in Victoria and Western Australia.[67]

17.51 Most respondents who addressed this issue supported specific offences in the draft legislation.

17.52 Some of those respondents preferred offences similar to those in either Victoria or Western Australia.[68] Some others, including the Queensland Law Society, supported the offences in the White and Willmott Model.

17.53 A medical practitioner submitted that '[s]pecific criminal offences related to noncompliance with the legislation are a crucial safety measure'.

17.54 An academic submitted that:

> The two most likely ways in which criminal misconduct could occur with relation to [voluntary assisted dying] would be in exerting duress on a person to force them to stay alive or agree to die. Less significant criminal misconduct could attach to giving faulty information on means, over-charging, discriminating, etc.

17.55 Another respondent commented that:

> [Voluntary assisted dying] is so new and different from most other issues that it would be amazing if the issues could be addressed adequately without defining at least a few specific criminal offences.
>
> But please don't invent so many offences that the system chokes in micromanagement.

17.56 Christians Supporting Choice for Voluntary Assisted Dying submitted that offences similar to those in either Victoria or Western Australia 'would be suitable', and that penalties 'should be high for persons administering a [voluntary assisted dying] substance outside the provisions of the Act, and for coercion'.

17.57 Professors White and Willmott stated that they 'continue to support' their approach in the White and Willmott Model and 'consider it is appropriate for the legislation to include specific criminal offences related to non-compliance with the legislation', but did not otherwise comment on the form or scope of those offences.

17.58 The Queensland Law Society submitted that the suggested offences in the White and Willmott Model are generally adequate. It considered that an additional offence

66 White and Willmott Model pt 9.
67 QLRC Consultation Paper No 79 (2020) Q-46.
68 A few of these respondents submitted that, in addition to the offences in the Western Australian Act, the draft legislation should include an offence for falsification of records or forms as is provided in the Victorian Act.

should be included, in similar terms to Western Australia, 'which requires any unused or remaining substance prescribed … to be returned to an authorised supplier if the patient revokes the decision to administer the substance'.[69] It further submitted that the offences should be 'scrutinised during the first review of the legislative framework to ensure that they are appropriately constructed and fit for purpose'.

17.59 The Australian Lawyers Alliance considered that offences should be created to deter people from acting outside the framework. In particular, it stated that the following situations should be covered by offences in the legislation:

a. Another person other than an authorised medical or nursing practitioner administers medication to a person obtained under a permit;

b. A medical or nursing practitioner administers medication knowing that it has not been authorised by the [voluntary assisted dying] scheme;

c. A person induces another person to request [voluntary assisted dying];

d. A person induces another person to self-administer medication obtained through [voluntary assisted dying];

e. Medical or nursing practitioners fail to notify the Board of various matters and provide documents as required under the [voluntary assisted dying] scheme.

17.60 Other respondents identified particular offences that should be created. For example, the Queensland Nurses & Midwives' Union submitted that it should be 'an offence to coerce, threaten or intimidate another person into accessing voluntary assisted dying'. Go Gentle Australia submitted that there should also be 'penalties for doctors who do not give a timely response to a person's request to access [voluntary assisted dying]'.

17.61 Another respondent considered that health practitioners, '[f]amily, friends and carers must not pressure an individual to accept killing' as this 'amounts to murder'. In their view, health practitioners 'must not introduce the topic of [voluntary assisted dying]' and '[s]anctions must include a prison sentence, fine and blocking of access to the estate'.

17.62 The Queensland Police Service supported 'the creation of new offences to deal with particular risks arising under any new legislative scheme'. For offences of 'inducement', it queried the utility of the qualifying words used in the Victorian and Western Australian legislation:

> The QPS queries whether these inducement offences as drafted in other jurisdictions by including the words dishonesty, undue influence or coercion, unnecessarily limit the scope of the offence, or unnecessarily complicate the offence. The QPS notes there are no such words included in section 311(b) (Aiding Suicide) of the Criminal Code. The act of inducement seems to be the essence of the offending behaviour intended to be prevented by the offence; how this inducement is achieved would seem a factor more suited to consideration when determining the severity of penalty.
>
> Inclusion of dishonesty, undue influence or coercion may have an educative benefit for the public in terms of setting expectations. However, this objective could be achieved without limiting the scope of the offence with a change in how the offence is formulated.
>
> Further, by limiting the inducements to the act of accessing voluntary assisted dying or self-administering the substance, the QPS queries whether there are potentially other steps of the process a person could be induced into completing, which may not be captured.

17.63 It referred to the importance of 'clear and unambiguous' provisions to 'assist investigators ascertain the evidentiary requirements for an offence and ensure the law can be properly enforced'.

69 See *Voluntary Assisted Dying Act 2019* (WA) s 105(1).

17.64 The Office of the Health Ombudsman also supported the inclusion of specific criminal offences, submitting that 'such an approach is relevant to the protection of the health and safety of consumers and will be of assistance in the regulation of health practitioners'.

17.65 A few respondents expressed concern about the inclusion of specific offences.[70] The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted, for example, that:

> Current law covers a range of professional obligations for medical specialists including specialist anaesthetists and specialist pain medicine physicians. … However, the introduction of specific legal responsibility and offences relating to [voluntary assisted dying] may affect families in dispute with each other, access to [voluntary assisted dying] and heath practitioner willingness to be involved in [voluntary assisted dying].

17.66 Some respondents queried the effectiveness of offences, noting concerns about whether breaches would be detected or whether offences would be enforced and penalties sufficiently high. Palliative Care Social Work Australia submitted that a 'thorough psychosocial assessment' should occur as part of the request and assessment process, which would identify psychosocial stressors and assist in detecting and addressing coercion.[71]

17.67 A few respondents also suggested that participating health practitioners should be protected from harassment or public identification. The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that:

> As well as protecting medical practitioners in terms of liability, ANZCA also suggests that consideration be given in the legislation to protect medical practitioners from harassment. Examples provided include making it an offence to protest within a certain radius of where assisted dying services are accessible and making it an offence to publish the personal details of practitioners providing this service.

17.68 The Pharmacy Guild of Australia, Queensland Branch similarly considered that:

> Any voluntary assisted dying legislation, or regulations designed to facilitate the operation of this legislation also include provisions that forbid any activities that would publicly identify pharmacies that are/are not dispensing such medications, acknowledging that there may be a need for a government department to have a secure and confidential database.

The Commission's view

17.69 Specific offences should be included in the draft legislation.[72] They arise out of the particular features of the scheme and are needed to secure key safeguards.

Inducement by dishonesty or coercion

17.70 An important feature of the scheme is that assisted dying must be voluntary. A request for and access to assisted dying is voluntary only if the person is exercising their own free choice. Legislation is a blunt instrument and cannot remove all risk of potential

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70 One of these respondents submitted that '[s]uch matters should be dealt with via professional disciplinary processes or civil claims, not the criminal law'.

71 The draft Bill provides for the coordinating practitioner to refer the question of whether the requesting person is acting voluntarily and without coercion to another appropriately skilled and trained person for determination: see Chapter 8 above.

72 Offences can apply to bodies corporate as well as to individuals: *Acts Interpretation Act 1954* (Qld) s 46. A higher maximum penalty for corporations—of five times the prescribed maximum—applies under the *Penalties and Sentences Act 1992* (Qld) s 181B.
Some of the offences the Commission recommends are specified as crimes or misdemeanours and are therefore indictable: Criminal Code (Qld) s 3(3). Those offences fall within the jurisdiction of the District Court: see District Court of Queensland Act 1967 (Qld) ss 60, 61(1). For offences that are not specified as a crime or misdemeanour, a proceeding for the offence would be a summary proceeding under the Justices Act 1886 (Qld): see *Acts Interpretation Act 1954* (Qld) s 44(1)(2)(d).
Where the maximum penalty for the offence is a term of imprisonment, the court may impose a fine in addition to, or instead of, the imprisonment: see *Penalties and Sentences Act 1992* (Qld) s 153(2). The maximum fine that may be imposed for a single offence for an individual under s 153 of that Act is 4175 penalty units (presently $557 153) where the court is a District Court, or 165 penalty units (presently $22 019), where the court is a Magistrates Court: s 46(1)(a)(i), (b).
The current value of a penalty unit in Queensland is $133.45: Penalties and Sentences Regulation 2015 (Qld) s 3.

coercion or exploitation. However, the draft Bill should include the best legal safeguards to address such risk, taking into account the need for workable and clear legislation.

17.71 Therefore, in addition to other provisions aimed at this issue,[73] the draft Bill makes it an offence for a person, dishonestly or by coercion, to induce another person to make or revoke a request for access to voluntary assisted dying, or to self-administer the substance. This would include:

- making or revoking a first request, second request or final request for voluntary assisted dying;
- making or revoking an administration decision (including a decision for practitioner administration); or
- self-administering the substance.

17.72 For the purpose of these offences, 'induce' has its ordinary meaning[74] and 'coercion' is defined to include intimidation or a threat or promise, including by an improper use of a position of trust or influence.[75] This captures the idea of 'undue influence', without using that term. Undue influence is part of the law of equity and has a particular meaning in civil law contexts like contract law,[76] but is not widely used in criminal law. The use of 'undue influence' may cause unnecessary confusion. Therefore, we prefer to use the terms dishonesty and coercion, with 'coercion' defined.[77] The same definition of coercion is used in the draft Bill as part of the eligibility criteria.[78]

17.73 The draft Bill specifies these offences as misdemeanours, with a maximum penalty of seven years imprisonment.[79] This reflects the seriousness of the conduct in undermining the autonomy and voluntary choice of the person.

Failing to give required information or giving false information

17.74 Another important safeguard is the requirement for requests, assessments and other stages of the process to be documented, and for that documentation to be given to the oversight body. Failing to give the required information, falsifying a document or otherwise providing false information about a person's request, eligibility or other matter would undermine the oversight and safe operation of the scheme.

17.75 If there is intent to defraud, some conduct would be covered by the Criminal Code.[80] However, specific offences with a lower penalty level in the draft Bill would serve as a visible disincentive and ensure there is an appropriate mechanism to deal with noncompliance, or take non-compliance into account in disciplinary proceedings, without needing to prove intent to defraud.

73 The draft Bill requires, as part of the eligibility criteria, the request and assessment process, and the requirements for practitioner administration, that the requesting person is acting voluntarily and without coercion: see Chapters 7 and 8 above.

74 The term 'induce' means 'to lead or move by persuasion or influence, as to some action, state of mind, etc': *Macquarie Dictionary* (online at 27 November 2020) 'induce'.

75 This extends the ordinary meaning of 'coercion' as 'force or compel, as to do something'; 'to compel by forcible action': *Macquarie Dictionary* (online at 27 November 2020) 'coerce'.

76 See generally Westlaw AU, *Laws of Australia* [35.8.10] (1 August 2017); Lexis Advance, *Encyclopaedic Australian Legal Dictionary*, 'undue influence'.

77 Cf *Powers of Attorney Act 199*8 (Qld) s 61, which makes it an offence for a person to 'dishonestly induce' a person to make or revoke an enduring document.

78 See Chapter 7 above.

79 See generally n 72 above.

80 Criminal Code (Qld) s 430. See also ss 1 (definition of 'record') and 643. It is a crime under s 430 for a person, 'with intent to defraud' to: make a false entry in a record; omit to make an entry in a record; give a certificate or information that is false in a material particular; in any way falsify, destroy, alter or damage a record; or produce or make use of a record the person knows is false in a material particular. The maximum penalty is 10 years imprisonment. As to intent to defraud (that is, to use deceit to deprive another person of a right or to cause another person to act to their detriment or prejudice or contrary to what would otherwise be their duty), see LexisNexis Australia, *Carter's Criminal Law of Queensland* [s 430.20], [s 643] (2020).

17.76 Accordingly, the draft Bill makes it an offence for a person to fail to give a copy of a document or form to the Board that the person is required to give under the legislation. The maximum penalty is 100 penalty units (presently $13 345).[81] This is generally consistent with the legislation in Victoria, Western Australia and New Zealand.[82]

17.77 The draft Bill also makes it an offence for a person to:

- give information to the Board, in the administration of the legislation, that the person knows is false or misleading in a material particular—this will apply to information in an approved form given to the Board or a response given to a request for information from the Board;
- make a statement that the person knows is false or misleading in a material particular in a form or other document required to be made under the legislation—this will cover, for example, a false certification by a witness in an approved form; or
- otherwise falsify a form or other document required to be made under the legislation—this will capture the alteration or other falsification of a document or form, such as the production of a 'fake' prescription for a voluntary assisted dying substance, or a wholly false assessment record form where the person has not made a request for voluntary assisted dying.[83]

17.78 Those offences are specified as misdemeanours, with a maximum penalty of five years imprisonment,[84] reflecting the seriousness of the conduct in undermining the veracity of the process and the safe operation of the scheme. The level of imprisonment is also consistent with the Victorian Act.[85]

Failing to return unused substance as required

17.79 Another safeguard is ensuring that access to and provision of a voluntary assisted dying substance is appropriately restricted.

17.80 Where the substance is supplied for practitioner administration, the administering practitioner will have the substance and be responsible for appropriately disposing of any unused or remaining substance after the person has died.[86]

17.81 However, in the case of self-administration, the substance will be in possession of the person (or their agent) or their appointed contact person until it is used. A health practitioner is not required to be present when the substance is administered.

17.82 Therefore, the draft Bill requires the contact person to give any of the substance that is unused after the person's death to an authorised disposer, and to do so as soon as practicable and in any case within 14 days after the day of the person's death. Similarly, if the person revokes a self-administration decision after the substance has been supplied, the contact person must give the substance to an authorised disposer as soon as practicable and in any event within 14 days after the self-administration decision is revoked. Failure to comply with those obligations is an offence, with a maximum penalty of 100 penalty units.[87]

81 See generally n 72 above.

82 See *Voluntary Assisted Dying Act 2017* (Vic) s 90 (60 penalty units, presently $9913); *Voluntary Assisted Dying Act 2019* (WA) s 108 ($10 000); *End of Life Choice Act 2019* (NZ) s 39(1), (3) (three months imprisonment or $10 000).

83 For this offence, 'falsify' has its ordinary meaning. 'Falsify' means 'to alter fraudulently', 'to represent falsely; misrepresent': *Macquarie Dictionary* (online at 22 December 2020) 'falsify'. See also, eg, *R v Webber* (1988) 15 NSWLR 49 in which the New South Wales Court of Criminal Appeal held that the term 'falsify', in the context of the *Crimes Act 1901* (NSW) s 158, should be given its ordinary meaning of 'making false in any way' and does not require actual alteration of the document.

84 See generally n 72 above.

85 See *Voluntary Assisted Dying Act 2017* (Vic) ss 87, 88 (five years imprisonment or 600 penalty units or both; in the case of a body corporate 2400 penalty units). Cf *Voluntary Assisted Dying Act 2019* (WA) s 102 (seven years imprisonment or, in the case of summary conviction, three years imprisonment and $36 000).

86 The administering practitioner is also required under the draft Bill to dispose of the substance in their possession if the requesting person revokes the practitioner administration decision: see Chapter 11 above.

87 See generally n 72 above.

17.83 The draft Bill defines an 'authorised disposer' as a registered health practitioner or person in a class of registered health practitioners who is authorised by the chief executive to dispose of a voluntary assisted dying substance under the legislation.[88]

17.84 The possibility of criminal liability for breach of this obligation may in some cases be a disincentive to accepting, or continuing in, the role of contact person. This, in turn, might limit a person's access to the scheme.[89] However, safe disposal of a substance prescribed under the legislation is an important safeguard.

17.85 The approach in the draft Bill is consistent with Victoria and Western Australia.[90]

Conduct outside the scheme: unauthorised administration of the substance

17.86 The Commission has considered whether the draft Bill should include any specific offences for conduct falling outside the parameters of the scheme, as is done in some other jurisdictions. Specifically, we have considered whether there should be an offence for the unauthorised administration of a voluntary assisted dying substance.

17.87 Voluntary assisted dying would be unlawful under the Criminal Code but for the provisions of the draft legislation that authorise it in particular circumstances. The offences in the Criminal Code for unlawful killing and aiding suicide will continue to apply to unauthorised administration of the substance. Therefore, it is not strictly necessary for the draft Bill to include a separate offence.

17.88 However, the unauthorised administration of a substance under the draft Bill covers a range of potential conduct. It could include an inadvertent breach, such as where a family member or carer provides some assistance to the person in self-administering the substance. It would include situations where a person administers a substance but is not qualified to do so, either knowingly or inadvertently. It would also include egregious breaches where a person knowingly or recklessly acts outside the scheme, for example, where the administering practitioner knows the person has not made or has withdrawn their request or does not have the required decision-making capacity.

17.89 The offences in the Criminal Code for unlawful killing and aiding suicide carry a maximum penalty of life imprisonment.[91] Significantly, in the case of murder, a sentence of life imprisonment upon conviction is mandatory.[92]

17.90 Given the range of possible circumstances in which conduct might fall outside the limits of what is authorised by the scheme, we consider it desirable for the draft legislation to include a separate and specific offence, with a lower maximum penalty. This would provide additional flexibility in the appropriate exercise of prosecutorial discretion on whether to prosecute and, if so, for which offence.[93]

17.91 Accordingly, the draft Bill provides that it is an offence for a person to administer a voluntary assisted dying substance to another person unless the person is authorised to do so under clause 53(6) of the draft Bill. The draft Bill specifies the offence as a crime, punishable by up to 14 years imprisonment.[94] The offence has a similar scope to that in the Western Australian Act.

88 See Chapter 11 above.
89 As to the role of the contact person, see Chapter 11 above.
90 See *Voluntary Assisted Dying Act 2017* (Vic) s 89 (12 months imprisonment or 120 penalty units—presently $19 826—or both); *Voluntary Assisted Dying Act 2019* (WA) s 105 (12 months imprisonment).
91 See Criminal Code (Qld) ss 305(1), 306(1), 307(1), 310(1), 311.
92 See Criminal Code (Qld) s 305(1).
93 See generally Department of Justice and Attorney-General (Qld), *Director's Guidelines* (30 June 2016) [1], [4], [5](ii).
94 See generally n 72 above.

17.92 We considered whether the maximum penalty for this offence should be life imprisonment (as in Victoria and Western Australia) or set at a lower level,[95] recognising that the offence is intended to be available when prosecution under the Criminal Code is not considered appropriate or desirable.

17.93 The offence in the draft Bill should be distinguished from those in the Criminal Code that cover the same conduct.[96]

17.94 One distinction is that a sentence of life imprisonment is mandatory for murder, whereas a maximum penalty for this offence—even if set at life imprisonment—would allow a lower sentence to be imposed, having regard to the nature and circumstances of the case. This is the position for manslaughter, aiding suicide and the other offences in Chapter 28 of the Criminal Code for which life imprisonment is the maximum penalty.

17.95 Other offences in the Criminal Code carry a maximum sentence of life imprisonment. For example, offences of sexual assault,[97] robbery[98] and burglary[99] carry a maximum penalty of life imprisonment where the offence is accompanied by specified circumstances of aggravation. However, there are very few offences outside the Criminal Code for which a maximum penalty of life imprisonment is imposed.[100]

17.96 Some guidance on a lower maximum penalty might be found in other offences. For example, the maximum penalty is seven years imprisonment for performing, or assisting in the performance of, a termination of pregnancy by an unqualified person[101] and is 14 years imprisonment for 'administering poison with intent to harm', when accompanied by specified circumstances of aggravation such as where the poison endangers the person's life.[102]

17.97 On balance, we consider that a maximum penalty of 14 years imprisonment for the offence in the draft Bill is appropriate. This distinguishes the offence from the Criminal Code offences, while retaining a high maximum penalty indicative of the seriousness of the conduct.

17.98 The offence of unauthorised administration under the draft Bill is not intended to cover the field. The Commission expects that the most serious cases involving unauthorised administration would be dealt with under the Criminal Code, where a higher sentence up to life imprisonment may be imposed. The offence in the draft Bill should be available when prosecution under the Criminal Code for murder, aiding suicide or another relevant offence in Chapter 28 is not considered appropriate or desirable. The choice of which offence to charge will remain a matter for the prosecuting authority.[103]

Non-disclosure of confidential information

17.99 The HR Act recognises the right of individuals to protection of their privacy.[104]

17.100 The *Information Privacy Act 2009* imposes a general obligation on government agencies to comply with privacy principles in the collection and handling of personal

95 The fact that a lesser penalty would be available for the offence under the voluntary assisted dying legislation would be irrelevant to sentence if the offender were convicted of murder or aiding suicide under the Criminal Code: see *Elias v The Queen* (2013) 248 CLR 483.
See generally Office of Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook* (2008) [3.6.2].

96 See Department of the Premier and Cabinet (Qld), *The Queensland Legislation Handbook* (6th ed, 2019) [2.12.4], in which it is noted that 'if the Criminal Code provides for an offence, it is undesirable that another Act should erode its nature as a comprehensive code by providing for the same or essentially the same offence'.

97 Criminal Code (Qld) s 352(3).

98 Criminal Code (Qld) s 411(2).

99 Criminal Code (Qld) s 419(2), (3), (4).

100 See, eg, *Drugs Misuse Act 1986* (Qld) s 6(1)(a), (2), for the offence of supplying a dangerous drug, in specified circumstances; and *Terrorism (Commonwealth Powers) Act 2002* (Qld) ss 101.1(1), 101.6(1), 103.1, for particular terrorism offences.

101 Criminal Code (Qld) s 319A(1), (2).

102 Criminal Code (Qld) s 322(a). In the absence of specified aggravated circumstances, the maximum penalty for this offence is seven years imprisonment: 322(b).

103 By way of analogy, see, eg, Criminal Code (Qld) ss 310 (manslaughter), 328A(4) (dangerous driving causing death), discussed in *R v Frost; Ex parte AttorneyGeneral (Qld)* (2004) 149 A Crim R 151, 157 [27] (Jerrard JA; McPherson JA and Helman J agreeing).

104 *Human Rights Act 2019* (Qld) s 25.

information.[105] Under those principles, an agency is not to disclose personal information to another person unless an exception applies. Exceptions include where the person consents to the disclosure or the disclosure is authorised or required by law.[106]

17.101 Other Acts commonly include provisions prohibiting the disclosure of personal or other information acquired by a person in performing a function or exercising a power, or in their capacity as an office holder, under the Act. Subject to exceptions, non-compliance is an offence.[107]

17.102 Persons involved in the administration of voluntary assisted dying legislation will acquire personal information while performing their functions, which may often be of a sensitive nature. The protection of privacy requires that such information be protected from unauthorised disclosure.

17.103 Existing provisions provide some protection. The Board would be subject to the principles in the *Information Privacy Act 2009*,[108] registered health practitioners including pharmacists are obliged under their professional codes to respect patient privacy,[109] and other entities with whom the draft legislation may interact, such as the Registrar-General under the *Births, Deaths and Marriages Registration Act 2003*, would be subject to privacy provisions in their own legislation.[110] However, the nature and scope of those provisions vary. Some persons may not be covered, such as the contact person or a witness.

17.104 To provide clarity and ensure consistency, the draft Bill should prohibit disclosure of personal information obtained in the administration of the legislation. The establishment of a new legislative scheme creates new roles and new forms of personal information. It is desirable for non-disclosure of that information to be addressed in the same legislation.

17.105 Consistently with other legislation, the draft Bill provides that a person must not make a record of or disclose personal information about an individual that the person obtains in the course of, or because of, the exercise of a function or power under the draft Bill other than:

- for a purpose under this Act;
- with the consent of the person to whom the information relates;
- in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal; or
- as authorised or required by law.

17.106 Failure to comply is an offence, with a maximum penalty of 100 penalty units.[111]

17.107 The provision would apply, for example, to a person who is or has been a member of the Board or a person engaged to assist the Board, a coordinating practitioner, a consulting

105 See *Information Privacy Act 2009* (Qld) ss 17, 26–28, 30–32, schs 3–4. 'Personal information' means 'information or an opinion, including information or an opinion forming part of a database, whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion': s 12. See also, in relation to the National Privacy Principles which apply to health agencies, the definitions of 'health information' and 'sensitive information' in s 11 sch 5.

106 See *Information Privacy Act 2009* (Qld) sch 3 IPP 11, sch 4 NPP 2.

107 See, eg, *Anti-Discrimination Act 1991* (Qld) s 220; *Disability Services Act 2006* (Qld) s 228; *Family and Child Commission Act 2014* (Qld) ss 36–37; *Fire and Emergency Services Act 1990* (Qld) s 153A(1)–(2); *Guardianship and Administration Act 2000* (Qld) ss 246, 249–249A; *Health Ombudsman Act 2013* (Qld) s 272; Health Practitioner Regulation National Law (Queensland) ss 214, 216; *Hospital and Health Boards Act 2011* (Qld) s 84; and *Public Health Act 2005* (Qld) ss 279AK–279AM. The maximum penalties for the offences vary, for example, between 50 penalty units ($6 672), 100 penalty units ($13 345) and 200 penalty units ($26 690).

108 See *Information Privacy Act 2009* (Qld) ss 18(1)(d), 21(1)(a)(i), which provides that an entity established for a public purpose by an Act is a public authority, and that a public authority is an 'agency'. An agency, other than a health agency, must comply with the IPPs: s 27. A 'health agency' is defined to mean the Department of Health or a Health and Hospital Service, and must comply with the NPPs: ss 11, 31, sch 5.

109 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.4]; Pharmacy Board of Australia, *Code of Conduct for Pharmacists* (March 2014) [3.4].

110 See, eg, *Births, Deaths and Marriages Registration Act 2003* (Qld) s 46, which provides that, when giving information in the register to an entity, the registrar must as far as practicable protect the persons to whom the information relates from unjustified intrusion on their privacy.

111 See generally n 72 above.

practitioner or an administering practitioner, an authorised supplier, a contact person or an agent of the requesting person who is authorised by the legislation to perform certain actions, a witness, or another person involved in administering the legislation such as an officer or employee of the Department.

17.108 The prohibition on disclosure applies only to information obtained through the exercise of a function or power under the legislation. It would not, for example, prevent family discussion of information acquired because of the person's relationship and not because of the person's functions under the draft Bill. Consent is also an exception.

17.109 The exceptions for disclosure ensure that personal information may still be disclosed where it is necessary under the legislation, for example, for the referral of a matter by the Board to another entity, for the assessment of a person's eligibility, for reporting as required to the Board, and for supplying or disposing of the substance under the legislation.

17.110 The prohibition applies to personal information about an individual. 'Personal information' has the same meaning as under the *Information Privacy Act 2009*.[112] As such, it would not include statistical or other information that could not reasonably be expected to result in the identification of the individual to whom it relates. 'Personal information' is also defined in the draft Bill to make it clear that it does not apply to information that is publicly available.

Public identification or harassment of participating practitioners

17.111 We have considered whether it is necessary or desirable to include provisions in the draft legislation to protect participating health practitioners, including pharmacists, from public identification or harassment.

17.112 Some practitioners may be reluctant to have their participation in the scheme publicly known. Such concern is not unique to voluntary assisted dying and may arise in other contexts.

17.113 Part 4 of the *Termination of Pregnancy Act 2018* includes specific provisions that prohibit particular conduct within stated distances of termination services premises (not including pharmacies). This was in response to evidence of ongoing activities outside such premises which may impact on the safety, privacy and well-being of women accessing those services and of service providers.[113] The provisions in that Act do not include a general harassment offence, or provisions about the anonymity of service providers.

17.114 We consider the present situation is different. First, voluntary assisted dying might be accessed or provided in a variety of locations and premises, including the person's own home. Second, until voluntary assisted dying has become a lawful option and has been available for some time, it will not be known whether harassing or intimidating activities are likely to occur or whether, if they do occur, their nature or extent would justify a legislative response.

17.115 There are existing mechanisms in the general law to address instances of harassment, intimidation or discrimination, including offences of public nuisance, unlawful stalking, and use of a postal or carriage service to threaten or harass;[114] and the prohibition on certain forms of discrimination under the *Anti-Discrimination Act 1991*, including in the area of work.

17.116 Therefore, we do not consider that provisions protecting health practitioners from public identification or harassment should be included in the draft legislation. If there is evidence of significant issues arising in practice after the legislation is implemented,

112 *Information Privacy Act 2009* (Qld) s 12: see n 105 above.

113 See generally QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) ch 5; Explanatory Notes, Termination of Pregnancy Bill 2018 (Qld) 10–12.

114 See the discussion in QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) [5.6]–[5.16].

this matter could be revisited. Under the draft Bill, the effectiveness of the Act must be reviewed within three years after it has commenced operation, and the functions of the Board include ongoing reporting on systemic and other issues.[115]

PROTECTIONS FROM LIABILITY

Other jurisdictions

17.117 Most jurisdictions include protections from liability for those who act in accordance with the voluntary assisted dying legislation. There are differences in the scope of the protections and how they are achieved. They apply to criminal liability and, in some cases, to civil or other liability.

Overseas jurisdictions

17.118 The New Zealand Act states the circumstances in which a person is protected from criminal liability.[116] It also amends the *Crimes Act 1961* (NZ) to the effect that the offence of 'aiding and abetting suicide' is 'subject to' those immunity provisions.[117]

17.119 The New Zealand Act includes protection from civil liability for a person who, in good faith and believing on reasonable grounds that a person wishes to exercise the option of assisted dying, 'causes, assists, or facilitates' the person's death in accordance with the requirements of the Act.[118] However, it provides that 'nothing in this section affects the right of any person' to bring disciplinary proceedings against a health practitioner, to bring proceedings under the *Health Practitioners Competence Assurance Act 2003* (NZ) or the *Health and Disability Commissioner Act 1994* (NZ), or to apply for judicial review.[119]

17.120 In Canada, the federal Criminal Code excludes 'medical assistance in dying' carried out in accordance with the legislative requirements from offences of culpable homicide and counselling or aiding suicide.[120]

17.121 Protections from criminal and civil liability, and from disciplinary action, are included in state legislation in some jurisdictions in the United States.[121] The provisions vary, but by way of example, the legislation in Oregon provides that:[122]

> No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

Australian jurisdictions

17.122 The legislation in Victoria, Western Australia and Tasmania includes protections from liability for health practitioners and others who act in good faith in accordance with the legislation.

115 See Chapters 18 and 19 below.

116 *End of Life Choice Act 2019* (NZ) s 37. This includes a health practitioner who does any or all of the acts specified in accordance with the Act, a person who exercises the option of assisted dying under the Act, and a person who, in good faith and believing on reasonable grounds that a person wishes to exercise the option of assisted dying, 'causes, assists, or facilitates' the person's death in accordance with the requirements of the Act: s 37(1), (3), (5)–(6).

117 See *End of Life Choice Act 2019* (NZ) s 41 sch pt 1; *Crimes Act 1961* (NZ) s 179.

118 *End of Life Choice Act 2019* (NZ) s 38(1).

119 *End of Life Choice Act 2019* (NZ) s 38(2).

120 *Canada Criminal Code*, RSC 1985, c C-46, ss 227(1)–(5), 241(2)–(5), (5.1).

121 See, eg, *California End of Life Option Act 2015*, Cal Health and Safety Code, § 443.14(a)–(c); *Colorado EndofLife Options Act 2016*, 25 Colo Rev Stat, § 25-48-116(1)–(2); *District of Columbia Death with Dignity Act 2016*, DC Code § 7–661.11; *Oregon Death with Dignity Act 1997* Or Rev Stat, § 127.885.4.01(1); *Vermont Patient Choice at End of Life Act 2013*, 18 Vt Stat Ann § 5283; Washington Death with Dignity Act, RCW § 70.245.190(1)(a)–(b).

122 *Oregon Death with Dignity Act 1997* Or Rev Stat, § 127.885.4.01(1).

17.123 For example, section 80 of the Victorian Act provides that:[123]

> A registered health practitioner who, in good faith and without negligence, acts under this Act believing on reasonable grounds that the act is in accordance with this Act is not in respect of that act—
>
> (a) guilty of an offence; or
>
> (b) liable for unprofessional conduct or professional misconduct; or
>
> (c) liable in any civil proceeding; or
>
> (d) liable for contravention of any code of conduct.

17.124 The same protection is extended under section 81 of that Act to a registered health practitioner or ambulance paramedic who, in good faith, does not administer life saving or life sustaining medical treatment to a person who has not requested it, and believes on reasonable grounds that the person is dying after taking a voluntary assisted dying substance in accordance with the Act.[124]

17.125 Section 79 of the Victorian Act includes protection for other persons acting in good faith in accordance with the Act:[125]

> A person who in good faith does something or fails to do something—
>
> (a) that assists or facilitates any other person who the person believes on reasonable grounds is requesting access to or is accessing voluntary assisted dying in accordance with this Act; and
>
> (b) that apart from this section, would constitute an offence at common law or under any other enactment—
>
> does not commit the offence.

17.126 The Western Australian and Tasmanian Acts also confer protection on a person who 'is present' when another person takes a voluntary assisted dying substance in accordance with the legislation.[126]

17.127 The Victorian Panel observed that, together with the offences under the legislation, the inclusion of protections 'is of paramount importance' in establishing clear parameters and 'certainty about the scope of the law' within which health practitioners are to operate. It noted that 'the vast majority' of practitioners and members of the community 'can be relied upon to act lawfully', and that it is important to protect those who participate in voluntary assisted dying in good faith and without negligence.[127]

Queensland

17.128 If enacted, voluntary assisted dying legislation will authorise certain acts that would otherwise be unlawful. This raises the question, whether, or to what extent, protections from potential liability under existing criminal offences should be included in the legislation.

17.129 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should include 'protections from liability for practitioners and patients participating in the scheme'.[128]

17.130 The White and Willmott Model includes provisions in similar terms to those in Victoria.[129]

123 See, to similar effect, *Voluntary Assisted Dying Act 2019* (WA) s 114. See also *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 133.

124 See, to similar effect, *Voluntary Assisted Dying Act 2019* (WA) s 115. See also *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 135(3).

125 See, to similar effect, *Voluntary Assisted Dying Act 2019* (WA) s 113(a). See also *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 135(1)–(2).

126 *Voluntary Assisted Dying Act 2019* (WA) s 113(b); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 133(b).

127 Vic Ministerial Advisory Panel Final Report (2017) 176–7, Rec 54.

128 Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

129 White and Willmott Model pt 7 cll 40, 41(1), 42.

Submissions

17.131 The Consultation Paper asked whether the draft legislation should include protections for health practitioners and others who act in good faith and without negligence in accordance with the legislation, in similar terms to those in the Victorian Act.[130]

17.132 One respondent opposed such protections, submitting that they are problematic in part because the term 'good faith' may be open to different interpretations. In their view, any good faith provision should have specified criteria that must be satisfied.

17.133 However, all the other respondents who addressed this issue agreed with the inclusion of protections in the draft legislation.

17.134 Dying With Dignity NSW submitted that:

> We hear all the time about how end of life care is currently compromised because health professionals feel unsure about their legal situation and they err on the side of caution, often causing unnecessary suffering for their patients. Health professional[s] need certainty.

17.135 STEP Queensland considered that '[w]ithout such protections, it is less likely that health practitioners would be willing to be involved in the provision of voluntary assisted dying'. The United Workers Union submitted that the inclusion of legislative protections is consistent with other jurisdictions and 'reflects best practice'.

17.136 AMA Queensland also supported such protections, noting the importance of having 'very clear parameters as to the scope the doctor can act within'. Another respondent similarly submitted that it 'is important that participants should feel safe and be protected from unexpected surprises, particularly from interfering busybodies'.

17.137 Professors White and Willmott stated that they 'continue to support' their approach 'to protections for health practitioners who act in good faith and without negligence' in the White and Willmott Model. The Queensland Law Society expressed general support for this approach.[131]

17.138 Christians Supporting Choice for Voluntary Assisted Dying supported protections similar to those in the Victorian legislation. They also suggested that, as in Western Australia, protection could be given for persons such as 'invited family members, who may be present during self-administration'.

17.139 A medical defence organisation and professional indemnity insurer submitted that there should be protections concerning the decision of a health practitioner or health care organisation to participate, or decline to participate, in voluntary assisted dying, as well as for acts or omissions associated with voluntary assisted dying where the person is acting in good faith and without negligence. In its view, protection should apply to 'civil liability, regulatory and disciplinary sanction and administrative action'. Similarly, the Royal Australian College of General Practitioners Queensland submitted that:

> Doctors who choose to opt-in should have unambiguous legal protection for all associated services, including the administration of the substance in circumstances where the patient has specifically requested assistance in accordance with relevant state legislation.

17.140 The Queensland Police Service submitted that consideration should be given to the intended application of existing criminal offences, such as aiding suicide, and whether clarification might be required 'to avoid any potential unintended consequences of the new scheme':

130 QLRC Consultation Paper No 79 (2020) Q-47.

131 The Bar Association of Queensland did not comment on specific provisions, but supported the White and Willmott Model overall as 'the most appropriate'.

> For example, would a relative who drives another to their appointments for the purposes of progressing the voluntary assisted dying process be committing the offence of aiding another in killing himself or herself (s 311 of the Criminal Code).

17.141 An academic observed that, because of the existing criminal law, family members and health practitioners cannot lawfully assist an individual to end their life, and intentional ending of another person's life, 'even upon their request and with their consent', can amount to murder. As such, 'the actions permitted under the proposed … legislation conflict with current Queensland criminal law'. In this respondent's view, exemptions are therefore required:

> Protection from criminal responsibility is imperative, as it is absurd that a person could be convicted based on the very same actions explicitly permitted under the proposed Qld legislation. Criminal liability remains where a person does not act in accordance with the draft legislation and their obligations. Further, to enhance transparency and clarity, the proposed framework should contain a division relating to the amendment of the Criminal Code 1899 (Qld) ('QCC') in the context of its homicide and suicide provisions.

17.142 This respondent submitted that the following protections from criminal liability, comparable to those in Victoria and Western Australia, should be included:

> 1. Persons who, in good faith, assist another to request access to, or access [voluntary assisted dying] in accordance with the Qld [voluntary assisted dying] Act should be protected from criminal liability. As a consequence, persons, including, for example, family members, friends, social workers and therapists, who facilitate access to the [voluntary assisted dying] scheme on behalf of another would not be criminally liable for doing so. Currently this conduct would likely fall under aiding in suicide as per s 311 QCC.
>
> 2. An exemption from criminal liability should also be afforded to persons being present when another self-administers or is administered a prescribed substance in accordance with the [voluntary assisted dying] Act. This would mean that persons, including, for example, family members and friends, would be exempt from criminal responsibility for aiding in suicide, s 311 QCC, for being present when the patient is dying. The Victorian legislation is missing such an express provision while it can be found in the Western Australian law.
>
> 3. Health practitioners acting in good faith, with a certain skill level and in accordance with the Qld [voluntary assisted dying] Act (or believing on reasonable grounds to be acting in accordance with the Act) should not be criminally liable for their acts. Consequently, medical professionals prescribing the lethal medication for a patient to self-administer while acting in accordance with the Act would not be criminally liable for aiding in suicide, s 311 QCC. Moreover, medical professionals who administer the lethal medication to a patient in accordance with the Act in case of physician-administration would not be criminally liable for murder as per ss 302, 305 QCC.
>
> 4. Certain persons, including health practitioners, ambulance officers and other persons who are under a duty to administer life-saving treatment, who fail to administer life-saving treatment to persons dying after self-administering or being administered a prescribed substance in accordance with the proposed [voluntary assisted dying] Act should not be criminally liable.

17.143 The same academic also submitted that, 'in order to achieve transparency and clarity', sections 302 and 311 of the Criminal Code should be consequentially amended to exempt health practitioners from liability for acts done in accordance with, or in the reasonable belief that they are in accordance with, the voluntary assisted dying legislation:

> One amendment [to section 311] would have to relate to the immunity of medical professionals who are acting in accordance with the Qld [voluntary assisted dying] Act or believe on reasonable grounds to be acting in accordance with the Act. Another

> exemption from criminal liability under this section would concern persons being present when another self-administers or is administered a prescribed substance in accordance with the act.
>
> Secondly, an exemption would have to be included in the murder provision, s 302 QCC, enshrining that a medical professional does not commit an offence under the section if they act in accordance with the Qld [voluntary assisted dying] Act or believe on reasonable grounds to be acting in accordance with this Act

The Commission's view

Interaction with the Criminal Code

17.144 As noted earlier, the offences of unlawful killing and aiding suicide would continue to apply to conduct falling outside the draft legislation. Specific additional offences in the draft Bill are also recommended.

17.145 We have also considered the extent to which provision should be made, in the Criminal Code or the draft Bill, to exclude lawful actions taken under the voluntary assisted dying legislation from the offences of unlawful killing and aiding suicide.

17.146 On balance, we consider it desirable to address these matters in the draft legislation.

17.147 First, we recommend the inclusion of provisions in the draft Bill to protect a person from criminal responsibility (and from civil liability) in certain circumstances. It is clear and simple for the protection to be contained in the draft legislation. The scope of that protection would govern the extent to which a person is immune from prosecution for a criminal offence, including a relevant offence under Chapter 28 of the Criminal Code.

17.148 Second, for the avoidance of any doubt, we consider that the draft legislation should make it clear that a person who does an act or makes an omission in the specific circumstances covered by those protections does not commit an offence against the relevant sections of the Criminal Code. In particular, this should refer to the offences in sections 300, 302, 303, 305 and 310 (murder and manslaughter), 306 (attempt to murder), 307 (accessory after the fact to murder), 309 (conspiring to murder) and 311 (aiding suicide) of the Criminal Code.[132]

17.149 This has the advantage of clearly stating the effect of the protections for the relevant offences in the Criminal Code, while keeping those provisions together in the draft Bill and avoiding any need to amend the Criminal Code.

Protection from liability in the voluntary assisted dying legislation

17.150 Liability for health practitioners and others involved in voluntary assisted dying under the legislation may arise in many contexts.[133] Protections from liability should be given in the legislation to provide clarity and certainty for those who may act under, or interact with, the legislation. It should ensure adequate protection in appropriate circumstances, while recognising that there should continue to be consequences for inappropriate conduct outside the limits of the scheme. It should also recognise the continuing and important role of the national health care regulatory framework.

Protection for health practitioners and others acting in good faith and without negligence under the legislation

17.151 The operation of, and access to, the voluntary assisted dying scheme will depend on the involvement of a range of persons, including medical and other health practitioners. While potential liability should still apply where, for example, a person has acted

132 The declaratory provisions in ss 284 ('consent to death immaterial') and 296 ('acceleration of death') of the Criminal Code (Qld) would be relevant in some cases, but the operative provisions are the offence provisions mentioned above, including ss 300, 302 and 311 for murder and aiding suicide.

133 See generally [17.1] ff above.

dishonestly or recklessly, participants should be confident they will not be exposed to criminal sanctions or civil liability if they act appropriately under the legislation.

17.152 Consistent with other Australian jurisdictions, the draft legislation should confer protection from civil and criminal liability on a health practitioner who acts in good faith and without negligence under the legislation. However, this should apply not only to a health practitioner, but to any person who so acts under the legislation—including, for example, an agent of the person authorised by the legislation to perform certain actions, the contact person, or a witness.

17.153 This protection will provide comfort to health practitioners and other persons who participate in the process.

17.154 The protection should apply to liability for any criminal offence, including under the Criminal Code, and to liability in a civil proceeding. It should cover both acts and omissions.

17.155 Having regard to protective provisions in other Queensland Acts,[134] this can be achieved by a provision in the draft Bill to the effect that: 'no civil or criminal liability[135] attaches to any person for an act done or omission made in good faith and without negligence in accordance with, or for the purposes of, this Act'.

17.156 For the avoidance of doubt, the draft Bill provides that, where relevant in a proceeding, the party alleging that the protection does not prevent liability from attaching to a person bears the onus of proving that the person did not do the act or make the omission in good faith in the circumstances covered by the protection.[136] Similar onus of proof provisions should be included for the other protection provisions the Commission recommends below.

Disciplinary proceedings

17.157 However, that protection should not extend to disciplinary proceedings. There is an existing health practitioner disciplinary framework which protects the public interest in ensuring professional competence. That framework should be left to operate on its own terms.

17.158 A key safeguard in the draft Bill is the ability for concerns about the conduct of health practitioners in relation to voluntary assisted dying to be referred or notified to the Health Ombudsman. This ensures strong oversight of the scheme, recognising the important role of the health practitioner regulatory framework.

17.159 It is preferable for the Health Ombudsman and the relevant National Boards, as the case may be, to assess and deal with complaints or concerns about a health practitioner's conduct. The aim of the disciplinary framework is not to punish individual practitioners but to manage risks and protect the public. In some cases, a practitioner's conduct might not give rise to criminal or civil liability but could nevertheless raise concerns about matters of practice. Systemic issues might also be identified that can be addressed by changes to professional standards, education or training.

17.160 The draft Bill therefore provides that nothing in the legislation that confers protection from liability prevents the Board from referring a matter it identifies to the Health Ombudsman, or any person from notifying a concern or making a complaint about a health practitioner's conduct under the National Law or the *Health Ombudsman Act 2013*, respectively.

17.161 This approach is consistent with the New Zealand Act.

134 See, eg, *Fire and Emergency Services Act 1990* (Qld) s 153B(1).

135 'Liability' is defined broadly to mean 'any liability or obligation (whether liquidated or unliquidated, certain or contingent, or accrued or accruing)': *Acts Interpretation Act 1954* (Qld) s 36 sch 1 (definition of 'liability'). Civil liability is ordinarily understood to refer to liability in respect of some civil obligation, and is distinguished from what may be the subject of disciplinary proceedings: see, eg, *Neumann v Hutton* (2020) 3 Qd R 419, 431–2 [35], [37] (Martin J).

136 See, eg, the provision of this kind in *Fire and Emergency Services Act 1990* (Qld) s 153B(3).

Protection for persons who, in good faith, assist a person to access, or are present when a person accesses, voluntary assisted dying

17.162 It is also appropriate for a person to be protected from criminal liability if they:

- in good faith, assist another person to request, or access, voluntary assisted dying in accordance with the legislation; or
- are present when another person self-administers or is administered the substance in accordance with the legislation.

17.163 Consistent with the Victorian Act and the White and Willmott Model, the first of those provisions should apply where the person 'believes on reasonable grounds' that the other person is requesting, or accessing, voluntary assisted dying in accordance with the legislation. It should apply to acts or omissions. Given the ordinary meaning of the words 'assist' and 'facilitate', it is not necessary to include both.[137] Assisting does not include actual administration.

17.164 This provision will ensure that a person who assists the requesting person to access voluntary assisted dying under the legislation will not be guilty of a criminal offence, including the offence of 'aiding suicide' under the Criminal Code.

17.165 This might include, for example, a family member, carer, support person, or health professional who: helps the person obtain information, make or attend appointments or gather necessary documentation; or, in the case of self-administration, prepares[138] the substance for the person (for example by dissolving or flavouring it) or gives the substance to the person for lawful self-administration (for example, by handing a cup containing the substance to them). It would also include the authorised actions of, for example, the contact person or an agent of the person under provisions of the draft Bill dealing with the supply of the substance.[139] It is appropriate that such actions, done in support of a person's lawful access to voluntary assisted dying, are protected. The involvement of such individuals, acting informally or under specific authorisations, is likely to be of significant practical importance.

17.166 The second of the provisions above confers protection on a person who is 'present' during lawful administration of the substance. This is consistent with the approach in Western Australia and Tasmania. The provision will avoid the possibility that such a person may inadvertently be caught by the prohibition on aiding suicide. It will provide reassurance that loved ones or others may be with the person.

Protection for health practitioners and ambulance officers who, in good faith, do not administer life sustaining treatment

17.167 We have also considered the position of health practitioners or ambulance officers who attend a person who is dying after lawfully taking a voluntary assisted dying substance. Unlike loved ones who may be present during the person's death, a health practitioner or ambulance officer who attends in their professional capacity has professional duties.

17.168 It has been observed that 'rescuers' such as ambulance officers face a dilemma when attending a life-threatening emergency, when it will usually be difficult or impossible to communicate directly with the patient:[140]

> They may be liable for assault if they treat a person who is validly refusing treatment, but liable in negligence if they do not provide treatment and later legal action finds that the patient was not competent to refuse treatment [or it was not refused]. This dilemma is compounded by the fact that paramedics must make their decision in urgent,

137 The term 'assist' means 'to give support, help, or aid to in some undertaking or effort, or in time of distress' and 'to give aid or help'; the term 'facilitate' means 'to make easier or less difficult; help forward (an action, a process, etc.)' or 'to assist the progress of (a person)': *Macquarie Dictionary* (online at 15 January 2021) 'assist' and 'facilitate'.

138 The term 'prepare' is defined in the draft Bill: see Chapter 11 above.

139 The role of an agent and of the contact person is discussed in Chapter 11 above.

140 Eburn, above n 16, 54. See further at 54–6, 66–7.

emotionally charged situations without the ability to fully identify, or explain, all the relevant facts to the patient.

17.169 The draft Bill should confer protection on a health practitioner (including a paramedic)[141] or ambulance officer who, in good faith, does not administer life sustaining treatment[142] to a person who has not requested it, where they believe on reasonable grounds that the person is dying after administration of a voluntary assisted dying substance in accordance with the legislation. Similar provision is made in the other Australian jurisdictions.

17.170 The protection should apply to liability for a criminal offence or in a civil proceeding but should not extend to disciplinary proceedings.[143]

17.171 The provision addresses the concern that a health practitioner or ambulance officer might be civilly liable for failing to provide aid or assistance in an emergency. Although there are existing protections in other legislation, they have a limited scope, applying where services are performed without payment or where aid is provided 'while performing duties to enhance public safety'.[144]

NOTIFICATIONS TO THE HEALTH OMBUDSMAN

The National Health Practitioner Regulation Law

17.172 The National Law provides a system of mandatory and voluntary 'notifications' of concerns about health practitioners' conduct.[145] Other health practitioners and employers must notify specified concerns of a serious nature. For example, a notification must be made if another health practitioner or employer forms a reasonable belief that a health practitioner has behaved in way that is 'placing the public at risk of harm by practising the profession in a way that constitutes a significant departure from accepted professional standards'.[146]

17.173 Voluntary notifications may be made by any person or other entity 'that believes that a ground on which a voluntary notification may be made exists'. The grounds include concerns, for example, that a health practitioner has demonstrated poor professional conduct or shown knowledge, skill, judgment or care of a lesser standard than what is reasonably expected:[147]

> (1) A voluntary notification about a registered health practitioner may be made to the health ombudsman on any of the following grounds—
>
> (a) that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;
>
> (b) the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the practitioner's health profession is, or may be, below the standard reasonably expected;
>
> …

141 Paramedicine is a recognised health profession under the National Law: see Health Practitioner Regulation National Law (Queensland) s 5 (definition of 'health profession', para (ja)). See also [17.15] above.

142 The reference to life sustaining treatment is intended to have the generally recognised meaning of health care or other clinical intervention implemented for the purpose of prolonging or sustaining life, that is, medical treatment intended to save a person whose life is under imminent threat: see, eg, Queensland Ambulance Service, *Clinical Practice Manual: Glossary, Abbreviations and Acronyms* (2021) (definition of 'life-sustaining treatment'); and Queensland Health, Clinical Excellence Division, *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*, Document No QHGDL-462:2019 (January 2018) 2 (on 'life-sustaining measures').
It is not intended to adopt the specific and narrow meaning given to the defined term 'life-sustaining measures' in the *Guardianship and Administration Act 2000* (Qld) sch 2 s 5A; or *Powers of Attorney Act 199*8 (Qld) sch 2 s 5A.

143 See [17.157] ff above.

144 See n 19 above.

145 See Health Practitioner Regulation National Law (Queensland) pt 8 divs 2, 3. See generally AHPRA & National Boards, 'Concerns about practitioners' (27 November 2020) <https://www.ahpra.gov.au/Notifications.aspx>; and Office of the Health Ombudsman, 'Make a notification' <https://www.oho.qld.gov.au/for-providers/make-a-notification>.

146 See Health Practitioner Regulation National Law (Queensland) ss 140(d), 141(1)(a), (2), 141B(1)(c), (2), 142(1).

147 See Health Practitioner Regulation National Law (Queensland) ss 144(1)(a)–(b), 145.

17.174 In most of the other Australian states and territories, notifications are made to AHPRA.[148]

17.175 In Queensland, notifications are made to the Health Ombudsman. In certain circumstances, the Health Ombudsman may refer matters to AHPRA for action by the relevant National Board.[149]

17.176 Generally, the Health Ombudsman deals with 'serious matters', that is, complaints or concerns that a registered health practitioner has behaved in a way that constitutes professional misconduct or where a ground may exist for the suspension or cancellation of the registered health practitioner's registration. Other matters may be dealt with by AHPRA and the National Boards, for example, where there is a concern that a health practitioner has or may have an impairment.[150]

Notifications under voluntary assisted dying legislation

Other jurisdictions

17.177 Different approaches are taken in Victoria and Western Australia.

17.178 The Victorian Act includes provisions about mandatory and voluntary notifications, which are linked to particular features of the scheme. It provides that another health practitioner or employer of a health practitioner must, and any person may, notify AHPRA if they believe on reasonable grounds that a health practitioner:[151]

> (a) who provides health services or professional care services to a person is—
>
> (i) in the course of providing those services to the person, initiating a discussion or attempting to initiate a discussion with that person that is in substance about voluntary assisted dying that is not, or would not be, in accordance with this Act; or
>
> (ii) in substance, suggesting or attempting to suggest voluntary assisted dying to the person that is not, or would not be, in accordance with this Act; or
>
> (b) is offering to provide or attempting to provide access to voluntary assisted dying in a manner that is not, or would not be, in accordance with this Act.

17.179 As such, the Victorian Act mandates notification to AHPRA in circumstances where a health practitioner may not have acted in accordance with the Act.

17.180 The Victorian Panel considered that notification to AHPRA should be clearly stated in the legislation to 'highlight that any departures from accepted professional standards will not be tolerated' and to 'respond to the community concern that a health practitioner may act outside the legal framework'.[152]

17.181 The Western Australian Act does not include any similar provisions.

17.182 The Western Australian Panel observed that 'there are already pathways and processes' for raising concerns in relation to health practitioners.[153] It has also been noted that the Voluntary Assisted Dying Board can make essential notifications to AHPRA.[154]

148 See AHPRA & National Boards, 'NSW and Qld' (5 May 2020) <https://www.ahpra.gov.au/Notifications/Further-information/NSW-and-Qld.aspx>. See also the references in n 145 above.

149 See *Health Ombudsman Act 2013* (Qld) ss 91–91E; Health Practitioner Regulation National Law (Queensland) pt 8 div 5.

150 See *Health Ombudsman Act 2013* (Qld) pt 9 div 1; Health Practitioner Regulation National Law (Queensland) pt 8 divs 5, 12.

151 *Voluntary Assisted Dying Act 2017* (Vic) ss 75(1), 76(1), 77. For the definition of 'health services' and 'professional care services', see s 3(1) of that Act.

152 Vic Ministerial Advisory Panel Final Report (2017) 178, Recs 55, 56.

153 See WA Ministerial Expert Panel Final Report (2019) 94. See also Chapter 18 below.

154 See Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5140 (RH Cook, Minister for Health).

17.183 However, the Western Australian Act includes the following declaratory provision:[155]

> (1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Western Australia).
>
> (2) Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

Queensland

17.184 The Parliamentary Committee did not directly address this issue. However, it observed that:[156]

> A decision by a registered practitioner to assist the ending of another person's life may raise questions about the practitioner's professional ethics and conduct. All professions regulated in the National Registration and Accreditation Scheme for the health professions (the National Scheme) have a Code of Conduct that sets out the expectations for professional conduct by registered practitioners within the profession which may be relevant to a [voluntary assisted dying] scheme.

17.185 In its submission to the Parliamentary Committee, the Health Ombudsman stated that:[157]

> Registered health practitioners that may be engaged in this area are likely to come within the jurisdiction of the [Office of the Health Ombudsman] and AHPRA. Therefore, practitioners' conduct and performance could be regulated to some extent within the existing framework. Whether the [Office of the Health Ombudsman] would have broader jurisdiction over services in this space will depend on whether the practice constitutes a health service.

17.186 The White and Willmott Model does not include specific notification provisions, explaining that:[158]

> This Bill does not contain additional provisions in relation to notifications to the Australian Health Practitioner Regulation Agency as the existing law requiring mandatory notifications and permitting voluntary notifications is considered to be adequate.

Submissions

17.187 Our Consultation Paper asked whether notifications to the Health Ombudsman of concerns about health practitioners' professional conduct should:[159]

- be dealt with by specific provisions in the draft legislation, as in Victoria; or
- be governed by existing provisions under the National Law, as in Western Australia.

17.188 Some respondents, including AMA Queensland, preferred the Victorian approach. The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld considered that notification provisions (together with specific criminal offences and protections) 'will strengthen compliance with the legal framework and acts as an additional safeguard against non-compliance to the legislation'. Palliative Care Nurses Australia Inc. and Palliative Care Social Work Australia submitted, respectively, that specific provisions would 'increase health professional awareness' and 'clarify requirements'.

17.189 However, most respondents who addressed this issue, including the Australian College of Nurse Practitioners, AHPRA and the Queensland Law Society, supported

155 *Voluntary Assisted Dying Act 2019* (WA) s 11.
156 Qld Parliamentary Committee Report No 34 (2020) 141, quoting AHPRA, Submission 1237 (18 April 2019) 1.
157 See Qld Parliamentary Committee Report No 34 (2020) 141, quoting Health Ombudsman, Submission 1257 (23 April 2019) 4.
158 White and Willmott Model, Explanatory Notes 7.
159 QLRC Consultation Paper No 79 (2020) Q-45.

the Western Australian approach of allowing notifications to be governed by the existing law.[160]

17.190 A member of the public submitted that:

> This is yet another example of the benefit of more thought. The Western Australian approach is more thoughtful and likely to be more efficient and to introduce fewer unexpected nasty surprises. The Victorian approach is an example of 'it seemed like a good idea at the time'.

17.191 Another respondent submitted that '[a]pplication of established legislation will maintain clarity for practitioners familiar with the rules'.

17.192 The Clem Jones Group submitted that:

> The long-term outcome of any [voluntary assisted dying] system should be to mainstream the [voluntary assisted dying] process, therefore to achieve that aim we believe it is preferential to use existing processes for handling concerns about the conduct of health professionals involved in a [voluntary assisted dying] system in Queensland.

17.193 A medical defence organisation and professional indemnity insurer expressed a similar view, submitting that these matters should be handled within existing mechanisms like other health practitioner complaints. It submitted that the view of the Victorian Panel 'fails to recognise the inherent uncertainties around key issues, such as what is "initiating" a discussion about voluntary assisted dying'. It further submitted that '[t]here is no evidence of any community perceptions that a health practitioner may act outside the legal framework'.

17.194 Professors White and Willmott submitted that they 'continue to support' their approach in the White and Willmott Model 'to rely on existing legislation'. In a joint submission, two other academics expressed qualified support for this approach:

> In the interests of maintaining coherence with other law governing health practitioner misconduct, the existing law contained in the Health Practitioner Regulation National Law (Queensland) should be applied, as per the [Western Australian] Act, at least in the first instance.
>
> In the event the existing provisions prove to be inadequate, it may become appropriate to incorporate specific provisions into the [voluntary assisted dying] legislation.

17.195 Another respondent submitted that they were 'unsure how best to deal with misconduct by medical practitioners', expressing concern whether 'fair assessment and censure' would be given by bodies who do not support 'the fundamental human right to die'. In their view, there may be a need to 'ban discrimination against people wishing to exert their right to live or die'.

17.196 The Office of the Health Ombudsman referred to its submission to the Parliamentary Committee.[161] It also observed that the purpose of the *Health Ombudsman Act 2013* 'can be described as protecting the health and safety of health consumers, promoting high standards in health service delivery and facilitating responsive complaint management'.

17.197 In this context, the Office of the Health Ombudsman submitted that both the Victorian and Western Australian approaches are 'workable' and that it is ultimately a matter for government to decide, having regard to the seriousness of the relevant conduct:

> If government considers that conduct, such as providing access to voluntary assisted dying in a manner that is not in accordance with the legislative regime, is generally of such a serious nature (irrespective of the individual circumstances of a particular

160 Another respondent submitted that notifications should be dealt with under both the existing legislation and any voluntary assisted dying legislation.

161 See [17.185] above.

matter) that it should always be reported to the health practitioner regulator, then the Victorian approach should be favoured.

Alternatively, it would be open for government to rely on the existing notification requirements in the National Law. This would leave it to the notifier to determine whether:

- it was considered that there was a significant departure from accepted professional standards requiring a mandatory notification; or
- the performance issue/s and or conduct of the practitioner in question was less serious and thus could be the subject of a voluntary notification.

17.198 The Office of the Health Ombudsman considered that:

> The Victorian approach provides for clarity at the expense of a loss of some nuance. The Western Australian approach allows for the consideration of individual circumstances at the expense of some uncertainty. Both approaches have their advantages and disadvantages.

17.199 AHPRA reiterated its comments made to the Parliamentary Committee.[162] It referred to its role in administering the national registration and accreditation scheme for health practitioners in Australia and providing support to the National Board of each health profession. It noted that AHPRA and the National Boards 'have different and complementary roles and responsibilities across the core regulatory functions of the National Scheme: accreditation, registration, notifications, compliance, and professional standards'. It also noted the 'co-regulatory arrangements' in Queensland for managing complaints about the health, performance or conduct of registered health practitioners:

> In Queensland, the Office of the Health Ombudsman receives all complaints regarding registered health practitioners. It decides whether to keep the complaint or refer it to a National Board and AHPRA to manage.

17.200 AHPRA submitted that the arrangements in Victoria and Western Australia 'are still relatively new, and our experience to date in these jurisdictions indicates that either option is workable'. It considered that, while the Victorian approach provides clarity, the streamlined approach in Western Australia is preferred:

> Option A [Victoria] has merit in providing clear requirements for what practitioner conduct, specific to the application of the proposed [voluntary assisted dying] scheme, should mandatorily be reported to the regulator for consideration and potential action. However, AHPRA believes that Option B [Western Australia] has merit on the basis of maintaining a streamlined legislative approach to dealing with complaints regarding registered health practitioners within the provisions of the Health Practitioner Regulation National Law (Queensland) and the *Health Ombudsman Act 2013*.
>
> Such a streamlined approach would recognise that matters of practitioner conduct are often multi-factorial and may not be limited to matters related to voluntary assisted dying. It may also remove the potential for variations in the interpretation and application of practitioner misconduct which may consequently be open to confusion or challenge. AHPRA also suggests that Option B is also more likely to support National Boards to apply regulatory decision making that fully considers public expectations in matters of practitioner conduct, rather than potentially being required to apply a strict legislative test.

The Commission's view

17.201 We do not consider it necessary for the draft Bill to include specific provision for notification of health practitioner concerns to the Health Ombudsman (or AHPRA).

162 See [17.184] above.

17.202 We prefer that those matters be dealt with under the existing provisions of the National Law. Unnecessary duplication or confusion from additional requirements should be avoided.

17.203 The Board can make notifications in the performance of its referral function. Similarly, health practitioners and employers must and other persons may make a notification to the Health Ombudsman where relevant concerns arise, including about services relating to voluntary assisted dying.

17.204 For the avoidance of doubt, the legislation should make it clear that noncompliance with the requirements of the draft Bill may be dealt with as a matter of professional discipline under the National Law. The draft Bill provides that, in considering a notification or referral under the National Law, or a complaint under the *Health Ombudsman Act 2013*, about a registered health practitioner's professional conduct or performance, regard may be had to whether the practitioner contravened a provision of the voluntary assisted dying legislation.

17.205 This is of a broadly similar effect to the Western Australian Act and is consistent with the approach in the *Termination of Pregnancy Act 2018*.[163]

17.206 This declaratory provision should also apply to a person who provides a health service, within the meaning of the *Health Ombudsman Act 2013*.[164] This will ensure that non-compliance by such a person, including with the recommended prohibition on initiating discussion can be considered in a complaint to the Health Ombudsman.[165]

17.207 Implementation of the legislation, if enacted, will require consultation with the Health Ombudsman and AHPRA to ensure any necessary procedural or administrative arrangements are put in place to support the new scheme.

163 See *Termination of Pregnancy Act 2018* (Qld) s 9.
164 See *Health Ombudsman Act 2013* (Qld) s 7, at n 31 above.
165 The prohibition against initiating discussion of voluntary assisted dying is discussed in Chapter 6 above.

RECOMMENDATIONS

Criminal offences under the voluntary assisted dying legislation

17-1 It should be an offence for a person, dishonestly or by coercion, to induce another person to:

(a) make or revoke a request for access to voluntary assisted dying, including an administration decision; or

(b) self-administer a voluntary assisted dying substance.

For the purpose of these offences, 'coercion' should be defined to include threats, promises or intimidation of any kind, including by improper use of a position of trust or influence. The offences should be specified as misdemeanours and have a maximum penalty of seven years imprisonment.

17-2 It should be an offence—with a maximum penalty of 100 penalty units—for a person to fail to give a copy of a document or form to the Voluntary Assisted Dying Review Board that the person is required to give under the legislation.

17-3 It should be an offence for a person to:

(a) give information to the Board, in the administration of the legislation, that the person knows is false or misleading in a material particular;

(b) make a statement that the person knows is false or misleading in a material particular in a form or other document required to be made under the legislation; or

(c) otherwise falsify a form or other document required to be made under the legislation.

The offences should be specified as misdemeanours and have a maximum penalty of five years imprisonment.

17-4 Where a voluntary assisted dying substance has been supplied for a person for self-administration, the contact person must:

(a) if the person revokes the self-administration decision—give the substance to an authorised disposer as soon as practicable and in any event within 14 days after the self-administration decision is revoked; and

(b) if the person dies—give any unused or remaining substance to an authorised disposer as soon as practicable and in any event within 14 days after the self-administration decision is revoked.

Failure to do so should be an offence with a maximum penalty of 100 penalty units.

17-5 It should be an offence for a person to administer a voluntary assisted dying substance to another person unless the person is authorised to do so under the provision in Recommendation 10-7 above. The offence should be specified as a crime and have a maximum penalty of 14 years imprisonment.

17-6 A person must not make a record of or disclose personal information that the person obtains, in the course of, or because of, the exercise of a function or power under the legislation, other than:

(a) for a purpose under this legislation;

(b) with the consent of the person to whom the information relates;

(c) in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal; or

(d) as authorised or required by law.

Failure to comply should be an offence with a maximum penalty of 100 penalty units.

For the purpose of this provision, 'personal information' should have the same meaning as under section 12 of the *Information Privacy Act 2009*, but should not include information that is publicly available.

Protections from liability in the voluntary assisted dying legislation

17-7 No civil or criminal liability should attach to any person for an act done or omission made in good faith and without negligence in accordance with, or for the purposes of, this Act.

17-8 Criminal liability should not attach to a person who:

(a) in good faith, does something or omits to do something that assists another person who the person believes on reasonable grounds is requesting access to, or is accessing, voluntary assisted dying in accordance with the legislation; or

(b) is present when another person self-administers or is administered a voluntary assisted dying substance in accordance with the legislation.

17-9 If a health practitioner or ambulance officer, in good faith, does not administer life sustaining treatment to another person in circumstances where:

(a) the other person has not requested the administration of life sustaining treatment; and

(b) the health practitioner or ambulance officer believes on reasonable grounds that the other person is dying after self-administering or being administered a voluntary assisted dying substance in accordance with the legislation,

no civil or criminal liability should attach to the health practitioner or ambulance officer for not administering the life sustaining treatment.

17-10 For the avoidance of doubt, the draft Bill provides that, where relevant in a proceeding, the party alleging that the provision in Recommendation 17-7 above does not apply bears the onus of proving that the person did not do the act or make the omission in good faith in the circumstances covered by the protection. Provision to similar effect should be included for the provisions in Recommendations 17-8 and 17-9 above.

Interaction with the Criminal Code

17-11 For the avoidance of any doubt, the draft Bill provides that a person who does an act or makes an omission in the circumstances mentioned in Recommendations 17-7 to 17-9 above does not commit an offence against sections 300, 302, 303, 305, 306, 307, 309, 310 or 311 of the Criminal Code.

Disciplinary proceedings

17-12 The draft Bill provides that nothing in that part of the Bill prevents:

(a) a person from making a notification about a health practitioner's conduct under the National Law;

(b) a person from making a health service complaint about a person under the *Health Ombudsman Act 2013*; or

(c) the Voluntary Assisted Dying Review Board from referring a matter it identifies to the Health Ombudsman.

Notifications to the Health Ombudsman

17-13 For the avoidance of doubt, in considering:

(a) a notification or a referred matter under the Health Practitioner Regulation National Law (Queensland); or

(b) a complaint under the *Health Ombudsman Act 2013*;

about the professional conduct or performance of a registered health practitioner or a person who provides a health service, regard may be had to whether the practitioner or person contravened a provision of the voluntary assisted dying legislation.

'Health service' for this provision has the meaning given in section 7 of the *Health Ombudsman Act 2013*.

CHAPTER 18

An oversight body: the Voluntary Assisted Dying Review Board

Chapter 18: An oversight body: the Voluntary Assisted Dying Review Board

CHAPTER SUMMARY

We must consider 'appropriate safeguards' and 'ways in which compliance with the Act can be monitored'.[1] An oversight body is essential to achieving these two objectives.

This chapter 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 r***esearching*** 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.

We recommend that the Board has all the powers necessary to perform its functions.

We also recommend specific provisions about the Board's proceedings including about minutes, quorum, chairpersons, and committees.

THE NEED FOR AND ROLE OF AN OVERSIGHT BODY

Other jurisdictions

18.1 A common feature of the voluntary assisted dying frameworks in other jurisdictions, including Victoria and Western Australia, is an oversight body. The nature of the entity and the scope of its functions vary. Typically, the oversight body is responsible for reviewing cases, after the person's death, to monitor the application of the legislation.

1 Terms of reference, paras 5, 6.

Overseas jurisdictions

18.2 Oversight under the New Zealand Act is provided by the End of Life Review Committee and the Registrar (assisted dying). Based on mandatory notification requirements for every assisted death, the Review Committee is to consider whether the information 'shows satisfactory compliance' with the legislation. It is to report to the Registrar and direct it to 'follow up' on any information the Review Committee considers does not show satisfactory compliance. The Registrar's functions include referring complaints about health practitioners' conduct to other relevant entities, including the Health and Disability Commissioner and the New Zealand Police, and providing an annual report to the Minister for presentation to Parliament.[2]

18.3 The Netherlands, Belgium and Luxembourg have similar oversight mechanisms. The physician is to notify and provide specified information about the death to the relevant oversight body for review.[3] The oversight body examines the information to determine whether the relevant requirements and procedures were followed. If it does not consider the legislation was followed, it is to report or refer the matter to the public prosecutor or other relevant agency. The oversight body is also required to provide an annual (in the Netherlands) or a biennial (in Belgium and Luxembourg) report for Parliament with statistical information.[4]

18.4 A similar system of reporting and retrospective case review is adopted by the legislation in Quebec. It establishes the 'Commission on end-of-life care' which 'has the mandate of overseeing the application of the specific requirements relating to medical aid in dying in compliance' with the legislation.[5] Federal legislation in Canada also provides for the collection and publication of information about requests for medical assistance in dying by the Minister of Health.[6]

18.5 In the United States of America, the oversight bodies vary from state to state. As an example, the legislation in Oregon provides for the Department of Human Services to 'annually review a sample of records', collect information from health care providers, and 'make available to the public an annual statistical report of information collected'.[7]

Tasmania

18.6 The Tasmanian Act establishes the Voluntary Assisted Dying Commission. The Commission is required to monitor, collect statistical information about, and distribute information on the operation of the legislation.[8]

18.7 The Act provides for the Commission to review the exercise of functions and powers 'in relation to a death that has occurred as a result of the administration of a [voluntary assisted dying] substance under, or purportedly under, [the] Act'. It allows (but does not require) the commission to investigate matters about the operation or administration of the Act and 'communicate to appropriate persons or authorities any concerns' about noncompliance with the Act. The Commission must also keep records of various matters and provide an annual report to the Minister for tabling in Parliament.[9]

2 See *End of Life Choice Act 2019* (NZ) ss 21, 26, 27(1), (4), (6)–(7), 29. The End of Life Review Committee is to consist of a medical ethicist, a medical practitioner who practices in the area of end of life care, and one other health practitioner.

3 The oversight bodies are, respectively, one of the five 'regional review committees' in the Netherlands, the Federal Commission for the Control and Evaluation of the application of the law in Belgium, and the National Commission for Control and Assessment of the application of the law in Luxembourg.

4 See *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* ss 34, 8–11, 17–18; Regional Euthanasia Review Committees (The Netherlands), *Euthanasia Code 2018: Review procedures in practice* (April 2018) [2.2]; *Belgian Euthanasia Act 2002* ch IV art 5, ch V arts 6–9; Luxembourg Law on Euthanasia and Assisted Suicide 2009 ch IV art 5, ch V arts 6–9.

5 See *Quebec Act respecting end-of-life care*, RSQ c S-32.001 ch 5 ss 38–39, 42–43, 46–47. Concerns about non-compliance are reported to the Collège des médecins du Québec (Quebec College of Physicians). The Commission is to report annually on its activities to Minister for tabling in Parliament.

6 See *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166, s 13(1)–(2).

7 See *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.865.3.11.

8 See *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 110(1), 114(1)(a), (g)–(h).

9 See *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 114(2), 119–121.

18.8 The Tasmanian Panel observed that '[i]ndependent oversight and annual reporting is necessary to ensure public confidence in [voluntary assisted dying] and to identify emerging issues such as barriers to access'.[10]

Victoria and Western Australia

18.9 The Victorian Act confers oversight functions on the Voluntary Assisted Dying Review Board. The Western Australian Act takes a similar approach, with the Voluntary Assisted Dying Board.

18.10 In broad terms, the Board's role in those jurisdictions is to monitor and report on the operation and effectiveness of the legislation. This includes reviewing voluntary assisted dying cases, researching and advising on the operation of the legislation, collecting and reporting statistical information about voluntary assisted dying, and referring potential breaches of the legislation to appropriate agencies for investigation.[11]

18.11 The Board ensures compliance with the legislation. It is also intended to promote transparency and accountability and identify improvements to the framework.[12]

18.12 In Victoria, it was explained that:[13]

> The [Voluntary Assisted Dying Review] Board is established for the purpose of monitoring voluntary assisted dying in Victoria. The Board's functions and powers include promoting compliance and continual improvement of practice, conducting analysis and research regarding voluntary assisted dying, consulting and engaging with the community and professional groups regarding voluntary assisted dying, reporting to the Houses of the Parliament on the operation of voluntary assisted dying, and providing reports or advice to the Minister or Secretary as required.

18.13 Similarly, in Western Australia, it was explained that:[14]

> The [Voluntary Assisted Dying] Board is established for the purpose of ensuring proper adherence to the legislation and to recommend safety and quality improvements.
>
> The Board will have mainly advisory and monitoring functions in relation to voluntary assisted dying, including: monitoring matters related to voluntary assisted dying, collecting and maintaining data, conducting research and analysis, reporting to the Houses of the Parliament on the operation of voluntary assisted dying, and providing reports, advice and recommendations on best practice or areas needing improvement to the Minster for Health and to Parliament.

18.14 There is a focus on reviewing completed cases to monitor compliance.[15] The review of cases enables the Board to monitor the way the legislation is applied, collect and analyse data about voluntary assisted dying, and refer identified issues to other agencies.[16]

18.15 Significantly, the Board's role does not include enforcement or dispute resolution. Those matters are left to other existing agencies, to which the Board refers any relevant identified issues.[17] A similar approach is taken in overseas jurisdictions.[18]

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10 See Tas Review Panel Report (2021) 67.

11 See generally Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 32; Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health); Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 39; Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5140 (RH Cook, Minister for Health).

12 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health); Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5140 (RH Cook, Minister for Health).

13 Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 32.

14 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 39.

15 See, eg, Vic Ministerial Advisory Panel Final Report (2017) 161–4, Rec 47.

16 See, eg, ibid 161–4. See also WA Ministerial Expert Panel Final Report (2019) 94. See [18.139] ff below as to review of cases.

17 See [18.152] ff below as to referral of matters to other agencies. See also Chapter 17 above.

18 See [18.2]–[18.5] above.

18.16 The Victorian Panel recommended the establishment of the Board to 'serve as the principal point of governance and administration for the new framework':[19]

> A central body can provide leadership and expert guidance to support safety and improve quality. It is best able to serve as the repository for reporting and data collection so it can monitor activity, compliance, trends and any other system risks. It will provide a clear and transparent point of accountability for health practitioners and will provide reassurance to the Victorian community that voluntary assisted dying will be carefully monitored and reviewed.

18.17 It preferred that the Board be established as a statutory entity, similar to existing consultative councils that have a role in health governance in Victoria:[20]

> The Panel considered the options and affirmed that a statutory entity is the preferred model for establishing an oversight body. Statutory models of governance provide a strong relationship with the legislative framework under which an oversight body operates. The independence of a statutory [entity] ensures transparency with respect to its operations.

18.18 In particular, the Panel noted that the consultative councils have their roles, functions and operations set out in legislation, are independent statutory entities, and work separately from but in collaboration with the government and health care system. It also noted that some of their functions are similar to those that would be appropriate for an oversight body under voluntary assisted dying legislation, including review of cases, identifying improvements, and disclosing information to relevant entities in the public interest.[21]

18.19 The Western Australian Panel also considered that the 'creation of a statutory body such as a Board to review and monitor voluntary assisted dying' would be 'a key safeguard', as well as 'a practical source of advice or recommendations to Government'.[22]

Queensland

18.20 The Parliamentary Committee considered that voluntary assisted dying legislation in Queensland should include 'a transparent review mechanism' as one of several safeguards against coercion.[23] It recommended a system of 'thorough documentation and reporting at all stages of the voluntary assisted dying process'.[24] It also recommended that the framework should provide for:[25]

> the establishment of a review body similar to the Victorian Voluntary Assisted Dying Review Board to provide oversight of the scheme.

18.21 The White and Willmott Model also supports the Victorian approach. In particular, it suggests that an oversight body should:[26]

> review … each case of voluntary assisted dying to ensure that it complied with the requirements of the Act … The Board's monitoring role also requires oversight of the system as a whole to ensure that it is functioning as intended and to make recommendations for improvement where needed.

19 See Vic Ministerial Advisory Panel Final Report (2017) 159–60, Rec 46. Cf Vic Parliamentary Committee Final Report (2016) 230–31, proposing 'an Assisted Dying Review Board, to review each approved request for assisted dying' and 'an entity, End of Life Care Victoria', to provide policy and strategic direction, collect and analyse data, and provide information, education and training about end of life care in Victoria, including assisted dying.

20 Vic Ministerial Advisory Panel Final Report (2017) 159–60.

21 Vic Ministerial Advisory Panel Final Report (2017) 159–60. As an example, the Panel referred to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, established by the *Public Health and Wellbeing Act 2008* (Vic) pt 4 div 3.

22 WA Ministerial Expert Panel Final Report (2019) 94. See generally WA Joint Select Committee on End of Life Choices Report (2018) 224 [7.86], 229 [7.89].

23 Qld Parliamentary Committee Report No 34 (2020) 132.

24 Ibid 132, Rec 8.

25 Ibid 145, Rec 19.

26 White and Willmott Model pt 6.

18.22 The White and Willmott Model does not include draft provisions for this—observing that details are likely to vary between jurisdictions—but notes that the legislation should address the establishment, functions and powers of the oversight body.[27]

18.23 In an earlier publication, Professors White and Willmott explained that 'oversight promotes all of the values that underpin our proposed legislative model', but that those values 'do not necessarily provide precise guidance as to what that system might look like'. Taking into account models in other jurisdictions, they favoured the 'establishment of a new retrospective review body dedicated to overseeing an assisted dying regime':[28]

> This removes questions or associations of unlawful or inappropriate behaviour [as might be the case if deaths were reviewed by a coroner] and the body's focus on assisted dying means it could be comprised of people with specific and relevant expertise in this area. The body's functions could include independent review of assisted dying cases (retrospectively), systems-level monitoring of the assisted dying regime (including the ability to make recommendations for systemic reform), and appropriate data collection and reporting.

Oversight bodies under other rights-based legislation

18.24 Oversight bodies are a feature of other rights-based legislation in Queensland. This includes the Public Advocate under the *Guardianship and Administration Act 2000*, the Health Ombudsman under the *Health Ombudsman Act 2013*, the Queensland Human Rights Commission under the HR Act and the Information Commissioner under the *Information Privacy Act 2009*.

18.25 The roles of such bodies vary, but often includes reviewing, monitoring or promoting compliance with the legislation, or identifying and reporting on systemic or operational issues.[29]

18.26 For example, the HR Act requires public entities to act and make decisions in a way that is compatible with human rights[30] (including those relating to medical treatment and health care).[31] One of the functions of the Queensland Human Rights Commission is to 'review public entities' policies, programs, procedures, practices and services in relation to their compatibility with human rights'.[32] Relevantly, it also has education, reporting and advice functions.[33]

Other death review bodies

18.27 There are also bodies with review functions for particular categories of deaths in Queensland.

18.28 Notably, this includes the investigation by a coroner of 'reportable deaths', including health care related deaths.[34] The focus of those investigations is on determining how the person died and what caused their death.[35] Where the death is investigated at an inquest, the coroner may also make comments about matters connected with the death, including ways to prevent deaths in similar circumstances from happening.[36]

18.29 In addition, the Domestic and Family Violence Death Review and Advisory Board is established under the *Coroners Act 2003* to review domestic and family violence deaths

27 Ibid.

28 L Willmott and B White, 'Assisted Dying in Australia: A Values-based Model for Reform' in I Freckelton and K Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 508–9.

29 See, eg, *Guardianship and Administration Act 2000* (Qld) ss 209–209A; *Health Ombudsman Act 2013* (Qld) s 25(c), (d); *Human Rights Act 2019* (Qld) s 61(c), (h); *Information Privacy Act 2009* (Qld) s 135.

30 *Human Rights Act 2019* (Qld) s 4(b), pt 3 div 4. The term 'public entity' includes, for example, a government entity within the meaning of s 24 of the *Public Service Act 2008* (Qld), the Queensland Police Service and a local government: s 9.

31 *Human Rights Act 2019* (Qld) ss 17(c), 37(1).

32 *Human Rights Act 2019* (Qld) s 61(c).

33 *Human Rights Act 2019* (Qld) ss 61(d)–(f), (h)–(i), 91–92.

34 See *Coroners Act 2003* (Qld) pt 3. 'Reportable death' and 'health care related death' are defined in ss 8, 10AA respectively. See also Chapter 12 above.

35 *Coroners Act 2003* (Qld) s 45(2).

36 *Coroners Act 2003* (Qld) s 46(1).

in Queensland. The purpose of review is to identify patterns, trends and risk factors, and ways to prevent and reduce such deaths. Reviews do not involve investigating the circumstances of individual deaths but have a systems level focus.[37]

18.30 Similarly, the Child Death Review Board is established under the *Family and Child Commission Act 2014* to carry out systems reviews following child deaths connected to the child protection system. Again, the focus is on identifying systemic issues to find ways to improve services in the child protection system and prevent avoidable deaths. Reviews do not involve investigating individual deaths.[38]

18.31 Each of those bodies is primarily concerned with preventable deaths occurring in a wide range of potentially complex circumstances. In contrast, voluntary assisted dying legislation concerns voluntary deaths of terminally ill adults that are authorised under specific provisions of the legislation. It is nevertheless essential that the voluntary assisted dying process is subject to appropriate scrutiny so that unauthorised deaths do not occur, and to identify systemic issues and opportunities for improvement.

Quality assurance committees

18.32 The *Hospital and Health Boards Act 2011* provides for the establishment of approved 'quality assurance committees' to improve the safety and quality of health services.[39] Their focus is assessing and evaluating the quality of clinical practices and health services.

18.33 A quality assurance committee's specific responsibilities, membership and procedures are governed by the instrument that establishes it and provisions of the *Hospital and Health Boards Act 2011*.[40]

18.34 Under that Act, a quality assurance committee is to comprise 'individuals with training and experience appropriate to the services to be assessed and evaluated by the committee'. Its functions must include 'the assessment and evaluation of the quality of health services, the reporting and making of recommendations concerning those services and monitoring the implementation of its recommendations'.[41]

18.35 For example, the Queensland Maternal and Perinatal Quality Council was established to collect and analyse clinical information to investigate and monitor trends in the incidence and causes of maternal and perinatal mortality and morbidity, identify issues, and recommend safety and quality improvements to the Minister for Health.[42] The Council presently has 28 members from various backgrounds (including the chairperson and deputy chairperson) and four sub-committees.[43]

18.36 A quality assurance committee may be established by the chief executive of the Department of Health or (individually or jointly) by a Hospital and Health Service, the licensee of a private health facility, or a professional association, society or college.[44]

37 See *Coroners Act 2003* (Qld) pt 4A. The purpose of reviews and the functions of the Domestic and Family Violence Death Review and Advisory Board are set out in ss 91A, 91D. See also Queensland Courts, 'Review of deaths from domestic and family violence' (25 January 2021) <https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence>.

38 See *Family and Child Commission Act 2014* (Qld) pt 3A. The purpose of reviews and the functions of the Child Death Review Board are set out in ss 29A, 29D. See also Child Death Review Board, 'Our purpose' (2021) <https://www.cdrb.qld.gov.au/>.

39 See *Hospital and Health Boards Act 2011* (Qld) pt 6. See also Queensland Health, Clinical Excellence Division, 'Quality Assurance Committees' (4 September 2020) <https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/quality-assurance-committees>.

40 See *Hospital and Health Boards Act 2011* (Qld) pt 6; *Hospital and Health Boards Regulation 2012* (Qld) pt 5.

41 *Hospital and Health Boards Act 2011* (Qld) s 82(3)(b)–(c).

42 Queensland Government, 'Queensland Maternal and Perinatal Quality Council Terms of Reference' (July 2016) 1 <https://www.health.qld.gov.au/__data/assets/pdf_file/0027/431964/qmpqc-tor.pdf>. See generally Queensland Health, Clinical Excellence Division, 'Queensland Maternal and Perinatal Quality Council' (4 September 2020) <https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/queensland-maternal-and-perinatal-quality-council>.

43 See Queensland Health, Clinical Excellence Division, 'Membership' (3 March 2021) <https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/queensland-maternal-and-perinatal-quality-council/membership>. As to subcommittees, see Queensland Maternal and Perinatal Quality Council Terms of Reference, above n 42, 2–3.

44 *Hospital and Health Boards Act 2011* (Qld) s 82(1)–(2).

Submissions

18.37 The Consultation Paper asked whether the draft legislation should provide for an independent oversight body responsible for monitoring compliance with the legislation.[45]

18.38 Almost all the respondents that addressed this issue agreed that the legislation should provide for such a body.[46]

18.39 Some of those respondents submitted that this would promote public confidence. For example, the Clem Jones Group submitted that:

> We believe it is important for building and maintaining public confidence in a [voluntary assisted dying] scheme that Queenslanders know its operation is subject to scrutiny by well qualified and independently minded individuals.

18.40 A medical defence organisation and professional indemnity insurer submitted that the creation of an oversight body has 'significant merit' because of 'the complexity and gravity of issues involved around voluntary assisted dying'.

18.41 Many respondents highlighted the importance of an oversight body as a safeguard in providing oversight and monitoring the scheme. The Australian Lawyers Alliance submitted that 'it is imperative' that the voluntary assisted dying framework 'can be closely monitored, regularly reviewed and reported on', and that '[a] Board should be created to oversee' the scheme. The Cancer Council Queensland also submitted that, '[i]f assisted dying is introduced, its operation will need to be underpinned by continuous and adequately resourced monitoring and evaluation of all aspects of the scheme'. Dying With Dignity NSW made a similar submission.

18.42 The Queensland Nurses & Midwives' Union submitted that the creation of an oversight body is 'a major safeguard that will ensure processes are followed and provide oversight of the scheme'. The AMA Queensland considered that this would provide 'an extra safeguard against coercion'. Similarly, the Royal Australian College of General Practitioners Queensland considered an oversight mechanism should be included 'to ensure the integrity of the system, and to provide protections to keep the community safe'.

18.43 Another respondent submitted that this would be a way to 'ensure that people have equal access' to voluntary assisted dying and to promote community acceptance of voluntary assisted dying.

18.44 Several respondents supported an oversight body similar to those in Victoria or Western Australia or as contemplated by the White and Willmott Model. However, a few respondents submitted that those bodies provide 'administrative' oversight only and that more is required to ensure 'meaningful review' of the operation of the legislation.[47]

18.45 Another respondent, who supported the creation of an oversight body, considered that it would be ineffective if there is no power to enforce the law, there is conflict of interest, or 'medical practitioners know that they can do the wrong thing and get away with it'. The same respondent submitted that coroners should have a key role in investigating deaths under the legislation, as well as 'proposed death[s] of all people who cannot self-administer' a voluntary assisted dying substance.

45 QLRC Consultation Paper No 79 (2020) Q-43.

46 Another respondent submitted that the legislation should 'probably' provide for an oversight body. Another respondent submitted that a 'robust oversight mechanism' should be implemented as part of the legislation.

47 See also [18.202]–[18.204] below.

18.46 The Lutheran Church of Australia Queensland District submitted that, in addition to an 'independent public sector body' with 'end to end responsibility around policy, oversight, activity, complaints, ethics, reporting and review', there should be an 'Inspector-General' for voluntary assisted dying to review the operation of the scheme and assist Parliament in overseeing the legislation.[48]

18.47 However, another respondent submitted that an oversight body is unnecessary because 'there are already sufficient bodies to which people can complain about (perceived) medical malpractice'. In their view, an oversight body might be desirable if the draft legislation were to be based on a different model that did not rely on medical practitioners.

The Commission's view

18.48 The draft legislation should include an independent oversight body.

18.49 Voluntary assisted dying involves the significant and final act of bringing forward a person's death. The death will be authorised only if the requirements of the legislation are followed. Voluntary assisted dying raises concerns about the potential for coercion or abuse, intersects with end of life and palliative care, may be carried out in a range of domestic or institutional settings, and may involve many individuals and entities with conflicting views or interests. The need for a robust oversight mechanism—to ensure transparency and accountability and to monitor compliance with the legislation—is clear.

18.50 Voluntary assisted dying evokes strong views. It is also a new and relatively untested area of law in Australia. If introduced, the legislation will confer new rights and responsibilities. It will authorise actions that would otherwise be unlawful. It will impact on, and need to operate within, other existing frameworks that govern end of life care in Queensland. An oversight mechanism is necessary to monitor the operation of the legislation, identify systemic issues and build a knowledge base about voluntary assisted dying in Queensland.

18.51 We consider the best and most effective oversight mechanism is an independent body established by statute and conferred with clearly defined functions under the legislation. This will provide a visible and centralised point of oversight and ensure a clear division of responsibilities between the oversight body and other areas of the Department. It will also provide for independent expertise and enhance community confidence in the scheme.

18.52 Independent scrutiny is critical because the scheme may apply in both the public and private health systems and involve a wide range of individuals and institutions.

18.53 The draft Bill includes many procedural steps and requirements. These are important safeguards. However, it is equally important that these requirements are understood by those involved in the process. The expertise of an independent oversight body with community engagement functions will help ensure that individuals, health practitioners, health service providers and others understand their rights and obligations under the legislation.

18.54 Accordingly, Part 8 of the draft Bill provides for the establishment of an oversight body with the functions and powers outlined in this chapter.

18.55 We recognise that the establishment of an oversight body will have a financial cost. However, we consider this is justified by the public interest in a robust oversight mechanism. The oversight body will need to be adequately resourced to perform its functions effectively.

48 This respondent additionally submitted that the oversight body have a role in 'processing' requests for voluntary assisted dying. In turn, they submitted that the conduct of the scheme be overseen by an InspectorGeneral to assist Parliament 'in determining in an ongoing manner whether the new legislation has been properly implemented and that unforeseen consequences are detected and remedied early'. They also submitted that coroners should 'be attentive to referrals … around [voluntary assisted dying] cases'.

ESTABLISHMENT

Other jurisdictions

Victoria and Western Australia

18.56 The Voluntary Assisted Dying Review Board is established by the Victorian Act.[49] It is supported by Safer Care Victoria, an administrative office of the Department of Health and Human Services. It is one of three consultative review councils in Victoria that monitor and report on specific areas of specialised health care.[50]

18.57 Similarly, the Voluntary Assisted Dying Board is established, as an agent of the Crown,[51] by the Western Australian Act.[52] It will be based within the Department of Health (Western Australia).[53] The chief executive officer of the Department of Health is to ensure the Board has 'the staff, services and facilities, and other resources and support, that are reasonably necessary to enable it to perform its functions'.[54] The Board is to give effect to written directions from the Minister about the performance of its functions. A direction cannot, however, be given about the performance of a function concerning a particular person or matter.[55]

Establishment of oversight board	Vic	WA
Established by statute	s 92	s 116
Agent of the Crown having the status, immunities and privileges of the Crown (WA only)	—	s 117
Subject to Ministerial direction (WA only)	—	s 123
Provided with staff and other resources and support reasonably necessary to perform its functions (WA only)	—	s 121

Queensland

18.58 The Parliamentary Committee recommended the establishment of a review body 'similar to the Victorian Voluntary Assisted Dying Review Board', but did not otherwise comment on the form it should take.[56]

18.59 The White and Willmott Model does not address this issue, other than to express general support for the Victorian approach.[57]

18.60 There is no single model for the establishment of a statutory entity. Various approaches are taken, depending on the entity's purpose, the nature of its functions, the degree of operational independence that may be required, and other factors such as the entity's financial requirements.

49 *Voluntary Assisted Dying Act 2017* (Vic) s 92.

50 See Safer Care Victoria, 'About us' (2021) <https://www.bettersafercare.vic.gov.au/about-us/>; Safer Care Victoria, *Annual Report 2019–20* (2020) 46, 54–6. The other two councils are the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, and the Victorian Perioperative Consultative Council.
The Board is also empowered, with the Minister's approval, to co-opt a person with special knowledge or skills to assist it in a particular matter: *Voluntary Assisted Dying Act 2017* (Vic) s 100, at [18.181] below.

51 *Voluntary Assisted Dying Act 2019* (WA) s 117.

52 *Voluntary Assisted Dying Act 2019* (WA) s 116.

53 Information provided by Department of Health (WA), 19 March 2021.

54 *Voluntary Assisted Dying Act 2019* (WA) s 121. The Board is also empowered, with the Minister's approval, to co-opt a person with special knowledge or skills to assist it in a particular matter: s 122, at [18.181] below.

55 *Voluntary Assisted Dying Act 2019* (WA) s 123. The Minister is also entitled to information or documents in the possession of the Board (but may obtain personal information about a person only if the person has consented to its disclosure): s 124.

56 See Qld Parliamentary Committee Report No 34 (2020) 145, Rec 19.

57 See White and Willmott Model pt 6.

Submissions

18.61 Our Consultation Paper did not ask how an oversight body should be established.

18.62 Some submissions expressed general support for the creation of a statutory entity similar to those established in Victoria or Western Australia, or contemplated by the White and Willmott Model. As noted above, a few respondents suggested alternative approaches, such as requiring matters to be investigated by a coroner or creating an Inspector-General to review the operation of the legislation.

The Commission's view

Statutory board

18.63 The draft Bill provides that the Voluntary Assisted Dying Review Board is established.

18.64 We favour the approach in Victoria and Western Australia of establishing a statutory board. This is also consistent with other legislative frameworks in Queensland.[58]

18.65 It is anticipated the Board would be located within and administratively supported by the Department of Health. For the purpose of the *Financial Accountability Act 2009*, the Board is intended to be an entity that is a 'part of a department' and not a 'statutory body'.[59]

18.66 Some alternative approaches were considered, but ultimately rejected.

18.67 One option was for the chief executive of the Department of Health to establish a quality assurance committee under the *Hospital and Health Boards Act 2011*.[60] This would adopt an existing feature of Queensland's health service framework and rely on existing provisions. It would provide flexibility since the oversight body would be governed in part by terms of reference or other instrument of appointment from the chief executive.

18.68 However, a quality assurance committee is focused primarily on clinical matters, rather than legislative compliance. Therefore, it is not well suited as an oversight body which focuses on legislative compliance to ensure voluntary assisted dying deaths have been carried out lawfully.

18.69 It is preferable for the oversight body to be established and governed by the voluntary assisted dying legislation which, if introduced, will create a new set of rights, obligations and procedures. This will help ensure an integrated legislative framework with a robust oversight mechanism.

18.70 Another option was to establish a separate independent 'statutory body', such as an independent commissioner's office, that operates outside the structure of a government department. This would be especially suitable where the role of the body involves enforcement, dispute resolution or the regulation of public entities or government agencies.[61] This approach would ensure a high degree of independence but would also likely require greater resources.

18.71 On balance, the creation of a separate statutory body is not necessary. An independent board established by the legislation and located within the Department is a more flexible and appropriate model. The functions of the oversight body are not of a regulatory nature, but are focused on monitoring, advising and reporting. Specific provisions can be included in the legislation to secure the independent performance of those functions and to address accountability. This is the approach in the draft Bill.

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58 See [18.27]–[18.31] above.

59 See *Financial Accountability Act 2009* (Qld) ss 8(3), 9(2)(b). Accordingly, the requirements under that Act relating to annual financial statements and annual reports would not apply.

60 See [18.32] ff above.

61 See, eg, the Ombudsman established under the *Ombudsman Act 2001* (Qld) pt 2, which has responsibility for investigating the administrative actions of government departments, local governments and public authorities; the Health Ombudsman established under the *Health Ombudsman Act 2013* (Qld) pt 2, which has responsibility for complaints and investigations about health services; and the Queensland Human Rights Commission established under the *Anti-Discrimination Act 1991* (Qld) ch 9 p 1, which has responsibility, among other things, for complaints under the *Human Rights Act 2019* (Qld).

18.72 Ultimately, the status and location of the oversight body are matters for the Government to determine. Whichever approach is taken, the oversight body should have the functions, powers and other main features outlined in this chapter. A different model, such as a separate statutory body, would require different provisions according to its status.[62]

Independence

18.73 Consistent with other Queensland legislation,[63] the draft Bill provides that the Board must act independently and in the public interest in performing its functions. It also provides that the Board is not subject to direction by the Minister or another person about how it performs its functions.[64]

18.74 This approach differs from the Western Australian Act. That Act provides that the Board must give effect to a direction given by the Minister about the performance of its functions, other than a direction about the performance of its functions concerning a particular person or matter.[65]

18.75 Independence and impartiality in the performance of the Board's functions is necessary to ensure public confidence in the oversight body and, by extension, in the voluntary assisted dying legislation.[66] Also, because the Board is not established as a separate statutory body outside the structure of a government department, it is desirable for the legislation to include provisions to ensure the independent performance of the Board's functions.

Staff and assistance

18.76 Consistent with other Queensland legislation,[67] the draft Bill provides that the chief executive of the Department must ensure the Board has the administrative support services reasonably required for it to perform its functions effectively and efficiently.

18.77 A similar provision is included in the Western Australian Act.[68]

18.78 This will ensure the Board has sufficient staff, equipment and other support services to carry out its functions, including information and communication technology and document management services.

18.79 As explained below, the draft Bill also empowers the Board to engage persons, from time to time, to help in performing its functions.

62 For example, the legislation would need to specify whether the statutory body represents the State and is a statutory body to which the *Financial Accountability Act 2009* (Qld) and *Statutory Bodies Financial Arrangements Act 1982* (Qld) apply: see, eg, Department of the Premier and Cabinet (Queensland), The *Queensland Legislation Handbook* (6th ed, 2019) [2.12.10]. Provisions about the membership, appointment and procedures of a statutory body would also likely be different.

63 See, eg, *Coroners Act 2003* (Qld) s 91H; *Family and Child Commission Act 2014* (Qld) s 29F. See also, eg, *Guardianship and Administration Act 2000* (Qld) s 211.

64 The Minister may, however, ask the Board to provide information, reports or advice about particular matters: see [18.252] ff below.

65 See *Voluntary Assisted Dying Act 2019* (WA) s 123.

66 See further [18.51]–[18.52] above.

67 See, eg, *Coroners Act 2003* (Qld) s 91I. See also, eg, *Education (Accreditation of Non-State Schools) Act 2017* (Qld) s 120; *Radiation Safety Act 1999* (Qld) s 179.

68 See *Voluntary Assisted Dying Act 2019* (WA) s 121.

MEMBERSHIP

Other jurisdictions

Victoria

18.80 Members of the Voluntary Assisted Dying Review Board are appointed by the Minister, by order published in the Government Gazette.[69] The Minister must also appoint a member of the Board to be chairperson, and may appoint another member of the Board to be deputy chairperson.[70]

18.81 A person is eligible for appointment as a member if the Minister is satisfied they have 'appropriate knowledge and skills to perform all of the duties and functions of a member of the Board'.[71]

18.82 The Victorian Panel considered that membership should be extensive and multidisciplinary. It noted strong support in its consultation for a broad range of experts, including ethicists, nurses, pharmacists and psychologists, as well as community members.[72] The Panel favoured the approach taken to consultative councils in Victoria whose extensive membership ensures 'appropriate flexibility' and the availability of 'relevant expertise'.[73] It recommended that members be appointed by the Minister and that 'the appointments reflect the appropriate knowledge and experience required for the Board to perform its functions'.[74]

18.83 The Victorian Act does not specify the number of members that may, or must, be appointed. The present Board has 13 members and is chaired by a retired Supreme Court Justice.[75] The members include an intensive care specialist, a consultant physician in geriatric medicine, a palliative care expert, a specialist general practitioner and health educator, a medical oncologist, palliative care physicians, a neurologist, an emeritus professor of nursing, a medication safety specialist, a lawyer, and two 'consumer' community members.

18.84 Members are appointed—on a full-time or part-time basis as specified in the instrument of appointment—for a term of up to three years with the possibility of reappointment. However, the initial Board must be constituted by members appointed for a term of up to six years, who are eligible for reappointment for a further term of up to three years.[76]

18.85 The present Board members were appointed in June 2018 for a term of six years.[77] It has been suggested that this 'will allow the same Board to establish statewide procedures prior to [the legislation] commencing in June 2019, and to review the operation of the law after five years'.[78]

Western Australia

18.86 In Western Australia, members of the Voluntary Assisted Dying Board are also appointed by the Minister for a term of up to three years with the possibility of reappointment.[79] Unlike Victoria, there is no separate provision for the appointment of inaugural members for a longer term.

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69 *Voluntary Assisted Dying Act 2017* (Vic) s 95(1). Members are entitled to the fees and allowances fixed from time to time by the Minister: s 99.

70 *Voluntary Assisted Dying Act 2017* (Vic) s 98(1)–(2). A person appointed as chairperson or deputy chairperson may be reappointed, may resign or be removed from the office, and ceases to hold the office upon ceasing to be a member: s 98(3)–(6).

71 *Voluntary Assisted Dying Act 2017* (Vic) s 95(2).

72 Vic Ministerial Advisory Panel Final Report (2017) 165–6.

73 Ibid. See n 50 above as to other consultative councils in Victoria.

74 Vic Ministerial Advisory Panel Final Report (2017) 166, Rec 48. The 'policy intent' of the Panel's recommendation was to 'ensure multidisciplinary membership'.

75 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 16.

76 *Voluntary Assisted Dying Act 2017* (Vic) s 96.

77 Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 18.

78 Safer Care Victoria, 'Voluntary Assisted Dying Review Board members' (19 November 2020) <https://www.bettersafercare.vic.gov.au/about-us/vadrb/members>.

79 *Voluntary Assisted Dying Act 2019* (WA) ss 125, 127. Members are entitled to the remuneration and allowances determined from time to time by the Minister, on the recommendation of the Public Sector Commissioner: s 131.

18.87 The Minister must designate one member to be the chairperson of the Board and another member to be the deputy chairperson.[80]

18.88 The Act does not specify when a person is eligible for appointment as a member. However, the Western Australian Panel recommended that membership should include a 'suitable mix of appropriate and relevant medical, legal and pharmacy expertise related to voluntary assisted dying as well as community representation'.[81]

18.89 The Act fixes the number of members. It provides that the Board 'consists of five members appointed by the Minister'.[82] This includes the chairperson and deputy chairperson.[83] As an 'administrative necessity to ensure the Board has sufficient members',[84] the Act enables a temporary appointment to be made if a member is unable to act.[85]

Membership of oversight board	Vic	WA
The Board consists of the members, chairperson and any deputy chairperson (Vic), or of five members (WA), appointed by the Minister	s 94(1)	s 125
There are to be five members (WA only). This includes the chairperson and deputy chairperson.	—	s 125
Members are appointed by the Minister	s 95(1)	s 125
Members are appointed on a full-time or part-time basis (Vic only)	s 96(1)(b)	—
Minister must be satisfied the person has the appropriate knowledge and skills (Vic only)	s 95(2)	—
Members are appointed for a term of up to three years, with the possibility of reappointment	s 96(1)	s 127
Inaugural members to be appointed for a term of up to six years, with the possibility of reappointment for up to three years (Vic only)	s 96(2)	—
Minister must appoint (Vic) or must designate (WA) one member to be chairperson and may appoint (Vic) or must designate (WA) one member to be deputy chairperson	s 98(1)(2)	s 126(1)
Members are entitled to fees and allowances set from time to time by the Minister	s 99	s 131

Queensland

18.90 Neither the report of the Parliamentary Committee nor the White and Willmott Model addresses the membership, composition or administrative support of an oversight body, other than to express general support for the establishment of body similar to that in Victoria.[86]

18.91 Some guidance can be taken from other Queensland legislation that establishes similar bodies with review and reporting functions.[87]

Submissions

18.92 Some respondents commented on the membership or composition of an oversight body under the draft legislation.

18.93 For example, Dying With Dignity NSW submitted that:

> We would recommend a smaller board as in Western Australia rather than the very large one in Victoria. This is to facilitate the efficient and effective working of the Board.

80 *Voluntary Assisted Dying Act 2019* (WA) s 126(1).
81 WA Ministerial Expert Panel Final Report (2019) 94, Rec 27.
82 *Voluntary Assisted Dying Act 2019* (WA) s 125.
83 *Voluntary Assisted Dying Act 2019* (WA) s 126(1).
84 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 41.
85 *Voluntary Assisted Dying Act 2019* (WA) s 130.
86 See generally Qld Parliamentary Committee Report No 34 (2020) 145, Rec 19; White and Willmott Model pt 6.
87 See [18.24]–[18.31] above.

> It is not necessary to spell out the skills required by such a Board. The legislation could just mention 'suitable qualifications'. One would expect this to include medical, legal and ethical expertise.

18.94 Other respondents referred to the need for members with a range of experience. For example, Go Gentle Australia submitted that 'a board is best served by members with a wide range of experience in public health, consumer advocacy, palliative care, and legal services', and that they 'believe Queenslanders will draw comfort from a similar approach' to Victoria.

18.95 The AMA Queensland made a similar submission, noting that the oversight body should have 'a mix of legal, medical practitioners, academics and consumer representatives'. The National Seniors Queensland Policy Advisory Group suggested 'a mix of medical and lay representatives'.

18.96 The Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld supported 'the inclusion of a broad range of stakeholders including cultural and religious representation'. MIGA submitted that representation from professions with expertise in 'clinical, ethical and legal matters' is required.

18.97 Go Gentle Australia also suggested the inclusion of 'a representative from the disability communities, in recognition of their particular concerns about how they are regarded by the medical community'. A member of the public submitted that '[d]isabled people should be the majority of any review board evaluating both the worth of our lives and the efforts taken to safeguard them.

18.98 Some respondents, although not commenting on these issues, supported a statutory entity similar to those in Victoria or Western Australia or as contemplated by the White and Willmott Model.

The Commission's view

Membership

18.99 The draft Bill provides that the Board consists of the members appointed under the Act by the Minister. It provides for at least five but no more than nine members (including the chairperson).

18.100 This will ensure the Board is not reduced to an ineffective number, and will provide adequate scope for the appointment of members from multiple disciplines with an appropriate cross-section of expertise and experience.[88] At the same time, the upper limit on the number of members will help ensure that the Board can function effectively. A larger membership may be unwieldy and would have a higher demand on resources.[89]

18.101 In this respect, the draft Bill differs from both Victoria and Western Australia.

18.102 The Victorian Act does not specify any minimum or maximum number of members of the Board. This has the advantage of flexibility. However, it does not provide any guidance about the intended composition of the Board and, in our view, is too openended. It would be open to appoint a very large or a very small number of members. A very large membership could create practical difficulties in the Board's operation and administration, as well as higher costs. A very small Board may lack the desirable breadth of expertise and experience and could have practical difficulties if a member is temporarily unable to act.

18.103 In contrast, the Western Australian Act provides that the Board consists of five members, including the chairperson and deputy chairperson. This provides greater certainty but, in our view, is too limiting. An upper limit of five members in total might be

88 See further [18.116] ff below. Similarly, see, eg, *Hospitals and Health Boards Act 2011* (Qld) s 23(1), which provides for '5 or more' members; and Health Practitioner Regulation National Law (Queensland) s 29(2), which provides for 'at least 5' members.

89 A similar approach combining a minimum requirement and an upper limit on members is taken under other Acts: see, eg, *Queensland Institute of Medical Research Act 1945* (Qld) ss 3(5), 4A, 5(1).

too small to ensure the desired mix of expertise and experience or to enable the Board to meet its workload.

18.104 We prefer the flexibility of our recommended provision. There must be at least five members. New or additional members may be appointed at any time provided the total membership does not exceed nine. The draft Bill also empowers the Board to establish committees for its work.[90]

18.105 Potential difficulties in satisfying the required minimum number of members, in the event of a member's absence or inability to act, may be abated by having a membership of more than five members at any one time.

Appointment of chairperson

18.106 The draft Bill provides that the Minister must appoint a member of the Board to be the chairperson.[91]

18.107 The chairperson holds office for the term stated in the instrument of appointment, with the possibility of reappointment. The person ceases to hold office as chairperson if they resign from the office of chairperson or cease to be a member of the Board. In accordance with the *Acts Interpretation Act 1954*, the Minister may remove a person from the office of chairperson at any time.[92]

18.108 The appointment provisions are generally consistent with the legislation in Victoria. The Western Australian Act similarly provides for the Minister to designate one of the members as chairperson.[93]

18.109 Also, the draft Bill sets out the role of the chairperson. Consistent with other Queensland legislation,[94] it provides that the chairperson is responsible for leading and directing the activities of the Board to ensure it performs its functions appropriately. This gives clarity about the nature of the office.

Appointment of deputy chairperson

18.110 The draft Bill provides that the Minister may also appoint a member of the Board to be the deputy chairperson.

18.111 The draft Bill permits, rather than requires, the appointment of a deputy chairperson.[95] This is consistent with the Victorian Act and differs from the Western Australian Act. This gives greater flexibility.

18.112 The draft Bill provides that the deputy chairperson is to act as the chairperson during any vacancy in the office of chairperson and all periods when the chairperson is absent or cannot perform the duties of that office. This is similar to the Western Australian Act and other Queensland legislation.[96]

18.113 The *Acts Interpretation Act 1954* allows another person to be appointed to act as chairperson in the event of such vacancy or absence arises.[97] However, it is desirable for the draft Bill to permit the Minister to appoint a deputy chairperson for this purpose. This means an appointed deputy chairperson can step in without delay, rather than needing to appoint an acting chairperson.

90 See [18.305] below.

91 The power of appointment may be exercised 'as occasion requires' and includes incidental powers, including the power to remove or suspend a person appointed to the office and to appoint another person to act in the office if the person is removed, suspended, absent or unable to discharge the functions of the office, or the office becomes vacant: *Acts Interpretation Act 1954* (Qld) s 25.

92 See *Acts Interpretation Act 1954* (Qld) s 25(1)(b)(i).

93 See *Voluntary Assisted Dying Act 2017* (Vic) s 98(1), (3)–(6); and *Voluntary Assisted Dying Act 2019* (WA) s 126(1). The Western Australian Act does not include provisions, specific to the office of chairperson, about the terms of office or ways in which the person may cease to hold office.

94 See, eg, *Coroners Act 2003* (Qld) s 91K(3); *Family and Child Commission Act 2014* (Qld) s 29W(2).

95 Similarly, see, eg, *Coroners Act 2003* (Qld) s 91M(1)–(2); *Family and Child Commission Act 2014* (Qld) s 29Y(1).

96 See, eg, *Coroners Act 2003* (Qld) s 91M(5); *Family and Child Commission Act 2014* (Qld) s 29Y(6); *Penalties and Sentences Act 1992* (Qld) s 202(4).

97 See *Acts Interpretation Act 1954* (Qld) s 25(1)(b)(ii), (iv)–(v), (3)–(4).

18.114 Under the *Acts Interpretation Act 1954*, the deputy chairperson has all the functions and powers of the chairperson when acting in that role.[98]

18.115 As with the office of chairperson, a person ceases to be deputy chairperson if they resign from the office or cease to be a member of the Board. The Minister may also remove a person from the office of deputy chairperson at any time.[99]

Appointment of members

18.116 The composition of the Board should reflect a wide range of relevant expertise and experience, as well as Queensland's cultural and geographic diversity. We agree with the Victorian and Western Australian Panels that membership of the oversight body should be multi-disciplinary and include community representation.

18.117 We have considered how best to achieve this in the draft legislation and, in particular, the extent to which the legislation should impose requirements about the composition of the Board. As with other aspects of the legislation, the provisions for appointment of members should avoid undue complexity, and be relatively clear and practical to apply. The provisions must also support the purpose of the Board in providing a robust and effective oversight mechanism in which the public can have confidence.

18.118 We have also had regard to other Queensland legislation.[100]

18.119 On balance, we prefer an approach that provides greater guidance than the legislation in either Western Australia (which is silent as to the desired composition of its Board) or Victoria (which provides limited guidance in general terms only).[101] This will provide clarity and assurance for members of the public, as well as guidance for the Minister. At the same time, the provisions should not be so prescriptive as to remove the flexibility required to ensure their practical operation.

18.120 Accordingly, the draft Bill provides that the Minister may appoint a person as a member of the Board only if satisfied that the person:

- has expertise in medicine, nursing, pharmacy, psychology, social work, ethics, law or another area the Minister considers relevant to the performance of the Board's functions; or
- is otherwise, because of the person's experience, knowledge or skills, likely to make a valuable contribution to the work of the Board.

18.121 The Minister must also ensure that the membership of the Board:

- includes persons with a range of experience, knowledge or skills relevant to the Board's functions;
- takes into account the social, cultural and geographic characteristics of the Queensland community; and
- does not include a majority of persons who are public service employees.

18.122 Similar to the Victorian Act, these provisions require the Minister to be satisfied the person has relevant expertise, skills, knowledge or experience for the performance of the Board's functions. However, additional guidance is given by listing areas of expertise that are likely to be relevant. These areas are consistent with those identified by the Victorian and Western Australian Panels, and provide a good indication of the main areas of expertise that should be reflected in the Board's membership.

98 See *Acts Interpretation Act 1954* (Qld) s 24C(1)–(2). Additionally, by virtue of s 24C(3) of that Act, anything done by the deputy chairperson while purporting to act as the chairperson is not invalid merely because the occasion for the person to act as chairperson had not happened or had ceased. Express provision to similar effect is made in the *Voluntary Assisted Dying Act 2019* (WA) s 126(3).

99 Under the *Acts Interpretation Act 1954* (Qld) s 25(1)(b)(i).

100 See especially *Coroners Act 2003* (Qld) s 91L; *Family and Child Commission Act 2014* (Qld) s 29X. See also, eg, *Health and Wellbeing Queensland Act 2019* (Qld) s 18; *Hospital and Health Boards Act 2011* (Qld) s 23; *Penalties and Sentences Act 1992* (Qld) s 201(2)–(3).

101 See *Voluntary Assisted Dying Act 2017* (Vic) s 95(2).

18.123 Additionally, 'social work' is included in the listed areas of expertise. This reflects the valuable contribution of this discipline in working with individuals, families and communities. It recognises that voluntary assisted dying decisions, like other significant life and death decisions, are likely to involve the individual within the context of their families and carers, and may be impacted by other social, cultural and psychological factors.

18.124 Specialties or areas of practice within these fields are likely to be of particular relevance in this context, such as palliative medicine and palliative care nursing, geriatric medicine, neurology, health law, and elder law. However, we do not consider it desirable for the areas of expertise listed in the draft provision to specify that level of detail, as this may have an inadvertent and unnecessarily narrowing effect on its interpretation.

18.125 For the same reason, the draft provision does not limit membership to persons with expertise in the areas mentioned above. In particular, the draft Bill provides for the appointment of a person who the Minister considers would make a valuable contribution to the work of the Board because of their experience, knowledge or skills. Significantly, this may include a community member. It could, for example, include a person with relevant experience working in regional or remote areas, and would provide added scope for the appointment of persons with disability, and people from different cultural or linguistic backgrounds.

18.126 The draft provisions also specify matters the Minister must consider about the composition of the Board as a whole. This is to ensure, to the greatest extent practicable, that the overall membership is suitably mixed so that, for example, the Board is not dominated by persons from one profession or area of the State. We are concerned, in particular, that the Board should not have a solely metropolitan focus but should also have a regional outlook.

18.127 Some flexibility is necessary to ensure the appointment process, and the Board's ability to carry out its functions, is not hampered by a lack of available persons suitable for appointment. It is not, therefore, desirable for the legislation to impose a 'quota' on representation. It is sufficient to impose a requirement on the Minister to ensure the membership takes into account the diversity of the Queensland community.

18.128 Relevant guidelines for government boards in Queensland recognise the importance of community engagement and diversity in board membership. The guidelines note, consistent with relevant government policy, that:[102]

> it may be appropriate to appoint members with certain expertise or from certain sections of the community such as seniors, youth, women, Aboriginal people, Torres Strait Islanders, or people from culturally and linguistically diverse backgrounds.

18.129 It is anticipated that the Board, through its own processes and operation, would exercise its power to engage appropriate persons from diverse backgrounds to help in performing its functions, including, where relevant, people with disability and Aboriginal or Torres Strait Islander people.[103]

102 Department of the Premier and Cabinet, *Welcome Aboard: A guide for members of Queensland Government Boards, committees and statutory authorities* (4th ed, July 2010) [4.1] <https://www.premiers.qld.gov.au/publications/categories/policies-and-codes/handbooks/welcome-aboard.aspx>. See also at [4.2] and [4.4]; and Queensland Government, 'Inclusion and diversity' (13 June 2019) <https://www.qld.gov.au/about/join-a-board/inclusion-and-diversity>.

103 See [18.265] below.

Persons who are not eligible to be a member

18.130 Consistent with other Queensland legislation,[104] the draft Bill also includes standard provisions about persons who are not eligible for appointment as a member. This includes a person who is an insolvent under administration under section 9 of the Corporations Act 2001 (Cth) or has a conviction (other than a spent conviction)[105] for an indictable offence. It also includes a person who is a member of the Legislative Assembly.

Term and conditions of appointment

18.131 The draft Bill provides that members are appointed for a term of no more than three years and may be reappointed.

18.132 This is consistent with the legislation in Western Australia and, with some modifications, in Victoria. It is also consistent with other Queensland legislation.[106]

18.133 The draft Bill differs from the Victorian Act by not providing for a longer term of appointment for the inaugural members of the Board.[107] Continuity in membership during the implementation of the voluntary assisted dying framework and first years of its operation may be valuable. Equally, a change in membership might be considered beneficial. The simplicity and flexibility of providing for a term of appointment up to three years as determined by the Minister, with the possibility of reappointment, is preferred.

18.134 Consistent with other Queensland legislation,[108] the draft Bill provides that members are to be paid the remuneration and allowances decided by the Minister and that, for matters not provided for by the Act, a member holds office on the terms and conditions decided by the Minister.[109]

18.135 The draft Bill also includes provisions about when there is a vacancy in the office of a member, including where the member resigns from the office, is removed from the office by the Minister, or becomes ineligible for appointment as a member.[110] Consistent with other legislation, it provides that the Minister may remove a member from office if satisfied the member is incapable of satisfactorily performing the member's functions.

FUNCTIONS AND POWERS

Other jurisdictions

Victoria and Western Australia

18.136 The functions and powers of the Boards in Victoria and Western Australia are similar, but not identical.[111] They cover several matters.

Monitoring the operation of the legislation

18.137 The first, and perhaps overarching, function of the Boards in Victoria and Western Australia is to monitor the operation of the legislation. Many of the other functions conferred on the Boards add to or support this function in specified ways.

18.138 In Western Australia, the Board monitors 'the operation of [the] Act'. In contrast, the Board in Victoria monitors 'matters related to voluntary assisted dying'. This may be

104 See, eg, *Coroners Act 2003* (Qld) s 91L(2); *Family and Child Commission Act 2014* (Qld) s 29X(4).
105 As to spent convictions, see the *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld).
106 See, eg, *Coroners Act 2003* (Qld) s 91O; *Family and Child Commission Act 2014* (Qld) s 29ZA.
107 See *Voluntary Assisted Dying Act 2017* (Vic) s 96(2)–(3).
108 See, eg, *Coroners Act 2003* (Qld) s 91N; *Family and Child Commission Act 2014* (Qld) s 29Z; *Health Ombudsman Act 2013* (Qld) s 248; *Hospital and Health Boards Act 2011* (Qld) s 26(2).
109 Under relevant guidelines, a public sector employee appointed to the Board would not be entitled to remuneration for their service on the Board, unless specifically approved by Government: see generally Department of the Premier and Cabinet, *Welcome Aboard: A guide for members of Queensland Government Boards, committees and statutory authorities* (4th ed, July 2010) [5.1]–[5.3], [8.3].
110 Similarly see, eg, *Coroners Act 2003* (Qld) s 91P; *Family and Child Commission Act 2014* (Qld) s 29ZB; *Health Ombudsman Act 2013* (Qld) ss 249–250; *Hospital and Health Boards Act 2011* (Qld) ss 27–28.
111 See *Voluntary Assisted Dying Act 2017* (Vic) s 93(1); *Voluntary Assisted Dying Act 2019* (WA) s 118.

a wider scope than monitoring the operation of the legislation. For example, it might encompass—as matters 'related to' voluntary assisted dying—the application of professional codes of ethics where voluntary assisted dying is requested, or funding and service arrangements that have a direct impact on access to voluntary assisted dying.

Monitoring function	Vic	WA
to monitor matters related to voluntary assisted dying (Vic)	s 93(1)(a)	—
to monitor the operation of the Act (WA)	—	s 118(a)

Review of cases

18.139 The Boards' oversight and monitoring role is given effect, in part, by the review of completed voluntary assisted dying cases under the legislation. The review of cases aims to ascertain compliance with the legislative requirements and identify any issues that should be referred to other entities. The relevant functions are worded differently in each jurisdiction.

18.140 The Victorian Act provides that, in addition to monitoring matters related to voluntary assisted dying, the Board is to 'review the exercise of any function or power under [the] Act'.[112] The Act does not specify the scope or timing of such review.

18.141 The Western Australian Act provides that the Board is to 'monitor the operation of [the] Act', but does not refer expressly to the 'review' of the exercise of functions or powers.[113]

Review function	Vic	WA
to monitor matters related to voluntary assisted dying (Vic) / to monitor the operation of the legislation (WA)	s 93(1)(a)	s 118(a)
to review the exercise of any function or power under the Act (Vic only)	s 93(1)(b)	—

18.142 The Parliamentary Committee in Victoria considered that a board should review cases where a request for voluntary assisted dying is approved 'to ensure that doctors are complying with requirements of the assisted dying framework'.[114] In considering the role and functions of the Board, the Victorian Panel stated that:[115]

> One of the core functions of the Board should be to review each case of voluntary assisted dying, as well as each assessment for voluntary assisted dying, to ensure there has been compliance with the statutory requirements. Researchers have noted that examining both granted and refused requests is important to be able to assess adherence to the eligibility criteria.[116] Ensuring compliance with procedural safeguards is an important safeguard in and of itself.[117] (notes in original)

18.143 Similarly, the Western Australian Joint Select Committee recommended that an appropriate oversight body be established and 'authorised and resourced to … review all voluntary assisted dying deaths'.[118] This was supported by the Western Australian

112 See *Voluntary Assisted Dying Act 2017* (Vic) s 93(1)(a), (b).
113 See *Voluntary Assisted Dying Act 2019* (WA) s 118(a).
114 Vic Parliamentary Committee Final Report (2016) 231–2. It also considered that the Board should inform the participating medical practitioners of its findings no later than 90 days after the person's death: 232.
115 Vic Ministerial Advisory Panel Final Report (2017) 162–3. It recommended the conferral of functions to that effect on the Voluntary Assisted Dying Review Board: 164, Rec 47.
116 P Lewis and I Black, 'Adherence to the Request Criterion in Jurisdictions Where Assisted Dying Is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland' (2013) 41(4) *Journal of Law, Medicine & Ethics* 885, 895.
117 External Panel on Options for a Legislative Response to *Carter v Canada, Consultations on Physician-Assisted Dying: Summary of Results and Key Findings* (Final Report, 15 December 2015) 103–4 <https://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/pad.pdf>.
118 WA Joint Select Committee on End of Life Choices Report (2018) 224 [7.86], 229 [7.89].

Panel, which observed that such a function is consistent with the approach taken in other jurisdictions.[119]

18.144 The review of cases is facilitated by a system of mandatory reporting to the Board throughout the voluntary assisted dying process. The 'comprehensive reporting requirements' in the legislation 'enable the [B]oard to check that each stage of the voluntary assisted dying process is being correctly followed'.[120]

18.145 There are differences in the reporting requirements under the Victorian and Western Australian legislation, as noted in Chapter 8 above. Prescribed information must be given to the Board at each stage, ensuring that the voluntary assisted dying process is fully documented. This includes information about eligibility assessments and final reviews, reporting about the supply and return of the substance and notification of the person's death.[121] This then enables the Board to review each case. The Board may also request information from any person, including the nominated contact person, to assist with its review.[122]

18.146 It appears that the review of cases is intended to be conducted retrospectively, that is, once the voluntary assisted dying process is complete.[123] In recommending case review by the Board, the Victorian Panel observed that '[n]o other jurisdiction has an independent body that makes contemporaneous rulings about the legality of particular cases of voluntary assisted dying', and that 'such a process would be extremely traumatic for participants'. The Panel observed that the assessment of eligibility is a matter for clinical judgment within a therapeutic relationship and that the Board's role in reviewing cases is to ensure adherence to the statutory requirements.[124]

18.147 However, the Board in Victoria explains that, in practice, it undertakes both initial administrative checks of the forms provided by medical practitioners during the process, as well as the retrospective review of completed cases to determine compliance with the legislation:[125]

> **Application and assessment checks**
>
> Medical practitioners submit the relevant forms and required evidence on behalf of the applicant to the Voluntary Assisted Dying Review Board. This is done via the Voluntary Assisted Dying Portal.
>
> At this point, the secretariat for the Board undertakes an administrative check to ensure sufficient information has been provided. At times, medical practitioners may be asked to clarify or provide more information. This is done to ensure there are no delays when a permit application is made to the Secretary, [Department of Health & Human Services].
>
> …

119 See WA Ministerial Expert Panel Final Report (2019) 93–4, 138, referring in particular to Belgium and the Netherlands. See [18.3] above.

120 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5140 (RH Cook, Minister for Health). See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 9, 11–12, 14, 16–17, 19–20, 22, 25–7, in which it is explained that the intent of the reporting provisions is to 'ensure that the Board is notified progressively of the patient's participation in the voluntary assisted dying process', from the time of the first request and 'including the outcome of each assessment, to track that the correct process is being followed in each case of voluntary assisted dying'.
In Victoria, see generally Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health).

121 See especially *Voluntary Assisted Dying Act 2017* (Vic) ss 21(2), 30(2), 41(2), 60(2), 66(2); *Voluntary Assisted Dying Act 2019* (WA) ss 22(1), 29(2), 33(1), 40(2), 46, 50, 51(4), 60(1), 61(4), 74(3), 76(3), 78(3). See also the process diagrams in Chapters 8 and 10 above.

122 See *Voluntary Assisted Dying Act 2017* (Vic) s 103; *Voluntary Assisted Dying Act 2019* (WA) s 150, at [18.182][18.184] below.

123 See, eg, Vic Parliamentary Committee Final Report (2016) 231–2; Vic Ministerial Advisory Panel Final Report (2017) 161–2; WA Ministerial Expert Panel Final Report (2019) 93.

124 Vic Ministerial Advisory Panel Final Report (2017) 162.

125 Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 4. The Board reviews cases 'retrospectively' each month: 15.

Compliance review

Once a voluntary assisted dying application is complete, either because the applicant has died or chosen not to continue with the process, the Board rigorously reviews all the forms and information submitted to determine if the case was compliant with the Act.

The secretariat seeks feedback from nominated contact people, medical practitioners and other agencies that support the voluntary assisted dying process. This is to assist the Board with its numerous responsibilities, including the individual application review process, education, research and future improvements.

18.148 Limited evaluative evidence is available about this approach. There appear to be mixed views among those who have used the legislation. In one small empirical survey of medical practitioners, a participant commented that:[126]

> I think the Act, by being so prescriptive, makes it incredibly hard for doctors to go outside it. So, compared with Canada, where you do what you do, and then the coroner reviews what you've done after and may be critical. That's not going to happen in Victoria because it's so constricted. You can't get the permit unless the Department is on side and all the paperwork is done perfectly. It's looked at prospectively. It's looked at by the Department, it's overseen by the Board. You can't go wrong. In fact, it's terribly protective. Because all the risk is taken out by having it so managed.

18.149 There have been criticisms of the 'bureaucratic requirements' of the Victorian Act, including the time it may take for paperwork to be completed.[127]

18.150 An interview-based study of the perspectives of participating medical practitioners in Victoria identified the Board as the primary 'gatekeeper'.[128] It was explained that the process for submitting forms means that the process cannot continue until the Board has 'approved' the forms at each step:

> although framed as the 'VADRB' or 'Board', it was clear that participants were commenting on the processes of its Secretariat. ...
>
> Participants described the Secretariat undertaking a prospective approval process at each of the three points when doctors uploaded a form (and other documentation) into the Portal. Participants reported this gatekeeping function because no further steps could be taken until the Secretariat approved and returned the relevant form to the doctor. Portal design meant that the next required form did not become accessible to the doctor in the Portal until the previous form had been approved.

18.151 The study identified that some practitioners considered that this 'prospective approval process' is 'bureaucratic', causes 'unnecessary delays' and is 'not apposite for very sick patients'. For example, practitioners reported that each approval step took about 24 hours, that forms could be returned for typographical or minor errors, and that requests for further details could be 'unrealistic' or 'disconnected from clinical realities'. However, it was also noted that the approval process 'protected doctors and ensured safety'. Some considered the Board's approval of forms is reasonable or necessary, and some noted that the process becomes easier to navigate with more experience.

126 J Rutherford, 'Doctors and the *Voluntary Assisted Dying Act 2017* (Vic): Knowledge and General Perspectives' (2020) 27 *Journal of Law and Medicine* 952, 957. That article reports the findings of a qualitative study of Victorian medical practitioners' general knowledge and perspectives on the legislation. It involved a survey of 25 medical practitioners recruited from a range of specialties and who had no in-principle objection to voluntary assisted dying. It formed part of a larger study into some Victorian doctors' experience of the legislation in the first eight months of its operation.

127 See generally P Komesaroff et al, 'One year of voluntary assisted dying in Victoria: 400 have registered, despite obstacles', *The Conversation* (online, 30 June 2020) <https://theconversation.com/one-year-of-voluntary-assisted-dyingin-victoria-400-have-registered-despite-obstacles-141054>. Those authors are undertaking a federally funded research project examining the impact of the Victorian legislation.

128 BP White et al, 'Prospective oversight and approval of assisted dying cases in Victoria, Australia: a qualitative study of doctors' perspectives', *BMJ Supportive & Palliative Care* (forthcoming). The study involved semistructured interviews with 32 medical practitioners who have participated as either a 'coordinating medical practitioner' or 'consulting medical practitioner' in the Victorian scheme.

Referral of matters

18.152 The Boards in Victoria and Western Australia are not empowered to investigate complaints or determine professional disciplinary matters. Instead, as part of their oversight and monitoring role, the Boards refer matters to other agencies.

18.153 The Acts provide that the Board is to refer 'any issue' (in Victoria) or 'any matter' (in Western Australia) 'identified by the Board in relation to voluntary assisted dying' that is relevant to the functions of one of several specified entities.[129] The specified entities include the Commissioner of Police, AHPRA, the Registrar of Births, Deaths and Marriages, the State Coroner and the Department that administers the voluntary assisted dying legislation.

18.154 The Western Australian Act also provides for referral, if relevant, to the chief executive officer of the Department that administers the *Prisons Act 1981* (WA) and the Director of the Health and Disability Services Complaints Office appointed under the *Health and Disability Services (Complaints) Act 1995* (WA).

18.155 In Western Australia, complaints about a health, disability or mental health service can be made to the Health and Disability Services Complaints Office. If a complaint relates to a registered health practitioner, AHPRA must be notified, and an appropriate way to manage the complaint is agreed between those two agencies.[130]

18.156 A similar health complaints system applies in Victoria.[131] The Health Complaints Commissioner is not listed as a referral entity in the Victorian Act. However, the Health Practitioner Regulation National Law (Victoria) provides for AHPRA to agree with a state health complaints entity for an issue to be dealt with by the state entity if appropriate.[132]

18.157 In Victoria, the Board's referral function is supported by an express power to disclose 'identifying information' to a specified entity.[133]

Referral function	Vic	WA
to refer any issue (Vic) / matter (WA) identified by the Board in relation to voluntary assisted dying that is relevant to (Vic) / relevant to the functions of (WA)— – the Commissioner of Police – the Registrar of Births, Deaths and Marriages – the Secretary of the Department of Health and Human Services (Vic) / chief executive officer of the Department of Health (WA) – the State Coroner – the Australian Health Practitioner Regulation Agency ('AHPRA') – the Director of the Health and Disability Services Complaints Office (WA only) – the chief executive officer of the department that administers the Prisons Act 1981 (WA only)	s 93(1)(e)	s 118(c)

18.158 The Explanatory Notes to the Western Australian Bill explain the intended scope and purpose of the referral function:[134]

129 *Voluntary Assisted Dying Act 2017* (Vic) s 93(1)(e); *Voluntary Assisted Dying Act 2019* (WA) s 118(c).

130 See generally Health and Disability Services Complaints Office, 'Complaint Resolution Process' (2 October 2020) <https://www.hadsco.wa.gov.au/Complaints/Complaint-Resolution-Process>. See also *Health and Disability Services (Complaints) Act 1995* (WA) ss 31, 32A; Health Practitioner Regulation National Law (Western Australia) s 150.

131 See generally Health Complaints Commissioner (Vic) and AHPRA, 'How to make a complaint about a health practitioner, health service, or holder of records' (December 2020) <https://www.ahpra.gov.au/Notifications/Further-information/Guides-and-fact-sheets.aspx#brochures>. See also *Health Complaints Act 2016* (Vic) s 26; Health Practitioner Regulation National Law (Victoria) s 150.

132 See Health Practitioner Regulation National Law (Victoria) s 150(1), (3).

133 See *Voluntary Assisted Dying Act 2017* (Vic) s 104, which provides that, in making a referral, the Board may use and disclose identifying information obtained by the Board in performing its functions or exercising its powers, but 'must not refer a matter' in such a case 'unless the Board reasonably believes the identifying information discloses a matter that is relevant to the functions and powers of that person or body'. In Victoria and Western Australia, the Boards' functions also include collecting, using and disclosing information.

134 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 39. See also Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5140 (RH Cook, Minister for Health); Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health).

> The Board will not have an investigatory or enforcement role. There are preexisting agencies with these functions, such as the Western Australia Police, the State Administrative Tribunal, the Health and Disability Services Complaints Office and the Australian Health Practitioner Regulation Agency.
>
> Subclause (c) specifically enables the Board to refer any matter that the Board identifies in relation to voluntary assisted dying to a number of persons or bodies. The Board may only do so if it reasonably believes the information is relevant to one or more of the functions of the relevant body. The Board may use and disclose personal information collected by it as a result of performing any of its functions or exercising a power, for the purpose of referring matters to the bodies listed in subclause (c).
>
> One of the purposes of this provision is to enable the Board to refer suspected contraventions of the Bill to the appropriate body. The body to which referrals are made will depend on the conduct in question. The body will then be able to investigate the matter referred pursuant to its own legislation. For example, if the Board refers a matter to the Coroner on the basis that the death is or may be a reportable death because the death was not in accordance with the Voluntary Assisted Dying Act, then the Coroner is able to investigate the matter pursuant to the Coroners Act 1996 (WA).

18.159 The Western Australian Panel similarly observed that 'there are already pathways and processes that exist for people to raise concerns in relation to health and medical treatment or services'. It noted support in its consultation for complaints about health practitioners' compliance with voluntary assisted dying laws to be handled through those existing mechanisms.[135]

18.160 The Victorian Panel also explained that:[136]

> In the case of administrative, clerical, or minor procedural errors on the part of either medical practitioner, … the Board would provide feedback to ensure the medical practitioners involved follow proper procedure in the future. In the case of breaches, the Board would forward its report to the appropriate authority. Depending on the nature of the breach this may be Victoria Police, the Coroner, and/or or the Australian Health Practitioner Regulation Agency. Those bodies would then determine whether to investigate the case further.

18.161 The Board in Victoria has referred one matter to another agency in the first 18 months of operation of the legislation:[137]

> The Board found that while the applicant was eligible for a voluntary assisted dying permit, there was a failure to comply with the procedural requirements of the Act by a medical practitioner. The Board referred the matter to the Australian Health Practitioner Regulation Agency (AHPRA).

Research and data collection

18.162 The Boards in Victoria and Western Australia are also given specific functions relating to research and data collection.

18.163 The Victorian Act provides that the Board is to 'conduct analysis of, and carry out research in relation to, information or forms given to the Board in accordance with [the] Act'. It is also to 'collect, use and disclose forms and information provided in accordance with [the] Act for the purposes of carrying out a function of the Board'.[138]

135 WA Ministerial Expert Panel Final Report (2019) 93–4.

136 Vic Ministerial Advisory Panel Final Report (2017) 161, referring to Vic Parliamentary Committee Final Report (2016). See also Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health).

137 Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 15. See also Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 14; Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 9.

138 *Voluntary Assisted Dying Act 2017* (Vic) s 93(1)(g), (i). In addition, the Board is to 'provide information about voluntary assisted dying, and other matters identified by the Board in the performance of a function under [the] Act': s 93(1)(h).

18.164 Similar provision is made in the Western Australian Act, although it refers to 'information', rather than to information and 'forms'.[139]

Research and data collection functions	Vic	WA
to conduct analysis of, and carry out research in relation to, information or forms (Vic) / information (WA) given to the Board in accordance with (Vic) / under (WA) the Act	s 93(1)(g)	s 118(d)
to collect, use and disclose forms and information (Vic) / information (WA) provided in accordance with (Vic) / under (WA) the Act for the purposes of carrying out a function of the Board	s 93(1)(i)	s 118(e)

18.165 In addition, the Boards in Victoria and Western Australia have specific obligations to 'record and retain statistical information' about voluntary assisted dying. Different information is specified in each jurisdiction, as shown below.[140]

The Board must record and retain statistical information about—	
Victoria: s 117(1)–(2)	Western Australia: s 152(1)
persons who have been issued with a voluntary assisted dying permit persons who have died after taking a voluntary assisted dying substance in accordance with the Act	—
in respect of the persons in each of the two categories above— – the disease, illness or medical condition of the person that met the requirements of the eligibility criteria – if the person died after taking a voluntary assisted dying substance in accordance with the Act—the age of the person at the date of their death	the disease, illness or medical condition of a person that met the diagnosis requirements of the eligibility criteria (whether or not the person made a final request) if a person has died after taking a voluntary assisted dying substance in accordance with the Act—the age of the person on the day of their death
—	participation in the request and assessment process, and access to voluntary assisted dying, by persons who are regional residents
—	any matter specified in a direction from the Minister to the Board

18.166 In Victoria, the Board must make the statistical information 'publicly available in a de-identified form on an internet site maintained by the Board'.[141] Some information has been included in the Voluntary Assisted Dying Review Board's sixmonthly reports, which are published on the Board's website.[142]

18.167 In Western Australia, the Board may be directed by the Minister to retain and record statistical information about a particular matter and to include that information in its annual report.[143] The Act does not otherwise require the publication of statistical information collected by the Board.

18.168 The Victorian Panel explained that:[144]

> one of the Board's functions would be to collect and monitor data so that it can oversee the operation of the legislative framework directly, rather than having this data reported through the Department of Health and Human Services or another body. The Panel recognises that as the Board establishes its operations for ongoing implementation

139 *Voluntary Assisted Dying Act 2019* (WA) s 118(d)–(e).
140 See *Voluntary Assisted Dying Act 2017* (Vic) s 117; *Voluntary Assisted Dying Act 2019* (WA) s 152.
141 *Voluntary Assisted Dying Act 2017* (Vic) s 117(3).
142 See the reports available at Safer Care Victoria and the Victorian Agency for Health Information, 'Voluntary Assisted Dying Review Board' (3 March 2021) <https://www.bettersafercare.vic.gov.au/about-us/vadrb>.
143 *Voluntary Assisted Dying Act 2019* (WA) s 152(2)–(3).
144 Vic Ministerial Advisory Panel Final Report (2017) 163–4. It recommended that the Board's functions should include 'collecting information and data', and 'facilitating and conducting research relating to voluntary assisted dying': 164, Rec 47.

> it would form a view about additional data that may be required to oversee voluntary assisted dying in Victoria. Therefore, it is intended that the Board be able to request further reports and information to supplement what is set out in the legislation so it can perform its functions.[145]
>
> …
>
> The Panel also proposes that the Board, as custodian of the data that is collected and monitored under this framework, should have a role in facilitating research. In this way the Board would be able to identify opportunities for quality improvement and disseminate guidance based on the analysis of the data collected. (note added)

18.169 The importance of data collection and evaluation of information was also recognised by the Western Australian Panel. It recommended that data collection 'should include all aspects of the process of voluntary assisted dying and comprehensive information relating to the person accessing voluntary assisted dying', including:[146]

- aspects related to the person (demographics, medical condition/s, vulnerable population group)
- aspects related to the care status of the person (palliative care, other support services involved)
- aspects related to the practitioners involved (type, location)
- voluntary assisted dying eligibility / ineligibility status (and reasons)
- voluntary assisted dying procedural data and benchmarks
- aspects related to medication prescription
- aspects related to medication administration (planned and actual, location)

18.170 The Panel noted the 'importance of balancing data collection with not unduly creating administrative burden', but considered it important to ensure that the information collected is 'comprehensive enough' to meet the Board's reporting requirements 'as well as deepening knowledge about voluntary assisted dying'.[147]

Reporting and advising on matters related to the legislation

18.171 The Boards in Victoria and Western Australia also have functions relating to providing reports, information and advice on matters under the legislation. There are some differences in the wording, but the functions are broadly similar in each jurisdiction.

18.172 In Victoria, the Board is to 'provide reports to each House of the Parliament on the operation of [the] Act and any recommendations for the improvement of voluntary assisted dying'. Its functions also include reporting to the Minister or the Secretary of the Department 'in respect of any matter relevant to the functions of the Board as requested', and providing 'advice' to the Minister or the Secretary of the Department 'in relation to the operation of [the] Act.[148]

18.173 In Western Australia, the Board is to give 'advice, information and reports' to the Minister or the chief executive of the Department 'on matters relating to the operation of [the] Act, including any recommendations for the improvement of voluntary assisted dying'. The Board is to do so 'on its own initiative or on request'.[149]

145 See *Voluntary Assisted Dying Act 2017* (Vic) s 103; and, in Western Australia, *Voluntary Assisted Dying Act 2019* (WA) s 150, at [18.182] below.

146 WA Ministerial Expert Panel Final Report (2019) 93–5, Rec 28. See also WA Joint Select Committee on End of Life Choices Report (2018) 224 [7.86], 229 [7.89], in which it was recommended that an appropriate oversight body be established, authorised and resourced to 'maintain a database of all relevant statistics related to assisted dying'.

147 WA Ministerial Expert Panel Final Report (2019) 94–5.

148 *Voluntary Assisted Dying Act 2017* (Vic) s 93(1)(c), (k)–(l).

149 *Voluntary Assisted Dying Act 2019* (WA) s 118(b).

Reporting and advising functions	Vic	WA
to provide reports on: – the operation of the Act and any recommendations for the improvement of voluntary assisted dying, to the Parliament (Vic) – matters relating to the operation of the Act including any recommendations for the improvement of voluntary assisted dying, on own initiative or on request, to the Minister or the Department (WA)	s 93(1)(c)	s 118(b)
to provide reports in respect of any matter relevant to the functions of the Board as requested, to the Minister or the Department (Vic)	s 93(1)(l)	—[150]
to provide information: – about voluntary assisted dying and other matters identified by the Board in the performance of a function under the Act (Vic) – on matters relating to the operation of the Act, on own initiative or on request, to the Minister or the Department (WA)	s 93(1)(h)	s 118(b)
to provide advice to the Minister or the Department: – in relation to the operation of the Act (Vic) – on matters relating to the operation of the Act, on own initiative or on request (WA)	s 93(1)(k)	s 118(b)

18.174 As discussed later in this chapter, the Boards in those jurisdictions also have specific annual reporting obligations.

18.175 The Victorian Panel explained that:[151]

> the Voluntary Assisted Dying Review Board should have a strong focus on quality and safety. One of the key functions of the Board should be to provide transparency and accountability on the operation of the framework by reporting publicly on and identifying trends and recommendations for improvement.

Community engagement

18.176 In Victoria, the Board has additional functions about community engagement and the promotion of compliance and continuous improvement.

Community engagement and improvement functions	Vic	WA
to promote compliance with the Act by providing information about voluntary assisted dying to registered health practitioners and members of the community	s 93(1)(d)	—
to promote continuous improvement in the quality and safety of voluntary assisted dying to those who exercise any function or power under the Act	s 93(1)(f)	—
to consult and engage in relation to voluntary assisted dying with the community, relevant groups, government departments and agencies, and registered health practitioners who provide voluntary assisted dying services	s 93(1)(j)	—

18.177 The Victorian Panel recommended that the Board's functions should include:[152]

- supporting improvement by … maintaining and disseminating guidelines to support the operation of the legislation, in collaboration with other agencies and professional bodies and services; and
- any other functions necessary to promote good practice.

18.178 The Western Australian Panel recognised the importance of education to ensure voluntary assisted dying processes are safe and compassionate, particularly during

150 But see *Voluntary Assisted Dying Act 2019* (WA) s 118(f), which states that the Board has 'any other function given to the Board under this Act', and s 155, which provides for the Board to give an annual report to the Minster on the operation of the Act, including information relevant to the performance of the Board's functions.

151 Vic Ministerial Advisory Panel Final Report (2017) 164. It recommended that the Board's should include 'monitoring … and reporting on matters related to voluntary assisted dying': 164, Rec 47. See also Vic Parliamentary Committee Final Report (2016). See also Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health).

152 Vic Ministerial Advisory Panel Final Report (2017) 164, Rec 47.

implementation of the legislation.[153] It did not make specific recommendations for community engagement or education functions to be given to the oversight Board.[154]

18.179 As a 'catch-all', the Western Australian Act provides that the Board has 'any other function given to the Board under the Act'.[155]

Powers necessary to perform its functions

18.180 The Boards in Victoria and Western Australia have all the powers necessary to perform their functions.[156]

18.181 Additionally, each Board is empowered to 'co-opt any person with special knowledge or skills' to assist it in a particular matter. The approval of the Minister is required.[157] The Victorian Act provides that '[a] person who has been coopted to assist the Board is to be considered to be a member of the Board until the period of cooption ends'.[158] In contrast, the Western Australian Act provides that a coopted person 'may attend meetings of the Board and participate in its deliberations but cannot vote at a meeting of the Board'.[159]

18.182 In each jurisdiction, the Board may also request information from any person, including the nominated contact person, to assist it in performing any of its functions.[160] The Western Australian Act additionally provides that a person may comply with such a request 'despite any enactment that prohibits or restricts the disclosure of the information'.[161]

18.183 The Victorian Panel observed that:[162]

> as the Board establishes its operations for ongoing implementation it would form a view about additional data that may be required to oversee voluntary assisted dying in Victoria. Therefore it is intended that the Board be able to request further reports and information to supplement what is set out in the legislation so it can perform its functions.

18.184 In its third report, the Voluntary Assisted Dying Review Board explained that:[163]

> [In 2020], we started seeking formal feedback from the medical practitioners who support applicants through the process.
>
> …
>
> The secretariat seeks feedback from nominated contact people, medical practitioners and other agencies that support the voluntary assisted dying process. This is to assist the Board with its numerous responsibilities, including the individual application review process, education, research and future improvements.

Powers of oversight board	Vic	WA
has all the powers that are necessary or convenient (Vic) / that it needs (WA) to perform its functions	s 93(2)	s 119
may, with the Minister's approval, co-opt any person with special knowledge or skills to assist it in a particular matter	s 100	s 122
may request any person, including a contact person, to give information to the Board to assist it in performing any of its functions	s 103	s 150

153 See WA Ministerial Expert Panel Final Report (2019) 96–100.
154 Cf WA Joint Select Committee on End of Life Choices Report (2018) 224 [7.86], 229 [7.89], in which it was recommended that an appropriate oversight body should be established, authorised and resourced to 'provide community education and resources' and 'provide health professional education and resources'.
155 *Voluntary Assisted Dying Act 2019* (WA) s 118(f).
156 *Voluntary Assisted Dying Act 2017* (Vic) s 93(2); *Voluntary Assisted Dying Act 2019* (WA) s 119.
157 *Voluntary Assisted Dying Act 2017* (Vic) s 100(1); *Voluntary Assisted Dying Act 2019* (WA) s 122(1).
158 *Voluntary Assisted Dying Act 2017* (Vic) s 100(2).
159 *Voluntary Assisted Dying Act 2019* (WA) s 122(2).
160 See *Voluntary Assisted Dying Act 2017* (Vic) s 103; *Voluntary Assisted Dying Act 2019* (WA) s 150(1).
161 *Voluntary Assisted Dying Act 2019* (WA) s 150(2).
162 Vic Ministerial Advisory Panel Final Report (2017) 163.
163 Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 2, 4. See also Safer Care Victoria, *Annual Report 2019–20* (2020) 56.

Queensland

18.185 The Parliamentary Committee did not comment specifically on the functions or powers that should be conferred on an oversight body.[164]

18.186 The White and Willmott Model suggests a similar monitoring role to the Board in Victoria. It suggests the 'posthoc' review of cases and referral of instances of non-compliance to other entities:[165]

> In terms of individual cases, the Board should conduct a post-hoc review of each case of voluntary assisted dying to ensure that it complied with the requirements of the Act and this duty should be specified in the Act. The Board's powers should include the ability to request further information beyond that provided by the first medical practitioner if it considers this necessary. If there are concerns about compliance, the Board should be empowered to refer that case to entities such as the police, the Coroner and the Australian Health Practitioner Regulation Agency.

18.187 In an earlier publication, Professors White and Willmott considered that 'the value of reducing suffering' supports retrospective case review. They explained that:[166]

> The proposed legislative model requires at least two independent doctors to be satisfied of eligibility, part of which is to be satisfied of the intolerable nature of the patient's suffering. Given this safeguard, the value of reducing suffering points us towards a retrospective model rather than requiring further delay for the person who is in this intolerable state while yet another body be satisfied that he or she is eligible to receive assistance.

18.188 The White and Willmott Model supports monitoring functions relating to the legislation as a whole, including recommending improvements and collecting and reporting data:[167]

> The Board's monitoring role also requires oversight of the system as a whole to ensure that it is functioning as intended and to make recommendations for improvement where needed. To support this, the Board would collect and analyse data provided to it by registered medical practitioners in their reporting. It may also need to collect further information to undertake this overall monitoring role. This data (in de-identified form) should also be made publicly available for community scrutiny in the form of annual reports tabled in Parliament.

18.189 Also, the White and Willmott Model suggests that the oversight body should have a role in providing education:[168]

> The Board should also have power to undertake educational initiatives for registered health practitioners and the wider community to promote understanding of, and compliance with, the requirements of the Act.

18.190 Some guidance can also be taken from other Queensland legislation.[169]

Submissions

18.191 Our Consultation Paper asked whether the oversight body should have some or all of the functions and powers conferred on the Boards under the Victorian or Western Australian Acts.[170]

18.192 Most respondents that addressed this question supported functions similar to those in Victoria or Western Australia, or as contemplated by the White and Willmott Model. In contrast, a few respondents were critical of those approaches.

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164 See generally Qld Parliamentary Committee Report No 34 (2020) 145, Rec 19.
165 White and Willmott Model pt 6.
166 L Willmott and B White, 'Assisted Dying in Australia: A Values-based Model for Reform' in I Freckelton and K Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 508.
167 White and Willmott Model pt 6.
168 Ibid.
169 See [18.24]–[18.31] above.
170 QLRC Consultation Paper No 79 (2020) Q-44.

18.193 Some respondents supported specific functions, including monitoring the scheme and legislative compliance, reviewing voluntary assisted dying cases, referring or reporting concerns to relevant investigatory or disciplinary entities, collecting and analysing data and information on aspects of the scheme, providing education, and engaging with the community and promoting compliance or continuous improvement.

18.194 The Australian Lawyers Alliance submitted that the oversight body should be established:

> to monitor the [voluntary assisted dying] scheme, approve permits, review the exercise of any function under the [voluntary assisted dying] scheme, [and] report to Parliament …

18.195 Another respondent was 'unsure' what functions and powers the oversight body should have but submitted that its 'main role would be to ensure that duress is not exerted on people to either stay alive or die, and that discrimination does not occur'.

Monitoring

18.196 Dying with Dignity Victoria Inc submitted that '[a]n oversight body is useful in both ensuring adherence to standards, and providing comfort to the population that risks are managed appropriately'.

18.197 The Cancer Council Queensland observed that a voluntary assisted dying scheme will 'have a range of effects on end of life care' and will need to be monitored and evaluated. It submitted that:

> if assisted dying legislation is introduced, there should be a requirement for formal notification of each stage of the request process completed, and of the person's death (whether through assisted dying or not) to a designated body. Notification of each stage of the process would provide up-to-date and detailed information of how assisted dying requests are dealt with, for example, how many progress beyond each request stage and the reasons why or why not, and also factors relevant to requests that proceed to an assisted death and those that do not.

18.198 In its view, the monitoring and evaluation framework should consider a range of matters, including 'community perceptions of the operation of the scheme, and the experiences of patients, families, carers and health practitioners'. It submitted that:

> This kind of information will be essential to tracking how the scheme is working in practice and identifying any changes or additional measures that are needed to ensure that the scheme operates as intended, and that any negative, unintended effects are quickly detected and addressed.

Review of cases

18.199 Go Gentle Australia strongly supported a review board, submitting that '[t]ransparency will be important to guarantee public confidence in the legislation' and that, in their view, 'the review process [is] the final safeguard'.

18.200 Professors White and Willmott continued to support their approach in the White and Willmott Model.[171] They commented, however, that some 'practical issues' have emerged in the Victorian system:[172]

> We note … that some practical issues have arisen during Victoria's first year of implementation which may pose some barriers to access for patients seeking [voluntary assisted dying]. While the Victorian system requires the issue of a permit from the Secretary of the [Department of Health and Human Services] before administration can take place, there are additional checks undertaken by the Board at

171 Relevantly, the White and Willmott Model suggests that the oversight body should conduct a 'post-hoc' review of voluntary assisted dying cases.

172 See further [18.150]–[18.151] above.

> various stages throughout the process. This effectively means that there is checking at all stages during the process, at the time the permit is applied for, and retrospectively.
>
> As noted above, there is only anecdotal evidence available about how Victoria's system is operating but some of this evidence points to barriers to access due to the overall model design. This is consistent with early findings (not yet published) from our review of the Victorian [voluntary assisted dying] system's first year of operation.

18.201 The Cancer Council Queensland submitted that 'post-death review of an assisted death is necessary', but that 'sensitivity should be given to the privacy of the person who has died, and the privacy and experiences of grieving family members'.

18.202 Catholic Health Australia submitted that an oversight body should have 'a clinical and administrative compliance' function and, in particular, that a 'mechanism for contemporaneous review should be included':

> Such a body should periodically review whole cases from request to their end to ensure that an effective review can occur not only of administrative compliance ie. the right forms are filled out in the correct sequence, but that valid and reliable clinical assessments were conducted throughout the process.

18.203 In its view, the functions of the Boards in Victoria and Western Australia 'are for the provision of a post-hoc administrative review' which 'offer no protections or no safeguards against coercion, manipulation or other practices which may lead to exploitation'. It submitted that:

> only a contemporaneous review could possibly hope to detect coercion, manipulation, errors in diagnosis and errors in prognosis or other issues that could provide some safeguards. Contemporaneous review would more likely offer assurance and comfort that the best interests of a patient were being respected. Should a wrongful death occur as a result of errors being overlooked in the process a post hoc determination of that fact provides no comfort to the deceased or confidence for the community about administration of the Act.

18.204 A member of the public commented that the review function under the White and Willmott Model 'is confined to checking that the paperwork has been correctly completed'.[173]

18.205 The National Seniors Queensland Policy Advisory Group suggested a 'review committee' should be required to review submissions from the requesting person, their medical practitioners or appointed agent to ensure legislative requirements are met, and to 'endorse the decision within 14 days of the criteria being met'.

18.206 A few respondents, including the Royal Australasian College of Physicians, submitted that individual cases should be reviewed by a coroner, for example, to ensure compliance or where there may be claim of coercion.

Investigation or referral

18.207 One respondent, who supported an oversight body, submitted that it would be a 'toothless tiger' in practice unless it enforces the law.

18.208 Other respondents submitted, however, that the oversight body should not have an investigation or disciplinary function and that these functions should remain with other existing agencies. For example, the Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine submitted that:

> Any oversight body should not have investigatory powers and any investigation should be conducted by existing independent agencies. A report to any oversight body should facilitate practitioner support, rather than investigation. When there are concerns about

173 Another member of the public described the monitoring and review functions under the Victorian Act as 'passive' monitoring and review.

> irregularities, including acting outside the scope of practice; acting outside the law; family coercion; or misuse of a lethal drug, the oversight body should be required to refer these matters to other existing agencies.

18.209 MIGA made a similar submission, observing that such matters should be referred by the oversight body, using clear criteria, to 'those entities who have general healthcare oversight obligations', including the Health Ombudsman, AHPRA, the Medical Board, and the State Coroner.

18.210 The Office of the Health Ombudsman submitted that, where the legislation in Victoria and Western Australia provides for the referral of identified matters to AHPRA, corresponding provision should be included in Queensland for referral to the Health Ombudsman.

Data collection and research

18.211 Dying with Dignity NSW submitted that it 'is essential' that 'statistics are kept about the scheme's operation'.

18.212 The Royal Australasian College of Physicians submitted that '[t]here must be rigorous documentation and data collection to enable review of any scheme and to assess changes in practice and the impacts on health professionals, patients and families'. In its view, a 'major practical role' for participating health practitioners will be to capture information and report 'directly to a monitoring body' to enable audit of the scheme and to track trends and patient motivations. It noted, for example, that 'there could be a specific reportable form filled out and sent to a monitoring body for review'. In its view:

> All records in connection with a voluntary assisted death should be provided to a central body for transparent monitoring and to enable important research on areas such as uptake, the reasons for requests and requests amongst vulnerable groups.

18.213 The Royal Australasian College of Physicians considered that:

> Areas of key interest include the reasons for requests, patient demographics, requests amongst vulnerable groups, impact on suicide rates, the disposal of unused lethal medication and patient-level reporting processes for pharmacovigilance purposes.

18.214 Palliative Care Queensland submitted that:

> Governments should invest in research including data collection related to voluntary assisted dying to enable review of any scheme, the monitoring of safe practice and assess the impacts of voluntary assisted dying including the impact on patients, their families, their carers and personal supporters. In addition, investment will also be necessary to research the impact (including the cultural impact) that the introduction of voluntary assisted dying has on the health workforce.

18.215 Respondents also suggested data collection or research on matters such as 'the barriers to provision' of voluntary assisted dying, and improving end of life options for people who do not have decision-making capacity.[174] Some suggested the collection of a wider range of data than is reported in Victoria. For example, Go Gentle Australia submitted that data should be collected and reported about:

- number of people also receiving palliative care;
- numbers of people who apply but do not continue with [voluntary assisted dying] and their reasons;
- numbers of people who die before completing the [voluntary assisted dying] process;
- the location of the death eg, at home, in hospice, or hospital;
- the end of life concerns, eg being a burden, pain, control, etc.

174 See also the discussion of adults who lack or lose decision-making capacity in Chapter 7 above.

18.216 Christians Supporting Choice for Voluntary Assisted Dying submitted that the information collected and publicly reported should include: the number of requests for assessment that were refused; the number of those who were assessed as eligible but did not proceed; the number of prescriptions issued and used; complications, if any, following administration of the substance; the name and dose of the substance used; the approximate time from administration of the substance until death; whether the person was also receiving hospice or other palliative care support; whether the substance was self-administered or practitioner administered; the place and location of death; the person's end of life concerns; and the person's age and sex.[175]

18.217 The VALE Group also supported a wider range of information to be collected and reported publicly. It referred to an article published in The Conversation about the release of the first six-monthly report of the Board in Victoria, which notes the following information that could usefully be collected and reported:[176]

- information about patients requesting access to voluntary assisted dying before the formal first assessment and reasons they did not proceed;
- for those assessed, the differences in reported numbers at each stage of the assessment and approval process, for example, whether the patient died or decided not to proceed;
- how long it takes patients to progress from a first assessment through to the permit application stage; and
- demographic detail about the patients who have accessed voluntary assisted dying, such as their age, sex, level of education or income.

18.218 However, another respondent suggested that a data collection function like that in the Victorian Act 'will not protect anyone' as '[n]o one else will have access to the same data' and those involved may not be 'objective or impartial'.

Community engagement

18.219 Two academics jointly submitted that:

> The additional functions conferred on the Board under the Victorian Act (community engagement, compliance, and improvement) are all worthwhile functions. For this reason, the Victorian model is preferable to that implemented under the [Western Australian] Act.

18.220 Palliative Care Nurses Australia Inc. similarly submitted that the oversight body should have 'functions related to':

> health professional (including nursing) education, continuous quality improvement, and consultation and engagement with the community, relevant groups, government departments and agencies, and registered health practitioners who provide voluntary assisted dying services.

18.221 The Clem Jones Group considered that it 'envisage[s] an educational role for the oversight body':

> We believe public and professional understanding of voluntary assisted dying and any Queensland [voluntary assisted dying] law is essential and support the recommendation for public education campaigns, with a statutory body overseeing any [voluntary assisted dying] laws being the most appropriate body to undertake and coordinate such efforts.

175 This respondent also submitted that '[a]ll of the above should be in an online reporting format making it as simple as possible for the reporting medical practitioner to submit'.

176 See C Hempton and M Trabsky, 'Without more detail, it's premature to say voluntary assisted dying laws in Victoria are "working well"', *The Conversation* (online, 21 February 2020) <https://theconversation.com/without-more-detail-its-premature-to-say-voluntary-assisted-dying-laws-in-victoria-are-working-well-132096>.

The Commission's view

18.222 The functions of the independent oversight body should primarily focus on monitoring, reporting and advising on voluntary assisted dying under the legislation, and should be supported by appropriate powers.[177]

18.223 The Board's functions should encompass review of individual cases to ascertain compliance with the legislative framework. It should also include monitoring the operation of the legislation as a whole. This will help to build a picture of voluntary assisted dying in Queensland, to identify trends and patterns and any issues or areas for improvement, and ultimately to ensure the framework is compassionate, safe and practical. The Board should also have a role in disseminating information and engaging with the community.

18.224 To maintain its impartiality and avoid unnecessary and costly duplication of functions, the Board should not have an approval, dispute resolution or enforcement role. Eligibility assessments are a matter for the person's assessing medical practitioners; investigation and prosecution of offences are a matter for police; and health service complaints and professional discipline are matters for the Health Ombudsman, AHPRA and the national health practitioner boards. As part of its oversight role, the Board should be responsible for identifying and referring matters to such entities as appropriate. This approach is consistent with other jurisdictions, and with other death review bodies in Queensland.

Monitoring, review and referral functions

18.225 The draft Bill provides that the Board has the following functions for monitoring, review and referral:

- to monitor the operation of the Act;
- to review, for each completed request for voluntary assisted dying, whether participating entities complied with the Act; and
- to refer, to any of the following entities, issues identified by the Board in relation to voluntary assisted dying that are relevant to the entities' functions:
  - the Commissioner of the Police Service;
  - the Registrar-General under the *Births, Deaths and Marriages Registration Act 2003*;
  - the State Coroner;
  - the Health Ombudsman under the *Health Ombudsman Act 2013*;
  - the chief executive of the Department.

18.226 With some modifications, these are consistent with the similar functions in the Victorian and Western Australian legislation. They reflect the Board's primary oversight purpose of monitoring the operation of and compliance with the legislation.

18.227 Under the draft Bill, the Board is to monitor 'the operation of the Act'. This reflects the Western Australian approach. Monitoring 'the operation of the Act' would include the way the legislation is applied, whether its requirements and procedures are followed, and any patterns, issues or obstacles in its practical operation. It underpins and is supported by the other functions in the draft Bill.

18.228 The draft Bill expressly includes the review of voluntary assisted dying cases. This differs from the Western Australian Act, which refers to 'monitoring the operation of [the] Act' without any separate reference to the 'review' of cases. It is important to clearly set out the Board's review function.

177 Under the *Acts Interpretation Act 1954* (Qld), 'function' is defined to include duty, and 'power' is defined to include authority: s 36 sch 1.

18.229 The draft Bill refers to the review of a 'completed request for voluntary assisted dying'. A completed request means the request under the legislation can proceed no further, either because the person has died or the request has been discontinued. It does not matter whether the person died after taking a voluntary assisted dying substance, or otherwise while the request was on foot.

18.230 This highlights that reviews are of 'completed' requests, that is, they are to be undertaken retrospectively. This will allow any departures from the requirements of the legislation to be identified, with serious matters referred to other entities for follow up and other matters used to inform continuous improvement through, for example, training and education.

18.231 The draft Bill also specifies that the review of completed cases is to ascertain compliance by participating entities with the Act, namely coordinating practitioners, consulting practitioners, administering practitioners, authorised suppliers, authorised disposers, and contact persons. This makes clear the purpose and scope of the review function.

18.232 This provision differs from that in the Victorian Act, which refers to the review of 'the exercise of any function or power' under the Act. The Victorian provision has a potentially wider scope and is less clear.

18.233 It is not intended that the Board will review documentation during the request and assessment process. Administrative review of the documents as they are submitted may cause unnecessary delay. The adequacy of documentation can be addressed in the mandatory training for participating practitioners as well as in the design of the forms and the ICT system for their submission.

18.234 There are other safeguards built into the scheme that give additional scrutiny. As part of the request and assessment process, the draft Bill provides for an assessing practitioner to refer certain matters to another qualified person for determination, including whether the person has decision-making capacity or is acting voluntarily and without coercion.[178] An application for review may also be made in particular circumstances to QCAT.[179] There are also safeguards at the final review and practitioner administration stages.

18.235 The draft Bill provides for referral to the same group of entities as under the Victorian and Western Australian legislation. For example, where the identified issue relates to a potential offence against the draft Bill (or other legislation, such as the Criminal Code), the matter would be referred to the Commissioner of the Police Service; where it relates to a cause of death certificate or the registration of a death, it may be referred to the Registrar-General under the *Births, Deaths and Marriages Registration Act 2003*; and where there is a concern that a death may be a reportable death, it would be referred to the State Coroner.

18.236 Additionally, the draft Bill provides for the referral of matters to the Health Ombudsman. In Queensland, unlike most other jurisdictions, notifications of concerns under the National Law about health practitioners' conduct are made to the Health Ombudsman rather than to AHPRA.[180] The Health Ombudsman also deals with other complaints about health services.[181] Accordingly, where the Board identifies an issue that raises concern about a health practitioner's professional conduct or that could be a health service complaint, the matter would be referred to the Health Ombudsman.

178 See the discussion of referral of certain matters in Chapter 8 above.
179 See Chapter 16 above.
180 See the discussion of notifications to the Health Ombudsman in Chapter 17 above.
181 See generally *Health Ombudsman Act 2013* (Qld) pt 3; Office of the Health Ombudsman, 'What can I complain about?' (2020) <https://www.oho.qld.gov.au/health-consumers/what-can-i-complain-about/>.

18.237 The Board's referral functions operate as an additional formal oversight mechanism. They are not intended to exclude the possibility that a person may at any time report a suspected offence to police or make a complaint about a health practitioner's conduct to the Office of the Health Ombudsman.

Data collection, analysis and research functions and powers

18.238 The draft Bill provides that the Board has the following data collection, analysis and research functions:

- to record and keep information prescribed by regulation about requests for, and provision of, voluntary assisted dying; and
- to analyse information given to the Board under the Act, and research matters related to the operation of the Act.

18.239 The draft Bill also provides that, without limiting its general power, the Board may collect, use and disclose information given to it under the Act for the purpose of carrying out its functions.

18.240 These functions and powers are similar to those in the Victorian and Western Australian legislation.

18.241 Data collection, analysis and research is an important corollary to many of the Board's other functions and is necessary for its oversight role. It is particularly important for identifying patterns, trends or systemic issues, and monitoring the overall effectiveness of the legislation.

Statistical information

18.242 One of the significant roles of the oversight body is to act as a repository of reliable data about voluntary assisted dying cases.

18.243 Information about requests for, and provision of, voluntary assisted dying will be drawn from the mandatory reports provided to the Board by health practitioners and others throughout the voluntary assisted dying process, as well as follow up requests by the Board to persons involved in the process, such as the contact person. The information should be kept by the Board in deidentified form.

18.244 The Board's function of recording and keeping such information must not impose an undue burden on participants or result in undue delays. The 'paperwork' requirements of the legislation should be as streamlined as possible to achieve a compassionate and practical framework. However, a safe framework equally requires that adequate and relevant statistical information is obtained and reported to monitor the effectiveness of, and compliance with, the legislation.

18.245 In particular, de-identified information about a person's residential location, the place where they died, and the health practitioner's primary location of practice are likely to be important in identifying access and equity issues in rural, regional and remote areas of the State. Data collected under the legislation may also help inform related matters such as access to high quality palliative care.

18.246 We have considered the range and type of statistical information collected and reported in Canada and Oregon,[182] in Victoria and Western Australia, and as suggested in Tasmania.[183]

18.247 Some information might be considered essential to collect and record, including:

- the number of requests for voluntary assisted dying that are made;

182 See, respectively, *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166, s 13(2); Oregon Health Authority, Public Health Division, Oregon Death with Dignity Act 2019 Data Summary (Report, 2020) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>.

183 See Tas Review Panel Report (2021) 65.

- the number of persons who have died after taking a voluntary assisted dying substance in accordance with the legislation;
- for a person who has died after taking a substance in accordance with the legislation:
  - the disease, illness or medical condition of the person that met the eligibility criteria, and the person's age; and
  - whether the substance was self-administered or practitioner administered; and
- the number of health practitioners who have completed approved training under the legislation.

18.248 Other information may be of significant value in understanding the operation and effectiveness of the legislation and building a knowledge base about voluntary assisted dying, including:

- for an eligible person, the person's gender, residential location and, if reported by the person, the nature of the person's intolerable physical or psychological suffering;
- for a requesting person who is not eligible, the eligibility criteria that were not met;
- the number of prescriptions issued, and the name or details of the substances prescribed, under the legislation;
- for a person who has died after taking a substance in accordance with the legislation, where the person died (for example, in their home, a hospital, or nursing home);
- the time between the person's first, second and final requests and the provision of voluntary assisted dying;
- whether the coordinating practitioner or consulting practitioner consulted with other health practitioners or professionals in the assessment of the request;
- whether a nurse practitioner was involved in the process and, if so, the nature of their role;
- whether the requesting person was a pre-existing patient of the coordinating practitioner;
- the primary geographic location of the coordinating practitioner's and administering practitioner's practice; and
- the approximate duration of the coordinating practitioner's consultations with the requesting person.

18.249 However, it is more appropriate for regulations made under the draft legislation to specify the information that should be collected. Mandating specific information in the draft legislation might have unintended practical implications for the Board and participating health practitioners and, by extension, the persons requesting access to voluntary assisted dying.

18.250 This matter requires careful consideration, having regard to possible privacy implications,[184] and the potential to impose excessive burdens on participating health practitioners and other entities. National consistency in the collection of particular data might also be a relevant consideration. It might be considered appropriate to take an incremental approach to the information recorded, with the list of prescribed information being revised after the Board's first annual report or after the three year statutory review of the legislation.[185]

18.251 For these reasons, the draft Bill provides for the Board to record and keep the information *prescribed by regulation* about requests for, and provision of, voluntary

184 It is intended for statistical information to be recorded in de-identified form. See also the confidentiality provision recommended in Chapter 17 above.

185 As to statutory review of the Act, see Chapter 19 below.

assisted dying. This gives scope for further consideration during implementation of the legislation of the information that should be prescribed and greater flexibility to make subsequent changes.[186]

Reporting and advice function

18.252 The draft Bill provides that the Board has the following reporting and advice function:

- to provide, on the Board's own initiative or on request, information, reports and advice to the Minister or the chief executive of the Department in relation to the operation of the Act, the Board's functions, or the improvement of the processes and safeguards of voluntary assisted dying.

18.253 The draft Bill also imposes specific annual reporting obligations on the Board.[187]

18.254 With some modifications, this approach is similar to the Victorian and Western Australian legislation.

18.255 Rather than separate information, reporting and advice functions (as in Victoria), a more streamlined approach is taken (as in Western Australia).[188] The reporting and advice function encompasses any matter relating to the operation of the Act, including the Board's annual reports on the performance of its functions. It could include reporting of de-identified information collected by the Board about voluntary assisted dying.

18.256 Under the draft Bill, the Board is to provide 'information' to the Minister or chief executive of the Department. Although the Board's powers would enable relevant information to be included in a report or advice given to the Minister or chief executive,[189] the draft Bill should ensure that information may also be provided to those entities outside any such report or advice. It may be desirable, for example, for the chief executive to ask for information about the number of requests made in a specific geographic area of the State to inform policy decisions.

18.257 The Board's reporting and advice function is central to its oversight role. Together with the specific provisions about annual reports and statistical records, it ensures transparency and accountability. It is the primary way matters observed by the Board in its oversight role are made known and, where relevant, can be actioned.

18.258 The Board should be accountable to the Minister and the chief executive of the Department and, through them, to the Parliament and the community. Therefore, reports and advice should be given to the Minister or chief executive. The draft Bill also provides for the Board's annual reports to be given to the Minister for tabling in Parliament, and for de-identified statistical information to be included in those reports.[190]

Community engagement functions

18.259 The draft Bill provides that the Board has the following community engagement functions:

- to promote compliance with the Act, including by providing information about the operation of the Act to registered health practitioners and members of the community;
- to promote continuous improvement in the compassionate, safe and practical operation of the Act; and

186 See generally Chapter 21 below.
187 See [18.289] ff below.
188 See *Voluntary Assisted Dying Act 2019* (WA) s 118(b).
189 The Board is empowered, for example, to disclose information for the purpose of its functions, which would include is reporting and advice function: see [18.239] above.
190 See [18.291]–[18.293] below.

- to consult and engage with the community and any entity[191] the Board considers appropriate in relation to voluntary assisted dying.

18.260 These functions are similar to those in the Victorian Act. They will assist with the Board's oversight role and other functions.

18.261 The voluntary assisted dying framework involves, and depends for its effectiveness on, a range of public and private, professional and community organisations and individuals. An important aspect of the Board's role in ensuring compliance with the Act is to engage with the community and relevant entities.

18.262 Consultation and engagement are likely to assist the Board in reporting and advising on matters about the operation of the legislation. It may also assist the Board in promoting compliance and continuous improvement by contributing to awareness of the operation and requirements of the legislation.

18.263 The Board's consultation and engagement activities would complement the training and education role of the Department, as discussed in Chapter 21 below.

Other functions and powers

18.264 The draft Bill provides that the Board has 'any other function' given to it under the Act. It has general power to do anything necessary or convenient to be done in the performance of its functions.[192]

18.265 The draft Bill also provides that the Board may, with the approval of the chief executive of the Department, engage persons with suitable qualifications and experience to help in performing its functions. This assistance might include, for example, conducting analysis or research, preparing reports, or providing legal advice. The engagement may be in an honorary capacity or for remuneration.

18.266 Like in Western Australia, a person engaged under this provision may attend meetings of the Board and participate in its deliberations but may not vote at a meeting of the Board. This will maintain an appropriate distinction between the Board and persons it engages for assistance and will ensure the number of Board members is not artificially enlarged.[193]

18.267 Also, the draft Bill provides that the Board may consult with, and ask for information from, other entities to help in performing its functions. Such an entity might include a government department, a public or private hospital or other health service provider, a medical practitioner, or a contact person. The draft Bill also includes standard provisions to protect a person from liability for giving information to the Board.[194]

18.268 These provisions will ensure the Board has sufficient powers to perform its functions effectively. They are generally consistent with the legislation in Victoria and Western Australia and reflect similar provisions in other Queensland legislation.[195]

ANNUAL AND OTHER REPORTING REQUIREMENTS

Other jurisdictions

Victoria and Western Australia

18.269 The reporting and data collection functions of the Boards in Victoria and Western Australia are intended to promote transparency and accountability, give the

191 This has a wide meaning. Under the *Acts Interpretation Act 1954* (Qld) s 36 sch 1, 'entity' includes a person and an unincorporated body, and 'person' includes an individual and a corporation.

192 Similarly see, eg, *Anti-Discrimination Act 1991* (Qld) s 236(2); *Coroners Act 2003* (Qld) s 91G(1); *Guardianship and Administration Act 2000* (Qld) s 210(1).

193 Similarly see, eg, *Voluntary Assisted Dying Act 2019* (WA) s 122(2). Cf *Voluntary Assisted Dying Act 2017* (Vic) s 100(2).

194 See [18.310] below.

195 See, eg, *Anti-Discrimination Act 1991* (Qld) s 236(2); *Coroners Act 2003* (Qld) ss 91G(1)–(2); *Family and Child Commission Act 2014* (Qld) ss 29G(1), 29E(2), 29P; *Penalties and Sentences Act 1992* (Qld) ss 199(2), 200, 203I.

Boards 'a holistic view of the process', and enable the identification of trends and recommendations for improvement.[196]

18.270 The Victorian Panel considered, for example, that:[197]

> One of the key functions of the Board should be to provide transparency and accountability on the operation of the framework by reporting publicly on and identifying trends and recommendations for improvement.

18.271 The Boards in Victoria and Western Australia have specific annual reporting obligations.

18.272 In Victoria, six-monthly reports on the operation of the legislation are to be provided to Parliament for the first two years of operation. After the first two years, annual reports are required.[198]

18.273 These reports may include recommendations on 'any systemic voluntary assisted dying matter identified by the Board during the reporting period'.[199] They may also include 'any de-identified information of a person, who has during the relevant reporting period accessed or requested access to voluntary assisted dying under [the] Act'.[200] The Act does not otherwise specify particular content to be included.[201]

18.274 The most recent report of the Voluntary Assisted Dying Review Board, for the six month period from 1 July to 31 December 2020, includes data about applicants in that period, including their average age and the percentage of those resident in a regional or rural area. It also includes data about the diagnosis category of those who were issued a permit under the legislation and subsequently died.[202]

18.275 The Victorian Act also provides that the Minister or the Secretary of the Department of Health and Human Services 'may request the Board to consider and report on a matter relevant to the functions of the Board'.[203]

18.276 In Western Australia, annual reports 'on the operation of [the] Act' are given to the Minister, who must cause them to be tabled in Parliament.[204] The Act specifies the following matters that must be included in the report:[205]

> (a) any recommendations that the Board considers appropriate in relation to voluntary assisted dying; and
>
> (b) any information that the Board considers relevant to the performance of its functions; and
>
> (c) the number of any referrals made by the Board under section 118(c); and
>
> (d) the text of any direction given to the Board under section 123(1) or 152(2);[206] and
>
> (e) details of any disclosure under section 140(1) that relates to a matter dealt with in the report and of any resolution under section 142 in respect of the disclosure;[207] and
>
> (f) statistical information that the Board is directed under section 152(2) to include in the report; and

196 See generally Vic Ministerial Advisory Panel Final Report (2017) 163–4; Vic Parliamentary Committee Final Report (2016) 232–3. See also Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2945 (J Hennessy, Minister for Health); Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5140 (RH Cook, Minister for Health).

197 Vic Ministerial Advisory Panel Final Report (2017) 164.

198 See *Voluntary Assisted Dying Act 2017* (Vic) ss 107–112.

199 *Voluntary Assisted Dying Act 2017* (Vic) ss 107(2), 110(3).

200 *Voluntary Assisted Dying Act 2017* (Vic) s 111(1). Information that the Board considers would prejudice any criminal proceeding or investigation, any civil proceeding, or any proceeding of the Coroners Court must not be included in a report: s 111(2).

201 Relevant statistical information must be 'publicly available in a de-identified form on an Internet site maintained by the Board' but is not required by the legislation to be included in the Board's annual reports: *Voluntary Assisted Dying Act 2017* (Vic) s 117(3).

202 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 10, 11.

203 *Voluntary Assisted Dying Act 2017* (Vic) s 109.

204 *Voluntary Assisted Dying Act 2019* (WA) s 155(1), (4).

205 *Voluntary Assisted Dying Act 2019* (WA) s 155(2).

206 See [18.57] and [18.167] above.

207 See [18.298] below.

> (g) information about the extent to which regional residents had access to voluntary assisted dying, including statistical information recorded and retained under section 152(1)(c), and having regard to the access standard under section 156.[208] (notes added)

18.277 Significantly, the annual report must include information about the extent to which regional residents had access to voluntary assisted dying. The Board may also be directed by the Minister to include particular statistical information in the report.[209]

18.278 An annual report must not contain 'personal information about a patient, medical practitioner or other person who has participated in the request and assessment process or the process for accessing voluntary assisted dying'.[210]

Queensland

18.279 The Parliamentary Committee did not make any specific recommendations about these matters.[211]

18.280 As noted above, the White and Willmott Model suggests that the oversight body would collect data as part of its oversight monitoring role and that this should 'be made publicly available', in de-identified form, 'for community scrutiny in the form of annual reports tabled in Parliament'.[212]

18.281 Some guidance can also be taken from other Queensland legislation.[213]

Submissions

18.282 As noted above, many respondents supported the approach to oversight in Victoria or Western Australia, or as contemplated by the White and Willmott Model. Some commented specifically on the oversight body's reporting obligations.[214]

18.283 The Australian Lawyers Alliance considered that one of the safeguards of any voluntary assisted dying scheme is an oversight body to monitor the scheme and 'report to Parliament'. In contrast, another respondent submitted that annual reports 'are at best a reactive safeguard and not a preventative safeguard', and then only if they 'identify problems [and] problem practitioners'.

18.284 Catholic Health Australia submitted that the oversight body should 'have capacity to record and be required to publish (de-identified) in an annual report' the reasons given by a person for requesting voluntary assisted dying. In its view, reports should be 'available to the general public and published on the website of the Review Board'. A medical practitioner submitted that reports on the operation of the legislation should be 'made at regular intervals'.

18.285 Christians Supporting Choice for Voluntary Assisted Dying submitted that:

> in addition to any Report prepared for Parliament, a Public Report [should] be made available each year to give transparency to the operation of the [voluntary assisted dying] law, as is done in Oregon.

18.286 Go Gentle Australia and the VALE Group also supported the oversight body publicly reporting on data about voluntary assisted dying.

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208 See [18.165] above. The *Voluntary Assisted Dying Act 2019* (WA) s 156 provides that the chief executive officer of the Department 'must issue a standard (the ***access standard***) setting out how the State intends to facilitate access to voluntary assisted dying for persons ordinarily resident in Western Australia' including, specifically, 'for regional residents'.

209 *Voluntary Assisted Dying Act 2019* (WA) s 152(2)–(3).

210 *Voluntary Assisted Dying Act 2019* (WA) s 155(3)(a). An annual report must not contain information that would prejudice any criminal investigation or proceeding, any civil proceeding, or any proceeding in the Coroner's Court of Western Australia: s 155(3)(b).

211 See generally Qld Parliamentary Committee Report No 34 (2020) 145, Rec 19.

212 See White and Willmott Model pt 6.

213 See [18.24]–[18.31] above.

214 See also the discussion of submissions about research and data collection earlier in this chapter.

18.287 The Royal Australasian College of Physicians submitted that the operation of the legislation and collected data should be scrutinised by a parliamentary committee 'with the potential for its review, amendment, further public consultation or withdrawal'.

18.288 In contrast, the AMA Queensland considered that 'data of how many people accessed [voluntary assisted dying] should not be publicly available' but 'should be available if requested by an organisation or government body requiring the information for professional use'.

The Commission's view

18.289 Some information about the activities of the Board in each financial year would be included in the annual report of the Department, under which the Board is located, in accordance with requirements imposed by the *Financial Accountability Act 2009*.[215]

18.290 However, the oversight body should be required to prepare and provide its own annual report. This is an essential accountability and transparency measure and a core aspect of the Board's role in monitoring and promoting compliance with the legislation. It is also generally consistent with the approach under the Victorian and Western Australian legislation, and with other Queensland legislation.[216]

18.291 Accordingly, the draft Bill requires the Board to give the Minister an annual report about the performance of the Board's functions within three months after the end of each financial year.

18.292 Without limiting this, the annual report must include information for the financial year about:

- the number of completed requests for voluntary assisted dying the Board has reviewed under clause 117(1)(b) of the draft Bill;
- the number of referrals, if any, the Board has made to other entities under clause 117(1)(c) of the draft Bill;
- recommendations of the Board relevant to the performance of its functions—including, for example, recommendations about systemic matters in voluntary assisted dying or the improvement of voluntary assisted dying; and
- a summary in de-identified form of the information required to be recorded and kept by the Board under clause 117(1)(d) of the draft Bill.

18.293 The Minister must table a copy of the annual report in the Legislative Assembly within 14 sitting days after receiving it.

18.294 The draft Bill also provides that the Board may at any time, and must on request, give the Minister or the chief executive of the Department a report about the Board's functions. A copy of a report given to the Minister must be tabled by the Minister in Parliament within 14 sitting days after receiving it.

18.295 These provisions will ensure that the Board can report formally on significant matters, including the results of any research or systemic issues the Board has identified, on its own initiative or on request of the Minister or chief executive.

215 A Department's annual report must be given to the Minister by a day agreed to allow tabling of the report within three months after the end of the financial year: see *Financial Accountability Act 2009* (Qld) s 63; *Financial and Performance Management Standard 2019* (Qld) ss 46(2), 47(2)–(3). Among other things, the Department's annual report must include information prescribed under the *Human Rights Act 2019* (Qld) s 97(2), including 'details of any actions taken during the reporting period to further the objects of [that] Act'.

216 See, eg, *Coroners Act 2003* (Qld) s 91ZB; *Family and Child Commission Act 2014* (Qld) s 29J; *Guardianship and Administration Act 2000* (Qld) s 220; *Penalties and Sentences Act 1992* (Qld) s 203J.

18.296 An annual or other report of the Board must not include personal information about an individual unless the information was provided to the Board for the purpose of publication.[217] 'Personal information' has the meaning given under the *Information Privacy Act 2009* but does not include information that is publicly available. Deidentified information may be included, provided the individual's identity is not apparent and cannot reasonably be ascertained from the information.[218]

PROCEDURE AND OTHER MATTERS

Proceedings

18.297 In establishing the oversight body, it is necessary to deal with its procedure.

18.298 In Victoria and Western Australia, some matters are detailed in the legislation, including the number of members that constitute a quorum, who is to preside at a meeting, and the power to appoint or establish subcommittees.[219] The Western Australian Act additionally deals with the disclosure, and effect on voting, of a member's 'material personal interest' in a matter for the Board's consideration.[220] Subject to the provisions of the legislation, the Boards in those jurisdictions are to regulate their own proceedings.[221]

18.299 Neither the report of the Parliamentary Committee nor the White and Willmott Model address these matters.[222] Some guidance can be taken from other Queensland legislation.[223]

The Commission's view

18.300 The Board's basic procedural framework should be established by the legislation. Matters that are required to ensure clear guidance for and accountability of the Board should be specified, while other matters should be left to the Board's own determination.

18.301 Accordingly, the draft Bill provides that, subject to other provisions of the draft Bill, the Board may conduct its business, including its meetings, in the way it considers appropriate.

18.302 It includes provisions to the following effect:

- A meeting may be held using any technology allowing reasonably contemporaneous and continuous communication between members;
- A question at a meeting of the Board is to be decided by a majority of the votes of the members present and, if the votes are equal, the member presiding has a casting vote;
- A resolution of the Board is valid, even though it is not passed at a meeting, if written agreement is given by at least half the members and notice of the resolution is given under procedures approved by of the Board;
- The Board must keep minutes of its meetings and a record of its decisions and resolutions;
- A quorum for a meeting of the Board is at least half of the members;

217 Similarly see, eg, *Human Rights Act 2019* (Qld) ss 91(4), 92(4).

218 See *Information Privacy Act 2009* (Qld) s 12, which defines 'personal information' to mean 'information or an opinion, including information or an opinion forming part of a database, whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion'. The obligations applying to an agency under that Act would apply to the Board as a 'public authority': ss 18(1)(d), 21(1)(a)(i).

219 See *Voluntary Assisted Dying Act 2017* (Vic) ss 101(1)–(2), 102; *Voluntary Assisted Dying Act 2019* (WA) ss 132134, 136–139, 145–148.

220 See *Voluntary Assisted Dying Act 2019* (WA) ss 140–144.

221 *Voluntary Assisted Dying Act 2017* (Vic) s 101(3); *Voluntary Assisted Dying Act 2019* (WA) s 135.

222 See generally Qld Parliamentary Committee Report No 34 (2020) 145, Rec 19; White and Willmott Model pt 6.

223 See [18.24]–[18.31] above.

- The chairperson is to preside at all meetings at which the chairperson is present and, if absent from a meeting, the deputy chairperson is to preside; and
- If neither the chairperson nor the deputy chairperson is present, the member chosen by the members present is to preside.

18.303 These are based on provisions in other Queensland legislation that establish similar bodies.[224] They are also of broadly similar effect to the Victorian and Western Australian legislation.

18.304 The draft Bill also provides that the Board may establish committees to assist in the performance of its functions, in similar terms to the legislation in Victoria and Western Australia. This is a practical measure to help the Board manage its work effectively. Subcommittees relating to different subject areas are utilised, for example, by the Queensland Maternal and Perinatal Quality Council.[225]

18.305 Importantly, the draft Bill also deals with potential conflicts of interests. This is appropriate to ensure a clear obligation of disclosure and clear procedures when a disclosure is made. The draft provisions apply if a member has a direct or indirect interest in a matter being considered, or about to be considered, at a meeting which could conflict with the proper performance of the member's duties about the consideration of the matter. They are to the general effect that:

- the member must disclose the nature of the interest at a meeting as soon as practicable after the relevant facts come to their knowledge;
- particulars of the disclosure are to be recorded by the Board;
- unless the Board directs otherwise, the member must not be present when the Board considers the matter (or whether to give a direction under this provision) and must not take part in the Board's decision about the matter; and
- if those provisions are contravened, the Board's decision is not invalidated, but the Board must reconsider the decision if it becomes aware of the contravention.

18.306 Provisions to the same effect are in other Queensland legislation.[226]

Protections from liability

18.307 Consideration has also been given to whether any protections from liability are needed for the oversight body.

18.308 Protective provisions are not uncommon in other legislation that establishes oversight bodies or review boards.

The Commission's view

18.309 Members of, and persons engaged by, the Board should be given protection from personal civil liability for acts done or omissions made honestly and without negligence under the legislation. Liability should instead attach to the State. This is consistent with provisions in other Queensland legislation.[227] Such persons may in some cases be covered by the protection that applies to State employees under the *Public Service Act 2008*.[228] However, that does not apply, for example, if the person's office is honorary.[229] For the avoidance of doubt and to ensure consistency, specific provision is included in the draft Bill.

224 See especially *Coroners Act 2003* (Qld) ss 91T–91W; *Family and Child Commission Act 2014* (Qld) ss 29ZF–29ZI; *Penalties and Sentences Act 1992* (Qld) ss 203D–203H. See also, eg, *Hospital and Health Boards Regulation 2012* (Qld) ss 18–22.

225 See [18.35] above.

226 See especially *Coroners Act 2003* (Qld) s 91X; *Family and Child Commission Act 2014* (Qld) s 29ZJ.

227 See, eg, *Anti-Discrimination Act 1991* (Qld) s 265; *Coroners Act 2003* (Qld) s 91ZE; *Family and Child Commission Act 2014* (Qld) s 39; *Information Privacy Act 2009* (Qld) s 183.

228 See *Public Service Act 2008* (Qld) ss 26C, 26B(1)(a), (d)–(f), (2), (4).

229 See *Public Service Act 2008* (Qld) ss 26B(3)(a), 13(1)(d).

18.310 In addition, any person, acting honestly, who gives information to the Board as requested under the legislation should be protected from liability for giving that information. Again, similar provision is made in various other Queensland legislation.[230]

18.311 These protections will help support the effective operation of the oversight body.

RECOMMENDATIONS

Establishment of an independent oversight body

18-1 An independent Voluntary Assisted Dying Review Board, consisting of at least five but no more than nine members appointed by the Minister and with relevant expertise, experience, knowledge or skills, should be established by the legislation to:

(a) monitor the operation of the Act;

(b) review, for each completed request for voluntary assisted dying, whether or not the following persons complied with the Act:

(i) coordinating practitioners;

(ii) consulting practitioners;

(iii) administering practitioners;

(iv) authorised suppliers;

(v) authorised disposers; and

(vi) contact persons;

(c) refer to the following entities issues identified by the Board in relation to voluntary assisted dying that are relevant to the entities' functions:

(i) the Commissioner of the Police Service;

(ii) the Registrar-General under the *Births, Deaths and Marriages Registration Act 2003*;

(iii) the State Coroner;

(iv) the Health Ombudsman under the *Health Ombudsman Act 2013*;

(v) the chief executive of the Department;

(d) record and keep information prescribed by regulation about requests for, and provision of, voluntary assisted dying;

(e) analyse information given to the Board under the Act and research matters related to the operation of the Act;

230 See *Human Rights Act 2019* (Qld) s 99. See also, eg, *Coroners Act 2003* (Qld) s 91ZF; *Family and Child Commission Act 2014* (Qld) s 29T; *Hospital and Health Boards Act 2011* (Qld) s 89.

(f) provide, on the Board's initiative or on request, information, reports and advice to the Minister or the chief executive of the Department in relation to the operation of the Act, the Board's functions, or the improvement of the processes and safeguards of voluntary assisted dying;

(g) promote compliance with the Act, including by providing information about the operation of the Act to registered health practitioners and members of the community;

(h) promote continuous improvement in the compassionate, safe and practical operation of the Act; and

(i) consult and engage with the community and any entity the Board considers appropriate in relation to voluntary assisted dying; and

(j) perform any other function given to the Board under the Act.

18-2 The Board and its operation should have the features set out in this chapter and included in the draft Bill, including about its independence, staff and assistance, membership and appointment of members, appointment and roles of the chairperson and a deputy chairperson, general and other powers, annual and other reporting requirements, proceedings and protections from liability.

CHAPTER 19

Other matters

Chapter 19: Other matters

CHAPTER SUMMARY

This chapter deals with a small number of general matters necessary to support the main provisions of the draft voluntary assisted dying legislation.

INTERPRETERS

19.1 Queensland has a diverse cultural and linguistic profile. In 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.[1] Four per cent of Queensland's population also identified as Aboriginal or Torres Strait Islander.[2]

19.2 Some persons who seek access to voluntary assisted dying may not be fluent, or may be unable to communicate, in English. They may require the assistance of an interpreter.

19.3 One of the guiding principles informing the Commission's review is 'the need for the legislation to be well adapted to Queensland's geographic, cultural and health care environment'.[3]

19.4 The Parliamentary Committee also noted 'the desirability of including provisions about equal access to voluntary assisted dying and end of life health care for all Queenslanders regardless of where they reside, with consideration of the specific cultural needs of Aboriginal and Torres Strait Islander Queenslanders'.[4]

Language interpreters and translators

19.5 In Australia, the principal accrediting body for translators and language interpreters is the National Accreditation Body for Translators and Interpreters ('NAATI').[5]

19.6 As NAATI provides different levels of accreditations, a range of different interpreters can be 'NAATI certified'. NAATI's certification hierarchy includes the following categories of interpreter:

- 'Certified Provisional Interpreters' can accurately transfer non-complex, non-specialised messages from a source language into a target language;[6]
- 'Certified Interpreters' can accurately transfer complex, non-specialised messages from a source language into a target language;[7]
- 'Certified Specialist Health Interpreters' and 'Certified Specialist Legal Interpreters' who are experts in health and legal interpreting, respectively;[8] and
- 'Recognised Practising' interpreters, a status granted in emerging or low community demand languages for which NAATI does not offer certification (but for which regular professional development must still be undertaken).[9]

1 Department of Local Government, Racing and Multicultural Affairs (Qld), *Diversity Figures June 2018* (Report, June 2018) 5, 23.
2 Ibid 28.
3 QLRC Consultation Paper No 79 (2020) [3.2].
4 Qld Parliamentary Committee Report No 34 (2020) 113.
5 NAATI, *Annual Report 2019–2020* (2020) 8.
6 NAATI, 'Certified Provisional Interpreter' <https://www.naati.com.au/become-certified/certification/certified-provisional-interpreter/>. This certification is equivalent to a 'Paraprofessional Interpreter' in NAATI's previous accreditation system, which was abolished in 2018 but is still referred to in several policies and guidelines.
7 NAATI, 'Certified Interpreter' <https://www.naati.com.au/become-certified/certification/certified-interpreter/>. This certification is roughly equivalent to a 'Professional Interpreter' in NAATI's previous accreditation system.
8 NAATI, 'Certified Specialist Health Interpreter' <https://www.naati.com.au/become-certified/certification/certified-specialist-health-interpreter/>; NAATI, 'Certified Specialist Legal Interpreter' <https://www.naati.com.au/become-certified/certification/certified-specialist-legal-interpreter/>.
9 NAATI, 'Recognised Practising' <https://www.naati.com.au/become-certified/certification/recognised-practising/>.

Queensland

Queensland legislation and policy

19.7 Queensland legislation provides for the participation of interpreters in courts, proceedings, and conciliations,[10] or requires that they be present for the exercise of certain powers.[11] Where eligibility requirements are imposed, the legislation does not expressly refer to NAATI or any other accreditation bodies.[12]

19.8 There are various policies, procedures and guidelines that prescribe when public entities should engage interpreters and their eligibility requirements. For instance, the Queensland Language Services Policy provides that Queensland government entities will:[13]

> work with qualified interpreters as much as possible and develop a plan to ensure that services can still be delivered in circumstances where a qualified interpreter is not available …

19.9 The policy and its corresponding Queensland Language Services Guideline both define a 'qualified interpreter' to constitute:[14]

- where NAATI accreditation testing is available for a language — an interpreter certified by NAATI at a Professional or Paraprofessional level;
- where NAATI accreditation testing is not available for a language — an interpreter certified by NAATI at a Recognised Interpreter level; and
- where a NAATI certified interpreter is unavailable — an interpreter with Australian tertiary level interpreting qualifications.

19.10 However, both the Queensland Government Language Services Guideline and the corresponding Policy provides that a non-qualified interpreter should be used only in urgent or life-threatening situations or emergencies, where a qualified interpreter is unavailable.[15]

19.11 Queensland courts and tribunals are subject to the guideline 'Working with interpreters in Queensland Courts and Tribunals,' which adopts and implements the Recommended National Standards for Working with Interpreters in Courts and Tribunals.[16] The guideline provides for when a court or tribunal must engage an interpreter according to whether the language in question falls into one of four 'tiers'. Languages are classified into Tiers A to D based on how many interpreters are available for the language.[17]

10 See, eg, *Queensland Civil and Administrative Tribunal Act 2009* (Qld) ss 29, 44; *Evidence Act 1977* (Qld) s 131A; *Human Rights Act 2019* (Qld) ss 32(2)(i), 84; *Youth Justice Act 1992* (Qld) ss 18, 72, 158.

11 See, eg, *Police Powers and Responsibilities Act 2000* (Qld) ss 433, 440, 512; *Transport Operations (Passenger Transport) Act 1994* (Qld) ss 129M, 129ZC; *Terrorism (Preventative Detention) Act 2005* (Qld) ss 50, 60.

12 For interpreters, the principle accreditation bodies in Australia are NAATI and Speech Pathology Australia.

13 Department of Communities, Child Safety and Disability Services (Qld), *Queensland Language Services Policy* (November 2016) 5.

14 Ibid 9. It should be noted that a 'qualified interpreter' can also include a Conference Interpreter, which is the highest interpreter accreditation level. As interpreters accredited at this level engage in simultaneous interpreting required by international conferences, they are unlikely to be utilised by public sector agencies: Multicultural Affairs Queensland, Department of Communities, Child Safety and Disability Services (Qld), *Language Services Guidelines* (February 2016) 6–7.

15 Multicultural Affairs Queensland, Department of Communities, Child Safety and Disability Services (Qld), *Language Services Guidelines* (February 2016) 6; Department of Communities, Child Safety and Disability Services (Qld), *Queensland Language Services Policy* (November 2016) 5.

16 Queensland Courts, *Guideline: Working with Interpreters in Queensland Courts and Tribunals* (June 2019) cl 2.3.

17 Judicial Council on Cultural Diversity, *Recommended National Standards for Working with Interpreters in Courts and Tribunals* (2017) 42–52. These tiers are determined based on data provided by NAATI about the number of interpreters for each language. Tier A languages are required to have NAATI-accredited Professional Interpreters engaged 'subject to cultural and all other reasonable concerns'. However, all other language tiers may have a 'Suitable Person' interpret in proceedings with the leave of the court or tribunal. A 'suitable person' is defined in the guideline as 'an interpreter who has some of the attributes of a qualified interpreter where no interpreter can be found, a bilingual': Queensland Courts, *Guideline: Working with Interpreters in Queensland Courts and Tribunals* (June 2019) cll 11.4, 11.5, sch 1.

19.12 Specific to public health care, Queensland Health's policy is to use NAATI accredited or recognised interpreters rather than bilingual workers or patient family and friends.[18] Queensland Health staff are required to engage a professional interpreter where a person's English skills are assessed to be inadequate to properly understand a significant clinical situation, a person has a Queensland Government interpreter card or a person requests an interpreter.[19]

White and Willmott Model

19.13 The White and Willmott Model includes a provision to the effect that, if an interpreter assists a person in making a second, written request to access voluntary assisted dying they 'must certify on the request that the interpreter provided a true and correct translation of any material translated'.[20]

Other jurisdictions

Victoria and Western Australia

19.14 Both the Victorian Panel and the Western Australian Panel emphasised the importance of ensuring access to culturally and linguistically diverse communities, and to those with alternative communication or other needs.[21]

19.15 Each Panel noted that information about voluntary assisted dying should be available to people in a manner and language that is culturally appropriate and that they understand.[22]

19.16 The Panels also recommended the use of accredited interpreters. The Victorian Panel considered this to be 'an important safeguard in ensuring the interpretation is independent and that the person is acting voluntarily'.[23] Similarly, the Western Australian Panel recommended that interpreters involved in providing information about voluntary assisted dying should be qualified, accredited, independent and not stand to benefit from the death of the person.[24]

19.17 In Victoria and Western Australia, the legislation recognises the role of interpreters in voluntary assisted dying. Both Acts impose eligibility requirements on an interpreter who assists a person seeking access to voluntary assisted dying.[25]

Accreditation requirements

19.18 Both the Victorian and Western Australian legislation requires interpreters to be accredited by specific national bodies.

19.19 In Victoria, the person must be accredited by a body prescribed in a regulation.[26] The Victorian regulations prescribe NAATI as an accrediting body for interpreters.[27]

18 Queensland Health, 'Queensland Health Interpreter Service—FAQ' (12 June 2012) <https://www.health.qld.gov.au/multicultural/interpreters/qhis_faq>.

19 Queensland Health, 'Interpreter Services in Queensland Health—Information for staff' (30 January 2019) <https://www.health.qld.gov.au/multicultural/interpreters/qhis-for-staff>.

20 White and Willmott Model cl 27(5). It also suggests that 'provisions regulating the use of interpreters' are one of the specific matters that 'could or should be' addressed in voluntary assisted dying legislation: pt 9.

21 Vic Ministerial Advisory Panel Final Report (2017) 84, 96–7, Rec 11; WA Ministerial Expert Panel Final Report (2019) 44, 46, 48.

22 Vic Ministerial Advisory Panel Final Report (2017) 83, 96; WA Ministerial Expert Panel Final Report (2019) Rec 11, which recommended that '[t]he Government should play a central role in providing information to the general public and health professionals about how to access voluntary assisted dying. This information must be translated, culturally appropriate and accessible via multiple formats'.

23 Vic Ministerial Advisory Panel Final Report (2017) 96.

24 WA Ministerial Expert Panel Final Report (2019) 29.

25 *Voluntary Assisted Dying Act 2017* (Vic) ss 34(5), 40(5), sch 1; *Voluntary Assisted Dying Act 2019* (WA) ss 29(4)(j), 40(4)(l), 42(6), 51(3), 60(2)(g), 66(1)(f), 60(2)(g). Provision is also made for interpreters to assist a person in revoking an administration decision: s 57(4)(f).

26 *Voluntary Assisted Dying Act 2017* (Vic) s 115.

27 *Voluntary Assisted Dying Regulations 2018* (Vic) reg 11. The regulation also prescribe Speech Pathologists Australia as an accrediting body for speech pathologists.

19.20 In Western Australia, an interpreter must be accredited by a body approved by the Secretary of the Department of Health.[28] Accredited interpreters are 'those who hold a credential issued under the NAATI (National Accreditation Authority for Translators and Interpreters) certification scheme'.[29]

19.21 In addition to accreditation requirements, Victoria and Western Australia also require that an interpreter assisting a person must not:[30]

- be a family member of the person;
- believe or have knowledge either that they are a beneficiary under a will of the person or that they may otherwise benefit financially or in any other material way from the death of the person;
- be an owner of, or be responsible for, the management and operation of, any health facility at which the person is being treated or resides; or
- be a person who is directly involved in providing health services or professional care services to the person.

19.22 These eligibility requirements are to ensure that 'an interpreter is appropriately qualified and does not have a conflict of interest that may influence their ability to act as an independent and impartial interpreter'.[31]

19.23 It has been suggested by others, however, that a requirement for interpreters to be accredited professionals may be onerous in practice.[32]

Tasmania

19.24 The Tasmanian Act provides that where a 'relevant communication' is made between a person and a 'relevant practitioner' and the person cannot communicate in a language in which both are fluent, a third party who is fluent in that language can make the 'relevant communication' between the person and the practitioner.[33] Similarly, where a relevant practitioner is 'unfamiliar with the … person's method of communication', a third party is permitted to make a relevant communication.[34]

19.25 If the third party is making 'relevant communications' between a medical practitioner and a person seeking to access voluntary assisted dying, the practitioner must be satisfied that:[35]

- the person has decision-making capacity, wishes for the third party to make the communications on their behalf, and is acting voluntarily in that wish;
- the third party is not a family member of the person, a residential care provider for the person, or directly involved in providing health services or professional care services to the person; and
- the third party 'does not know or believe' that they are likely to benefit, directly or indirectly, from the person's death.

28 *Voluntary Assisted Dying Act 2019* (WA) s 162(2)(a).

29 Department of Health (WA), 'Voluntary assisted dying in Western Australia: Information for interpreters' (2021) 1 <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Information-for-Interpreters.pdf>.

30 *Voluntary Assisted Dying Act 2017* (Vic) s 115(b); *Voluntary Assisted Dying Act 2019* (WA) s 162(2).

31 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 48. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 35; Vic Ministerial Advisory Panel Final Report (2017) 96; and WA Ministerial Expert Panel Final Report (2019) 28, noting that it received feedback during consultation that 'family members should not be used as interpreters as they may influence the nature of the information conveyed between the person and the health practitioner'.

32 B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 442.

33 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 15(3). In this case, the relevant practitioner must also be satisfied the third party is 'accredited by a prescribed body as a translator in the relevant language'. The Tasmanian provisions aim to ensure that practitioners 'can be confident that the person is acting entirely voluntarily', while recognising that 'some circumstances may make communication between medical practitioners and family members necessary': Tas Review Panel Report (2021) 43.

34 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 15(2).

35 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 15(2)–(4).

19.26 It has also been recognised that training for interpreters, along with other professionals, must be provided to ensure high quality care and support for participating practitioners.[36]

Submissions

19.27 The Consultation Paper asked whether the draft legislation should require an interpreter who assists a person in requesting or accessing voluntary assisted dying to be accredited and impartial, in similar terms to the Victorian and Western Australian legislation.[37]

19.28 Most respondents who addressed this question agreed that an interpreter should be accredited and impartial. However, some respondents raised concerns about the accessibility of accredited interpreters in Queensland's rural and remote regions. Some respondents considered that the use of online communications, telecommunications or telehealth may alleviate this concern.

19.29 In a joint submission, two academics considered that 'thought should be given to whether any exceptions might be permitted' if there are no independent or accredited interpreters in the person's language.

The Commission's view

19.30 The draft legislation should set out the requirements for a person who performs the role of interpreter. The aim of these requirements is to ensure an interpreter is appropriately qualified and does not have a conflict of interest that may influence their ability to act as an independent and impartial interpreter.

19.31 The draft Bill provides that an interpreter for a person requesting access to voluntary assisted dying:

- must be accredited by a body approved by the chief executive of the Department; and
- must not:
  - be a family member of the person; or
  - know or believe that they are a beneficiary under a will of the person or that they may otherwise benefit financially or in any other material way from the death of the person; or
  - be an owner of, or be responsible for the management of, any health facility at which the person is being treated or resides; or
  - be a person who is directly involved in providing a health service or personal care service to the person.

19.32 In exceptional circumstances where an accredited interpreter is not available, the chief executive of the Department may also approve a person who does not meet the accreditation requirements to act as an interpreter. This will give the chief executive the flexibility to accredit a person who speaks emerging or low demand languages for which NAATI certification is not yet available.

REGULATION MAKING POWER

19.33 The draft Bill provides that the Governor in Council may make regulations under the legislation. This would include regulations to:

- prescribe the statistical information about requests for, and provision of, voluntary assisted dying that the Board is required to record and keep pursuant to clause 117(1)(d) of the draft Bill;

36 Tas Review Panel Report (2021) 77 [6.4.6].
37 QLRC Consultation Paper No 79 (2020) Q-33.

- prescribe any additional matter required to be certified by the administering practitioner following administration of a voluntary assisted dying substance pursuant to clause 55(2)(c) of the draft Bill;
- prescribe requirements for the use of the voluntary assisted dying substance, including labelling, storage and disposal requirements, pursuant to clauses 65(1)(c), 67, 70(2)(d), 71, 73–74, 79 of the draft Bill; and
- prescribe matters that must be included in an approved form under the legislation.

APPROVED FORMS

19.34 The draft Bill provides that the chief executive of the Department may approve forms for use under the legislation. For example, this would include forms for:

- recording the outcome of a first assessment, consulting assessment, or final review of a request pursuant to clauses 24, 35 and 46 of the draft Bill (and which would identify the information that must be included in completing those forms);
- making a second request for access to voluntary assisted dying pursuant to clause 37 of the draft Bill;
- recording the revocation of a person's administration decision pursuant to clause 51 of the draft Bill;
- certifying the relevant matters upon practitioner administration pursuant to clause 55 of the draft Bill; and
- transferring the role of a coordinating practitioner or administering practitioner pursuant to clauses 47 and 56 of the draft Bill.

TECHNICAL ERRORS

19.35 The draft Bill provides that the validity of the request and assessment process under Part 3 or the administration process (in this case, consisting of an administration decision and the administration of a voluntary assisted dying substance) under Part 4 of the Act is not affected by:

- any minor or technical error in a form required to be completed;
- the failure of a person to provide a form within the time required; or
- the failure of a medical practitioner to do an act within the time required for doing the act.

19.36 A more limited provision, which applies only to minor or technical errors in approved forms, applies in Victoria, Western Australia and Tasmania.[38]

19.37 The inclusion of this provision in the draft Bill is necessary to ensure that a minor error, such as a misspelled name or an incorrectly dated signature on a form, is not sufficient to invalidate the request and assessment process or the administration process (as the case may be). It also makes it clear that, if a medical practitioner does not comply with the timeframes required for doing an act (for example, accepting or refusing a request) or for giving the Board a required form or document, this will not invalidate all or part of the relevant process. There will be circumstances, such as medical emergency or technological difficulties, that might prevent a practitioner from taking timely action.

19.38 Similar provisions to the one contained in the draft Bill about technical defects and non-compliance with time provisions not invalidating a process are common in legislation. Also, the inclusion of this specific provision in the draft Bill is not intended to affect the general operation of section 48A of the *Acts Interpretation Act 1954* in that regard.[39]

38 *Voluntary Assisted Dying Act 2017* (Vic) s 42; *Voluntary Assisted Dying Act 2019* (WA) s 52; *End-of-Life Choices (Voluntary Assisted Dying) Act 2020* (Tas) s 133.

39 Section 48A of the *Acts Interpretation Act 1954* (Qld) deals with compliance with forms that are prescribed or required to be approved under an Act.

REVIEW OF THE ACT

Queensland

19.39 The Parliamentary Committee recommended that any voluntary assisted dying legislation in Queensland should include a requirement for the legislation to be reviewed 'within three years' from the date of proclamation 'to ensure the legislation is effective and working appropriately'.[40] The White and Willmott Model includes a provision for review of the legislation after five years.[41]

Other jurisdictions

19.40 In Victoria, the Minister is to review and report on the 'operation' of the legislation in its fifth year.[42] The Act does not specify any particular matters that must be considered or included in that review. In recommending review after five years, the Victorian Panel stated that it 'would provide reassurance to stakeholders that the operation of the legislation will be subject to public scrutiny', and proposed that the review should include evaluation of:[43]

- the effectiveness of the legislation in allowing appropriate access for those people it intended to provide for;
- the effectiveness of the legislation in providing for the safeguards and protections for individuals and the community generally;
- the effectiveness of the implementation of voluntary assisted dying from a clinical, patient and family perspective;
- the effectiveness of the Voluntary Assisted Dying Review Board in monitoring, reporting and promoting improvements; and
- a review of the costs of voluntary assisted dying to the sector and parts of the community.

19.41 In Western Australia, the Minister is required to review and report on the 'operation and effectiveness' of the Act as soon as practicable after the first two years, and then at intervals of not more than five years.[44] This gives effect to the recommendation of the Western Australian Panel, which explained that:[45]

> Initially it will be important to identify any issues with the voluntary assisted dying legislation and to review whether it has been enacted and implemented appropriately. The Panel recommends that this occurs three years from the commencement of the legislation. Reviews every five years thereafter would be sufficient to ensure that the legislation remains in line with contemporary views and practices.

19.42 In Tasmania, the Governor is to appoint a panel of persons, nominated by the Minister, to review the 'operation and scope' of the Act as soon as practicable after the first three years. A panel of persons is then also to be appointed to review the 'operation' of the Act—including matters prescribed by regulation 'related to the operation of [the] Act, the scope of [the] Act, and [the] potential scope of [the] Act'—after the first eight years, and thereafter at five yearly intervals.[46] This has been recognised as 'important and appropriate' to ensure the operation of the legislation is consistent with its stated objectives and the community's views.[47]

40 Qld Parliamentary Committee Report No 34 (2020) 147, Rec 21.
41 White and Willmott Model pt 9.
42 *Voluntary Assisted Dying Act 2017* (Vic) s 116.
43 Vic Ministerial Advisory Panel Final Report (2017) 174.
44 *Voluntary Assisted Dying Act 2019* (WA) s 164.
45 WA Ministerial Expert Panel Final Report (2019) 102, Rec 31.
46 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 145(1)–(4). No matters have yet been prescribed.
47 Tas Review Panel Report (2021) 67.

19.43 Similarly, in New Zealand, the Ministry must review the 'operation' of the Act—and 'consider whether any amendments to [the] Act or any other enactment are necessary or desirable'—within the first three years after commencement and then at subsequent intervals of not more than five years.[48]

Submissions

19.44 The Consultation Paper asked whether there should be a statutory requirement for review of the operation and effectiveness of the voluntary assisted dying legislation in Queensland.[49]

19.45 There was widespread support in the submissions for a review requirement. Only one respondent opposed a statutory requirement, preferring to leave this to the Minister's discretion informed by community views.

19.46 Respondents supported a statutory requirement for review of the operation and effectiveness of the legislation 'given its importance and the need to ensure that it is operating in a manner that supports those people seeking voluntary assisted dying' and 'the fundamental and complex nature of this issue'.

19.47 It was submitted that review of the legislation is needed to ensure it is operating 'effectively' or 'properly' and 'to make recommendations for legislative amendments'. It was suggested that 'this would also assist in ensuring that issues such as whether people aged under 18 years should be eligible are reviewed'. Another respondent observed that review would need to be supported by the collection of data and 'robust scrutiny by disabled people and by professionals'.

19.48 Respondents suggested various timeframes for review of the legislation. Many supported review within three years after commencement of the legislation. It was observed that '[a]t that time, there will be data' from Victoria and Western Australia 'which can be used for benchmarking'.

19.49 Other respondents suggested a review period of two years, between two and five years, between three and five years, less than five years, or five years. One respondent commented that:

> The suggestion contained in the explanatory note to the White and Willmott Bill is that the legislation be reviewed after five years. This is common practice in relation to legislation of the Queensland Legislative Assembly; however, given that there appears to be some level of concern in relation to [voluntary assisted dying], a shorter timeframe for review might be appropriate.

19.50 Others suggested the legislation should be subject to 'regular review' or a review initially after two years and then every five years, review initially after three years and then every five years, or review 'at a set date or earlier if data collected by the [B]oard raises concerns'.

The Commission's view

19.51 Review of the operation and effectiveness of the voluntary assisted dying legislation is of significant importance given the sensitive and serious nature of the new legislative framework and the range of complex and practical considerations that will inform and impact its operation.

19.52 Review of the legislation will complement and be informed by the oversight and reporting functions of the Board. It will provide a clear mechanism for the consideration of issues arising in the implementation and initial operation of the legislation and the need for, or desirability of, legislative amendments or other changes.

48 *End of Life Choice Act 2019* (NZ) s 30(1).
49 QLRC Consultation Paper No 79 (2020) Q-48.

19.53 Accordingly, the draft Bill provides that the Minister must review the effectiveness of the Act as soon as practicable after the end of three years after the commencement. The three year period for review is intended to run from the time when the Act as a whole comes into operation, and not from the earlier commencement of specific provisions. This takes account of the implementation period which may involve staged commencement of a limited number of provisions.[50] The draft Bill also provides that the Minister must table a report on the outcome of the review in the Legislative Assembly as soon as practicable after finishing the review.

19.54 Three years after the commencement of the legislation is an appropriate period for its review. A shorter review period would provide insufficient time to evaluate the operation of the Act, and a longer period would delay the review and any resulting recommendations.

19.55 The review requirement is in wide terms, referring to 'the effectiveness' of the Act. This would encompass all aspects of the legislation, including, for example:

- the Queensland residency requirement in the eligibility criteria for access to voluntary assisted dying (and whether there is a continued need for that requirement, having regard to the introduction of similar legislation in other Australian jurisdictions);[51]
- the eligibility requirements to act as a coordinating practitioner, consulting practitioner or administering practitioner (including the role or potential role of nurses or nurse practitioners);
- the various witnessing requirements and timeframes under the legislation;
- the approved forms and matters prescribed by regulation under the legislation; and
- matters identified by the Board or concerning the Board's functions and powers.

19.56 The review might also consider other matters impacting on the effectiveness of the legislation, such as education, training, and accessibility.

19.57 For the avoidance of doubt and without limiting the matters to be considered, the draft Bill provides that the review must include a review of the eligibility requirements for access to voluntary assisted dying in clause 10(1) of the draft Bill.

19.58 The review of the legislation would inform consideration of the scope of the scheme, including any future consideration that might be given to allow, in defined circumstances, access to the scheme by 'Gillick competent' minors or advance decision-making about voluntary assisted dying. However, any extension of the scheme to include those matters should not be made until the new framework has been in place for some time and is operating effectively.[52]

19.59 It is unnecessary to impose an additional statutory requirement for further review of the legislation in subsequent periods, as is done in some other jurisdictions. It is anticipated that legislation of this nature will be monitored by the Department on a regular basis as a matter of course. The legislation will also be subject to continual oversight and reporting by the Board (with reports tabled in Parliament), including on collected data and systemic issues.[53]

50 See Chapter 21 below.
51 See the discussion in Chapter 7 above.
52 See further Chapter 7 above.
53 The Board's functions and reporting obligations are discussed in Chapter 18 above.

AMENDMENT OF THE *GUARDIANSHIP AND ADMINISTRATION ACT 2000* AND *POWERS OF ATTORNEY ACT 1998*

Introduction

19.60 Voluntary assisted dying is premised on the voluntary request of an eligible adult to access a particular end of life option. Two fundamental requirements that underpin the availability of voluntary assisted dying as a lawful option are that the requesting person is acting voluntarily and without coercion, and that they have decision-making capacity for voluntary assisted dying. Additionally, the process requires that the person's request is made personally, and not through another person.

19.61 This situates voluntary assisted dying outside the adult guardianship system, which is administered under the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* (the 'guardianship legislation').

19.62 The adult guardianship system is focused on decision-making for adults who have impaired decision-making capacity. It provides for substitute decision-makers—including attorneys appointed in advance by the adult under an enduring document or guardians or administrators appointed by QCAT (the 'tribunal')—to make decisions about certain matters on the adult's behalf. It also enables an adult to make decisions about some matters in an 'advance health directive' that can operate in the event the adult later loses decision-making capacity. The tribunal, or the Supreme Court in its *parens patriae* jurisdiction, may also consent to some matters for an adult with impaired capacity.

The need for consequential amendment

19.63 To ensure the guardianship legislation does not apply to voluntary assisted dying, consequential amendment to the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* is required.

19.64 The guardianship legislation applies to particular defined categories of 'matters':[54]

- personal matters (which include health matters);
- special personal matters (which are defined inclusively for specific matters such as making or revoking a will, exercising the right to vote in an election, consenting to marriage, and entering a plea of guilty on a criminal charge);
- special health matters (which are defined inclusively for specific health care such as sterilisation and termination of pregnancy); and
- financial matters.

19.65 It may be open to argument whether decisions about voluntary assisted dying fall within the scope of one or more of those matters, such as personal matters or health matters.

Personal matters

19.66 'Personal matter' is broadly defined as a matter, other than a special personal matter or special health matter, 'relating to the principal's care, including the principal's health care, or welfare, including, for example':[55]

- 'services provided to the principal'; and
- 'health care of the principal'.

19.67 On one view, voluntary assisted dying is a service provided to the person that relates to their welfare. It is directed toward alleviating suffering of a person who is dying and suffering intolerably. On another view, voluntary assisted dying has as its purpose bringing about the person's death and so is not directed to the person's welfare.

54 See *Guardianship and Administration Act 2000* (Qld) ss 3, 10, schs 2, 4 (definition of 'matter'); *Powers of Attorney Act 1998* (Qld) s 3, sch 2, 3 (definition of 'matter'). A 'matter' includes a type of matter.

55 *Guardianship and Administration Act 2000* (Qld) sch 2 pt 2 s 2; *Powers of Attorney Act 1998* (Qld) sch 2 pt 2 s 2.

Health matters

19.68 A 'health matter' is a matter relating to health care, other than special health care, of an adult.[56] 'Health care' is defined as 'care or treatment of, or a service or procedure for, the adult':[57]

> (a) to diagnose, maintain, or treat the adult's physical or mental condition; and
>
> (b) carried out by, or under the direction or supervision of, a health provider.

19.69 On one view, voluntary assisted dying might be argued to meet this definition by being a service or procedure that is intended to treat the person's physical or mental condition by alleviating suffering the person considers to be intolerable. On the other hand, it might be argued that voluntary assisted dying is an end of life option but does not 'treat' the person's physical or mental condition.

19.70 This uncertainty requires consequential amendment to make the position clear.

Options for amendment

19.71 There are three aspects of the guardianship legislation that should or might be excluded:

- an adult making decisions about voluntary assisted dying in an advance health directive;[58]
- an attorney, guardian or administrator making decisions about voluntary assisted dying for an adult with impaired capacity[59] (including a statutory health attorney for health matters);[60] and
- the tribunal exercising its powers to:
  - make declarations about the capacity of an adult to make decisions about voluntary assisted dying;[61] or
  - make or give, on an application of the adult or an interested person, a declaration, order, direction, recommendation or advice 'in relation to an adult with impaired capacity about something in, or related to', the *Guardianship and Administration Act 2000* or the *Powers of Attorney Act 199862*—which might be argued to include voluntary assisted dying.

Voluntary assisted dying as a 'special personal matter'

19.72 One option might be to amend the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* to provide that decisions about voluntary assisted dying are a 'special personal matter'.[63]

19.73 The guardianship legislation does not allow substitute decision-makers to exercise power for 'special personal matters'.[64] Directions about special personal matters also

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56 *Guardianship and Administration Act 2000* (Qld) sch 2 pt 2 s 4; *Powers of Attorney Act 1998* (Qld) sch 2 pt 2 s 4.

57 *Guardianship and Administration Act 2000* (Qld) sch 2 pt 2 s 5; *Powers of Attorney Act 1998* (Qld) sch 2 pt 2 s 5. 'Health provider' is defined broadly to mean 'means a person who provides health care, or special health care, in the practice of a profession or the ordinary course of business': s 3 sch 4 (definition of 'health provider').

58 See generally *Powers of Attorney Act 1998* (Qld) ch 3 pt 3 s 35.

59 See generally *Powers of Attorney Act 1998* (Qld) ch 3 pt 2 s 32, pt 3 s 35; *Guardianship and Administration Act 2000* (Qld) ss 12, 33.

60 See generally *Powers of Attorney Act 1998* (Qld) ch 4; *Guardianship and Administration Act 2000* (Qld) ch 5 div 2.

61 See *Guardianship and Administration Act 2000* (Qld) ss 81(1)(a), 146.

62 See *Guardianship and Administration Act 2000* (Qld) s 115(1).

63 An alternative of making voluntary assisted dying a 'special *health* matter' would still leave open the possibility that an adult can make directions about that matter in an advance health directive and that, unless expressly excluded, the tribunal could consent to such a matter for an adult: see *Powers of Attorney Act 1998* (Qld) s 35(1); *Guardianship and Administration Act 2000* (Qld) s 68(1).

64 The power to make decisions for an adult about special personal matters cannot be assigned in an enduring document: *Powers of Attorney Act 1998* (Qld) s 32(1)(a). Nor can it be granted to a substitute decision-maker by order of the tribunal: *Guardianship and Administration Act 2000* (Qld) s 14(3). Further, there are no other provisions in the guardianship legislation empowering other decision-makers for special personal matters.

An attorney, a guardian or an administrator may be appointed and exercise power only for personal matters or financial matters (as specified in the terms of their appointment): see *Powers of Attorney Act 1998* (Qld) s 32(1); *Guardianship and Administration Act 2000* (Qld) s 12(1).

cannot be given in an advance health directive.[65] 'These matters are regarded as being of such an intimate or personal nature that it would be inappropriate for another person to be given the power to make such a decision on behalf of an adult.'[66]

19.74 Special personal matters are defined as follows:[67]

> A ***special personal matter,*** for an adult, is a matter relating to 1 or more of the following—
>
> (a) making or revoking the adult's will;
>
> (b) making or revoking a power of attorney, enduring power of attorney or advance health directive of the adult;
>
> (c) exercising the adult's right to vote in a Commonwealth, State or local government election or referendum;
>
> (d) consenting to adoption of a child of the adult under 18 years;
>
> (e) consenting to marriage of the adult;
>
> (f) consenting to the adult entering into a civil partnership;
>
> (g) consenting to the adult terminating a civil partnership;
>
> (h) entering into, or agreeing to enter into, a surrogacy arrangement under the *Surrogacy Act 2010*;
>
> (i) consenting to the making or discharge of a parentage order under the *Surrogacy Act 2010*;
>
> (j) entering a plea on a criminal charge for the adult.
>
> *Note—*
>
> An attorney under an enduring document or a guardian may not be given power for a special personal matter.

19.75 This option would mean that decisions about voluntary assisted dying would not be a 'personal matter' or a 'health matter'. It would have the effect that:

- directions about voluntary assisted dying could not be given by an adult in an advance health directive; and
- decisions about voluntary assisted dying could not be made for an adult by a substitute decision-maker under the guardianship legislation.

19.76 The tribunal is not given specific power for special personal matters for an adult. However, the tribunal would arguably still have general power to make or give declarations, orders, recommendations or advice, including declarations about the capacity of an adult to make decisions about voluntary assisted dying.[68]

Declaratory provision excluding voluntary assisted dying

19.77 An alternative option is to amend the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* to include a declaratory provision to the effect that voluntary assisted dying is not a matter to which those Acts apply.

19.78 The Western Australia and Victorian legislation includes a declaratory provision to the effect that nothing in the guardianship legislation authorises decisions about voluntary assisted dying.

65 See generally *Powers of Attorney Act 1998* (Qld) s 35(1).
66 QLRC, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) vol 1, [6.21].
67 *Powers of Attorney Act 1998* (Qld) sch 2 pt 2 s 3; *Guardianship and Administration Act 2000* (Qld) sch 2 pt 2 s 3.
68 See *Guardianship and Administration Act 2000* (Qld) ss 81(1)(a), 115(1), 146.

19.79 The Western Australian Act provides for the following amendment to the *Guardianship and Administration Act 1990* (WA):[69]

> At the end of Part 1 insert:
>
> **3B. Act does not authorise decisions about voluntary assisted dying**
>
> Nothing in this Act authorises the making of a treatment decision, whether in an advance health directive or otherwise, in relation to voluntary assisted dying as defined in the *Voluntary Assisted Dying Act 2019* section 5.

19.80 Similarly, the Victorian Act included the following amendment to the guardianship legislation in that jurisdiction:[70]

> After section 8 of the **Medical Treatment Planning and Decisions Act 2016** insert—
>
> **'8A Act does not apply to decisions about voluntary assisted dying**
>
> Nothing in this Act authorises the making of either of the following with respect to voluntary assisted dying within the meaning of the *Voluntary Assisted Dying Act 2017*—
>
> (a) a statement in an advance care directive;
>
> (b) a decision by a medical treatment decision maker.'.

19.81 Under the *Medical Treatment Planning and Decisions Act 2016* (Vic), the tribunal may, on application or on its own motion, make an order about the decision-making capacity of a person 'in relation to a decision to which [that] Act applies'.[71] The amendment in the Victorian legislation may therefore also have the effect of excluding the tribunal's power to make declarations about capacity for decisions about voluntary assisted dying.[72]

19.82 To achieve a similar outcome in Queensland, a declaratory provision may need to be worded differently, given the broad terms in which the tribunal's power is conferred under the *Guardianship and Administration Act 2000*.

The Commission's view

19.83 Amendment to the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* is needed to exclude:

- an adult from making decisions about voluntary assisted dying in an advance health directive;
- a substitute decision-maker (such as an attorney, guardian or administrator) from making decisions about voluntary assisted dying for an adult with impaired capacity; and
- the tribunal from making or giving (under the guardianship legislation) a declaration, order, direction, recommendation or advice in relation to an adult about voluntary assisted dying, including a declaration about the capacity of an adult to make decisions about voluntary assisted dying (noting that the tribunal will have power to make particular decisions in the exercise of its recommended new review jurisdiction under the draft Bill).[73]

19.84 In particular, the Commission considers that a declaratory provision should be inserted into each of those Acts to the effect that 'voluntary assisted dying is not a matter to which this Act applies'.

69 *Voluntary Assisted Dying Act 2019* (WA) s 170.
70 *Voluntary Assisted Dying Act 2017* (Vic) s 140.
71 *Medical Treatment Planning and Decisions Act 2016* (Vic) s 5.
72 The tribunal would, however, have jurisdiction to make decisions (including, relevantly, about capacity) on an application for review made under the *Voluntary Assisted Dying Act 2017* (Vic): see Chapter 16 above.
73 See Chapter 16 above.

19.85 We consider that the voluntary assisted dying scheme has a different focus to, and sits outside, the adult guardianship system. The guardianship legislation should not apply to decisions about voluntary assisted dying.

19.86 The declaratory provision will remove any doubts that might otherwise arise about the potential application of the guardianship legislation to decisions about voluntary assisted dying.

19.87 It will ensure that voluntary assisted dying remains distinct and separate from the guardianship legislation. It will ensure that the substantive provisions concerning voluntary assisted dying, including the tribunal's jurisdiction for voluntary assisted dying cases, are kept together in the voluntary assisted dying legislation.

RECOMMENDATIONS

Interpreters

19-1 An interpreter for a person requesting access to voluntary assisted dying:

(a) must:

(i) be accredited by a body approved by the chief executive of the Department; or

(ii) have been granted an exemption by the chief executive of the Department; and

(b) must not:

(i) be a family member of the person;

(ii) know or believe that they are a beneficiary under a will of the person or that they may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees as an interpreter); or

(iii) be an owner of, or be responsible for the management of, any health facility at which the person is being treated or resides; or

(iv) be a person who is directly involved in providing a health service or personal care service to the person.

19-2 The chief executive of the Department may grant an exemption from the accreditation requirement if satisfied that no accredited interpreter is available in a particular case, and there are exceptional circumstances for granting the exemption.

Regulation making power

19-3 The draft Bill provides that the Governor in Council may make regulations under the Act, including a matter that must be included in an approved form under the Act.

Approved forms

19-4 The draft Bill provides that the chief executive of the Department may approve forms for use under the Act.

Technical errors

19-5 The validity of the request and assessment process under Part 3 or the administration process (consisting of an administration decision and the administration of a voluntary assisted dying substance) under Part 4 of the Act should not be affected by:

(a) any minor or technical error in a form required to be completed;

(b) the failure of a person to provide a form within the time required; or

(c) the failure of a medical practitioner to do an act within the time required for doing the act.

The inclusion of this provision in the draft Bill is not intended to affect the general operation of section 48A of the *Acts Interpretation Act 1954* in that regard.

Review of the Act

19-6 The Minister must review the effectiveness of the Act as soon as practicable after the end of three years after its commencement and:

(a) the review must include a review of the eligibility requirements for access to voluntary assisted dying under the Act; and

(b) as soon as practicable after finishing the review, the Minister must table a report about its outcome in the Legislative Assembly.

Amendment of the guardianship legislation

19-7 The draft Bill amends the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* to include a declaratory provision to the effect that voluntary assisted dying is not a matter to which those Acts apply.

CHAPTER 20

Commonwealth laws that impede access

Chapter 20: Commonwealth laws that impede access

CHAPTER SUMMARY

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

This chapter addresses the uncertainty surrounding the possible application of Commonwealth 'carriage service' offences to conduct that is authorised by state voluntary assisted dying laws. It is unclear whether providing information and advice about voluntary assisted dying by telephone, videoconference, email or other forms of electronic communication would contravene these Commonwealth provisions. This uncertainty is unsatisfactory. It led to the then Victorian Health Minister instructing doctors and other practitioners involved in the voluntary assisted dying process to conduct all discussions, consultations and assessments face-to-face to avoid potentially breaching the provisions.

The Victorian Board has made repeated calls for the Commonwealth to make an exemption so people, particularly those in regional areas, can have 'important conversations about voluntary assisted dying over the phone or via teleconference'.

The uncertain application of the Commonwealth law particularly affects individuals who are suffering and dying in regional, rural and remote areas. Their access to voluntary assisted dying may be greatly impaired if these forms of communication cannot be used to access information and advice.

In this chapter, we propose a way to address this uncertainty and avoid such adverse consequences.

ACCESS TO INFORMATION AND ADVICE

20.1 The operation of any voluntary assisted dying scheme will require access to information and advice. This may be provided by health professionals and state government services in different ways throughout the voluntary assisted dying process. It ranges from basic information about the scheme to more detailed advice about a person's eligibility and the process involved. In the final stages, it may involve detailed instructions about self-administration of the substance.

20.2 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. It may be practically impossible for a health practitioner to travel the long distance required to meet a patient in person and provide what may be only basic information and advice about voluntary assisted dying and other end of life options. In such cases, information may need to be given by telephone, video conference, email or some other form of electronic communication.

20.3 The need to use such means 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 regional, rural and remote parts of the state may have greatly impaired access to voluntary assisted dying.

THE POSSIBLE APPLICATION OF COMMONWEALTH 'CARRIAGE SERVICE' OFFENCES

20.4 Concerns have been raised about whether the use of telephone, video, email and other forms of electronic communications to convey information and advice about voluntary

assisted dying may contravene Commonwealth laws that prohibit the use of a 'carriage service' to counsel, promote or provide instruction on suicide.

20.5 Views differ about whether those laws apply to lawful conduct that is authorised by state voluntary assisted dying laws. This depends on:

- whether voluntary assisted dying is 'suicide' for the purpose of the Commonwealth offences; and
- if it is 'suicide', whether conduct involved in the process would satisfy both the physical and fault elements of the offences.

20.6 One view is that the Commonwealth offences do not apply and were never intended to have that effect. The Victorian and Western Australian Acts are said to have created 'a new form of dying' which is 'legally distinguishable from suicide'.[1] The result is that the use of telecommunications to provide information and advice about voluntary assisted dying would not contravene laws that prohibit the use of a carriage service to counsel, promote or provide instruction on suicide. This view has been advanced by Professors Stewart, Kerridge, and Komesaroff and Dr Le Brooy.[2]

20.7 In a Memorandum of Advice, dated 25 September 2020, Robert Richter QC and William Stark reach a similar conclusion. Their view is based, in part, on the conclusion that voluntary assisted dying is not 'common law suicide' but a new 'legal kind of dying'.[3] They also focus on the physical and fault elements of the offences and conclude that a medical practitioner who is engaging in a discussion about voluntary assisted dying will not have the intent required to commit an offence under the Criminal Code (Cth) provisions. For example, one such provision requires an intent by the party 'to use the material to counsel or incite committing or attempting to commit suicide'. Richter QC and Stark advise that it would be extremely difficult to achieve a conviction and, in the circumstances, it seems extremely unlikely that the Commonwealth Director of Public Prosecutions would prosecute a medical practitioner providing services in accordance with state voluntary assisted dying legislation.[4]

20.8 Dr Del Villar and her co-authors express a different view. They argue that although the legal position is untested, voluntary assisted dying would likely meet the definition of 'suicide' for the purpose of the Criminal Code (Cth).[5] The authors evaluate the likelihood of criminal liability for using a carriage service at various stages of the voluntary assisted dying process. Some actions, such as discussing voluntary assisted dying as one of a range of end of life options or conducting an eligibility assessment, are considered highly unlikely or unlikely to contravene the Criminal Code (Cth). The authors observe that the risk varies depending on the conduct involved, including the level of specificity of the information provided, and whether the communication occurs towards the beginning or end of the voluntary assisted dying process.[6] They recognise that establishing a breach of the provision also requires proof of the health practitioner's subjective intention.[7]

20.9 Uncertainty surrounding the application of the Commonwealth law to health practitioners who are authorised by state law to engage in the voluntary assisted dying process is concerning. The uncertainty should be resolved. It is inherently undesirable that health practitioners should be left under such an apparently unintended grey cloud. If the Commonwealth law is not clarified, some health practitioners may be deterred

1 C Stewart et al, 'Suicide-Related Materials and Voluntary Assisted Dying' (2020) 27 *Journal of Medical Law* 839, 840.
2 Ibid.
3 R Richter and W Stark, 'Memorandum of Advice: The Impact of *Commonwealth Criminal Code* on Operation of *Voluntary Assisted Dying Act 2017 (Vic)', Dying with Dignity Victoria* (2020) <https://www.dwdv.org.au/news/an-opinion-on-carriage-service>.
4 Ibid [14], [19].
5 K Del Villar et al, 'Voluntary assisted dying and the legality of using a telephone or internet service: The impact of Commonwealth "Carriage Service" offences' (2021) *Monash University Law Review* 47 (in press) <https://eprints.qut.edu.au/207083/>.
6 Ibid 54.
7 Ibid 43.

from participating in the process, particularly in rural, remote and regional areas where telehealth and other forms of electronic communication via a 'carriage service' is a necessity. Without access to health practitioners who are qualified to undertake the eligibility assessments and engage in other aspects of the process, including conversations with a patient about the final request for administration, people in remote areas will be disadvantaged and have unequal access to the process.

20.10 The Commission does not purport to give a definitive interpretation of the relevant provisions of the Criminal Code (Cth) or make any prediction about the risk that health practitioners might be prosecuted, let alone successfully prosecuted. Instead, this part of the report outlines the different arguments about the meaning of 'suicide' for the purpose of the Commonwealth law.

20.11 We recommend 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 including the ministers responsible for the justice and health portfolios, 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 did not apply to a death which is assisted in accordance with State or Territory voluntary assisted dying laws.

THE COMMONWEALTH LAW

20.12 Sections 474.29A and 474.29B of the Criminal Code (Cth) are detailed. In simple terms they prohibit the use of a 'carriage service' to:

- counsel or incite suicide or attempted suicide; or
- promote or provide instructions on a particular method of committing suicide.

20.13 Section 474.29B prohibits the possession or supply of 'suicide related material' of that kind with the intention that the material be used in committing an offence against section 474.29A.

20.14 These offences, which were introduced in 2005, find their place among other Commonwealth provisions which prohibit the use of a carriage service for improper purposes. The offences include the use of carriage services to communicate child abuse material and abhorrent violent material.[8] In practical terms the prohibitions apply to the use of telephone, email, the internet and other methods of electronic communication.

20.15 As with other offences contained in the Criminal Code (Cth), the relevant offence consists of physical elements and fault elements. For example, section 474.29A(1) makes it an offence to use a carriage service to access or transmit material which 'directly or indirectly counsels or incites committing or attempting to commit suicide'. The physical elements of that offence are the use of a carriage service to access or transmit material that counsels or incites committing or attempting to commit suicide. The fault or mental element of the offence is that the person either:

(i) intends to use the material to counsel or incite committing or attempting to commit suicide; or

(ii) intends that the material be used by another person to counsel or incite committing or attempting to commit suicide.

20.16 Section 474.29A(3) provides that a person does not commit the offence in section 474.29A(1) merely because the person uses a carriage service to:

(a) engage in public discussion or debate about euthanasia or suicide; or

(b) advocate reform of the law relating to euthanasia or suicide

8 Eg, Criminal Code (Cth) ss 474.22, 474.33.

if the person does not:

(c) intend to use the material concerned to counsel or incite committing or attempting to commit suicide; or

(d) intend that the material concerned be used by another person to counsel or incite committing or attempting to commit suicide.

20.17 A similar provision appears in section 474.29A(4) in respect of the offence in section 474.29A(2) concerning material that promotes or provides instruction on a particular method of committing suicide.

20.18 Dr Del Villar and her co-authors summarise the relevant Criminal Code (Cth) provisions as follows:[9]

Provision	Summary	Physical Elements		Fault Element
		The person:	***The material directly or indirectly:***	
474.29A(1) **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Counsel or incite suicide	• uses a **carriage service** • to **access**/ cause to be transmitted/ **transmit**/ make available/ publish or otherwise distribute • **material**	• **counsels or incites** • committing or attempting to commit **suicide**	the person **intends to use the material** (or the material be used by another) to • counsel or incite committing or attempting suicide
474.29A(2) **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Promote or provide instructions on methods of suicide	• use a **carriage service** • to **access**/ cause to be transmitted/ **transmit**/ make available/ publish or otherwise distribute • **material**	• **promotes** OR • **provides instruction** • on a particular method of committing **suicide**	the person **intends to use the material** (or the material to be used by another) to • promote/provide instruction on a method of suicide OR • the person **intends** it be used by another person to commit suicide
474.29B **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Possess or supply suicide related material	• has **possession/ control** of/ produces/ **supplies**/ obtains material	• **counsels or incites** committing or attempting to commit suicide; OR • **promotes or provides instruction** on a particular method of committing suicide	the person has possession/engages in supply with the **intention** that the material be used: • by that person; OR • by another person; in committing an offence against section 474.29A (even if committing the offence is impossible).

THE PURPOSE OF THE COMMONWEALTH LAWS

20.19 In simple terms, the provisions make it illegal for anyone in Australia to use a carriage service to counsel or incite suicide, or to provide instruction on a particular method of committing suicide.

20.20 The policy aim of the amendments is to 'protect vulnerable people who may be suicidal or have suicidal tendencies'.[10]

9 Table adopted with permission from Del Villar et al, above n 5, 14-15 (notes omitted).

10 Senate, Legal and Constitutional Legislation Committee, Parliament of Australia, *Provisions of the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005* (Report, May 2005) [3.2].

20.21 Opponents of the legislation identified that it extended to the elderly and terminally ill who, those advocates argued, might benefit from the existence of cyber suicide websites. In a submission to the Senate Legal and Constitutional Legislation Committee, the Voluntary Euthanasia Society of Queensland advocated for access to cyber-suicide websites and other pro-euthanasia websites. It noted that statistics showed that three persons over the age of 73 committed suicide each week in horrendous ways.[11] It argued that access to websites might have allowed these individuals to live if they had discussed their intentions.

20.22 Opponents of voluntary assisted dying supported the legislation. Participants on both sides of the debate recognised that it would preclude the elderly, including persons who were terminally ill, from accessing information that would enable them to commit suicide.[12] Evidence given to the Senate Legal and Constitutional Legislation Committee also indicated that if a doctor, during a telephone communication, provided information about a method of suicide which encouraged the use of that method, he or she would be subject to the legislation.[13]

20.23 The Parliamentary Debates also recognised that the legislation was not confined to protecting the young and vulnerable from accessing cyber-suicide websites and other information about suicide.[14] It related to counselling or inciting suicide, promoting a particular method of committing suicide or providing instruction on a particular method of suicide. The legislation was directed at suicide in general.

20.24 At the time the Commonwealth offences were enacted, certain conduct which is now authorised by state voluntary assisted dying legislation was illegal. Conduct which aids, abets or incites suicide is an offence under state or territory law. However, those offences do not apply to a person who assists another person to die in accordance with voluntary assisted dying laws.

20.25 The Commonwealth Parliament seemingly did not have lawful voluntary assisted dying in mind when it used the term 'suicide' in the relevant provisions. In 2005, when the Commonwealth laws were passed, no such legislation existed in Australia. The provisions were not targeted at activities that were authorised under voluntary assisted dying laws. Their application in the event that those laws were passed was not debated in Parliament.

IS AUTHORISED VOLUNTARY ASSISTED DYING 'SUICIDE' FOR THE PURPOSE OF THE COMMONWEALTH LAW?

20.26 It is unsettled whether voluntary assisted dying, authorised by a state law, constitutes 'suicide' within the meaning of the Commonwealth carriage service offences.

20.27 Issues of statutory interpretation are not resolved by the fact that a state law permits voluntary assisted dying or even declares that it does not constitute 'suicide'. The relevant issue of interpretation is not the meaning of 'suicide' under a state law which, for instance, prohibits assisted suicide by making it an offence to counsel or incite suicide. It is the meaning of 'suicide' in the Commonwealth provisions.

20.28 This issue, like any issue of statutory interpretation, requires consideration of the meaning of the statutory text, having regard to the statutory context in which the words appear and the purpose of the statute.[15]

11 Ibid [3.11].

12 Ibid [3.31]–[3.33], [3.40]–[3.44]; Commonwealth, *Parliamentary Debates*, Senate, 23 June 2005, 237 (B Greig), 241-2 (L Allison), 243 (B Brown).

13 Senate, Legal and Constitutional Legislation Committee, Parliament of Australia, *Provisions of the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005* (Report, May 2005) [3.52].

14 Eg, Commonwealth, *Parliamentary Debates*, House of Representatives, 11 May 2005, 55 (R McClelland).

15 *R v A2; R v Magennis; R v Vaziri* (2019) 373 ALR 214, [32]–[34].

The text

20.29 The Criminal Code (Cth) does not define 'suicide' for the purposes of the carriage service offences. The starting point, therefore, is the ordinary meaning of the word. The *Macquarie Dictionary* defines suicide as 'the intentional taking of one's own life'.[16] Legal definitions of suicide are similar. Suicide has also been described as 'self-murder'.[17]

20.30 We mention in this context conduct that falls outside of the legal definition of 'suicide' in Australian law. The predominant view is that, provided an individual has decision-making capacity, their refusal of life-sustaining treatment is lawful and, if it results in their death, the death is not regarded in law as suicide.[18] As a result, a refusal of medical treatment or of food and water by a patient with the intention of bringing about their death is not treated as suicide. Therefore, a nursing home, hospital or doctor respecting the patient's wishes would not be liable for the offence of assisting suicide.

Context and purpose

20.31 The Commonwealth law's purpose might be said to complement or supplement state and territory laws that prohibit assisting suicide by, for example, prohibiting persons from using a telephone or the internet to counsel or incite a person to commit suicide, promote a particular method of committing suicide or provide instruction on a particular method of committing suicide.

20.32 More broadly, the purpose of the law might be said to limit access by persons contemplating suicide to advice and information which, directly or indirectly:

- counsels or incites committing or attempting to commit suicide;
- promotes a particular method of committing suicide; or
- provides instruction on a particular method of committing suicide.

20.33 A relevant context is that, following reforms which commenced in the 1960s, suicide and attempted suicide is not a crime in any Australian state or territory. Previously, suicide was treated as a form of self-murder and was an offence. While suicide is no longer an offence, it is an offence to assist suicide. Those offences take different forms in the different Australian jurisdictions. In general terms, it is an offence to aid, abet, counsel or incite a suicide. Given that legal context in 2005, the target of the Commonwealth provisions might be said to be the use of a carriage service to *illegally* assist suicide.

The argument that voluntary assisted dying authorised by a state law is not 'suicide'

20.34 Professor Stewart and his co-authors accept that the word 'suicide' in the Commonwealth carriage service provisions adopts the ordinary meaning of 'suicide'. They point to passages in the Second Reading speech of the then Parliamentary Secretary to the Minister for Finance and Administration which are said to demonstrate the 'focused nature of the Parliament's intention'.[19] The prohibitions are said to have been targeted at those using the internet:[20]

> … to encourage suicide with destructive intent. Nowhere was it discussed or intended that the laws would prevent legalised voluntary assisted dying schemes from using telecommunications. Indeed, the fact that public discussion regarding legislation was actively protected by the provision strongly implies that Parliament intended not to

16 *Macquarie Dictionary* (online at 29 April 2021) 'suicide'; *X v The Sydney Children's Hospitals Network* (2013) 85 NSWLR 294, 308 [59].

17 *Stuart v KirklandVeenstra* (2009) 237 CLR 215, 236 [44]; *IL v The Queen* (2017) 262 CLR 268, 302 [79], 314 [111]–[112].

18 *X v The Sydney Children's Hospitals Network* (2013) 85 NSWLR 294, 308 [59]; Re JS [2014] NSWSC 302 at [34]; *Brightwater Care Group v Rossiter* (2009) 40 WAR 84, [24], [26]; H Ltd v J (2010) 107 SASR 352, 374 [67].

19 This speech related to a Bill introduced into Parliament in 2004. That Bill did not proceed, but it was in substantially the same terms as the Bill introduced and passed in 2005 to effect changes to the Commonwealth law: Commonwealth, *Parliamentary Debates*, House of Representatives, 11 May 2005, 55 (R McClelland).

20 Stewart et al, above n 1, 843.

> interfere with any State-based legislative agenda.

20.35 The learned authors conclude that the Victorian and Western Australian Acts establish 'voluntary assisted death as a category of death separate from suicide and from the prohibitions on assisted suicide'.[21] In their view, the Victorian and Western Australian Acts:[22]

> create a new form of dying – voluntary assisted death – which is legally distinguishable from suicide and that consequently, any use of telecommunications to provide information regarding voluntary assisted death would therefore not constitute a breach of laws to prevent the spread of suicide-related materials.

20.36 Additional regard is had to section 12 of the Western Australian Act which provides:[23]

> For the purposes of the law of the State, a person who dies as a result of the administration of a prescribed substance in accordance with this Act does not die by suicide.

20.37 Professor Stewart and his co-authors state that since the Commonwealth provisions do not define suicide, they may be taken to adopt state-based definitions. They conclude that:[24]

> If the State defines suicide as not including voluntary assisted death, the Federal definition of suicide must also exclude it.

20.38 On the issue of statutory purpose, they argue that when the Commonwealth Parliament created the prohibitions there was no state-based assisted dying regime and therefore it cannot be said that the Commonwealth Parliament intended to regulate legalised voluntary assisted dying. They conclude that the Commonwealth carriage services offences do not apply to health practitioners acting under such state-based legislation.[25]

20.39 The legal advice of Robert Richter QC and William Stark that the Commonwealth provisions are not breached by persons complying with the relevant state legislation is based, in part, upon the conclusion that state voluntary assisted dying laws create 'a new legal kind of dying' which is legally distinguishable from suicide.[26]

The competing argument

20.40 A competing view is that voluntary assisted dying by self-administration in accordance with legislation, such as the Victorian and Western Australian Acts, falls within the ordinary meaning of 'suicide' and the concept of suicide in law.

20.41 This view draws upon the suggested purpose of the Commonwealth provisions which extend to information or assistance to enable a terminally ill person to 'die with dignity'. The essence of the argument is that the relevant provisions, in their terms and in their purpose, apply to voluntary assisted dying. On this view, a person who intentionally takes their own life by self-administration in accordance with a state voluntary assisted dying law commits suicide.

20.42 The fact that a state law authorises voluntary assisted dying and may even declare that, for the purposes of the law of the state, it is not suicide, does not necessarily change the meaning of 'suicide' in the Criminal Code (Cth). Instead, there is a potential inconsistency between the Commonwealth law and the relevant state law. The state law expressly authorises intentional self-killing if the requirements of the law are met and allows health practitioners and others to communicate via telephone and other electronic means. If those communications fall within a prohibition in the Criminal Code

21 Ibid 844–5.
22 Ibid 840.
23 Ibid 845, citing *Voluntary Assisted Dying Act 2019* (WA) s 12.
24 Ibid 845.
25 Ibid.
26 Richter and Stark, above n 3, [4(b)], [18].

(Cth), then any authorisation given by state law to undertake those communications will be inoperative due to a direct inconsistency between the Commonwealth law and the state law.

20.43 Dr Del Villar and her co-authors consider these and competing arguments.[27] They identify the argument that voluntary assisted dying by self-administration would be considered 'suicide' as a matter of statutory interpretation under the Criminal Code (Cth). However, they conclude that the matter remains unsettled. The authors observe that the intention of the Commonwealth Parliament to create offences relating to the use of a carriage service for suicide related material occurred at a time when voluntary assisted dying was unlawful in all Australian states and territories. They recognise that it is possible to argue that the Commonwealth provisions should be restricted to *unlawfully* assisting a person to die, rather than assisting a person to exercise a legal right under state legislation.[28]

20.44 Dr Del Villar and her co-authors also recognise that a lawful category of intentional self-killing might not be classified as suicide. In that regard, altruistic self-killing (such as a soldier who sacrifices himself to save his comrades) might be treated as a category of intentional self-killing which is not suicide.[29] New Zealand authority supports that conclusion in certain obiter dicta comments.[30] There may be other grounds to argue a distinction between suicide and assisted dying which hastens a death which is going to occur within a relatively short time.[31] However, Dr Del Villar and her co-authors note that Collins J in *Seales v Attorney-General* rejected such an analysis. They also cite several Australian cases in which courts have ruled that 'actions taken to assist a loved one to die, intending that death will occur, fall within the legal concept of assisting suicide, even where there may be a rational reason for desiring death, such as the presence of terminal illness or intolerable pain'.[32]

20.45 Dr Del Villar and her co-authors counsel that until the courts have authoritatively settled the meaning of 'suicide' in the Criminal Code (Cth), it would be wise for medical practitioners to assume that voluntary assisted dying may be considered 'suicide' within the meaning of that law.[33]

THE PHYSICAL AND FAULT ELEMENTS OF THE COMMONWEALTH LAW

20.46 Even if lawful voluntary assisted dying was found to fall within the meaning of 'suicide' in the Commonwealth carriage service offences, this would clarify only a threshold issue. It is then necessary to consider whether certain conduct falls within a particular offence provision. This requires proof, beyond reasonable doubt, of the relevant physical and fault element elements.

20.47 The evaluation of the likelihood that any conduct would constitute an offence under a Commonwealth carriage service offence is complex and fact specific. The following provides a broad overview of the physical and fault elements of the relevant provisions. A fuller discussion of these matters is beyond the scope of this report.[34]

27 Del Villar et al, above n 5.
28 Ibid 23.
29 Ibid 19.
30 *Seales v Attorney-General* [2015] 3 NZLR 556, [137].
31 Del Villar et al, above n 5, 20 citing *Baxter v Montana*, 2009 MT 449 (Mont, 2009) [71] (Leaphart J); *Truchon v Procureur Général du Canada* [2019] QCCS 3792, [466] (Baudoui J).
32 Del Villar et al, above n 5, 20.
33 Ibid 24.
34 Some aspects are addressed in Del Villar et al, above n 5.

20.48 In simple terms, section 474.29A makes it an offence for a person to use a carriage service to access, transmit, make available, publish or otherwise distribute material where the person:

(i) intends to use the material to counsel or incite committing or attempting to commit suicide; or

(ii) intends that the material be used by another person to counsel or incite committing or attempting to commit suicide.

20.49 The relevant conduct covers a wide range of communications over a carriage service.

20.50 The term 'to counsel or incite' in this context probably has the meaning it bears in criminal offences concerned with aiding, abetting and procuring. This interpretation is supported by evidence to the Senate Committee which considered the legislation and the explanatory memorandum. Simply providing assistance and information might not constitute counselling. The offence appears to be directed at encouraging a person to commit suicide with intent to bring about that result. As Dr Del Villar and her co-authors observe, it 'would not cover providing broad general advice which is not intended to be acted upon'.[35]

20.51 Section 474.29A(2) concerns the same range of conduct in using a carriage service but in which the person, using the carriage service to distribute material, directly or indirectly promotes a particular method of committing suicide or provides instruction on a particular method of committing suicide.

20.52 In the case of this offence, the person must intend to use the material to promote, or provide instruction on, that method of committing suicide, or intend that the material be used by another person to promote, or provide instruction on, that method of committing suicide. The word 'promote' suggests a purposive element which might be assessed objectively.[36]

20.53 To satisfy the fault element of section 474.29A(2), the relevant person would need to intend that the material promote, or provide instruction on, that method of committing suicide.

20.54 Section 474.29B contains its own physical element concerned with possession of suicide related material with the intention that the material be used in committing an offence against section 474.29A.

20.55 Dr Del Villar and her co-authors acknowledge the complexity associated with the possible application of these provisions to the wide variety of communications that might occur via a carriage service in relation to the voluntary assisted dying process. They express the opinion that certain forms of communication, such as a care navigator services which act as a first point of contact for a person seeking information about voluntary assisted dying, would be most unlikely to constitute an offence.[37] Relevantly, Richter QC and Stark observe that the intent required for the offences in sections 474.29A(1)(c), 474.29A(2)(c) and 474.29B(1)(c) is quite specific. For example, the first provision requires an intention on the part of the person 'to counsel or incite' committing or attempting to commit suicide. In their opinion, 'it would be very difficult to establish that a medical practitioner who is engaging in a discussion about [voluntary assisted dying] had the requisite intent'.[38]

20.56 Dr Del Villar and her co-authors observe that the lowest level of risk is present in initial discussions with a patient about end of life options. 'Communications only relating to the range of treatment, non-treatment and palliative care options available to a patient,

35 Del Villar et al, above n 5, 30.
36 Ibid 31.
37 Ibid 40.
38 Richter and Stark, above n 3, [13].

including voluntary assisted dying as a possible option',[39] are regarded as highly unlikely to breach the Commonwealth provisions. However, as they explain, the more detailed and specific the information provided, the greater the risk. The risk would be higher if health practitioners provide specific advice about a method of voluntary assisted dying, the drugs to be used and the procedure to be followed by someone wishing to end their life in accordance with the statutory framework.[40]

20.57 The authors doubt that assessing eligibility for voluntary assisted dying via a carriage service would offend against the sections. The eligibility assessment is simply concerned with establishing relevant facts and does not involve the sending of material of the kind that seemingly attracts the Commonwealth offences. Also, as they note, it can persuasively be argued that the purpose of eligibility assessment is not to encourage or incite a person to access voluntary assisted dying. Subsequent discussions may be more problematic to the extent it might be said to evidence an intention to provide instruction about a particular method of suicide, namely voluntary assisted dying.[41]

20.58 Conduct in prescribing and dispensing a voluntary assisted dying substance via a carriage service requires separate consideration. The authors argue that, depending on how the communication was framed, there may be evidence to satisfy the fault element insofar as the coordinating medical practitioner or pharmacist intended to provide instruction on a method of committing suicide.[42]

20.59 Because of the legal uncertainty about the application of the Commonwealth provisions, Dr Del Villar and her co-authors suggest it would be prudent for doctors, care navigators and other health practitioners to avoid providing patients with information about voluntary assisted dying methods and procedures over the telephone or by telehealth.[43]

20.60 The authors assemble into a table the circumstances in which actions in the voluntary assisted dying process might contravene the Criminal Code (Cth):[44]

Action	Person(s)	Victorian Act provision(s)	Western Australian Act provision(s)	Likelihood of breaching the Criminal Code (Cth)
Provide contact details of a [voluntary assisted dying] provider	Care Navigator (as first point of contact)	N/A	N/A	Highly unlikely
Discuss it generally as one of a range of end of life options	Doctor; Other health practitioner; or Care Navigator	N/A	N/A	Highly unlikely
Provide information about it as an option or information about specific methods	Doctor; Other health practitioner; or Care Navigator	ss 19(1), 28(1)	ss 27(1), 38(1), 158(2)	Highly unlikely to possible, depending on the nature of the information and intention of the practitioner
Conduct eligibility assessment	Coordinating and consulting medical practitioners	ss 16, 25	ss 24, 30	Unlikely

39 Del Villar et al, above n 5, 42.
40 Ibid.
41 Ibid 44–7.
42 Ibid 50.
43 Ibid 43.
44 Table adopted with permission from Del Villar et al, above n 5, 53.

Action	Person(s)	Victorian Act provision(s)	Western Australian Act provision(s)	Likelihood of breaching the Criminal Code (Cth)
Referral to other specialists for consultations	Coordinating and/or consulting medical practitioner	s 22 (referral to consulting medical practitioner) ss 18, 27 (referral to specialist or psychiatrist when unable to determine eligibility)	s 30 (referral to consulting practitioner) ss 26, 37 (referral to specialist or psychiatrist when unable to determine eligibility)	Highly unlikely
Request a permit	Coordinating medical practitioner	s 43	N/A	Unlikely
Prescription of the substance and related processes	Coordinating medical practitioner	s 57	ss 69, 70	Highly likely
Processes relating to dispensing the substance	Pharmacist	s 58	s 72	Highly likely
Reporting required forms to Board	Coordinating and consulting medical practitioners, Pharmacist	ss 21, 30, 41, 49, 60, 63, 66	s 22, 33, 46, 50, 60	Highly unlikely

20.61 However, Dr Del Villar and her co-authors are not providing legal advice and nor is this report. Their assessments of the risk of potential prosecution are premised upon voluntary assisted dying in accordance with a state law constituting 'suicide' within the meaning of the Criminal Code (Cth). If it falls within the meaning of 'suicide' then, as the authors note, the spectrum of risk depends upon a number of matters, including the level of specificity of the information provided and whether the communication occurs towards the beginning or the end of the voluntary assisted dying process. Also, a breach of the Code requires proof beyond reasonable doubt of the health practitioner's subjective intention.

20.62 Some communications with patients are highly unlikely to engage the Commonwealth provisions because the discussions are of a general kind about end of life options. Conducting an eligibility assessment in neutral terms without counselling or inciting a patient to avail themselves of voluntary assisted dying is also thought to be unlikely to breach the Code. However, the more concrete or specific the information provided, the greater the risk. Communications with a patient about the final request for administration, prescription and dispensing of the substance attract a higher risk.

THE STATE OF UNCERTAINTY AND ITS PRACTICAL CONSEQUENCES

20.63 Because of the uncertain interpretation of the Commonwealth carriage service provisions and their potential application to at least some conduct, a prudent course for many health practitioners will be to not use telephone, telehealth or other forms of electronic communication to provide information or advice about voluntary assisted dying. Uncertainty about these matters led to the then Victorian Health Minister instructing doctors and other practitioners involved in voluntary assisted dying services to conduct all discussions, consultations and assessments face-to-face, so as to avoid potentially breaching the Commonwealth law.

20.64 The Victorian Voluntary Assisted Dying Review Board in its report for the period January-June 2020 stated the following about the inability to use telehealth because of the Commonwealth law:[45]

45 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 16.

> The current COVID-19 pandemic has highlighted the success of telehealth for healthcare access. Unfortunately, due to sections 474.29A and 474.29B of the *Commonwealth Criminal Code* 1995 as amended by the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005*, it is an offence to use a carriage service (such as telephone or telehealth) for suicide-related material, which may include voluntary assisted dying. This places medical practitioners at risk of prosecution. This was already a complicating factor for the medical community, but even more so during the pandemic.
>
> The Board has received anecdotal feedback about challenges faced by some applicants and families in completing face-to-face assessments while COVID-19 measures have been in place.
>
> The Board remains very concerned about the impact the criminal code may have on Victorians, particularly in rural and remote regions, who are unable to use telehealth technology to complete appointments.

20.65 In the same report, the Board repeated its call for the Commonwealth to make an exemption from the Criminal Code (Cth) 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'.[46]

20.66 The Board in its July-December 2020 report reiterated the impact of the Commonwealth carriage service offences and urged the Commonwealth to reconsider an exemption from the Criminal Code (Cth) for Victorians accessing voluntary assisted dying.[47]

20.67 As noted, generally it will be 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, in some circumstances it may be practically impossible for this to occur, particularly where a patient lives in a remote location.

20.68 Dr Del Villar and her co-authors make the following important observations:[48]

> If telehealth is prohibited for [voluntary assisted dying] and in-person communication is needed, numerous practical issues arise. Firstly, there are significant financial and resource costs in funding travel for medical practitioners, [voluntary assisted dying] Care Navigators and/or patients, to conduct consultations and assessments in person, which may be borne by the State and by individuals. But there are also likely to be issues regarding access to [voluntary assisted dying]. People in a terminal stage of illness may be too sick to travel, and a specialist who can spare an hour for a consultation in their usual place of business may be less willing to devote additional time (hours or days) to travel to a remote area.[49] Further delays may occur where allied health practitioners or translators are unavailable at the same time as medical practitioners.[50] Delays are concerning in this context, where the people seeking access to [voluntary assisted dying] are often critically ill and in significant pain or suffering.[51] Concerns about criminal liability under the *Commonwealth Criminal Code* for performing functions which are lawful under State [voluntary assisted dying] laws lead to complex logistical arrangements which impair equality of access to [voluntary assisted dying] for people living in rural and regional areas and cause inefficiency and waste. (notes in original)

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46 Ibid 1.

47 Voluntary Assisted Dying Review Board Report of Operations July–December 2020 (2021) 4.

48 Del Villar et al, above n 5, 56–7.

49 K Tretyakov, 'Medical Aid in Dying by Telehealth' (2020) 30(1) *Health Matrix* 325, 329. These concerns were also noted by the Voluntary Assisted Dying Review Board in Victoria and Cameron McLaren: Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 16; C McLaren, 'An Update on VAD: (Almost) A Year in Review', *Dying with Dignity Victoria* (16 June 2020) 2 <https://www.dwdv.org.au/news/an-update-on-vad-almost-a-year-in-review >.

50 In one case, it was reported that arranging all the required appointments for the voluntary assisted dying process took 6 months, and many times the interpreter did not attend or cancelled at the last minute: Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 16.

51 The Voluntary Assisted Dying Review Board Report includes an anecdotal report of a woman in significant pain spending a long day travelling to a specialist appointment in Melbourne: Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 16.

20.69 They submit, and the Commission agrees, that certainty is needed about liability under the Commonwealth provisions for using telephone or telehealth to communicate about voluntary assisted dying.

20.70 The Commission also agrees that it is:[52]

> clearly an undesirable legal situation where the residual uncertainty surrounding the application of the *Commonwealth Criminal Code* to medical practitioners, and others acting in accordance with State [voluntary assisted dying] laws, depends on an exercise of prosecutorial discretion. (note omitted)

20.71 Action is required to clarify this unsatisfactory legal position. This might be achieved by inserting a definition in the Criminal Code (Cth) that declares 'that "suicide" does not include voluntary assisted dying carried out lawfully pursuant to a law of a State or Territory'.[53] Such an exemption would not affect the application of the Commonwealth provisions to the pro-suicide websites and other electronic communications at which they were aimed.

20.72 In the meantime, Dr Del Villar and her co-authors suggest that it would be highly desirable for the Commonwealth Director of Public Prosecutions to issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state or territory voluntary assisted dying laws.[54]

20.73 They conclude:[55]

> If the *Commonwealth Criminal Code* is not amended, and prosecutorial guidelines are not issued, health practitioners face an unenviable choice between risking possible prosecution or insisting on some communications occurring in person, often involving cost and/or harm to them, their patients and the health system.

THE COMMISSION'S VIEW

20.74 Uncertainty about the possible application of the Commonwealth 'carriage service' offences to conduct that is authorised by state voluntary assisted dying laws is unsatisfactory. We recommend 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 and including the ministers responsible for the justice and health portfolios, 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 did not apply to a death which is assisted in accordance with state or territory voluntary assisted dying laws.

20.75 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.

52 Del Villar et al, above n 5, 57.
53 Ibid 58.
54 Ibid.
55 Ibid.

RECOMMENDATIONS

20-1 The Queensland Government, in consultation with other state governments in which voluntary assisted dying legislation has been enacted, raise for the consideration of senior members of the Commonwealth government, including the ministers responsible for the justice and health portfolios:

(a) the uncertain state of the law concerning the application of Commonwealth carriage service offences for suicide related material to conduct which is authorised by state or territory voluntary assisted dying legislation;

(b) the unintended consequences of the possible application of those laws to lawful voluntary assisted dying in:

(i) deterring health practitioners and health services from using telehealth and other electronic communication to provide information and advice about end of life options and the process of lawful and authorised voluntary assisted dying; and

(ii) denying persons who are dying, particularly persons in rural, regional and remote areas who are too sick to travel or who cannot be readily visited in person by a qualified health practitioner, equal access to lawful and authorised voluntary assisted dying; and

(c) the urgent need to amend the relevant Commonwealth laws to clarify that voluntary assisted dying which is authorised and lawful under state or territory law does not constitute 'suicide' for the purposes of sections 474.29A and 474.29B of the Criminal Code (Cth).

20-2 Pending the amendment of Commonwealth laws in that regard, the Commonwealth Director of Public Prosecutions be asked to consider issuing prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the Criminal Code (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state or territory voluntary assisted dying laws.

20-3 To aid the interpretation of the Commonwealth laws and to avoid their unintended application to lawful and authorised voluntary assisted dying, and to clarify that conduct which is authorised by legislation in Queensland in connection with voluntary assisted dying does not constitute the offence of aiding suicide, the voluntary assisted dying legislation provide:

> For the purposes of the law of the State, a person who dies as a result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act does not die by suicide.

CHAPTER 21

Implementation

Chapter 21: Implementation

CHAPTER SUMMARY

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:[1]

> 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'.[2] However, as noted by the Western Australian Panel:[3]

> 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.[4] 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.[5]

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.

The ***Voluntary Assisted Dying Review Board*** (discussed in Chapter 18) 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)

1 Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019) i.
2 Qld Parliamentary Committee Report No 34 (2020) 149.
3 WA Ministerial Expert Panel Final Report (2019) 102.
4 Department of Local Government, Racing and Multicultural Affairs (Qld), Diversity Figures June 2018, (Report, June 2018) 28.
5 Ibid 5, 23.

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.

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 and 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 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 tabling 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.

IMPLEMENTATION TASKFORCE/LEADERSHIP TEAM

21.1 In implementing their voluntary assisted dying schemes, both Victoria and Western Australia created an implementation group comprising experts from a range of disciplines and representation to provide advice, leadership and direction of the implementation activities—known as the Implementation Taskforce in Victoria and the Implementation Leadership Team in Western Australia.[6] Members were engaged in working groups to undertake key projects in their respective jurisdictions.[7]

21.2 Importantly, the Victorian Implementation Taskforce and the Western Australian Implementation Leadership Team were responsible for working and engaging with key stakeholders in their respective jurisdictions. The importance of this role was reflected in the terms of reference for the Victorian Implementation Taskforce:[8]

> The Taskforce … has a significant role in providing the Victorian community with the assurance that they are bringing to bear their expertise and experience to manage the implementation of voluntary assisted dying in a safe and compassionate way.

Victoria

21.3 In Victoria, the Ministerial Advisory Panel recognised:[9]

> That establishing an Implementation Taskforce is essential in order to provide the expertise, focus and leadership to develop the necessary resources, processes and systems over the period leading up to the commencement of any voluntary assisted dying legislation.

21.4 The Implementation Taskforce was responsible for:[10]

- establishing the Voluntary Assisted Dying Review Board;
- undertaking a gap analysis of the proposed End of Life Care Victoria functions in relation to existing entities and their role and making recommendations about the role of the proposed agency, including any ongoing resource and funding implications;
- establishing guidance, support resources, and organisational service models including: health care workforce information and support resources; clinical guidelines for health practitioners; consumer and community information and communication; service delivery frameworks and models of service delivery; and regulations and legislative guidance;
- establishing a coordination process with relevant agencies to periodically review resources to ensure they are up to date and reflect best practice;
- developing a specified training program about the obligations and requirements under the Victorian Act;

6 Department of Health & Human Services (Vic), 'Voluntary Assisted Dying Implementation Taskforce: Terms of Reference' (April 2018) <https://www2.health.vic.gov.au/about/publications/Factsheets/vad-implementation-taskforce-terms-of-reference>. In Western Australia, the team includes persons with expertise in palliative and aged care; experience in the care, disability, aged care and mental health sectors; Aboriginal Health Council of Western Australia; Australian Medical Association representative; Western Australia Primary Health Alliance representative; Royal Australian College of General Practitioners representative <Voluntary Assisted Dying Implementation (health.wa.gov.au)>.

7 Department of Health & Human Services (Vic), 'Voluntary Assisted Dying Implementation Taskforce: Terms of Reference' (April 2018) <https://www2.health.vic.gov.au/about/publications/Factsheets/vad-implementation-taskforce-terms-of-reference>.

8 Ibid.

9 Vic Ministerial Advisory Panel Final Report (2017) 187.

10 Department of Health & Human Services (Vic), 'Voluntary Assisted Dying Implementation Taskforce: Terms of Reference' (April 2018) <https://www2.health.vic.gov.au/about/publications/Factsheets/vad-implementation-taskforce-terms-of-reference>.

- undertaking research (in conjunction with a pharmacy department) to identify best practice substances for use in voluntary assisted dying;
- overseeing the establishment of the voluntary assisted dying permit approval process;
- overseeing and advising on the development of the Voluntary Assisted Dying Regulations; and
- providing leadership and focus for stakeholder and community communication strategies.

21.5 The Taskforce received support from a Secretariat within the Department of Health and Human Services.

21.6 The Secretariat's role was to:[11]

> coordinate the advice and input needed to inform the legal, clinical, service system arrangements, governance and data considerations that will support the implementation of compassionate and safe voluntary assisted dying activity in Victoria.

Western Australia

21.7 The Western Australian Panel found that the implementation of the Western Australian legislation should differ from the implementation of the Victorian legislation due to the large population living in rural and remote areas.[12]

21.8 The Western Australian Department of Health established the Voluntary Assisted Dying Act Implementation Project which included the establishment of the Implementation Leadership Team.[13]

21.9 Members have been appointed to lead workgroups tasked with:[14]

- establishing the Voluntary Assisted Dying Review Board;
- developing clinical guidelines and the service delivery framework;
- recommending suitable voluntary assisted dying substance/s for approval;
- developing a Statewide Pharmacy Service and Care Navigator Service;
- developing mandatory participating practitioner training;
- developing consumer, community and health provider information; and
- establishing secure data and reporting mechanisms.

21.10 The Team was able to draw on the experiences of Victorian service providers and hosted a series of webinars. The guest presenters from Victoria 'discussed their experience of implementation of voluntary assisted dying including aspects such as: individual and service preparation approach, what worked well and other learnings'.[15]

21.11 However, in learning from their Victorian counterparts, the Team noted that:[16]

> …WA has approximately 40% of the population of Victoria and the legislation governing voluntary assisted dying is not identical – WA resources should be used for understanding the requirements here in WA.

11 Ibid.

12 WA Ministerial Expert Panel Final Report (2019) 1.

13 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (May 2020). <https://www.osrecruitment.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-communique--May-2020.pdf>.

14 Ibid.

15 Department of Health (WA), 'Voluntary assisted dying' (26 February 2021) <https://ww2.health.wa.gov.au/voluntaryassisteddying>.

16 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (7 October 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-communique-October-2020.pdf>.

Submissions

21.12 Several respondents emphasised the importance of establishing an implementation taskforce, leadership team or similar entity to drive, facilitate and oversee the implementation of the voluntary assisted dying laws and process in Queensland. For example, Go Gentle Australia strongly recommended:

> The establishment of an Implementation Taskforce to coordinate the work that will need to be completed to prepare for the commencement of the legislation. The Taskforce must engage with, and involve, key stakeholders to develop effective implementation strategies and resources. Consistency in implementation and governance arrangements and staff support may best be facilitated in partnership with professional colleges and bodies such as the Australian Medical Association, Australian Nursing and Midwifery Federation, relevant professional colleges, pharmacy bodies, and consumer, carer and service representatives.

21.13 Similarly, the Royal Australasian College of Medical Administrators noted:

> that implementation of the framework requires qualified medical leadership and management to ensure that there is an appropriate clinical governance framework in place.

21.14 Some respondents also focused on the need for a board or similar entity to oversee and monitor compliance with the legislation. For example, one respondent supported a 'clear process for overseeing and monitoring complaints, concerns and policy deviation matters'.

21.15 Some respondents noted the importance of stakeholder engagement in implementing the voluntary assisted dying scheme. For example, Palliative Care Queensland submitted:

> The next stage of voluntary assisted dying development of laws, regulations and guidelines must be undertaken in consultation with medical and health experts. Development of the Victorian [voluntary assisted dying] legislation was guided by ethicists, lawyers, palliative care health professionals and others, and Queensland should have a similar format.

21.16 From a consumer perspective, the Torres and Cape Hospital and Health Service submitted:

> Culturally appropriate implementation needs to be considered in relation to Aboriginal and Torres Strait Islander communities. Consultation needs to take place with each community to ensure that the legislation can [be] implemented safely for both persons and the health care professionals. This needs to involve Aboriginal and Torres Strait Islander people and they need to be the facilitators of this legislation within their communities. Access and health literacy need to be taken into consideration.

21.17 Many respondents emphasised the need for readily available and equitable access to services and voluntary assisted dying resources in a geographically and culturally diverse state. Several respondents noted the challenges of adequate medical practitioner coverage in rural and remote areas.

21.18 For example, the Clem Jones Group submitted:

> We believe that a key factor in the successful application of a [voluntary assisted dying] law in Queensland will be the availability of and access to the various services and professionals working in a future [voluntary assisted dying] system.
>
> As in WA and unlike Victoria, our state is large and geographically diverse with many rural, regional, and remote communities.
>
> We therefore urge the QLRC to ensure provision in any [voluntary assisted dying] Bill take account of such factors …

21.19 Dying with Dignity NSW submitted that the scheme:

> should be equitable, meaning all Queenslanders should have equal access to the scheme… It shouldn't be harder for those living in non-metropolitan areas to access it… special thought should be given to the needs of Indigenous people. An Aboriginal consultation group should assist in the implementation plans.

21.20 One respondent submitted:

> There needs to be a legislated and practical method that addresses the real problems likely to be associated with funding and resourcing for rural or remote facilities… Legislation should either require Government to provide the appropriate funds and resources or address alternatives, perhaps involving moving applicants to sites where their needs can be met. The latter legislation may need, once again, to address tensions between state and federally funded facilities.

21.21 AMA Queensland submitted that 'the State should provide all of the funding and facilities for [voluntary assisted dying] services when [voluntary assisted dying] is provided in QLD'.

The Commission's view

21.22 While it is useful to draw upon the experiences of Victoria's and Western Australia's implementation processes, the implementation of voluntary assisted dying legislation in Queensland must be fit for purpose.

21.23 This includes ensuring that:

- the statewide pharmacy service and care navigator service are accessible for remote and rural Queenslanders;
- training is easily accessible by health practitioners across Queensland; and
- community and consumer information about voluntary assisted dying is available in multiple languages and 'Easy English'.[17]

21.24 Ensuring the scheme is tailored to Queensland's unique geography and demographics will require thorough planning, engagement with stakeholders and adequate resourcing and support.

21.25 An implementation taskforce or leadership team is critical to 'bringing along' stakeholders in the implementation of a voluntary assisted dying scheme in Queensland.

21.26 The taskforce or leadership team should comprise a multidisciplinary team of persons with expertise in relevant areas such as palliative, disability, mental health and aged care; representatives from peak bodies such as the Australian Medical Association, Royal Australian College of General Practitioners, and other specialist medical colleges; and Aboriginal and Torres Strait Islander representatives. It should provide advice, leadership and direction on implementation activities.

VOLUNTARY ASSISTED DYING REVIEW BOARD

21.27 We recommend establishing an independent Voluntary Assisted Dying Review Board, with legislated functions relating to monitoring, review and referral, data collection and research, reporting and advice, and community engagement. The establishment, role and function of the Board is discussed further in Chapter 18.

21.28 The Implementation Taskforce in Victoria and the Implementation Leadership Team in Western Australia were responsible for establishing their respective oversight bodies.

17 Easy English is information presented in a way that is very easy to understand through the use of images to support text, large font sizes and white space. Easy Read is currently used for communicating with people with disability and is becoming more widely used for audiences with low literacy levels, and in Aboriginal and Torres Strait Islander communities or where English is an additional language: The Information Access Group, 'What is Easy Read' <https://www.informationaccessgroup.com/what_is_easy_read.html>.

21.29 The Western Australian Team stated that '[t]here are many detailed aspects to establishing the Board.'[18] These include:

- ensuring the composition of Board members' expertise and experience aligns with the draft Bill's provisions;
- remuneration and allowances for Board members;
- the way the Board will conduct its business, such as frequency of meetings;
- the timing of the appointment of the Board;
- detail on how the Board will perform its powers and functions provided for under the draft Bill; and
- ensuring adequate support and resourcing of the Board to enable it to fulfil its powers and functions.

Timing of appointment of Board members

21.30 The Victorian Board was appointed 12 months before the commencement of the Victorian legislation.[19]

> Prior to the Act coming into effect, the Board used its first year to establish clear processes for both the Board itself, and voluntary assisted dying.[20]

21.31 The Western Australian Board has not yet been established, but is expected to operate under the umbrella of the Department of Health (Western Australia).[21]

Functions of the Board

21.32 The draft Bill outlines the Board's functions. Further detail as to how those functions will be operationalised is required.

21.33 The Board's functions are: to monitor the operation of the Act; to review compliance with the Act; to refer issues to relevant entities; to promote continuous improvement in the compassionate, safe and practical operation of the legislation; and to record and keep information prescribed by regulation.

21.34 The draft Bill also contemplates information sharing arrangements between various agencies. In implementing similar functions in Victoria, the Victorian Board noted that to ease referral processes and information sharing required by the legislative framework:[22]

> the Board worked closely with the Department of Health and Human Services, Births, Deaths and Marriages, the Victorian Civil and Administrative Tribunal, the Coroners Court of Victoria, Victoria Police, and the Australian Health Practitioners Regulation Agency. This ensured all agencies involved in the safe operation of the Act were clear on what information they could receive, when they would receive it and what they needed to do with it.

Resourcing and support

21.35 It is critical that the Board has the support and resources required to undertake its functions. This is provided for in the draft Bill.

21.36 The Western Australian Act includes a similar provision.[23] However, it is currently unclear what form this support will take for the Western Australian Board. The

18 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (18 December 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-December-2020.pdf>.

19 Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019) 2. See Victoria, Victorian Government Gazette S 190, 24 April 2018, 1: 1 July 2018 is the day on which Part 1 (except sections 4, 6, 7 and 8) and Part 9 (except Divisions 4 and 5) of that Act was proclaimed to commence; Victoria, Victorian Government Gazette S 319, 1 July 2018, 1: appointment of members.

20 Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019) 4.

21 See further, Chapter 18 below.

22 Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019) 4.

23 See *Voluntary Assisted Dying Act 2019* (WA) s 121.

Implementation Leadership Team has indicated that the Board 'will be well supported by the Department of Health when it commences on 1 July 2021'.[24]

21.37 In Victoria, Safer Care Victoria[25] supports the day-to-day operations of the Board. This includes:[26]

- receiving requests to access the Voluntary Assisted Dying Portal, and supporting users;
- receiving and progressing the required forms;
- corresponding with medical practitioners;
- preparing reports and case reviews for the Board to consider; and
- liaising with the nominated contact people, as well as agencies involved in supporting the voluntary assisted dying process.

21.38 Importantly, a dedicated team within the Department of Health and Human Services oversees and coordinates the Statewide Care Navigator Service, the Statewide Pharmacy Service, voluntary assisted dying training for medical practitioners and policy and guidance for health services, health professionals and the community to support voluntary assisted dying. Another team facilitates the process for permit application reviews by the Secretary, which then allows the substance to be dispensed.[27]

The Commission's view

21.39 A Voluntary Assisted Dying Review Board would play a critical role in the oversight of the operation of, and compliance with, voluntary assisted dying legislation. It provides an additional safeguard by ensuring transparency, accountability, independent and ongoing compliance monitoring, and a continuous learning process, as well as identifying ways for continuous improvement.

21.40 The breadth of Board members' expertise, as envisaged by the draft Bill, will help ensure that health practitioners, health care agencies and members of the community understand their rights and duties under the legislation.

21.41 The Board should be well supported and resourced to meet its legislated obligations. These include collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engagement and information sharing with other agencies.

21.42 The Board should be constituted and staffed, and its systems and processes developed and tested, well in advance of the date on which access to voluntary assisted dying commences in Queensland. This will allow the Board to be part of the implementation process and ensure that its systems work efficiently.

STATEWIDE CARE NAVIGATOR SERVICE

21.43 Useful information and resources about the voluntary assisted dying process should be accessible to medical practitioners, service providers, and the community. Many people wishing to access voluntary assisted dying and to find a participating medical practitioner are very sick and frail. They may have difficulty accessing information and will need additional support to navigate the various complexities inherent in the process.

21.44 Victoria established the Statewide Voluntary Assisted Dying Care Navigator Service (Care Navigator Service) to provide support and information to people wishing to access

24 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (18 December 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-December-2020.pdf>.

25 Safer Care Victoria operates as an Administrative Office in relation to the Department of Health and Human Services (the Department) under section 11 of the *Public Administration Act 2004* (Vic).

26 Voluntary Assisted Dying Review Board Report of Operations 2018–19 (2019) 3; Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 4.

27 Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020) 4.

voluntary assisted dying, participating medical practitioners and other service providers. The service also helps to connect a person with participating medical practitioners and appropriate health services.

21.45 The Care Navigator Service is an essential component of the system. It works well in Victoria and is highly regarded by participants.

21.46 The Western Australian Government has also established a Statewide Voluntary Assisted Dying Care Navigator Service.

21.47 The Tasmanian Panel noted evidence from its consultation workshop about the importance of a well-resourced care navigator service to enhance access to voluntary assisted dying, particularly if it can provide quality outreach and regional services.[28]

21.48 The care navigator service models in Victoria and Western Australia should be a key feature of any Queensland scheme, with appropriate modifications to suit the State's geographical and cultural challenges and its public and private health systems.

Victoria

21.49 The Care Navigator Service was established by the Victorian Government as part of the voluntary assisted dying framework overseen by the Implementation Taskforce. Commencing operation in February 2019, the Care Navigator Service provides a contact point across the State for the public, medical practitioners and health services seeking information and support about, or assistance with, voluntary assisted dying. The support provided seeks to complement that given to a person seeking access to the scheme by their coordinating practitioner, existing healthcare team, and other health services.[29]

21.50 The Care Navigator Service is established administratively and is currently hosted at the Peter MacCallum Cancer Centre in Melbourne. However, the Service is available to all Victorians who are seeking information about, or access to, voluntary assisted dying, no matter where they live.[30]

21.51 Care navigators can work closely with the person, their carers, family and friends, medical practitioners and healthcare teams to tailor support to the person's needs. The types of services that may be provided include:[31]

- general information about voluntary assisted dying;
- individual support and information;
- helping connect a person with appropriate medical practitioners and health services;
- assisting a person to find a participating medical practitioner;
- assisting a person to identify appropriate service referral pathways;
- information about or access to voluntary assisted dying support packages;
- holistic advice and follow-up on appropriate end of life care services; and
- education for health services and health practitioners.

21.52 The ongoing development of the Service will be informed through feedback from consumers and the health sector. In response to feedback, in early 2020, the Care Navigator Service was expanded across regional Victoria, providing additional care navigators to deliver consistent support across the State.[32]

21.53 A benefit of regional expansion is closer engagement with local and surrounding health

28 Tas Review Panel Report (2021) 11.

29 Department of Health & Human Services (Vic), 'The Statewide Voluntary Assisted Dying Care Navigator Service' (September 2019) <https://www2.health.vic.gov.au/~/media/Health/Files/Collections/Factsheets/T/The%20Statewide%20Voluntary%20Assisted%20Dying%20Care%20Navigator%20Service%20Factsheet%20-%20Final>.

30 Ibid.

31 Ibid.

32 Voluntary Assisted Dying Review Board, Report of operations: January–June 2020 (2020) 5.

services and primary health organisations which may help identify appropriate referral pathways for people and their families across the State. In addition, it enhances the knowledge of participating health practitioners which will facilitate more face-to-face consultations for those wishing to access voluntary assisted dying.[33]

21.54 The Care Navigator Service has provided valuable support and education for persons seeking to access voluntary assisted dying and their families, medical practitioners and health services.[34] Between June and December 2020, it helped 446 people who were seeking information about voluntary assisted dying.[35]

21.55 The effectiveness of the Care Navigator Service in facilitating equal access to voluntary assisted dying services across the State may be impeded by the Commonwealth Criminal Code offence provisions concerning the use of carriage services (such as telephone or email) to assist suicide or provide information about a method of committing suicide.[36] Those provisions are discussed in Chapter 20 of this report. They are also discussed below, since a proper understanding of their scope by health services and practitioners is important to the implementation of legislation.

21.56 The Victorian Government has established funding packages to help people meet medical practitioner costs that are not covered by the Commonwealth. Such packages may be used to meet the costs of transferring a person seeking voluntary assisted dying from a medical practitioner who does not support it to a participating practitioner. It might also be used to cover any out of pocket private consultation costs. Care navigators facilitate access to these packages by those seeking to use them.

21.57 The Statewide Care Navigators have also established a Community of Practice for health service staff with voluntary assisted dying in their roles. The aim is to share experiences, lessons and support between participants.[37]

Western Australia

21.58 The Western Australian Department of Health has also established a Statewide Voluntary Assisted Dying Care Navigator Service (Care Navigator Service) which becomes operational on 1 July 2021.[38] The Western Australian Panel recognised the important role of a care navigator service in providing information, support and advice to those seeking to access voluntary assisted dying and to medical practitioners. The Panel recommended that the Western Australian Government should develop a system of care navigators as part of the implementation process in Western Australia.[39]

21.59 The Care Navigator Service is established to support those involved with the voluntary assisted dying process in Western Australia, including healthcare workers, service providers, patients and members of the community.[40] Its functions will include providing general information and referring people to useful resources (including guides and factsheets) about voluntary assisted dying as well as to more specific information about the process for accessing voluntary assisted dying. Importantly, it can help connect a person with a medical practitioner who is willing and eligible to participate in voluntary assisted dying.[41]

33 Department of Health & Human Services (Vic), 'Voluntary assisted dying newsletter' (October 2019) <https://www.vision6.com.au/v/47492/6350830/email.html?k=YgU7aEF3DE2uu8xf6mn3CekpYAtE-h0ETHxho4A3y0A>.

34 Voluntary Assisted Dying Review Board Report of Operations June-December 2019 (2019) 7.

35 Vic Voluntary Assisted Dying Review Board Report of Operations June-December 2020 (2020) 8.

36 *Criminal Code Act 1995* (Cth) ss 474.29A, 474.29B.

37 Department of Health & Human Services (Vic), 'Voluntary assisted dying newsletter' (January 2020) <https://www.vision6.com.au/v/47492/7117956/email.html?k=u6THttw9TeH9VscZRwm0gilHO1XiM-jwD_tTpXzosVM>.

38 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the Statewide Voluntary Assisted Dying Care Navigator Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Care-Navigator-Service.pdf>.

39 WA Ministerial Expert Panel Final Report (2019) 49 Rec 12.

40 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the Statewide Voluntary Assisted Dying Care Navigator Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Care-Navigator-Service.pdf>.

41 Ibid.

21.60 The Care Navigator Service will be nurse-led and staffed by experienced health professionals. While it will be based within a hospital in the Perth metropolitan area, it will provide a statewide service for all Western Australians no matter where they reside.[42]

21.61 To ensure equality of access in a state as large as Western Australia, the Care Navigator Service will manage the Regional Access Support Scheme and assist eligible persons to access regional support packages under the Scheme. The Scheme assists with travel to a medical practitioner to access voluntary assisted dying. If a person has become too ill or is otherwise unable to travel, the Scheme may support a medical practitioner travelling to the person.[43]

Submissions

21.62 The Commission sought submissions on the key issues or considerations that should be taken into account in the implementation of voluntary assisted dying legislation in Queensland.[44]

21.63 Few respondents addressed these issues. Some expressed the need for a care navigator service to be established as part of the voluntary assisted dying framework in Queensland. Dying with Dignity Victoria Inc stated that 'the patient navigators are an essential resource. Without them many patients would have floundered, doctors too'.

21.64 Dying with Dignity Queensland also considered that a care navigator service should be established:

> There may be instances when a person wanting to access Voluntary Assisted Dying is unable to do so or even make a first request. DWDQ recommends that a [voluntary assisted dying] Navigation Service would provide access to information about Voluntary Assisted Dying and the process of access to it. DWDQ recommends that the [voluntary assisted dying] Navigation Service develop a pool of [voluntary assisted dying] trained registered medical practitioners and [voluntary assisted dying] trained registered nurses, and a pool of eligible witnesses to facilitate the Voluntary Assisted Dying process.

21.65 Go Gentle Australia submitted:

> The establishment of a [voluntary assisted dying] Care Navigator team that can assist with any or all queries regarding the correct process of the law. This team should also have access to doctors who have completed the [voluntary assisted dying] training and have indicated they are willing to participate so that referral to a participating doctor after refusal [from] a treating physician can be facilitated without delay.

21.66 Two academics jointly submitted:

> The Care Navigator Service, implemented under the WA Act, is a model which appears to have much to recommend it to QLD. In particular, it provides a support and information, and referral service, which could be particularly beneficial to patients who do not wish to discuss [voluntary assisted dying] with their current doctor, or for doctors who are conscientious objectors and do not wish to provide information to patients on [voluntary assisted dying].
>
> The model could also be adapted to provide additional support to patients and practitioners in remote and regional areas with limited access to medical practitioners, as well as support for patients from linguistically diverse backgrounds, for example by being able to refer to qualified practitioners with appropriate language skills.

42 Ibid.
43 Ibid.
44 QLRC, Consultation Paper No 79 (2020) Q-50.

The Commission's view

21.67 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.

21.68 The establishment of a well-resourced care navigator service, like the one developed in Victoria, is crucial to the success of any voluntary assisted dying scheme in Queensland. The support, information and connections provided by a care navigator service are essential to assist, inform and support individuals who are suffering and dying.

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

21.70 The information obtained through the Commission's consultations indicates that Victoria's Care Navigator Service has been invaluable for persons seeking to access the Victorian scheme and health practitioners willing to participate in it. Western Australia is currently developing a similar service.

21.71 A care navigator service for Queensland should provide services like those in Victoria. These include:[45]

- providing medical practitioners, those wishing to access voluntary assisted dying and the community in general, with wide-ranging information about the process and what is involved;
- giving support and information tailored to the person seeking it;
- providing education to health services and health practitioners;
- helping a person seeking to access voluntary assisted dying to connect with appropriate participating medical practitioners and health services.[46] This is essential if a person's own practitioner is not willing to participate;
- helping a person identify appropriate referral pathways;
- providing holistic advice and follow-up on end of life care services, including palliative care and treatment; and
- helping persons access financial support through the Regional Access Support Scheme.

21.72 It is particularly important that support packages are available, through Queensland Health, to help those in financial need who are seeking voluntary assisted dying. Such support would help people from regional, rural and remote areas with the cost of visiting a medical practitioner or for a medical practitioner to visit them. Part of the care navigators' role should be to facilitate access to such support.

21.73 The care navigator service should be established as early as possible as part of the implementation process in Queensland to ensure the timely engagement and training of skilled and culturally competent navigators and the development of information and other resources.

21.74 The care navigator service should be properly funded to allow it to provide services in rural and regional areas and thereby ensure access to the scheme by all Queensland residents. The challenges posed by the State's size, population spread, and diverse cultural and linguistic populations cannot be underestimated. It will require a great deal of planning and testing of the service's systems.

45 Department of Health & Human Services (Vic), 'The Statewide Voluntary Assisted Dying Care Navigator Service' (September 2019) <https://www2.health.vic.gov.au/~/media/Health/Files/Collections/Factsheets/T/The%20Statewide%20Voluntary%20Assisted%20Dying%20Care%20Navigator%20Service%20Factsheet%20-%20Final>.

46 This is to avoid issues regarding the Commonwealth *Criminal Code* offences concerning use of carriage services to incite suicide etc.

21.75 The care navigator service should be established under the umbrella of Queensland Health. This is consistent with the approach in Victoria and Western Australia.

STATEWIDE PHARMACY SERVICE

21.76 A framework for voluntary assisted dying must provide for supply and disposal of the voluntary assisted dying substance. This will ensure both public safety and compliance with Queensland's existing drugs and poisons framework.

21.77 To facilitate the supply and disposal of the voluntary assisted dying substance, we recommend the establishment of a 'statewide pharmacy service.' The service would coordinate and lead pharmacy services for voluntary assisted dying and provide information to health practitioners, patients, and others.

Supply and disposal of the voluntary assisted dying substance

21.78 While all Australian voluntary assisted dying frameworks provide for both the supply and disposal of the substance, each legislates supply and disposal differently:

- in Victoria, legislation provides for supply of the substance by a 'dispensing pharmacy,' but does not expressly authorise a pharmacist to supply the substance or specify who it must be supplied to.[47] Where a person elects to self-administer, the contact person must return any unused or remaining substance to the dispensing pharmacy for disposal;[48]
- in Western Australia, the substance is supplied by an 'authorised supplier'.[49] Depending on the administration pathway, any unused or remaining substance must be given to an 'authorised disposer'[50] or disposed of by an administering practitioner.[51] Registered health practitioners may be authorised as an authorised supplier or authorised disposer by the CEO;[52]
- in Tasmania, a pharmacist is permitted to supply the substance to a primary medical practitioner.[53] Once a person gives their final permission, the substance is given to the administering health practitioner to facilitate either self-administration or practitioner administration.[54] Any unused or remaining voluntary assisted dying substance must be returned to the pharmacist for disposal.[55]

Statewide Pharmacy Service models

21.79 As the Victorian Act did not outline the process for supplying and disposing of the substance, these aspects of the framework had to be addressed during implementation.[56]

21.80 To facilitate the supply and disposal of the substance, Victoria established a central statewide pharmacy service. While the Western Australian Act provides for both authorised suppliers and authorised disposers of the substance, it has also established a similar central statewide pharmacy service.

21.81 In both states, statewide pharmacy services are a central and essential source of information and education about the substance and its proper administration.

47 *Voluntary Assisted Dying Act 2017* (Vic) ss 3, 45(a), 46(a).
48 *Voluntary Assisted Dying Act 2017* (Vic) ss 39(2), 55. A failure by a contact person to return any remaining or unused voluntary assisted dying substance within 15 days' of a person's death is an offence: s 89.
49 *Voluntary Assisted Dying Act 2019* (WA) ss 58(4), 59(3).
50 *Voluntary Assisted Dying Act 2019* (WA) ss 67(1), 75, 105.
51 *Voluntary Assisted Dying Act 2019* (WA) s 77.
52 *Voluntary Assisted Dying Act 2019* (WA) s 79.
53 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 71.
54 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ss 74(2), 75(2). As a primary medical practitioner can also act as an administering health practitioner, there is not necessarily a change in possession of the voluntary assisted dying substance.
55 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021*(Tas) ss 75(4), 76(2)(4), 92(3).
56 BP White, L Willmott and E Close, 'Victoria's voluntary assisted dying law: clinical implementation as the next challenge' (2019) 210(5) *Medical Journal of Australia* 207.

Supply and disposal of voluntary assisted dying substances

21.82 While the Victorian Act does not prescribe a 'dispensing pharmacy', in practice all voluntary assisted dying substances are dispensed from a statewide pharmacy service established at the Alfred Hospital in Melbourne.[57] In its review of current voluntary assisted dying frameworks, the Tasmanian Panel noted that:[58]

> The Victorian approach is to centralise [voluntary assisted dying] pharmacy services in a tertiary hospital (The Alfred) and operate state-funded outreach services across the state to ensure a small team of pharmacists are trained and experienced in [voluntary assisted dying] and can provide services across the state.

21.83 Upon completing the compulsory voluntary assisted dying training, medical practitioners in Victoria are given a 'medication protocol' outlining information about the voluntary assisted dying substance.[59] This protocol instructs the coordinating medical practitioner to contact the Statewide Pharmacy Service before prescribing the substance to a person.[60]

21.84 Once a coordinating medical practitioner has prescribed the substance, the prescription is given directly to the Statewide Pharmacy Service. The Service then dispenses the substance either to a person or their coordinating medical practitioner, depending on whether there is a self-administration permit or practitioner administration permit.[61]

21.85 In cases of self-administration where a person is unable to travel, the Service will deliver the substance to them at their preferred time and place.[62] The Service also provides a locked box in which to store the substance to ensure compliance with the Victorian Act.[63]

21.86 As the dispensing pharmacy, the Service also receives any unused or remaining voluntary assisted dying substance from the contact person.[64] Where a contact person is unable to return the substance themselves, the Service can travel to collect it from them.[65]

21.87 Western Australia has established a similar Statewide Pharmacy Service to facilitate the supply of the substance.[66]

21.88 While Western Australia's Service will be based at a metropolitan tertiary hospital in Perth, it will provide the voluntary assisted dying substance to patients or practitioners anywhere in Western Australia.[67]

21.89 Authorised disposers have been defined separately for the purposes of the Western Australian Act, providing flexibility to separate the supply and disposal roles. A list of authorised disposers is yet to be published. The Service will liaise with authorised disposers 'regarding disposal of any unused or remaining voluntary assisted dying substance and supportive medications.'[68]

21.90 As Tasmania's Act has only recently passed, its model for supply and disposal remains to be decided. However, the Tasmanian Panel cited the 'hub and outreach' model implemented in Victoria and Western Australia as potentially well-suited to Tasmania's

57 AlfredHealth, 'State-wide pharmacy service for Voluntary Assisted Dying' (27 February 2019) <https://www.alfredhealth.org.au/news/state-wide-pharmacy-service-for-voluntary-assisted-dying/>.
58 Tas Review Panel Report (2021) 68.
59 Vic Guidance for Health Practitioners (2019) 54.
60 Ibid.
61 Ibid 56.
62 Voluntary Assisted Dying Review Board Report of operations: July–December 2020 (2021) 13.
63 Vic Guidance for Health Practitioners (2019) 58.
64 Ibid 64.
65 Ibid.
66 Tas Review Panel Report (2021) 68.
67 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the WA Voluntary Assisted Dying Statewide Pharmacy Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Statewide-Pharmacy-Service.pdf> 1-2.
68 Ibid 1.

size and regionally dispersed population.[69]

Providing information and support

21.91 Victoria and Western Australia's statewide pharmacy services are also designed to be central information hubs for medical practitioners and pharmacists.

21.92 In Victoria, the Statewide Pharmacy Service is described as 'a single point of support and advice for medical practitioners about voluntary assisted dying medication'.[70] Medical practitioners are advised that the Service can provide patient education material for both administration pathways. They also are instructed to review this material with any person accessing voluntary assisted dying.[71]

21.93 Similarly, one of the roles of the Western Australian Statewide Pharmacy Service is to 'provide information, education and support to a medical practitioner, nurse practitioner, or person accessing the voluntary assisted dying process.'[72]

Supply of the substance in Queensland

21.94 Under Queensland's current medicines and poisons framework, pharmacists may dispense S4 and S8 medicines provided they comply with specific quality standards and conditions.[73]

21.95 From approximately the third quarter of 2021 the *Medicines and Poisons Act 2019* (Qld) will provide a new regime for the regulation of substances, including the prescription, supply, administration, storing and disposal of S4 and S8 medicines.[74]

21.96 It is proposed to regulate the voluntary assisted dying substance separately from the *Medicines and Poisons Act 2019* (Qld), requiring the draft Bill to set out specific obligations, including for supply and disposal of the substance.

Submissions

21.97 While our Consultation Paper did not ask respondents to comment on supply or disposal of a voluntary assisted dying substance, it did ask what key issues or considerations should be taken into account in the implementation of voluntary assisted dying legislation.[75]

21.98 Some respondents highlighted the general importance of providing medical practitioners with services and education.

21.99 Other respondents supported centrally managing the supply of a voluntary assisted dying substance. The Pharmacy Guild of Australia, Queensland Branch submitted that:

> Any voluntary assisted dying legislation, or regulations designed to facilitate the operation of this legislation also include provisions that forbid any activities that would publicly identify pharmacies that are/are not dispensing such medications, acknowledging that there may be a need for a government department to have a secure and confidential database

21.100 Go Gentle Australia supported the central pharmacy model implemented in Victoria:

> We strongly support the establishment of a central pharmacy service, as implemented in Victoria. To allow sufficient coverage of the state, perhaps authorised branches of this service could be located at key rural locations in central and Northern Queensland.

69 Tas Review Panel Report (2021) 69.
70 Vic Guidance for Health Practitioners (2019) 54.
71 Ibid 54–5.
72 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the WA Voluntary Assisted Dying Statewide Pharmacy Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Statewide-Pharmacy-Service.pdf> 1.
73 *Health (Drugs and Poisons) Regulation 1996* (Qld) ss 81A-88, 192A-199.
74 *Medicines and Poisons Act 2019* (Qld) ss 33-42.
75 QLRC Consultation Paper No 79 (2020) Q-50.

The Commission's view

21.101 We recommend establishing a statewide pharmacy service to facilitate the supply of the voluntary assisted dying substance across Queensland and to provide a central source of information about the substance for people accessing voluntary assisted dying, and for their loved ones and medical practitioners.

21.102 We note that while the Victorian Act and the Western Australian Act have different provisions for the supply and disposal of the substance, both have established similar statewide pharmacy services. The service could be established and run out of a tertiary hospital pharmacy.

21.103 We recommend that any statewide pharmacy service be appropriately funded, resourced and staffed to ensure effective supply of the voluntary assisted dying substance. Further, Queensland's size and population distribution will need to be considered in establishing the service.

21.104 We recommend, at Chapter 11, that 'authorised supplier' and 'authorised disposer' be defined separately in the draft Bill. We consider that the statewide pharmacy service established for the supply of the substance should not necessarily be responsible for its disposal. Instead, a model for disposal should be determined by Queensland Health, with consideration given to accessibility of voluntary assisted dying by people in rural and remote areas.

21.105 We recommend that where a practitioner administration decision has been made and the administering practitioner possesses the substance, they should be authorised to dispose of it in accordance with disposal requirements prescribed by regulation. This approach is consistent with the Western Australian Act. The Commission considers this will facilitate accessibility in regional and remote areas of Queensland by allowing the administering practitioner to dispose of the substance safely instead of travelling potentially long distances to an authorised disposer.

MANDATORY TRAINING AND SUPPORT FOR HEALTH PRACTITIONERS

21.106 We recommend mandatory training for coordinating practitioners, consulting practitioners and administering practitioners about their respective roles and responsibilities. Further detail about mandatory training can be found in Chapter 13.

21.107 In Victoria and Western Australia, the coordinating practitioner and consulting practitioner must have completed the approved training before they can begin an eligibility assessment. In Western Australia, training requirements also apply to the administering practitioner. The training is approved by the Secretary of the Department of Health and Human Services in Victoria[76] and the Chief Executive Officer of the Department of Health in Western Australia.

Victoria

21.108 In Victoria, the training was developed by the Queensland University of Technology and relates to the following matters:

- requirements under the Victorian Act relating to coordinating practitioners and consulting practitioners, including their functions;
- assessing whether or not a person meets the eligibility criteria; and
- identifying and assessing risk factors for abuse or coercion.

76 Victoria, Victorian Government Gazette, No S 259, 26 June 2019, 1; Victoria, Victorian Government Gazette, No G 12, 21 March 2019, 471.

21.109 The training design:[77]

> …was based on two main principles: to comprehensively impart the legal duties imposed by the legislation; and to be readily accessible for busy doctors. The law was first mapped into a curriculum, and circulated to medical colleges, societies and professional organisations as well as international experts for feedback. The training was converted into an online e-learning format and tested at a focus group of doctors.

21.110 The training is coordinated by the Department of Health and Human Services End of Life Care team. It is designed to help medical practitioners become familiar with the safeguards and requirements built into the Victorian legislation, and what information and evidence they will need to supply.[78]

21.111 On commencement of the Victorian Act, 188 doctors completed or were in the process of completing the online training.[79] By the end of 2020, more than 450 medical practitioners had registered for the online training program and just under half of these were registered in the portal to support applications. In addition, more than a third (36 per cent) of registered medical practitioners were located in regional and rural Victoria.[80]

Western Australia

21.112 Similarly, in Western Australia, appropriate mandatory training for medical practitioners who will participate in the voluntary assisted dying process is being developed by the Queensland University of Technology.[81] This training will be in an online format and designed to enable access for practitioners across the state.[82]

21.113 The launch of the Western Australian Voluntary Assisted Dying Approved Training program is earmarked for June 2021.[83]

Submissions

21.114 Several respondents supported the need to provide training, education and support for medical practitioners and support staff. For example, Dying with Dignity Queensland submitted that:

> …clinicians need to know that [voluntary assisted dying] is legal, how their patients can access [voluntary assisted dying], and how they can complete the [voluntary assisted dying] training to begin delivering [voluntary assisted dying] services.

21.115 MIGA submitted that:

> It is important that clear, consensus guidelines, using hypothetical scenarios, be developed to cover issues and frequently asked questions which may arise, developed with input from a range of professional bodies (including MIGA), and issued with Queensland Government endorsement.

21.116 The adequacy of training for health professionals and its oversight was highlighted by respondents. For example, a medical practitioner stated:

> … the training for health professionals who participate in the process must be rigorous and subject to evaluation by experts. In Victoria the training is approximately 4 hours. This cannot possibly provide training about ways of exploring and responding to suffering.

77 B White et al, 'Development of Voluntary Assisted Dying Training in Victoria, Australia: A Model for Consideration' (online, 2020) *Journal of Palliative Care* 2.

78 Voluntary Assisted Dying Review Board Report of operations: January–June 2020 (2020) 7.

79 Voluntary Assisted Dying Review Board Report of operations: 2018–19 (2019) 2.

80 Voluntary Assisted Dying Review Board Report of operations: July–December 2020 (2021) 6.

81 QUT Australian Centre for Health Law Research, 'Voluntary Assisted Dying training for Western Australian medical and nurse practitioners' <https://research.qut.edu.au/achlr/projects/voluntary-assisted-dying-training-for-western-australian-medical-practitioners/>.

82 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (18 December 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-December-2020.pdf>.

83 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (26 February 2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-February-2021.pdf>.

21.117 In addition to mandatory training, respondents noted the need for appropriate support for practitioners and other service providers. Dying with Dignity Victoria Inc submitted:

> Support for practitioners involved is vital. The community of practice in Victoria started well after the Bill became live. Steps should be taken to ensure that an appropriate support process is in place well before any legislation begins.

The Commission's view

21.118 As mandatory assessment training forms part of the voluntary assisted dying framework proposed by the draft Bill, a training package needs to be developed that is tailored specifically to Queensland's legislative framework. We note that while it is instructive to look at the training modules developed for the Victorian and Western Australian legislative schemes, the draft Bill proposes a model unique to Queensland, and as such, the training modules will need to align with this model.

21.119 The training materials should provide a comprehensive training package without being unnecessarily long. A lengthy training module may deter medical practitioners from undergoing training and therefore reduce the pool of appropriately trained medical practitioners.

21.120 This is not to say that brevity should trump a comprehensive training package. We recognise that appropriate quality training of medical practitioners is critical to ensuring the safeguards embedded in the draft Bill are appropriately implemented.

21.121 Any mandatory training materials should be supplemented with sources of information and support for health practitioners who are trained to act as a coordinating practitioner, a consulting practitioner or an administering practitioner.

21.122 Apart from, and in addition to, training of and support for those qualified health professionals, there should be information and support available for other registered health practitioners and health care workers.

21.123 Our consultations with experts and participants in other states emphasised that training must be available for junior doctors and nurses who may receive an initial inquiry from a patient about voluntary assisted dying, or who provide ongoing support to a patient and their family through the process, should the patient choose to access it.

INTERPRETERS AND SPEECH PATHOLOGISTS

21.124 Interpreters and speech pathologists are essential to ensure the accessibility of any voluntary assisted dying scheme. The important and nuanced nature of the communications that must be facilitated by interpreters and speech pathologists means that they need to be appropriately qualified and independent.

21.125 Interpreters and speech pathologists may be required to be involved in sensitive end of life discussions. As noted above, the Western Australian Department of Health provides information for interpreters including about the implications of telehealth, and the need for interpreters to consider their own feelings and beliefs about voluntary assisted dying.[84] Support is provided to service providers, including interpreters and speech pathologists, through the Statewide Care Navigator Service in both Western Australia and Victoria.

21.126 In implementing the scheme, where such support services are required, referrals should be made to appropriately qualified interpreters and speech pathologists.

21.127 In addition, where possible, interpreters involved in the voluntary assisted dying process should have specific experience or qualifications to prepare them for end of life discussions, including about the option of voluntary assisted dying if this option is raised

84 Department of Health (WA), 'Voluntary assisted dying in Western Australia: Information for interpreters' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Information-for-Interpreters.pdf>.

by the patient.

21.128 For example, the National Accreditation Authority for Translators and Interpreters provides Certified Specialist Health Interpreters who have completed training and undertake continuous professional development in specialist health interpreting. They have full and detailed knowledge and understanding of how culture and language interact, and of the relevant codes of ethics and professional standards in the health domain.[85]

21.129 Where Queensland Health or other relevant entities identify a lack of qualified interpreters for a language or dialect, they should be provided with the resources to increase the range of interpreter services available. This could include funding to train and accredit interpreters in the relevant language.

21.130 Consistent with good clinical practice, any interpreter or speech pathologist who assists a person seeking access to voluntary assisted dying should be briefed and provided with relevant information about the process before undertaking the role.

INFORMATION AND COMMUNICATIONS TECHNOLOGY

21.131 The draft Bill contemplates practitioners having to submit a number of forms to the Board within specific and limited timeframes.

21.132 The information and communications technology (ICT) must be completely fit for purpose. Otherwise, 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.

21.133 Ms Jodhi Rutherford, an academic who has researched medical practitioner experiences of the Victorian scheme, submitted:

> The [Voluntary Assisted Dying] Portal is heavily criticised by some participants. Many were unprepared for the logistical burden it creates. The [Voluntary Assisted Dying] Portal's idiosyncratic process flows are identified by participants as the major cause of delay, with evident impact of their timely facilitation of [voluntary assisted dying] applications. While some participants who have done several cases say the [Voluntary Assisted Dying] Portal gets easier with time, they remark on its overall user-unfriendliness. This reporting indicates that the way the [Voluntary Assisted Dying] Act is being operated at a bureaucratic level is impeding efficient provision of [voluntary assisted dying]. This may be mere teething problems that will be ironed out in due course…

Victoria

21.134 The Victorian Voluntary Assisted Dying Portal[86] was launched in April 2019.[87] It is a secure online platform where registered medical practitioners can complete, submit, view and download the 12 forms required under the Victorian Act.[88]

21.135 Before accessing the portal, medical practitioners must pass the approved voluntary assisted dying training and provide evidence of their identity, fellowship with a specialist medical college or vocational registration.

21.136 Some level of access is also provided to authorised users to allow them to complete required actions under the Victorian Act. These users include:

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85 NAATI, 'Certified Specialist Health Interpreter' <https://www.naati.com.au/become-certified/certification/certified-specialist-health-interpreter/>.

86 Safer Care Victoria and the Victorian Agency for Health Information, 'Voluntary Assisted Dying Portal' (2021) <https://www.bettersafercare.vic.gov.au/notify-us/vad>.

87 Voluntary Assisted Dying Review Board Report of operations: 2018–19 (2019) 5.

88 Safer Care Victoria and the Victorian Agency for Health Information, 'Voluntary Assisted Dying Portal Terms of Use Agreement' (April 2019) <https://www.bettersafercare.vic.gov.au/sites/default/files/2019-05/VAD%20portal%20-%20terms%20of%20use%20agreement.pdf>.

- drugs and poisons officers (employees of the Department of Health and Human Services);
- the secretariat (employees of Safer Care Victoria);
- the statewide pharmacy service (employees of Alfred Health); and
- members of the Voluntary Assisted Dying Review Board.

21.137 Safer Care Victoria provides administrative day-to-day operational support of the portal.[89]

21.138 In Victoria, the portal is the only avenue for submitting forms to the Board.[90] The Board received feedback indicating that some medical practitioners find the portal difficult to use. This resulted in improvements being made to the way users experience the portal, including additional prompts and instructions for medical practitioners and exploring the development of training specific to the use of portal.[91]

21.139 Our consultations with the Board and other participants in Victoria indicated that the initial information technology to support the system needed to be improved and is currently undergoing further development.

Western Australia

21.140 In Western Australia, the Implementation Leadership Team has undertaken targeted consultation about the ICT solution for supporting practitioners to submit forms and otherwise comply with their reporting obligations under the Western Australian Act.[92]

The Commission's view

21.141 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.

21.142 The ICT system is critical in ensuring relevant documentation can be submitted to the Board in a timely fashion. In doing so, it enables the coordinating practitioner, the Board and other relevant entities to track a person's progress through the voluntary assisted dying process.

21.143 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.

21.144 If not, the process will become unworkable, and practitioners who might otherwise have been willing to participate in it will not do so.

POLICIES, PROCEDURES AND INFORMATION

21.145 Critical to the successful implementation of a voluntary assisted dying scheme in Queensland is accurate, relevant and accessible information and guidance about the voluntary assisted dying process.

21.146 Ensuring such information is accessible and available helps to ensure equitable access to voluntary assisted dying across a large state like Queensland. The importance of such educational material was underlined by a medical practitioner in Victoria who noted that, reflecting back a year after the commencement of the Victorian legislation, the

89 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 4.
90 Ibid 8.
91 Ibid 8.
92 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (7 October 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-communique-October-2020.pdf>.

implementation period:[93]

> was focused on how the legislation would be put into use, and not on an awareness campaign directed at the general community, many patients are not aware that [voluntary assisted dying] even exists as an option. Not only did the implementation period not address community awareness, but the awareness of the Act amongst the medical communities (in both specialist and GP circles) was not addressed. Most doctors do not know what they can and cannot talk about with patients with regards to [voluntary assisted dying], so many are avoiding these discussions for fear of saying the wrong thing.

21.147 Such information also underpins the principles of access to high quality end of life care and support for informed decision-making.

21.148 In preparation for the implementation of voluntary assisted dying frameworks in Victoria and Western Australia, a range of information, policies, guidelines and procedures have been developed. Generally, this information is targeted at those interested in accessing voluntary assisted dying, health practitioners who will be participating in it, as well as health service providers and members of the community generally.[94]

Policies and procedures

21.149 Based on the experience of other jurisdictions, the implementation of voluntary assisted dying will require government departments and agencies to develop a range of policies and procedures to support the implementation of the legislative provisions.

21.150 In Victoria, the Department of Health and Human Services developed a suite of policies for medical practitioners, patients and others.[95] These provide guidance on key aspects of the voluntary assisted dying framework, including:

- preparations for the implementation of the framework by healthcare providers;[96]
- how medical practitioners can train and register to participate in the framework;[97] and
- how the framework would impact other health professionals like nurses, allied health professionals and aged care providers.[98]

21.151 In preparation for the implementation of its framework, the Western Australian Department of Health has published numerous policies and guidelines.[99] These include policies that explain the Care Navigator Service,[100] the Statewide Pharmacy Service,[101]

93 C McLaren, 'An Update on VAD: (Almost) A Year in Review', *Dying with Dignity Victoria* (16 June 2020) 2 <https://www.dwdv.org.au/news/an-update-on-vad-almost-a-year-in-review>.

94 Department of Health (WA), 'Providing voluntary assisted dying in Western Australia: FAQs for health professionals' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/FAQs-for-Health-Professionals.pdf>. Further information is available at: <Voluntary assisted dying (health.wa.gov.au)> From this website, it is possible to subscribe to receive implementation updates.

95 Department of Health & Human Services (Vic), 'Voluntary Assisted Dying' <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying>.

96 Department of Health & Human Services (Vic), 'Preparing for voluntary assisted dying: *Voluntary Assisted Dying Act 2017*' (24 April 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/preparing-for-voluntary-assisted-dying>; Department of Health & Human Services (Vic), 'Health service policy guidance for voluntary assisted dying' (April 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-service-policy-guidance-for-voluntary-assisted-dying>.

97 Department of Health & Human Services (Vic), 'Medical practitioners wanting to participate in voluntary assisted dying' (May 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/medical-practitioners-wanting-to-participate-in-voluntary-assisted-dying>.

98 Department of Health & Human Services (Vic), 'Voluntary assisted dying guidance for aged care providers' (March 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-guidance-aged-care-providers>; Department of Health & Human Services (Vic), 'Voluntary assisted dying: Information for nurses and allied health practitioners' (September 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-information-for-nurses>.

99 Department of Health (WA), 'Voluntary Assisted Dying Implementation', (24 February 2021) <https://ww2.health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying/Implementation>.

100 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the Statewide Voluntary Assisted Dying Care Navigator Service?' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Care-Navigator-Service.pdf>.

101 Department of Health (WA), 'Accessing voluntary assisted dying in Western Australia: What is the Statewide Voluntary Assisted Dying Care Navigator Service?' (2021) <What is the Voluntary Assisted Dying Statewide Pharmacy Service? (health.wa.gov.au)>.

and how health professionals can participate in voluntary assisted dying.[102] There are also specific policies aimed at medical first responders and interpreters.[103]

Resources for medical practitioners

21.152 In Victoria, medical practitioners are provided comprehensive guidance about voluntary assisted dying.[104]

21.153 In addition, trained medical practitioners and health service staff involved in the voluntary assisted dying process as part of their roles can access specialist communities of practice.[105] The Victorian community of practice is administered by the Western Victoria Primary Health Network and seeks to assist in the development of a cohort of medical practitioners who are confident and supported in helping patients who request information about, or access to, voluntary assisted dying by sharing experiences, lessons and peer support.[106]

21.154 The Western Australian Implementation Leadership Team has been developing a voluntary assisted dying handbook, clinical guidelines and a service delivery framework.[107]

21.155 In Western Australia, information sheets for health practitioners provide high-level information about the voluntary assisted dying process and the role of the health practitioner in that process. Information is given about matters such as the request and assessment process, and potential issues such as conscientious objection and initiating discussions about voluntary assisted dying with patients. It also suggests where further information and support may be found.

21.156 Western Australia has also established a community of practice designed to provide additional support for participating health practitioners.

Resources for health service providers

21.157 The Victorian Department of Health and Human Services engaged the Victorian Healthcare Association to develop a model of care to support implementation of voluntary assisted dying in Victoria. The model has three high-level care pathways that may be applied across metropolitan and regional health services and is supported by safety and quality guidance.[108]

21.158 The Victorian Healthcare Association has also developed organisational resources to support the implementation process. These resources were developed with input from a consultative working group, which included representation from across public and private hospitals, community-based palliative care, community health, general practice, and residential aged care.[109] A Voluntary Assisted Dying Implementation Conference was held in May 2019.

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102 Department of Health (WA), 'Providing voluntary assisted dying in Western Australia: Health professional participation' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Health-Professional-Participation.pdf>; Department of Health (WA), 'Providing voluntary assisted dying in Western Australia: FAQs for health professionals' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/FAQs-for-Health-Professionals.pdf>.

103 Department of Health (WA), 'Voluntary assisted dying in Western Australia: Information for first responders and similar roles' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Information-for-First-Responders.pdf>; Department of Health (WA), 'Voluntary assisted dying in Western Australia: Information for interpreters' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Information-for-Interpreters.pdf>.

104 Vic Guidance for Health Practitioners (2019).

105 The Department of Health & Human Services (Vic) commissioned the Victorian and Tasmanian Primary Health Network Alliance to establish a Community of Practice for medical practitioners who have undertaken the voluntary assisted dying training.

106 Department of Health & Human Services (Vic), 'Voluntary assisted dying newsletter' (January 2020) <https://www.vision6.com.au/v/47492/7117956/email.html?k=u6THttw9TeH9VscZRwm0gilHO1XiM-jwD_tTpXzosVM>; Voluntary Assisted Dying Review Board Report of operations June–December 2019 (2020) 6.

107 It is anticipated that the Western Australian Voluntary Assisted Dying Guidelines will be launched in June 2021. Victorian practitioner guidelines are being used as a basis for the development of the Western Australian guidelines. Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (18 December 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-December-2020.pdf>.

108 Department of Health & Human Services (Vic), 'Voluntary assisted dying monthly newsletter' (January 2019). <https://www.vision6.com.au/v/47492/4591925/email.html?k=s7Mecs8YHco4s_i4kLI79OKCoIOf4aBuU_pLFVTUO3Y>.

109 Ibid.

21.159 The Implementation Leadership Team in Western Australia developed factsheets for health and other service providers, accompanied by presentations with more detailed information.[110]

21.160 Western Australia hosted a series of webinars targeted at palliative care providers, hospital and related service providers, general practitioners and nurse practitioners, and residential aged care providers. The webinars drew on the experiences of Victorian providers in implementing voluntary assisted dying.[111] In addition, an implementation conference for health practitioners is scheduled for late May 2021.[112]

Community education resources

21.161 As mentioned above, in developing community education resources, they must be tailored to Queensland's geographic and demographic environment.

21.162 The importance of community education resources was noted by a member of the Victorian Implementation Taskforce:[113]

> Informed decision making is a key guiding principle, so access to relevant consumer-oriented information is vital. Many people who ask for voluntary assisted dying will have done a great deal of information seeking online.
>
> The information provides support for people as they need to navigate a fairly complicated process at a late stage of their illness. The consumer information supports people in having conversations with their doctors about end of life and voluntary assisted dying.

Victoria

21.163 Community information and consumer guidelines were made available prior to the commencement of the Victorian Act.

21.164 In developing the resources, a working party on community and consumer information was created to develop credible and accurate information about voluntary assisted dying for the community and individuals who may be considering accessing voluntary assisted dying. As a result, a suite of community and consumer information was prepared and user-tested with community organisations, health practitioners and consumers.

21.165 As part of this work, a dissemination strategy was developed to ensure the information was accessible to the Victorian community. A review process has been established to ensure information and guidelines remain up-to-date. The Department of Health and Human Services is responsible for governance, receiving feedback and updating community and consumer information.

21.166 Community and consumer information is intended to provide people with access to accurate and up to date information about voluntary assisted dying. It also provides an information referral source for health professionals wanting to refer people to authorised information about voluntary assisted dying.

21.167 Victorian community information is produced in English, 'Easy English' and seventeen community languages. General community information is presented as Frequently Asked Questions.

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110 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (29 June 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Project-Team-Communique-June-2020.pdf>.

111 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (18 November 2020) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Project-team-Communique-November-2020.pdf>.

112 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (26 February 2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-February-2021.pdf>.

113 Department of Health & Human Services (Vic) 'Voluntary Assisted Dying Implementation Conference' (May 2019) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/implementation-conference>.

21.168 A member of the Victorian Implementation Taskforce noted:[114]

> The information provides support for people as they need to navigate a fairly complicated process at a late stage of their illness. The consumer information supports people in having conversations with their doctors about end of life and voluntary assisted dying.

Western Australia

21.169 Community education resources were developed by the Implementation Leadership Team in consultation with relevant stakeholders. These include resources outlining the voluntary assisted dying process, as well as targeted resources for persons supporting someone through the process, and contact persons. Information for interpreters and first responders has also been developed.[115]

21.170 A further tranche of information resources is scheduled to be released before 1 July 2021.[116]

Bereavement and counselling support

21.171 In addition to information, education and training, counselling and emotional support should be readily available for those seeking access to voluntary assisted dying, their family, friends and carers as well as participating health practitioners. As with other implementation measures, careful planning and resourcing are required.

21.172 As well as providing information about voluntary assisted dying generally, resources developed by the Victorian Department of Health and Human Services include a number of referral pathways to counselling and support services, including support during the voluntary assisted dying process, bereavement support after the person's death and support services for where a person is found ineligible to access voluntary assisted dying.[117]

21.173 Western Australia has developed similar resources and referral processes.[118]

21.174 In Queensland, the Parliamentary Committee received submissions raising the importance of access to counselling for the person seeking access to voluntary assisted dying, their families and carers, and for health practitioners involved in their care. The need for adequate funding of support and counselling services was also raised.[119] The Parliamentary Committee commented that counselling and support should be available to anyone who requests it and that bereavement counselling for loved ones was also important.[120]

Submissions

21.175 Many respondents supported community engagement and the provision of informative material and guidelines as integral to the successful implementation of the scheme.

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114 Ibid.

115 Department of Health (WA), '*Voluntary Assisted Dying Act 2019* Implementation Update' (26 February 2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/ILT-Communique-February-2021.pdf>.

116 Ibid.

117 Department of Health & Human Services (Vic) 'Getting support: Information for people considering voluntary assisted dying' (August 2019) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/getting-support>; Department of Health & Human Services (Vic), 'Voluntary Assisted Dying—Information for people considering voluntary assisted dying', (2020) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/information-for-people-considering-voluntary-assisted-dying>. The latter notes that the person's health practitioner or the Care Navigator Service should be able to assist the family member, friend or carer connect with the right supports and counselling services.

118 Department of Health (WA) 'Voluntary assisted dying in Western Australia: Considerations for an assisted death' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Considerations-for-an-Assisted-Death.pdf>. These bodies include: the Australian Centre for Grief and Bereavement (helps carers, family and friends deal with the death of a loved one) www.grief.org.au; Palliative Care WA (provides the WA community with a palliative care information and support line for helping to deal with grief and loss) www.palliativecarewa.asn.au/information-and-support; Carer's WA (provides counselling support to carers who are going through the experience of grief and loss) www.carerswa.asn.au; Department of Health (WA) 'Voluntary assisted dying in Western Australia: Being the Contact Person' (2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Being-the-Contact-Person.pdf>.

119 Qld Parliamentary Committee Report No 34 (2020) 137, referring to examples of submissions received during its inquiry.

120 Ibid 138.

A member of the public believed that materials and information about the [voluntary assisted dying] legislation should be able to be easily found or requested by the public, more so those without access to computer technology. Cancer Council Queensland submitted:

> If legislation for assisted dying passes, a large amount of work will be needed between passage of the legislation and implementation of the scheme to ensure that the community and health practitioners and health services are prepared for its commencement … This will include, for example, regulations, carefully tested information resources for patients and carers…

21.176 A joint submission by two academics considered it to be critical to engage with the community:

> to allay concerns about how the [voluntary assisted dying] laws will operate, what safeguards will be written into them, and to educate about how [voluntary assisted dying] will operate and be monitored.

21.177 Some respondents emphasised the need for support services for persons seeking to access voluntary assisted dying, their family, friends and carers and for health practitioners.

21.178 Dying with Dignity Victoria Inc submitted:

> Support for practitioners involved is vital. The community of practice in Victoria started well after the Bill became live. Steps should be taken to ensure that an appropriate support process is in place well before any legislation begins.

21.179 Palliative Care Social Work Australia was mindful of the emotions suffered by those persons who did not satisfy the eligibility criteria for voluntary assisted dying:

> Additionally, what about those people who request [voluntary assisted dying] but are not eligible? How are they supported? They have expressed a wish for suicide, so presumably this risk may be elevated if they are not eligible for the [voluntary assisted dying] pathway. There has been no discussion about this within the legislation and it should at least provide an exit point for them to receive some level of assessment and compassionate follow-up.

21.180 Palliative Care Social Work Australia also submitted that bereavement services should be offered to family members of those who have died after taking the voluntary assisted dying substance:

> Follow-up should also occur for family members of those who have died after taking the substance. Quality bereavement support is crucial, with necessary risk assessments being undertaken to assess for potential bereavement complexities. Pending on risk assessment reviews, continued follow-up or referrals to a bereavement specialist service may be necessary.

The Commission's view

21.181 Based on the implementation processes carried out in other states, it will be necessary for Queensland Health, in conjunction with Hospital and Health Services and other government departments and agencies, to develop policies and procedures to implement the voluntary assisted dying framework. Specific issues to be addressed by policies or procedures should include:

- how medical practitioners will register and train to participate in the framework;
- how healthcare providers can prepare their facilities and staff for the implementation of voluntary assisted dying;
- how to prepare and lodge forms with the voluntary assisted dying oversight body; and
- how to access the statewide pharmacy service, the care navigator service and other services involved in the voluntary assisted dying process.

21.182 In addition, a suite of materials will need to be developed to provide community awareness and referral processes for counselling and bereavement support.

21.183 The availability and accessibility of information and support aligns with the principle in the draft Bill of providing a person seeking access to voluntary assisted dying with high quality care and relief of emotional suffering.[121]

21.184 In summary, the implementation of a voluntary assisted dying scheme in Queensland should include the development of useful advice and information accessible on the State Government's voluntary assisted dying website and through other forms of communication. In addition to giving general advice, the website should provide links to relevant external counselling and support agencies. Such agencies should be given sufficient resources and funding to support this additional demand.

21.185 In addition, we recommend that communities of practice should be established to provide peer support to practitioners engaged in the voluntary assisted dying process.

THE EFFECT OF COMMONWEALTH CARRIAGE SERVICE PROVISIONS

21.186 The somewhat uncertain and seemingly unintended application of the Commonwealth carriage service offences has been discussed in Chapter 20. We recommend consultations be undertaken with other states and the federal government to remove this unnecessary uncertainty.

21.187 Ideally, that unintended barrier to accessing lawful voluntary assisted dying, particularly in rural and remote areas, should be removed before any Queensland scheme comes into full operation.

21.188 If voluntary assisted dying legislation is passed in Queensland, then the implementation process should have contingency plans if the Commonwealth provisions remain unamended. Participants, including practitioners, the care navigator service and interpreters, will need to be properly informed about what services can be provided by telehealth, telephone, email and other electronic 'carriage services'.

21.189 We share the views of legal scholars that the Commonwealth carriage offences do not affect many of the information provision and assessment services under the draft Bill.[122] However, the uncertainty that attaches to some parts of the process, such as the provision of more detailed advice about administration of substances and their prescription and dispensing, has led to a cautious approach being adopted in Victoria about health services and practitioners' use of 'carriage services'.

21.190 This has raised concerns, including those expressed by the Victorian Board, about the impact of the Commonwealth law, particularly on people in rural and remote regions, who may be unable to use telehealth technology for appointments.

21.191 Unless addressed, those problems of access are likely to be even more acute in Queensland due to its wide population spread and the concentration of qualified and trained health practitioners in the south-east corner of the State.

21.192 We suggest that the Queensland Government seek advice from the Crown Solicitor or senior counsel about the implications of the Commonwealth carriage offences on the operation of the voluntary assisted dying scheme in Queensland. This advice, in conjunction with other sources of advice, can form the basis for procedures and information to guide practitioners and health services through the appropriate use of telehealth, telephone and other electronic forms of communication at different stages of the process. Those procedures may prove unnecessary should the Commonwealth provisions be amended to clarify that lawful voluntary assisted dying is not subject to

121 See draft Voluntary Assisted Dying Bill 2021 (Qld) cl 5(d).
122 See Chapter 20 above.

them, or if the Commonwealth Director of Public Prosecutions issues guidelines of the kind recommended by the Commission. However, successful implementation of any scheme in Queensland must address the contingency that these things will not occur in the required time.

QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

21.193 The Queensland Civil and Administrative Tribunal should be adequately resourced to deal with applications for review, which will need to be considered with care, confidentiality and expedition.

TRANSFER OF CARE

21.194 In Chapter 15 a process is proposed whereby, in certain circumstances, persons may need to be transferred from facilities that choose not to participate in voluntary assisted dying to facilities that do, including hospitals and hospices operated by government Hospitals and Health Services. The demands such transfers may place on government services should be anticipated and appropriate places made available in hospitals and hospices for persons to undergo assessments and, if authorised, receive administration of voluntary assisted dying substances.

21.195 Processes and systems will need to be developed to allow persons to request a qualified practitioner to access facilities that do not participate or arrange transfer of persons to other facilities when that is reasonable.

PALLIATIVE CARE

21.196 The Queensland Government's response to the Parliamentary Committee's Report on Aged care, end of life and palliative care included additional funding for palliative care. It also included working with the federal government to provide additional funding for end of life care.[123]

21.197 We mention at different stages of this report our support for the Parliamentary Committee's recommendations about funding and support for palliative care.

21.198 To repeat, 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'.[124]

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

21.200 That important objective should be reflected in all processes associated with the implementation of a scheme for voluntary assisted dying in Queensland.

123 Queensland Government, Queensland Government Response: *Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Report No 33: Aged care, end-of-life and palliative care* (Final Response, tabled 24 September 2020) <https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2020/5620T1686.pdf>.

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

RECOMMENDATIONS

21-1 The Queensland Government should establish an implementation taskforce or leadership group which is a multidisciplinary team with expertise in relevant areas such as palliative, disability, mental health and aged care; representatives from peak bodies such as the Australian Medical Association, Royal Australian College of General Practitioners, and other specialist medical colleges; and Aboriginal and Torres Strait Islander representatives. The taskforce should provide advice, leadership and direction on implementation.

21-2 The Queensland Government should ensure that the Voluntary Assisted Dying Review Board has the support and resources required for it to meet its legislated obligations including collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engagement and information sharing with other agencies.

21-3 A Statewide Care Navigator Service should be established to support the voluntary assisted dying scheme in Queensland and to provide services such as:

(a) information, education and support about the voluntary assisted dying process;

(b) helping a person seeking to access voluntary assisted dying to connect with appropriate participating medical practitioners and health services, particularly if their own practitioner is not willing to participate;

(c) helping a person identify appropriate referral pathways;

(d) providing holistic advice and follow-up on appropriate end of life care services, including palliative care and treatment; and

(e) helping persons to access financial support.

21-4 A Statewide Pharmacy Service should be established, suited to Queensland's size and population distribution, and appropriately resourced to facilitate the supply of the voluntary assisted dying substance across Queensland. It should also provide a central source of information about the substance for persons accessing voluntary assisted dying, especially persons who self-administer, and for registered health practitioners.

21-5 The Queensland Government should develop a model for disposal of the voluntary assisted dying substance with particular consideration given to accessibility of voluntary assisted dying by people in rural and remote areas.

21-6 The Queensland Government should ensure that comprehensive mandatory assessment training is developed and available to qualified practitioners prior to full commencement of the legislation. It should also provide information and support for other health care practitioners, including junior doctors and nurses, who are asked by patients about the scheme or have to provide ongoing support to patients who chose to access it and to their families.

21-7 The Queensland Government should develop a user-friendly ICT system to support the voluntary assisted dying process and the collection of relevant data. It should provide resources to ensure that the ICT system is established early, tested, effective and maintained.

21-8 Appropriately qualified interpreters and speech pathologists should be available to assist in communications between health practitioners and persons seeking access to voluntary assisted dying. They should be skilled and trained in communicating about end of life choices, and specifically briefed about the voluntary assisted dying process before providing communication services about it.

21-9 The Queensland Government should develop policies, procedures and community information to support the implementation of the voluntary assisted dying framework, including health practitioner guidelines, health service provider information, information for persons seeking to access voluntary assisted dying and for the broader community. This should also include adequate resourcing for referral organisations to provide counselling and bereavement support.

21-10 Communities of practice should be established to provide peer support to health practitioners engaged in the voluntary assisted dying process.

21-11 The implementation process should consider the possible implications of the Commonwealth carriage service offences on providing certain services relating to voluntary assisted dying, particularly in rural and remote areas. The Government should seek further legal advice about this issue and develop procedures and processes to guide practitioners and health services about the appropriate use of telehealth, telephone and other electronic services in providing information and advice about voluntary assisted dying.

21-12 The implementation process should include contingency plans in the event that the Commonwealth carriage service offence provisions remain unamended. Participants, including practitioners and the care navigator service, will need to be properly informed about what services can be provided by telehealth, telephone, email and other electronic 'carriage services'.

21-13 The Queensland Civil and Administrative Tribunal should be adequately resourced to deal with applications for review.

21-14 The Queensland Government should develop processes and systems to allow access, upon a patient's request, by qualified practitioners to facilities that do not participate in voluntary assisted dying, or to arrange transfer of patients to other facilities when that is reasonable. The demands on government hospital and health services from transfers should be anticipated and appropriate places made available in hospitals and hospices for persons to undergo assessments and, if authorised, receive administration of voluntary assisted dying substances.

21-15 Any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care and treatment. This should be reflected in all processes associated with the implementation of a voluntary assisted dying scheme in Queensland.

IMPLEMENTATION PERIOD

21.201 The voluntary assisted dying legislation in Victoria,[125] Western Australia[126] and Tasmania[127] provide for an implementation period of up to 18 months between the passage of the legislation and its full commencement.

21.202 The Victorian Panel considered that this would allow adequate time to plan for and establish the voluntary assisted dying framework, including consulting with key stakeholders.[128]

21.203 The Western Australian Panel similarly observed that:[129]

> an adequate period of time—at least 18 months—will be required to enable Government and health services to plan, consult on and develop guidelines and protocols to ensure that the legislation is translated safely, effectively and appropriately for Western Australia.

21.204 The White and Willmott Model also suggests an 18-month delay in commencement 'to permit time for implementation'.[130] In other published work, White, Willmott and Close concluded:[131]

> The designated 18-month [voluntary assisted dying] implementation period provides scope to address these challenges and create the necessary clinical, legal and administrative infrastructure. This can be contrasted with Canada, where political delays led to their medical assistance in dying law coming into effect without an extended opportunity to prepare.

21.205 Numerous activities need to occur during the implementation period to ensure the safe and smooth commencement of voluntary assisted dying in Queensland. These include:

- establishing a Voluntary Assisted Dying Board, a Care Navigator Service and a Statewide Pharmacy Service;
- developing and rolling out a voluntary assisted dying training program for medical practitioners;
- developing and implementing a dedicated ICT system that can be used easily by practitioners to comply with time-sensitive processes;
- developing policies, procedures, guidelines and educational materials; and
- addressing the delivery of services in remote and regional areas, including the use of telehealth and other electronic services, where the provision of some services may be affected by the Commonwealth carriage offences.

21.206 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.

21.207 In avoiding unnecessary delay, while ensuring effective and safe implementation, it is instructive to learn from the experiences of other Australian states. The Queensland Parliamentary Committee noted that:[132]

> If voluntary assisted dying is legislated in Queensland the implementation of the Victorian and Western Australian voluntary assisted dying schemes will provide a basis for the extent and types of material needed to guide both community members and medical practitioners for the Queensland voluntary assisted dying scheme.

125 *Voluntary Assisted Dying Act 2017* (Vic) s 2(2); Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 1.
126 *Voluntary Assisted Dying Act 2019* (WA) s 2(b); Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 1.
127 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 2.
128 Vic Ministerial Advisory Panel Final Report (2017) 200, Rec 66.
129 WA Ministerial Expert Panel Final Report (2019) 102, Rec 30.
130 White and Willmott Model cl 2(2), Explanatory Notes 7.
131 BP White, L Willmott and E Close, 'Victoria's voluntary assisted dying law: clinical implementation as the next challenge' (2019) 210(5) *Medical Journal of Australia* 207-208.
132 Queensland Parliamentary Committee Report No 34 (2020) 149.

21.208 The experience of other States demonstrates the importance of allowing enough time to establish effective bodies 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.

21.209 Like Western Australia, Queensland spans a vast area with a diversity of cultures and languages. The 18-month implementation period in Western Australia has proved challenging, despite it learning from Victoria's experience. As the Western Australian system is in the process of being implemented, its practical operation in urban, regional, rural and remote settings is yet to be assessed.

21.210 We have worked co-operatively with Queensland Health during the review. Our recommendations on key features of the scheme and the resources needed to support it are unlikely to be a surprise to Queensland Health or anyone else who has studied the implementation of schemes in other states. This may have allowed some preparation for implementation in the event draft legislation of the kind recommended by the Commission becomes law. However, implementation can only begin in earnest if a legal framework for voluntary assisted dying becomes law.

21.211 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.

21.212 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.

21.213 We are conscious that a 15-month implementation period has been announced by the State government. If this is adopted, 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.

APPENDIX A

Terms of reference

Appendix A: Terms of reference

Terms of reference

Queensland's laws relating to voluntary assisted dying

Background

In Queensland, people seeking relief from prolonged intolerable suffering due to a life-limiting illness or a neurodegenerative condition are currently unable to access voluntary assisted dying (VAD). While these people may receive palliative care or a range of other supports, the options available to them are limited to refusal of medical treatment, refusal of food and/or hydration, palliative sedation and suicide. These options are further constrained by restrictions on what health practitioners can legally provide to their patients.

Voluntary assisted dying is a very complex and deeply personal issue, in which competing interests and views must be carefully balanced. The lives of the elderly and most vulnerable people in the community must be protected.

There are very divergent views held by the community, health, palliative and aged care providers and health and legal practitioners on the matter of voluntary assisted dying, with some supporting and others opposing voluntary assisted dying laws in Queensland.

On 14 November 2018, an inquiry on aged care, end-of-life and palliative care and voluntary assisted dying was referred to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee).

The Terms of Reference for the Committee Inquiry were as follows:

1. That the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee inquire into aged care, end-oflife and palliative care and report to the Legislative Assembly on:
    a. the delivery of aged care, end-of-life and palliative care in Queensland across the health and ageing service systems; and
    b. 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.
2. That in undertaking the inquiry, the Committee should consider:
    a. in relation to aged care, the terms of reference and submissions made to the Australian Government's Royal Commission into the Quality and Safety of Aged Care and, in recognising the Commission will occur in parallel, how to proactively work with the Commission to ensure an appropriate exchange of information to inform the conduct of the inquiry;
    b. outcomes of recent reviews and work including Queensland Health's Palliative Care Services Review; and
    c. the current legal framework, relevant reports and materials in other Australian states and territories and overseas jurisdictions, including the Victorian Government's Inquiry into end-of-life choices, *Voluntary Assisted Dying Act 2017* (Vic) and implementation of the associated reforms.
3. That the Committee report to the Legislative Assembly by 30 November 2019.

On 22 August 2019, the Queensland Parliament agreed to a motion that the date for the Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying, be extended from 30 November 2019 to 31 March 2020.

On 24 March 2020, the Committee tabled Report No. 33, *Aged care, end-of-life and palliative care* (AEP Report). The AEP Report includes 77 recommendations.

On 31 March 2020, the Committee tabled Report No. 34, *Voluntary assisted dying* (VAD Report) and Information Paper No. 5, *Summary of the Findings and recommendations from report No. 34 on Voluntary assisted dying* (Information Paper No. 5). The VAD Report includes 21 recommendations.

Recommendation 1 of the VAD Report is that the Queensland Government should use the well-considered draft legislation submitted to the inquiry by Professors Lindy Willmott and Ben White as the basis for a legislative scheme for voluntary assisted dying in Queensland. The Committee's proposed VAD legislation mostly aligns with the Victorian and Western Australian approaches.

In particular, the Committee recommended that any voluntary assisted dying scheme in Queensland:

- should limit eligibility to adults aged 18 years or older and Australian citizens or permanent residents ordinarily resident in Queensland;
- should require that, to be eligible to access voluntary assisted dying, a person must be diagnosed by a medical practitioner as having an advanced and progressive terminal, chronic or neurodegenerative medical condition that cannot be alleviated in a manner acceptable to the person, and that the condition will cause death;
- should limit eligibility to people with decision-making capacity.

Under the *Parliament of Queensland Act 2001*, the Queensland Government is required to table a response to the Committee's AEP and VAD Reports by 24 June 2020 and 1July 2020 respectively.

Terms of Reference

I, STIRLING JAMES HINCHLIFFE, Acting Attorney-General and Minister for Justice, refer to the Queensland Law Reform Commission, the issue of developing an appropriate legislative scheme for voluntary assisted dying for Queensland and the preparation of draft legislation to give effect to its recommendations, pursuant to section 10 of the *Law Reform Commission Act 1968*.

Scope

The provision of compassionate, high quality and accessible palliative care for persons at their end-of life is a fundamental right for the Queensland community.

The Queensland Law Reform Commission is asked to make recommendations about an appropriate voluntary assisted dying scheme and to prepare draft voluntary assisted dying legislation to give effect to its recommendations, with particular regard to:

1. the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland;
2. identifying who can access voluntary assisted dying;
3. the process for access to voluntary assisted dying to be initiated, granted or denied;
4. the legal and ethical obligations of treating health practitioners;
5. appropriate safeguards and protections, including for treating health practitioners;
6. ways in which compliance with the Act can be monitored;
7. timeframes for implementation of a scheme in Queensland, if progressed.

In preparing draft legislation, the QLRC should also have regard to the following:

A. The Parliamentary Committee's Report No 34 Report, *Voluntary assisted dying*, including the draft legislation in Appendix A of the Report (VAD Report) and Information Paper No. 5, *Summary of the Findings and recommendations from Report No. 34 on Voluntary assisted dying* (Information Paper No. 5];

B. The Parliamentary Committee's Report No 33 Report, Aged care, end-oflife and palliative care (AEP Report);

C. Consultation with stakeholders and the community that occurred during the Parliamentary Committee's consideration of the matter;

D. Views of experienced health and legal practitioners;

E. Views of the Queensland public;

F. Legislative and regulatory arrangements in other Australian and international jurisdictions.

Consultation

The QLRC shall consult with any group or individual, in or outside of Queensland, to the extent that it considers necessary.

Timeframe

The QLRC is to commence its review on and from 1 July 2020 and is to provide its final report and draft legislation to give effect to its recommendations to the AttorneyGeneral and Minister for Justice by ~~1 March 2021~~ **10 May 2021**.[1]

Dated the 21st day of May 2020

STIRLING HINCHLIFFE MP
Acting Attorney-General and Minister for Justice
Acting Leader of the House
Minister for Local Government, Minister for Racing and
Minister for Multicultural Affairs

1 This amendment to the terms of reference was made by letter from the Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence, the Hon Shannon Fentiman MP, to the Chair of the Queensland Law Reform Commission, the Hon Justice Peter Applegarth AM, dated 7 December 2020.

APPENDIX B

List of respondents

Appendix B: List of respondents

AMA Queensland

Anderson, KR

Anglican Bishop of North Queensland, The Right Reverend Dr Keith Joseph

Archbishop of Brisbane, The Most Reverend Mark Coleridge

Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine (ANZCA)

Australian Association of Social Workers

Australian Care Alliance

Australian Christian Lobby

Australian College of Nurse Practitioners (ACNP)

Australian College of Rural and Remote Medicine (ACRRM)

Australian Healthcare and Hospitals Association

Australian Health Practitioner Regulation Agency (AHPRA)

Australian Lawyers Alliance

Australian & New Zealand Society for Geriatric Medicine (ANZSGM)

The Australian Pain Society

Australian Psychological Society

Avant Mutual Group Limited

Bailey, AH (Rick)

Bar Association of Queensland

Bedford, David

Bickley, Shaun

Bonython, Dr Wendy and Assistant Professor Bruce Arnold

Boyne, Ken

Bradley, Gail

Braun, Dr Kerstin

Brodie, John R

Browne, Phil

Cairns OAM, Dr Will

Calabro, Andrew and Daniel Calabro

Cancer Council Queensland

Cartwright, Professor Colleen

Cassells, Margaret

Catholic Health Australia

Cherish Life Queensland Inc

Christians Supporting Choice for Voluntary Assisted Dying

Civil Liberties Australia

The Clem Jones Group

Dementia Australia

Democratic Labour Party

Department of Local Government, Racing and Multicultural Affairs

Donnelly, The Hon Greg MLC (NSW)

Douglas, Roy

Dying with Dignity NSW

Dying with Dignity Queensland Inc.

Dying with Dignity Victoria Inc

End of Life Choice Society New Zealand Inc

Exit International

FamilyVoice Australia

Francis, Neil

Foletta, David

Gillard, Henry

Greek Orthodox Archdiocese of Australia

Go Gentle Australia Ltd

Gold Coast Retirees Inc

Hann, Warren and Judy Fleiter

Health Consumers Queensland

Henderson, Joan and David

Heron, Robert

Hosie, Dr Annmarie

Human Rights Coalition (Australia)

Jacobs, Fiona

Jewell, Francoise

Johnston, Dr Carolyn

Jones, Eileen

Katie Rose Cottage Hospice

Kelly, Greg

Knights of the Southern Cross Care (Qld) Inc.

Knox, Matthew J

Lawrence, Marjorie

Lewis, Rodney

Lutheran Church of Australia Queensland District

Metcalf, Dr William J

McCabe, Dr Helen

McKeon, Dr James

McMahon, Bryan

MIGA

Minister for Disability Services (WA), The Hon Stephen Dawson

Musumeci, Joan

National Seniors Queensland Policy Advisory Group

O'Brien, Anthony Dennis

Office of the Health Ombudsman

Palliative Care Nurses Australia Inc.

Palliative Care Queensland

Palliative Care Social Work Australia

Perron, Marshall

The Pharmacy Guild of Australia, Queensland Branch

President of the Queensland Civil and Administrative Tribunal, The Hon Justice Martin Daubney AM

Prichard, Associate Professor Jeremy and Professor Richard Wortley

The Public Advocate

Queensland Baptists

Queensland Council of Unions

Queensland Law Society

Queensland Mental Health Commission

Queensland Nurses & Midwives' Union

Queensland Police Service

Queensland Registry of Births, Deaths and Marriages (RBDM Qld)

Queenslanders with Disability Network

Quinlan, Professor Michael

Richardson, Dr Philip G

The Right to Life Australia Inc.

The Roman Catholic Bishops of Queensland

Royal Australian College of General Practitioners (RACGP) Queensland

Royal Australasian College of Medical Administrators (RACMA)

Royal Australasian College of Physicians (RACP)

Rutherford, Jodhi

Santamaria QC, Paul D

Seczkowski, Joanna

Society of Trust & Estate Practitioners Australia Pty Limited (STEP Australia)

Society of Trust & Estate Practitioners Queensland (STEP Queensland)

Southern Cross Care (Qld)

Speech Pathology Australia

Spina, Damon

Syme AM, Rodney

Taylor, David

Tomlin, Faye

Torres and Cape Hospital and Health Service

Turner, Professor Jane

United Workers Union

Uniting Church in Australia Queensland Synod, Wesley Mission Queensland and UnitingCare Qld

van Gend, Dr David

Voluntary Assisted Life Ending (VALE) Group

White, Professor Ben and Professor Lindy Willmott

Williams, Rob

Wittmann, Alex

Workman, Cynthia

Young, Beverley

APPENDIX C

Comparative guide

Appendix C: Comparative guide

C.1 This table provides a brief guide to the provisions recommended in this Report, which are reflected in the draft Voluntary Assisted Dying Bill 2021.

C.2 It also provides a brief comparison between the main provisions of legislation about voluntary assisted dying in Australian and selected overseas jurisdictions. Specifically, the table refers to the following legislation:

- *Voluntary Assisted Dying Act 2017* (Vic);
- *Voluntary Assisted Dying Act 2019* (WA);
- *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas);
- *End of Life Choice Act 2019* (NZ);
- *Belgian Euthanasia Act 2002*;
- *Luxembourg Law on Euthanasia and Assisted Suicide 2009*;
- *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*;
- *Canada Criminal Code*, RSC 1985, c C-46;[1]
- *Oregon Death with Dignity Act 1997*, Or Rev Stat.[2]

C.3 This table should be read together with the discussion in the body of the Report.

1 This table does not refer to the *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, which is in substantially different terms.

2 Oregon is presented as an example of state legislation in the United States, as it was the first jurisdiction of the United States to enact physician assisted dying, in 1997. To date, similar legislation has been enacted in Washington, Vermont, California, Colorado, District of Columbia, Hawaii, New Jersey and Maine. There are some differences between the legislation in each of those jurisdictions.

		Draft Bill	Victoria	Western Australia	Tasmania	New Zealand	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
Criteria for access to assisted dying	Guiding principles in legislation	✓	✓	✓	✓					✓	
	18 years or more	✓	✓	✓	✓	✓				✓	✓
	Resident in jurisdiction	✓ (or granted exemption)	✓ (12 m)	✓ (12 m)	✓ (12 m)	✓					✓
	Person has decision-making capacity in relation to assisted dying	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Person is acting voluntarily and without coercion	✓	✓	✓	✓	✓ (practitioner must take no further action if reasonably suspect at any time person's wish is not free from pressure)	✓	✓	✓	✓	✓
	Diagnosed with an eligible disease, illness or medical condition (eg, advanced, incurable, progressive, will cause death)	✓	✓	✓	✓ (or injury)	✓ (terminal illness)		✓	✓	✓	✓
	Disease, illness or medical condition is expected to cause death within a specified timeframe	✓ (12m)	✓ (6 m, 12 m for a neuro-degenerative condition)	✓ (6 m, 12 m for a neuro-degenerative condition)	✓ (6 m, 12 m for a neuro-degenerative condition; unless exempted)	✓ (6 m)					✓ (6 m)
	Person is suffering	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Express provision that mental illness or disability alone is not an eligible disease, illness or medical condition	✓	✓	✓	✓	✓ (and advanced age)					✓ (disability)
	All criteria must be met	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Review by tribunal of some criteria (eg residency, decision making capacity or voluntariness)	✓	✓	✓	✓ (by Voluntary Assisted Dying Commission)						

		Draft Bill	Victoria	Western Australia	Tasmania	New Zealand	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
Request to access assisted dying	Health practitioner must not initiate discussion about voluntary assisted dying	✓ (heath care worker; unless medical practitioner or nurse practitioner also informs person of treatment and palliative care options at the same time)	✓	✓ (heath care worker; unless medical practitioner or nurse practitioner also informs person of treatment and palliative care options at the same time)	✓	✓					
	Person themselves must make request	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Person can make a request in an advance directive						✓	✓	✓		
	Person must make three requests	✓	✓	✓	✓	✓ (two requests by person; one request by practitioner for second opinion)					✓
	One request must be in writing	✓	✓	✓	✓	✓		✓	✓	✓	✓
	Two witnesses to written request	✓	✓	✓	✓ (or a commiss-ioner for declarations)					✓	✓
	Waiting period between first and final requests	✓ (unless likely to die or lose capacity)	✓ (unless likely to die)	✓ (unless likely to die or lose capacity)	✓ (unless likely to die or lose capacity)					✓	✓
	Any interpreter must be independent and accredited	✓	✓	✓	✓						
	Person may withdraw request at any time	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

		Draft Bill	Victoria	Western Australia	Tasmania	New Zealand	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
Assessment for access to assisted dying	Assessment of criteria for access is carried out by medical practitioners	✓	✓	✓	✓	✓	✓	✓	✓	✓ (or nurse practitioners)	✓
	Two independent assessments by two medical practitioners	✓	✓	✓	✓	✓	✓	✓	✓	✓ (or nurse practitioners)	✓
	Referral to another medical practitioner if eligibility cannot be determined (eg there is uncertainty about the person's diagnosis or decision-making capacity)	✓	✓	✓	✓	✓ (psychiatrist for competence to make an informed decision)					✓ (capacity)
	Person must be given particular information (eg about their diagnosis, options and the taking of the substance)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assessing medical practitioners	Meet minimum requirements about qualifications and experience	✓	✓	✓	✓	✓ (indepen-dent medical practitioner)					
	Complete mandatory training before assessing person	✓	✓	✓	✓						
	Conscientious objection	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	If conscientiously object, refer or provide information	✓ (give person information)		✓ (give person information)	✓ (contact details of Voluntary Assisted Dying Commission)	✓ (right to ask SCENZ Group for details of a replacement practitioner)		✓ (transfer file on request)	✓ (transfer file on request)		
	Mandated to report at points throughout the assisted dying process	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

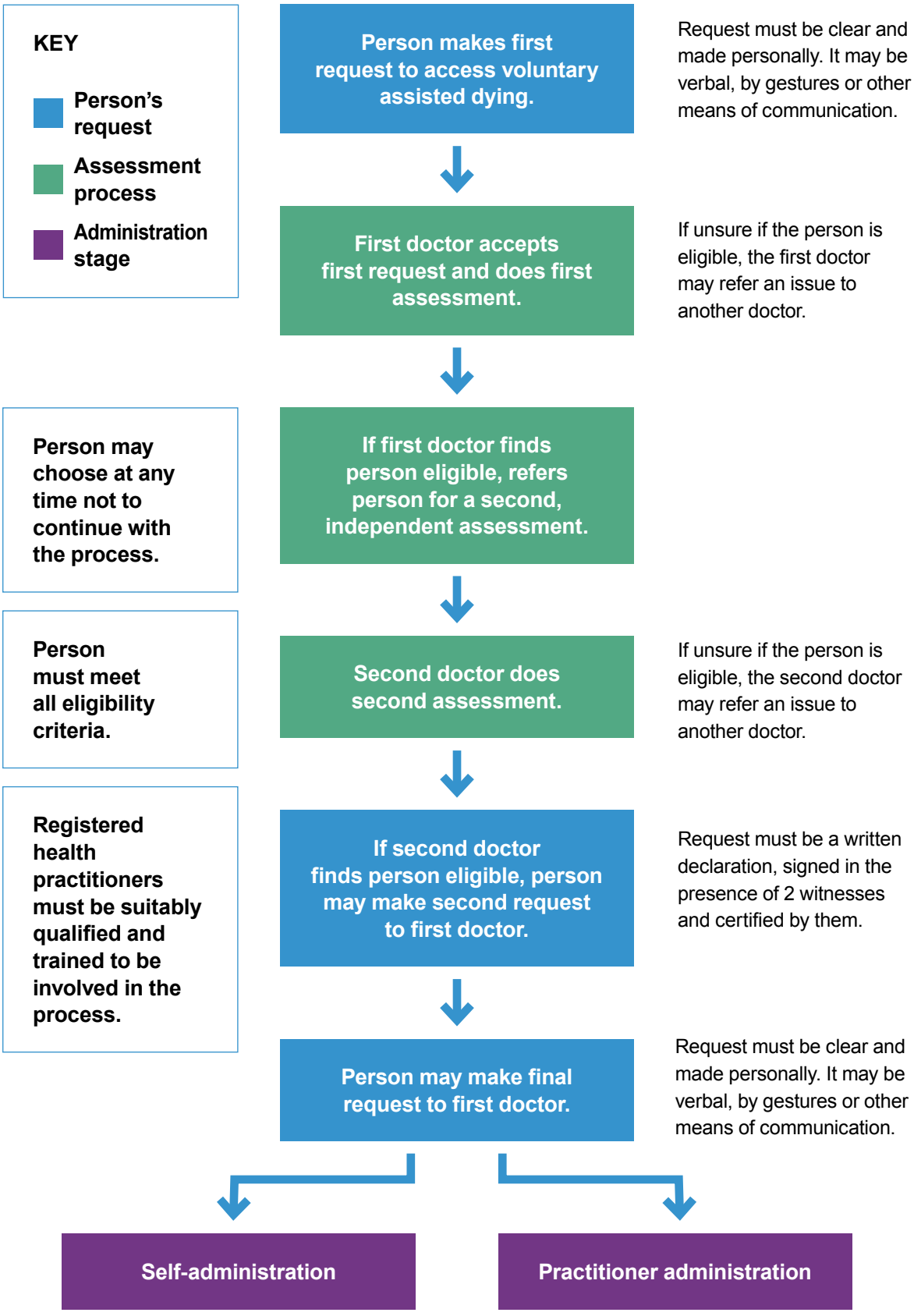
		Draft Bill	Victoria	Western Australia	Tasmania	New Zealand	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
Administration of substance	Additional approval process — permit required to prescribe and supply, or possess and administer, voluntary assisted dying substance		✓		✓	✓ (registrar must advise practitioner they are satisfied processes have been complied with)					
	Self-administration is default method	✓	✓	✓	✓						✓
	Practitioner administration permitted	✓ (if self-administration inappropriate)	✓ (if patient physically incapable of self-administration)	✓ (if self-administration inappropriate)	✓ (if self-administration inappropriate)	✓	✓	✓	✓	✓	
	Requirement for administration to be witnessed	✓ (practitioner administration)	✓ (practitioner administration)	✓ (practitioner administra-tion)							
	Provisions governing the management of the voluntary assisted dying substance eg, must be prescribed in accordance with requirements	✓	✓	✓	✓						✓
	A contact person must be appointed	✓	✓	✓ (self-administration)	✓ (self-administration)						
Offences and protections	Offence to induce a person, through dishonesty or undue influence, to request assisted dying	✓	✓	✓	✓						✓
	Offence to induce a person, through dishonesty or undue influence, to self-administer the substance	✓	✓	✓	✓		✓				
	Offence to falsify records, or make a false or misleading statement	✓	✓	✓	✓	✓ (offence to alter, destroy or complete a form without consent)				✓	✓
	Offence to fail to report on assisted dying	✓	✓	✓	✓					✓	
	Offence to administer the substance when not authorised to do so	✓	✓	✓							
	Offence for practitioner to wilfully fail to comply with requirement of legislation					✓ (medical practitioner, nurse practitioner, or psychiatrist)				✓	

		Draft Bill	Victoria	Western Australia	Tasmania	New Zealand	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
Oversightt	Offence for contact person to fail to return unused substance	✓	✓	✓	✓						
	Protection for a person who assists in or facilitates access to assisted dying	✓	✓	✓	✓	✓					
	Protection for health practitioners acting in good faith and without negligence	✓	✓	✓	✓	✓	✓			✓	✓
	Protection for health practitioners present at time of self-administration	✓	✓	✓	✓	✓				✓	✓
	Review by tribunal of some criteria for access (eg residency, decision making capacity or voluntariness)	✓	✓	✓	✓ (by Voluntary Assisted Dying Commission)						
	Oversight by an independent body	✓	✓	✓	✓	✓	✓	✓	✓		
	Implementation period for legislation	✓	✓	✓	✓	✓				✓	
	Review of legislation	✓	✓	✓	✓	✓		✓	✓	✓	

APPENDIX D

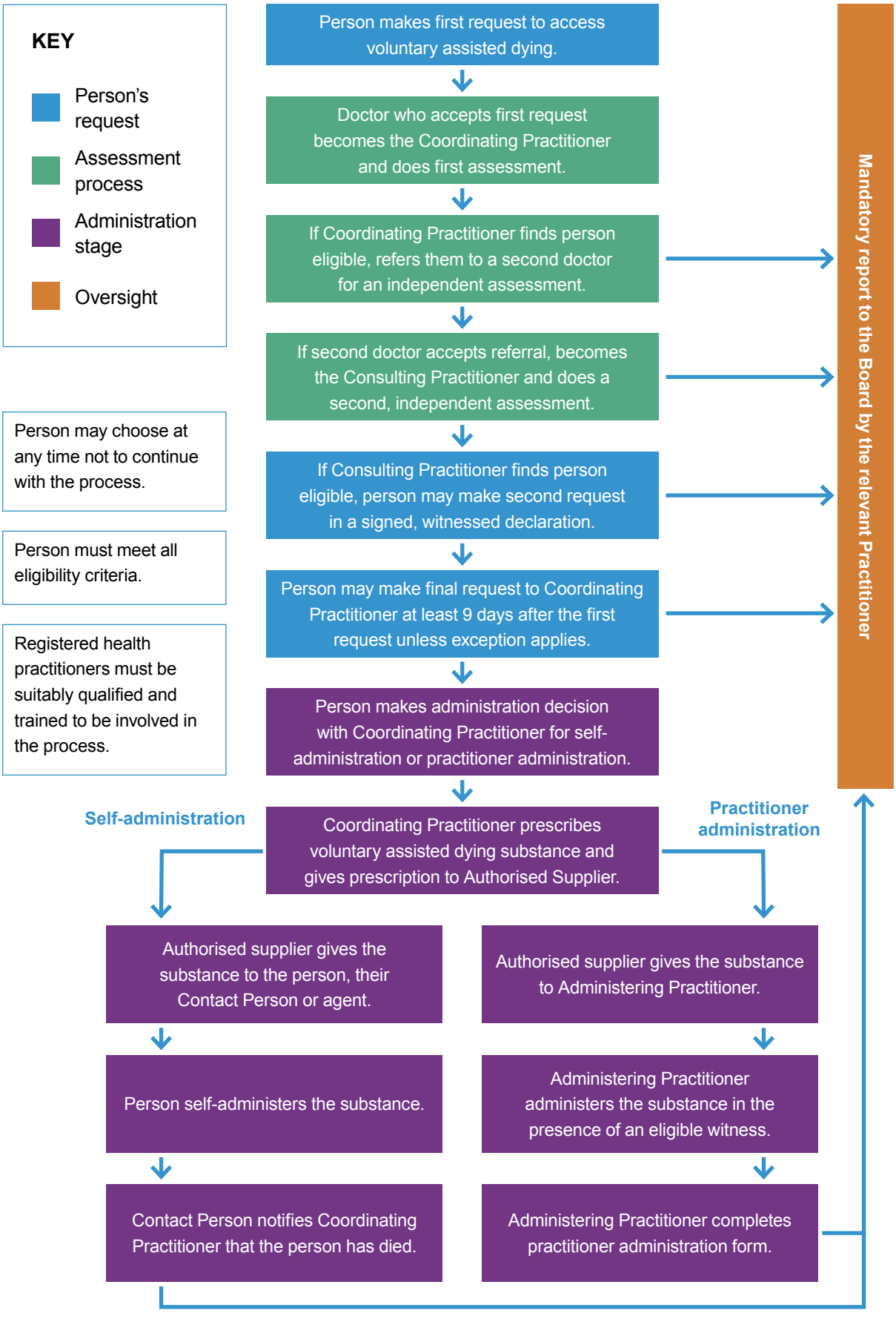
Diagrams of proposed process

D.1 The proposed process

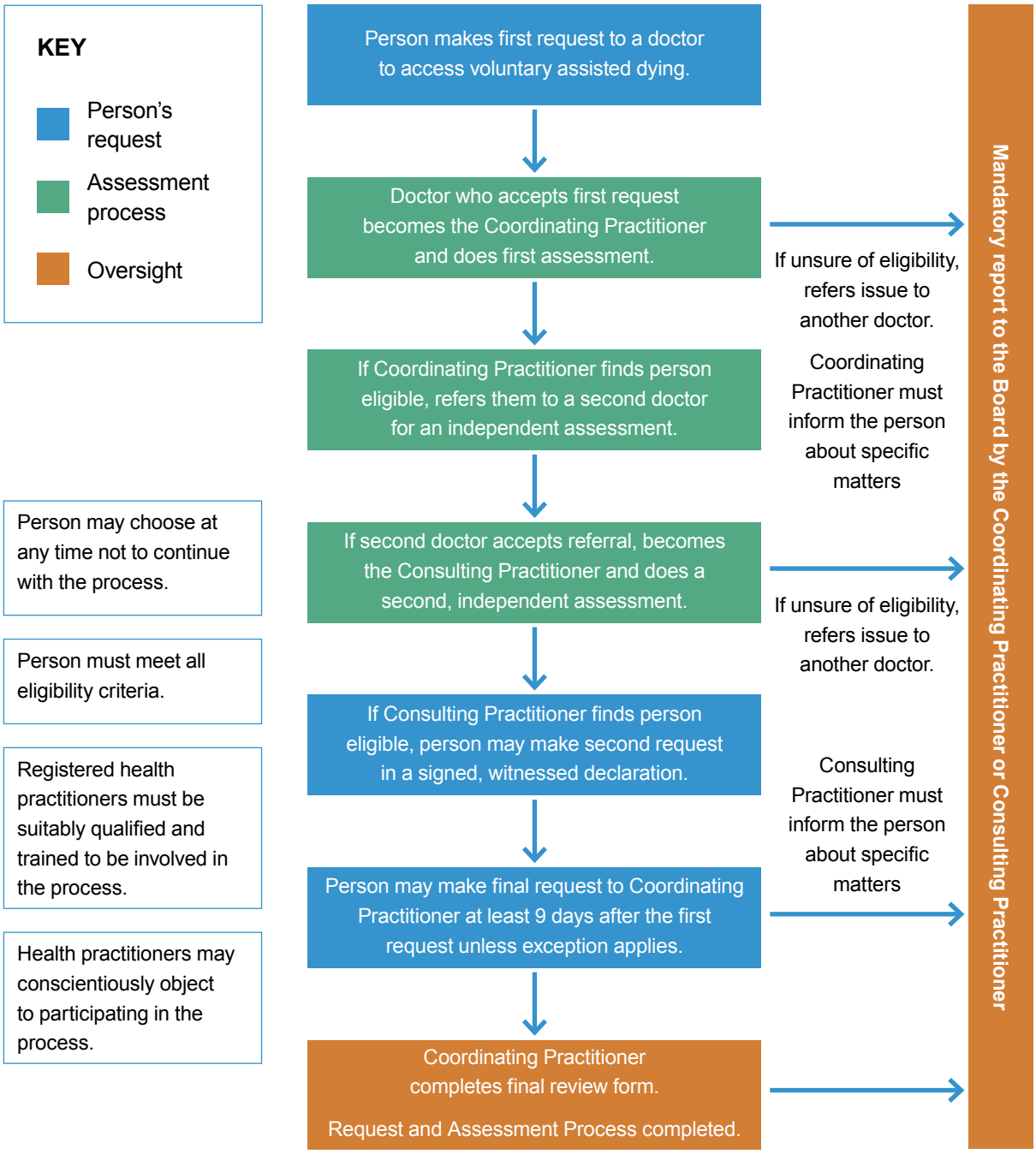


Administration follows choice of process, prescription and supply of substance.

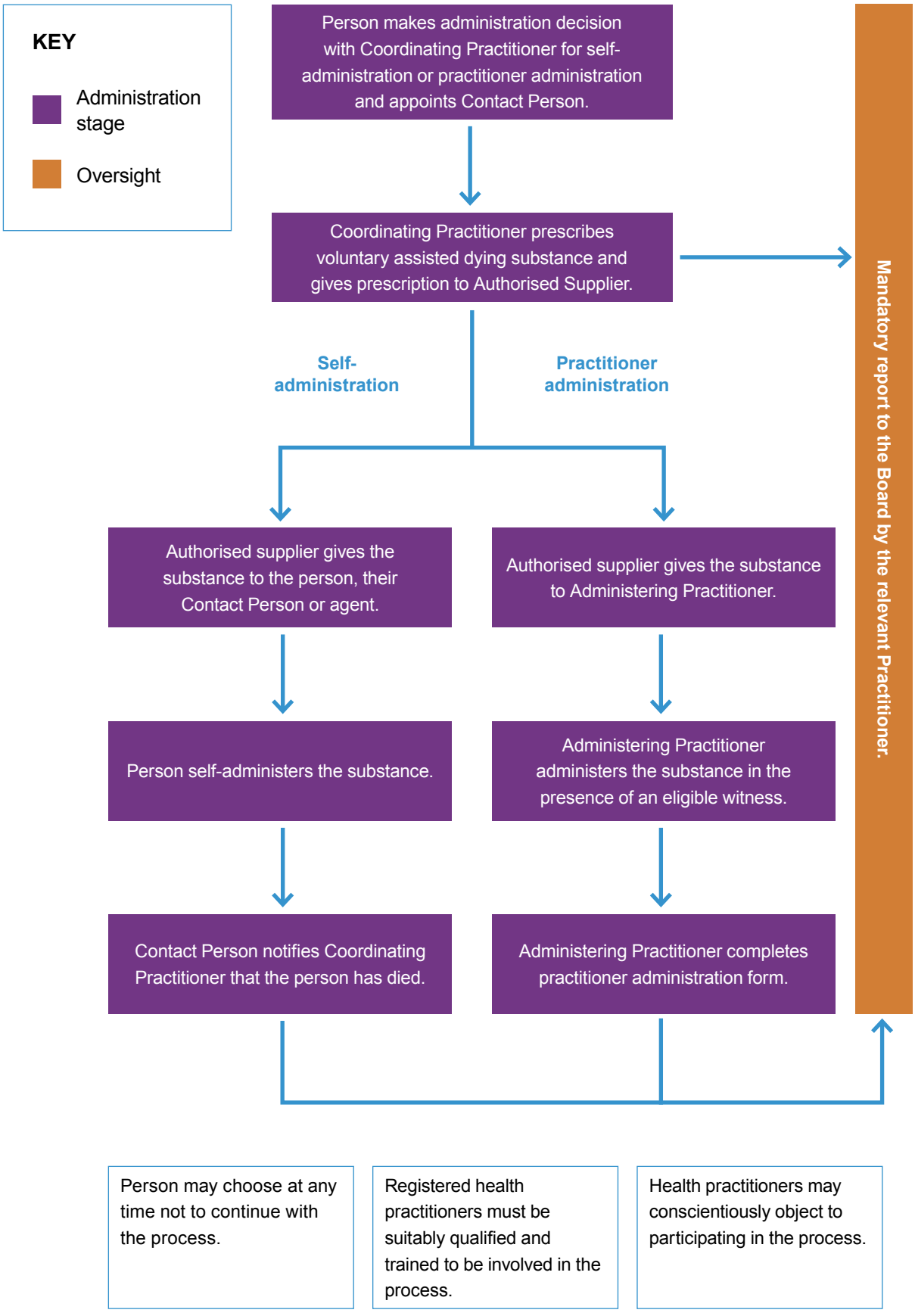
D.2 The proposed process in detail



D.3 The proposed request and assessment process in detail



D.4 The proposed administration stage in detail



APPENDIX E

List of recommendations

Appendix E: List of recommendations

CHAPTER 1: WHAT IS VOLUNTARY ASSISTED DYING?

1-1 A person should be 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.

1-2 The draft Bill provides that for the purposes of the law of Queensland, and for the purposes of a contract, deed or other instrument entered into in Queensland or governed by its law, a person who dies as the result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act:

(a) does not die by suicide; and

(b) 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.

CHAPTER 5: A LEGISLATIVE STATEMENT OF PURPOSES AND PRINCIPLES

5-1 The draft Bill includes a statement of purposes or objectives to aid its interpretation. 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.

5-2 In addition, the draft Bill includes a statement of the principles that underpin the legislation. Those principles 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.

CHAPTER 6: INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING

6-1 A health care worker who provides health services or professional care services to a person must not, in the course of providing those services to the person:

(a) initiate discussion with that person that is in substance about voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to that person.

6-2 That prohibition should not prevent a health care worker providing information about voluntary assisted dying to a person at that person's request.

6-3 That prohibition also should not prevent a medical practitioner or nurse practitioner initiating a discussion about voluntary assisted dying if, at the same time, they also inform the person about:

(a) the treatment options available to the person and the likely outcomes of that treatment; and

(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

6-4 For the purposes of the last three recommendations, the draft Bill provides:

health care worker means—

(a) a registered health practitioner; or

(b) another person who provides a health service or professional care service.

health service—see the *Health Ombudsman Act 2013*, section 7.

personal care service means assistance or support provided by a person to another person under a contract of employment or a contract for services, including the following—

(a) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals;

(b) assistance for persons with mobility problems;

(c) assistance for persons who are mobile but require some form of assistance or supervision;

(d) assistance or supervision in administering medicine; and

(e) the provision of substantial emotional support.

CHAPTER 7: ELIGIBILITY

Criterion one: eligible disease, illness or medical condition

7-1 The eligibility criteria should require that the person has been diagnosed with a disease, illness or medical condition that:

(a) is advanced, progressive and will cause death; and

(b) is expected to cause death within 12 months; and

(c) is causing suffering that the person considers to be intolerable.

7-2 To avoid doubt, the draft Bill provides that:

(a) A person is not eligible for access to voluntary assisted dying only because the person—

(i) has a disability as defined in section 11 of the *Disability Services Act 2006*; or

(ii) has a mental illness as defined in section 10 of the *Mental Health Act 2016*.

(b) However, a person who has a disability or who has a mental illness may be eligible for access to voluntary assisted dying if they meet all the eligibility criteria.

7-3 The draft Bill clarifies that suffering caused by the person's disease, illness or medical condition includes physical or mental suffering, and suffering caused by the treatment provided for that condition.

Criterion two: decision-making capacity

7-4 The eligibility criteria should also require the person to have decision-making capacity for voluntary assisted dying.

7-5 The draft Bill provides that a person has decision-making capacity for voluntary assisted dying if the person is capable of:

(a) understanding the nature and effect of decisions about access to voluntary assisted dying; and

(b) freely and voluntarily making decisions about access to voluntary assisted dying; and

(c) communicating decisions about access to voluntary assisted dying in some way.

7-6 The draft Bill provides that a person is presumed to have decision-making capacity for voluntary assisted dying unless the person is shown not to have that capacity.

7-7 The draft Bill provides that, in determining whether a person has decision-making capacity, regard must be had to the following:

(a) a person may have decision-making capacity to make some decisions but not others;

(b) capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it;

(c) it should not be presumed that a person does not have decision-making capacity:

(i) because of a personal characteristic such as age, appearance or language skills, or the fact that the person has an illness or disability; or

(ii) because the person makes a decision that others think unwise;

(d) a person is capable of doing one of the three things required to have decision-making capacity (see Recommendation 7-5) if the person is capable of doing the thing with adequate and appropriate support.

Such support could include:

(i) giving information or formats tailored to the needs of a person;

(ii) communicating or assisting a person to communicate the person's decision;

(iii) giving a person additional time and discussing the matter with the person;

(iv) using technology that alleviates the effects of a person's disability.

Criterion three: voluntary and without coercion

7-8 The eligibility criteria should also require that the person is acting voluntarily and without coercion.

7-9 The draft Bill defines the term 'coercion' to include threats, promises or intimidation of any kind, including by improper use of a position of trust or influence.

Criterion four: aged at least 18 years

7-10 The eligibility criteria should also require that the person is at least 18 years of age.

Criterion five: residency

7-11 The eligibility criteria should also 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'.

7-12 The draft Bill provides that the Director-General 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.

7-13 The inclusion of a residency requirement in any legislation should be reviewed as part of a future review of the legislation's operation.

7-14 Regulations, guidelines and forms should be developed to facilitate proof-of-residency requirements.

A further consideration: enduring request

7-15 It is unnecessary for the eligibility criteria to require that the person's request be enduring. This requirement is embedded in the detailed processes and safeguards contained in the draft Bill.

CHAPTER 8: THE REQUEST AND ASSESSMENT PROCESS

8-1 The draft Bill establishes a staged request and assessment process that includes requirements for the person to make three requests for access to voluntary assisted dying, and for two medical practitioners to assess the person's eligibility for access to voluntary assisted dying.

8-2 The term 'request and assessment process' means the process consisting of the following steps:

(a) a first request;

(b) a first assessment;

(c) a consulting assessment;

(d) a second request;

(e) a final request; and

(f) a final review.

The first request for access to voluntary assisted dying

8-3 A person may make a first request to a medical practitioner for access to voluntary assisted dying. The request must be:

(a) clear and unambiguous; and

(b) made by the person personally and not by another person on their behalf.

8-4 The person may make the first request verbally or by gestures or other means of communication available to the person.

The coordinating practitioner

8-5 If the medical practitioner to whom a first request is made accepts the first request, then the practitioner becomes the coordinating practitioner for the person.

8-6 The term 'coordinating practitioner', for a person, means a medical practitioner who accepts the person's first request.

The first assessment

8-7 If the coordinating practitioner is satisfied that the person:

(a) is eligible for access to voluntary assisted dying; and

(b) understands the information given to the person under Recommendation 8-38;

the coordinating practitioner must assess the person as meeting the requirements of the first assessment.

8-8 If the coordinating practitioner is not satisfied as to any matter in Recommendation 8-7:

(a) the practitioner must assess the person as not meeting the requirements of a first assessment; and

(b) the request and assessment process ends.

8-9 The coordinating practitioner must:

(a) inform the person of the outcome of the first assessment as soon as practicable after its completion;

(b) within two business days after completing the first assessment, complete a record of the assessment in the approved form (the 'first assessment record form') and give a copy of it to the Board;

(c) as soon as practicable after completing the first assessment record form, give a copy of it, and any documents accompanying it, to the person.

8-10 The first assessment record form:

(a) must include the outcome of the first assessment, including the coordinating practitioner's decision in respect of each of the eligibility criteria; and

(b) may be accompanied by documents supporting the coordinating practitioner's decision in respect of the eligibility criteria.

8-11 Other matters that are prescribed by regulation for inclusion in the first assessment record form should, as a minimum, include:

(a) the name, date of birth and contact details of the person;

(b) the following information about the person:

(i) gender;

(ii) nationality;

(iii) ethnicity;

(iv) whether the person has a disability;

(v) whether the person's first language is a language other than English;

(vi) whether the coordinating practitioner was assisted by an interpreter to communicate the information in Recommendation 8-38 to the person;

(c) the name and contact details of the coordinating practitioner;

(d) a statement confirming that the coordinating practitioner is eligible to perform that role;

(e) the date when the first request was made;

(f) the date when the first assessment was completed;

(g) the date when the person was informed of the outcome of the first assessment;

(h) if the person was assisted by an interpreter when having the first assessment, the name, contact details and accreditation details of the interpreter;

(i) if the person was referred to a registered health practitioner or other person under Recommendation 8-35 or 8-36, the outcome of the referral, including a copy of any report given by the registered health practitioner or other person to whom the person was referred;

(j) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment;

(k) that the practitioner provided the person with the required information, and that the person understood that information.

8-12 If the coordinating practitioner assesses the person as meeting the requirements of the first assessment, then the practitioner must refer the person to another medical practitioner for a consulting assessment.

The consulting practitioner

8-13 If the medical practitioner to whom a person is referred for a consulting assessment accepts the referral, then the practitioner becomes the consulting practitioner for the person.

8-14 The term 'consulting practitioner', for a person, means a medical practitioner who accepts a referral to conduct a consulting assessment of the person.

The consulting assessment

8-15 If the consulting practitioner is satisfied that the person:

(a) is eligible for access to voluntary assisted dying; and

(b) understands the information given to the person under Recommendation 8-40;

the consulting practitioner must assess the person as meeting the requirements of the consulting assessment.

8-16 If the consulting practitioner is not satisfied as to any matter in Recommendation 8-15, the practitioner must assess the person as not meeting the requirements of the consulting assessment.

8-17 The consulting practitioner must:

(a) inform the person and the coordinating practitioner for the person of the outcome of the consulting assessment as soon as practicable after its completion;

(b) within two business days after completing the consulting assessment, complete a record of the assessment in the approved form (the 'consulting assessment record form') and give a copy of it to the Board;

(c) as soon as practicable after completing the consulting assessment record form, give a copy of it, and any documents accompanying it, to the person and the coordinating practitioner for the person.

8-18 The consulting assessment record form:

(a) must include the outcome of the consulting assessment, including the consulting practitioner's decision in respect of each of the eligibility criteria; and

(b) may be accompanied by documents supporting the consulting practitioner's decision in respect of the eligibility criteria.

8-19 Other matters that are prescribed by regulation for inclusion in the consulting assessment record form should include:

(a) the name, date of birth and contact details of the person;

(b) the name and contact details of the consulting practitioner;

(c) a statement confirming that the consulting practitioner is eligible to perform that role;

(d) the date when the first request was made;

(e) the date when the referral for the consulting assessment was made;

(f) the date when the referral for the consulting assessment was received;

(g) the date when the consulting assessment was completed;

(h) the date when the person was informed of the outcome of the consulting assessment;

(i) the date when the coordinating practitioner for the person was informed of the outcome of the consulting assessment;

(j) if the person was assisted by an interpreter when having the consulting assessment, the name, contact details and accreditation details of the interpreter;

(k) if the person was referred to a registered health practitioner or other person under Recommendations 8-35 or 8-36, the outcome of the referral, including a copy of any report given by the registered health practitioner or other person to whom the person was referred;

(l) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment; and

(m) that the practitioner provided the person with the required information, and that the person understood that information.

8-20 If the consulting practitioner assesses the person as not meeting the requirements of a consulting assessment, the coordinating practitioner for the person may refer the person to another medical practitioner for a further consulting assessment.

Acceptance or refusal of a first request or a referral

8-21 A medical practitioner must refuse a first request for access to voluntary assisted dying or a referral for a consulting assessment if they are not eligible to act as a coordinating practitioner or consulting practitioner.

8-22 A medical practitioner may refuse a first request for access to voluntary assisted dying or a referral for a consulting assessment if the practitioner:

(a) has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a coordinating practitioner or consulting practitioner; or

(b) is unavailable or otherwise unable to perform the duties of a coordinating practitioner or consulting practitioner.

8-23 A medical practitioner who accepts a first request must, at the time of informing the person of their decision, give the person the approved information.

8-24 A medical practitioner who refuses a first request must, at the time of informing the person of their decision:

(a) inform the person that other registered health practitioners, health service providers or services may be able to assist them; and

(b) give the person:

(i) information about a registered health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person with the person's request; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to give the person information, including the name and contact details, about a health practitioner, health service provider or service who may be able to assist the person with the person's request.

8-25 A medical practitioner who receives a first request or a referral for a consulting assessment must, within the times specified in Recommendation 8-26:

(a) decide whether to accept or refuse the first request or referral; and

(b) inform the person, and in the case of a referral the coordinating practitioner, of their decision and, for a decision to refuse the request or referral, the reason for the decision.

8-26 For Recommendation 8-25, the following times apply:

(a) if the practitioner has a conscientious objection to voluntary assisted dying — immediately after the first request or referral is made;

(b) in any other case — within two business days after the first request or referral is made.

8-27 The term 'approved information' means information that is approved under the relevant clause of the draft Bill, described in Recommendation 8-28.

8-28 The chief executive of the Department must:

(a) approve information for the purposes of Recommendation 8-23; and

(b) publish the approved information on the Department's website.

8-29 A medical practitioner must record the following information in the person's medical record:

(a) the first request or referral for a consulting assessment;

(b) the practitioner's decision to accept or refuse the first request or referral;

(c) if the practitioner's decision is to refuse the first request or referral, the reason for the refusal and, for a first request, the steps taken to comply with Recommendation 8-24; and

(d) if the practitioner's decision is to accept the first request, the day on which the person is given the approved information.

8-30 Within two business days after deciding to accept or refuse a referral for a consulting assessment, the medical practitioner must complete a record of the acceptance or refusal of the referral in the approved form and give a copy of it to the Board.

Eligibility assessments

8-31 The coordinating practitioner for a person must assess whether or not the person is eligible for access to voluntary assisted dying (a 'first assessment').

8-32 The consulting practitioner for a person must assess whether or not the person is eligible for access to voluntary assisted dying (a 'consulting assessment').

8-33 Both the coordinating practitioner and the consulting practitioner may have regard to any relevant information about the person that has been prepared by, or at the instigation of, another registered health practitioner.

8-34 For the purposes of Recommendation 8-32, the consulting practitioner must, independently of the coordinating practitioner, form their own opinions on the matters to be decided.

8-35 If the coordinating practitioner or the consulting practitioner is unable to determine whether or not:

(a) the person has a disease, illness or medical condition that satisfies the eligibility criteria; or

(b) the person has decision-making capacity in relation to voluntary assisted dying;

the practitioner must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter.

8-36 If the coordinating practitioner or the consulting practitioner is unable to determine whether or not the person is acting voluntarily and without coercion, the practitioner must refer the person to another person who has appropriate skills and training to determine the matter.

8-37 If the coordinating practitioner or the consulting practitioner makes a referral under Recommendations 8-35 or 8-36, the practitioner who made the referral may adopt the determination of the registered health practitioner or other person in relation to the matter in respect of which the referral was made.

Information to be given to a person who meets the eligibility criteria

8-38 If the coordinating practitioner is satisfied the person is eligible for access to voluntary assisted dying, the coordinating practitioner must inform the person about the following matters:

(a) the person's diagnosis and prognosis;

(b) the treatment options available to the person and the likely outcomes of that treatment;

(c) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment;

(d) the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under the Act for the purposes of causing the person's death;

(e) that the expected outcome of self-administering or being administered a substance referred to in paragraph (d) is death;

(f) the method by which a substance referred to in paragraph (d) is likely to be self-administered or administered;

(g) the request and assessment process, including the requirement for a second request to be signed in the presence of two witnesses;

(h) that, if the person makes an administration decision, the person must appoint a contact person;

(i) that the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;

(j) that, if the person is receiving ongoing health services from another medical practitioner, the person may consider informing the other medical practitioner of the person's request for access to voluntary assisted dying.

8-39 The phrase 'palliative care and treatment' means care and treatment that:

(a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting; and

(b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering in order to improve their comfort and quality of life.

8-40 If the consulting practitioner is satisfied the person is eligible for access to voluntary assisted dying, the consulting practitioner must inform the person about the matters referred to in Recommendation 8-38.

8-41 Nothing in Recommendations 8-38 or 8-40 affects any duty a medical practitioner has at common law or under another Act.

The second request for access to voluntary assisted dying

8-42 If a person has made a first request and has been assessed as meeting the requirements of a first assessment and a consulting assessment, then the person may make another request in writing (the 'second request') for access to voluntary assisted dying.

8-43 The second request must be in the approved form and given to the coordinating practitioner for the person.

8-44 The second request must:

(a) specify that the person:

(i) makes it voluntarily and without coercion; and

(ii) understands its nature and effect; and

(b) be signed by the person, or a person described in Recommendation 8-45, in the presence of two eligible witnesses.

8-45 A person may sign the second request on behalf of the person making the request if:

(a) the person making the request is unable to sign the request; and

(b) the person making the request directs the person to sign the request; and

(c) the person signing the request:

(i) is at least 18 years of age; and

(ii) is not a witness to the signing of the request; and

(iii) is not the coordinating practitioner or consulting practitioner for the person making the request.

8-46 A person who signs the second request on behalf of the person making the request must do so in the presence of the person making the request.

8-47 If the person makes the second request with the assistance of an interpreter, the interpreter must certify on the request that the interpreter provided a true and correct translation of any material translated.

8-48 If the person gives a second request for access to voluntary assisted dying to the coordinating practitioner, the practitioner must record the following information in the person's medical record:

(a) the date when the second request was made;

(b) the date when the second request was received by the coordinating practitioner.

8-49 Within two business days after receiving a second request made by a person, the coordinating practitioner for the person must give a copy of it to the Board.

Witnessing requirements

8-50 Each witness to the signing of the second request must:

(a) certify in writing in the request that:

(i) in the presence of the witness, the person signed the request; and

(ii) the person appeared to sign freely and voluntarily; and

(b) state in the request that the witness is not knowingly ineligible to witness the signing of the second request.

8-51 Each witness who witnesses the signing of the second request by another person on behalf of the person making the request must:

(a) certify in writing in the request that:

(i) in the presence of the witness, the person making the request appeared to freely and voluntarily direct the other person to sign the request; and

(ii) the other person signed the request in the presence of the person making the request and the witness; and

(b) state in the request that the witness is not knowingly ineligible to witness the signing of the second request.

8-52 For the purposes of Recommendations 8-50 and 8-51 a person is eligible to witness the signing of the second request if the person:

(a) is at least 18 years of age; and

(b) is not ineligible to witness the signing of the second request.

8-53 A person is ineligible to witness the signing of the second request if the person:

(a) knows or believes that the person:

(i) is a beneficiary under a will of the person making the request; or

(ii) may otherwise benefit financially or in any other material way from the death of the person making the request; or

(b) is an owner, or is responsible for the management, of any health facility at which the person making the request is being treated or resides; or

(c) is the coordinating practitioner or consulting practitioner for the person making the request.

The final request for access to voluntary assisted dying

8-54 A person who has made a second request may make a further request to the person's coordinating practitioner for access to voluntary assisted dying (a 'final request').

8-55 The final request must be:

(a) clear and unambiguous; and

(b) made by the person personally, and not by another person on their behalf.

8-56 The person may make the request verbally or by gestures or other means of communication available to the person.

8-57 The coordinating practitioner must record the following information in the person's medical record:

(a) the date on which the final request was made;

(b) if the final request was made before the end of nine-day period described in Recommendation 8-64(a), the reason for it being made before the end of that period.

8-58 Within two business days after receiving a final request made by the person, the coordinating practitioner must complete a record of receiving the final request in the approved form and give a copy of it to the Board.

8-59 On receiving a final request, the coordinating practitioner must:

(a) review the following matters in relation to the person:

(i) the first assessment record form;

(ii) the consulting assessment record form;

(iii) the second request; and

(b) complete the approved form (the 'final review form') in relation to the person.

8-60 When conducting the review, the coordinating practitioner must take account of any decision made by QCAT in relation to a decision made in the request and assessment process.

8-61 The final review form must certify that:

(a) the request and assessment process has been completed in accordance with the requirements of the Act; and

(b) the coordinating practitioner is satisfied of each of the following:

(i) the person has decision-making capacity in relation to voluntary assisted dying;

(ii) the person, in requesting access to voluntary assisted dying, is acting voluntarily and without coercion.

8-62 Other matters that are prescribed by regulation for inclusion in the final review form should, as a minimum, include:

(a) the name, date of birth and contact details of the person;

(b) the name and contact details of the coordinating practitioner;

(c) that the coordinating practitioner has reviewed the matters in Recommendation 8-59(a);

(d) that the request and assessment process has been completed in accordance with this Act;

(e) if the person was assisted by an interpreter—the name, contact details and accreditation details of the interpreter.

8-63 The coordinating practitioner must:

(a) within two business days of completing the final review form, give a copy of it to the Board; and

(b) as soon as practicable after completing the final review form, give a copy of it to the person.

Waiting periods

8-64 A person's final request for access to voluntary assisted dying may not be made:

(a) before a period of nine days has elapsed, from and including the day on which the person made their first request for access to voluntary assisted dying, except as provided for in Recommendation 8-65; and

(b) in any case, until the day after the day on which the consulting assessment that assessed the person as meeting the requirements of a consulting assessment was completed.

8-65 A person's final request for access to voluntary assisted dying may be made before the end of the nine day period described in Recommendation 8-64(a) if:

(a) in the opinion of the coordinating practitioner, the person is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of that nine-day period; and

(b) the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner for the person as expressed in the consulting assessment.

No obligation for a person to continue the voluntary assisted dying process

8-66 There is no obligation for a person to continue after making a first request for access to voluntary assisted dying. Specifically, the draft Bill provides:

(a) the person may decide at any time not to continue the request and assessment process;

(b) the request and assessment process ends if the person decides not to continue the process;

(c) if the request and assessment process ends that way, the person may begin a new request and assessment process by making a new first request.

8-67 A person in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

CHAPTER 9: TRANSFER OF THE ROLE OF COORDINATING PRACTITIONER

9-1 Legislation should provide for the transfer of the role of the coordinating practitioner for a person, either at the person's request or on the coordinating practitioner's own initiative.

9-2 The coordinating practitioner may transfer their role to the consulting practitioner for the person if the consulting practitioner has assessed the person as eligible and accepts the transfer of the role.

9-3 The consulting practitioner must inform the coordinating practitioner whether they accept or refuse the transfer within two business days after receiving the request. If the consulting practitioner accepts the transfer, the coordinating practitioner must, within two business days of the acceptance, notify the person and Board of the transfer.

9-4 If the consulting practitioner refuses the transfer, the coordinating practitioner may:

(a) refer the person to another medical practitioner for a further consulting assessment; and

(b) transfer the role of the coordinating practitioner to that medical practitioner if the practitioner:

(i) accepts the referral for a further consulting assessment;

(ii) assesses the person as eligible for access to voluntary assisted dying; and

(iii) accepts the transfer.

9-5 Upon acceptance of the referral for a further consulting assessment, the consulting assessment that previously assessed the person as eligible for access to voluntary assisted dying should become void.

CHAPTER 10: ADMINISTRATION OF THE SUBSTANCE

Self-administration or practitioner administration

10-1 A person may in consultation with and on the advice of the coordinating practitioner:

(a) decide to self-administer a voluntary assisted dying substance (a 'self-administration decision'); or

(b) decide that the substance is to be administered by the administering practitioner (a 'practitioner administration decision').

10-2 A practitioner administration decision may only be made if the coordinating practitioner advises the person that self-administration of the substance is inappropriate having regard to any of the following:

(a) the person's ability to self-administer the substance;

(b) the person's concerns about self-administering the substance;

(c) the method for administering the substance that is suitable for the person.

Authorisation of prescription, supply and administration of the substance

Administration decision

10-3 An administration decision may be made only if:

(a) a person has made a final request; and

(b) the person's coordinating practitioner has completed the final review form.

10-4 An administration decision must be clear and unambiguous, and made by the person personally and not by another person on their behalf.

Revocation of administration decision

10-5 An administration decision may be revoked by the person at any time by informing the coordinating practitioner (in the case of a self-administration decision) or the administering practitioner (in the case of a practitioner administration decision). The relevant practitioner must record the revocation and give a copy of the approved form to the Board.

Requirements for self-administration

10-6 If the person makes a self-administration decision, they are authorised to self-administer the substance.

Requirements for practitioner administration

10-7 If the person makes a practitioner administration decision, 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:

(a) has decision-making capacity in relation to voluntary assisted dying; and

(b) is acting voluntarily and without coercion.

10-8 A person is eligible to witness the administration of the substance to another person if the witness is at least 18 years of age.

10-9 The witness must certify in the approved form (the 'practitioner administration form') that:

(a) the person appeared to be acting voluntarily and without coercion; and

(b) the administering practitioner administered the substance to the person in the presence of the witness.

10-10 If the administering practitioner administers the substance, the administering practitioner must certify in the practitioner administration form:

(a) that the person made a practitioner administration decision and did not revoke the decision; and

(b) that the administering practitioner was satisfied at the time of administering the substance that the person:

(i) had decision-making capacity in relation to voluntary assisted dying; and

(ii) was acting voluntarily and without coercion; and

(c) any other matter prescribed by regulation to be certified.

10-11 The administering practitioner must give a copy of the practitioner administration form to the Board within two business days after administering the substance.

Transfer of the role of administering practitioner

10-12 If a practitioner administration decision is made and the substance has been prescribed but the administering practitioner is unable or unwilling for any reason to administer the substance, the role of the administering practitioner must be transferred to another eligible practitioner. If the new practitioner accepts the role, they may be supplied the substance and must inform the person of the transfer, record the transfer and give a copy of the approved form to the Board.

CHAPTER 11: MANAGEMENT OF THE SUBSTANCE

11-1 'Voluntary assisted dying substance' should mean a Schedule 4 or Schedule 8 substance, or a combination of those substances, as defined in the Poisons Standard, approved by the chief executive for use under the Act for the purpose of causing a person's death.

11-2 The prescription of the substance be regulated by:

(a) authorising the coordinating practitioner, if the person has made an administration decision, to prescribe the substance for the person that is of a sufficient dose to cause death;

(b) requiring the coordinating practitioner to provide particular information in writing to the person before the substance is prescribed;

(c) requiring the prescription to include particular information;

(d) requiring that the prescription not provide for the substance to be supplied on more than one occasion;

(e) requiring the coordinating practitioner to give the prescription directly to an authorised supplier;

(f) requiring the coordinating practitioner to complete a record in the approved form stating the person's administration decision and that they have prescribed a voluntary assisted dying substance for the person, and give the form to the Board within two business days of prescribing the substance;

(g) providing for further prescribing requirements to be provided in regulation.

11-3 The supply of the substance be regulated by:

(a) authorising the authorised supplier who is given the prescription to:

(i) possess the substance for the purpose of preparing and supplying it;

(ii) prepare the substance; and

(iii) supply the substance;

(b) authorising the authorised supplier to supply the substance:

(i) if the person has made a self-administration decision—to the person, their contact person or agent;

(ii) if the person has made a practitioner administration decision—to the administering practitioner;

(c) requiring the authorised supplier to:

(i) provide particular information in writing to the recipient of the substance when supplying it following a self-administration decision;

(ii) confirm the authenticity of the prescription, the identity of the person who issued it and the identity of the person to whom the substance is to be supplied;

(iii) comply with labelling requirements prescribed by regulation;

(iv) complete a record of the supply of the substance in the approved form (the 'authorised supply form') and give a copy of the form to the Board within two business days of supplying the substance.

(d) if the person has made a self-administration decision—authorising:

(i) the person to receive the substance from the authorised supplier, their contact person or agent;

(ii) the contact person or agent to receive the substance from the authorised supplier;

(e) if the person has made a practitioner administration decision—authorising the administering practitioner to receive the substance from the authorised supplier;

(f) providing for further supply requirements to be provided in regulation.

11-4 'Authorised supplier' should mean a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive to supply a voluntary assisted dying substance under the Act.

11-5 The chief executive:

(a) may authorise an appropriately qualified registered health practitioner, or person in a class of registered health practitioners, to supply the substance under the Act;

(b) must, on request, give a person who is acting as a coordinating practitioner the name of one or more authorised suppliers.

11-6 The possession and storage of the substance be regulated by:

(a) authorising a person who has made a self-administration decision to possess the substance for the purpose of preparing and self-administering it;

(b) authorising the person's contact person or agent to possess the substance for the purpose of supplying it to the person and supply the substance to the person, if the person has made a self-administration decision;

(c) authorising the administering practitioner to possess the substance for the purpose of preparing it and administering it to the person, if the person has made a practitioner administration decision;

(d) providing that a person who receives a voluntary assisted dying substance must store it in accordance with requirements prescribed by regulation.

11-7 The administration of the substance be regulated by:

(a) if a self-administration decision has been made by the person—authorising:

(i) the person to prepare and self-administer the substance;

(ii) another person, requested by the person to prepare the substance, to:

(A) possess the substance for the purpose of preparing it;

(B) prepare the substance;

(C) supply the substance to the person;

(b) if a practitioner administration decision has been made—authorising the administering practitioner to prepare the substance, and administer the substance in the presence of an eligible witness, in accordance with the practitioner administration decision.

11-8 'Prepare' the substance should mean 'to do anything necessary to ensure that the substance is in a form suitable for administration and includes to decant, dilute, dissolve, reconstitute, colour or flavour the substance';

11-9 'Administer' the substance should mean 'to introduce the substance into the body of a person by any means'.

11-10 The return and disposal of the substance be regulated by:

(a) requiring the contact person to give any unused or remaining substance, if it has been supplied, to an authorised disposer as soon as practicable and within

14 days if the person dies, whether from natural causes or by self-administering the substance;

(b) requiring the contact person to give the substance, if it has been supplied, to an authorised disposer as soon as practicable and within 14 days of the person revoking their self-administration decision;

(c) authorising the contact person to possess the substance for the purpose of giving it to an authorised disposer and give the substance, or any unused or remaining substance, to an authorised disposer;

(d) requiring the authorised disposer to dispose of the substance, or any unused or remaining substance, as soon as practicable after receiving it from the contact person. The authorised disposer must comply with any disposal requirements prescribed by regulation;

(e) requiring the authorised disposer to complete a record of the disposal in the approved form (the 'authorised disposal form') and give a copy of the form to the Board within two business days of the disposal;

(f) requiring the administering practitioner to dispose of the substance, or any unused or remaining substance in their possession, as soon as practicable after the practitioner administration decision being revoked or the person's death. The administering practitioner must comply with any disposal requirements prescribed by regulation;

(g) requiring the administering practitioner to complete a record of the disposal in the approved form (the 'practitioner disposal form') and give a copy of the form to the Board within two business days of the disposal.

11-11 'Authorised disposer' should mean a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive to dispose of a voluntary assisted dying substance under the Act.

11-12 The chief executive:

(a) may authorise an appropriately qualified registered health practitioner, or person in a class of registered health practitioners, to dispose of a voluntary assisted dying substance under the Act;

(b) must, on request, give a person who is acting as a coordinating practitioner the name of one or more authorised disposers.

11-13 'Unused or remaining substance' should mean 'any of the voluntary assisted dying substance supplied for a person that remains unused or remaining after the person's death'.

11-14 The requirement to appoint, and the responsibilities of, a contact person, be regulated, including requirements that:

(a) the person must appoint a contact person if the person has made an administration decision;

(b) the contact person for a person who has made a self-administration decision is authorised to receive the substance from an authorised supplier, possess it and supply it to the person for self-administration;

(c) the contact person for a person who has made a self-administration decision is authorised to possess the substance for the purpose of giving it to an authorised disposer and give the substance, or any unused or remaining substance, to an authorised disposer for disposal. The contact person is required to give the substance to the authorised disposer as soon as

practicable and within 14 days of the person's death or a self-administration decision being revoked;

(d) the contact person for a person who has made a self-administration decision is required to inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or from some other cause, within two business days of becoming aware of the death;

(e) the contact person for a person who has made a practitioner administration decision is required to inform the coordinating practitioner if the person dies from a cause other than the administration of the voluntary assisted dying substance, within two business days of becoming aware of the death;

(f) the formal requirements for appointing a contact person are that:

(i) the contact person must be at least 18 years of age;

(ii) the contact person cannot be appointed unless they consent to the appointment;

(iii) the appointment must be made in the approved form (the 'contact person appointment form') and signed and dated by the person and the contact person. Another person (a second person) may complete the form on the person's behalf at their request if the person is unable to complete the form, provided the second person is at least 18 years of age and the second person signs the appointment form in the presence of the person;

(iv) the contact person appointment form must include:

(A) the details of the person, the contact person and the coordinating practitioner;

(B) a statement that the contact person consents to the appointment;

(C) a statement that the contact person understands their role under the Act, including the requirements to give the substance, or any unused or remaining substance, to an authorised disposer and the penalties for non-compliance; and

(D) if the person was assisted by an interpreter when making the appointment, the interpreter's details and a statement signed by the interpreter certifying that they provided a true and correct translation of any information translated;

(v) the person may revoke the appointment of the contact person. If the person revokes the appointment, they must inform the contact person of the revocation, upon which they cease to be the contact person and the person must make another appointment;

(vi) the contact person may refuse to continue in the role. They are required to inform the person of their refusal, upon which they cease to be the contact person and the person must make another appointment;

(g) the person or contact person is required to give the contact person appointment form to the coordinating practitioner;

(h) the coordinating practitioner may not prescribe the substance before receiving the contact person appointment form;

(i) the coordinating practitioner must give a copy of the contact person appointment form to the Board within two business days of receiving it;

(j) the Board may contact the contact person to request information;

(k) the Board, if the person has made a self-administration decision, is required to give information to the contact person within two business days of receiving the contact person appointment form about:

(i) the requirement to give the substance, or any unused or remaining substance, to an authorised disposer for disposal; and

(ii) the support services available to assist the contact person to fulfil the requirement.

11-15 To avoid doubt, the draft Bill includes consequential amendments to the *Medicines and Poisons Act 2019*, including to provide clarity on the relationship between the Voluntary Assisted Dying scheme and the *Medicines and Poisons Act 2019*.

11-16 Any additional requirements needed to regulate the use of the voluntary assisted dying substance, including in relation to the labelling, storage and disposal of the substance, should be prescribed in a standalone Voluntary Assisted Dying Regulation.

CHAPTER 12: NOTIFICATION AND CERTIFICATION OF DEATH

Death certification process

12-1 The medical practitioner completing the cause of death certificate for the person must:

(a) include the underlying disease, illness or medical condition as the cause of death on the cause of death certificate;

(b) not include any reference to voluntary assisted dying on the cause of death certificate.

Notification of death to the Voluntary Assisted Dying Review Board

12-2 The coordinating practitioner and administering practitioner must each notify the Voluntary Assisted Dying Review Board of the person's death in the approved form, within two business days of becoming aware of the person's death (whether or not after self-administering or being administered a voluntary assisted dying substance in accordance with the Act). This requirement should not apply if the administering practitioner has already notified the Board of the death of the person.

12-3 A medical practitioner who is required to give a cause of death certificate for the person and who reasonably believes or knows that the person self-administered or was administered a voluntary assisted dying substance in accordance with the Act, must, within two business days after becoming aware that the person has died, notify the Voluntary Assisted Dying Review Board, in the approved form, of the person's death. This requirement should not apply if the medical practitioner is the coordinating practitioner or administering practitioner.

Amendment of the Coroners Act 2003

12-4 The draft Bill amends the *Coroners Act 2003* to provide that the death of a person who has been administered or has self-administered a voluntary assisted dying substance in accordance with the draft Bill's provisions is not a reportable death for the purposes of the *Coroners Act 2003*.

CHAPTER 13: HEALTH PRACTITIONERS' QUALIFICATIONS AND TRAINING

Minimum qualification and experience requirements for coordinating practitioners and consulting practitioners

13-1 A medical practitioner should be eligible to act as a coordinating practitioner or a consulting practitioner for a person requesting access to voluntary assisted dying if:

(a) the medical practitioner:

(i) holds specialist registration and has practised for at least one year as the holder of that registration; or

(ii) holds general registration and has practised for at least five years as the holder of that registration; or

(iii) holds specialist registration and has practised for at least five years as the holder of general registration; or

(iv) is an overseas-trained specialist who holds limited registration or provisional registration; and

(b) the medical practitioner meets the approved medical practitioner requirements.

13-2 The chief executive must approve medical practitioner requirements and publish them on the Department's website.

13-3 The draft Bill provides that:

(a) 'general registration' means 'general registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession';

(b) 'limited registration' means 'limited registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession';

(c) 'provisional registration' means 'provisional registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession'; and

(d) 'specialist registration' means 'specialist registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession in a recognised specialty'.

Minimum qualification and experience requirements for administering practitioners

13-4 A person should be eligible to act as an administering practitioner if the person is:

(a) a medical practitioner who is eligible to act as a coordinating practitioner for the person requesting access to voluntary assisted dying;

(b) a nurse practitioner who meets the approved nurse practitioner requirements; or

(c) a registered nurse who has practised in the nursing profession for at least five years and meets the approved nurse requirements.

13-5 The chief executive must approve nurse practitioner requirements and nurse requirements and publish them on the Department's website.

Approved training

13-6 The coordinating practitioner must not begin the first assessment, and the consulting practitioner must not begin the consulting assessment, unless the practitioner has completed approved training.

13-7 The administering practitioner must complete approved training to be eligible to act as an administering practitioner.

13-8 The chief executive must approve training and publish the approval on the Department's website.

Other requirements

13-9 The coordinating practitioner, consulting practitioner, administering practitioner, or another health practitioner or other person to whom the person is referred to determine certain eligibility matters:

(a) must not be a family member of the person requesting access to voluntary assisted dying; and

(b) must not know or believe that they—

(i) are a beneficiary under a will of the person requesting access to voluntary assisted dying; or

(ii) may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services as the coordinating practitioner, consulting practitioner or administering practitioner for the person, or in connection with the referral.

CHAPTER 14: PARTICIPATION BY INDIVIDUALS AND CONSCIENTIOUS OBJECTION

14-1 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:

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) participate in an administration decision;

(d) prescribe, supply or administer a voluntary assisted dying substance;

(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

14-2 A registered health practitioner who, because of a conscientious objection, refuses to do any of those things for a person seeking information or assistance about voluntary assisted dying should be required to:

(a) inform the person that other health practitioners, health service providers or services may be able to assist them; and

(b) give the person:

(i) information about a health practitioner, health service provider or service who, in the first practitioner's belief, is likely to be able to assist the person; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person.

14-3 A speech pathologist who is requested to assist a person to access voluntary assisted dying and who has a conscientious objection to voluntary assisted dying should have the right to refuse to do any of the following:

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) participate in an administration decision;

(d) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

14-4 A speech pathologist who refuses on the grounds of conscientious objection to do any of those things should be required to:

(a) inform their employer or the other person who requested their services of their conscientious objection;

(b) inform that party of another speech pathologist or speech pathology service who, in their belief, is likely to be able to assist in providing the requested speech pathology services; and

(c) not intentionally impede the person's access to speech pathology services in relation to voluntary assisted dying.

14-5 A speech pathologist who is employed or otherwise engaged by a health service provider that they know (or ought reasonably to know) provides, or is likely to provide, services relating to voluntary assisted dying should be required to:

(a) inform the health service provider of their conscientious objection; and

(b) discuss with the health service provider how they can practice in accordance with their beliefs without placing a burden on their colleagues or compromising a person's access to voluntary assisted dying.

CHAPTER 15: PARTICIPATION BY ENTITIES

Form of regulation

15-1 Legislation should include provisions about the process that must be followed in circumstances where an entity does not provide access to voluntary assisted dying at its facility.

15-2 In simple terms, an 'entity' is a non-natural person which owns, occupies or operates a facility that provides a health service, residential aged care or a personal care service (as defined in the draft Bill).

Access to information

15-3 Where a person receiving relevant services from a relevant entity at a facility asks the entity for information about voluntary assisted dying, and the entity does not provide at the facility the requested information, the entity (and any other entity that owns or occupies the facility) must:

(a) not hinder the person's access at the facility to information about voluntary assisted dying; and

(b) allow reasonable access by a registered health practitioner or a staff member of an official voluntary assisted dying care navigator service to provide the requested information to the person.

Making a first request and later requests

15-4 Where a person receiving relevant services from a relevant entity at a facility wishes to make a 'first request' for access to voluntary assisted dying and the entity does not provide access to the request and assessment process at the facility:

(a) the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by a registered health practitioner who is qualified and willing to receive a 'first request' under the legislation and whose presence for that purpose is requested by the person or the person's agent; or

(b) if such a practitioner is not available to attend to receive a first request at the facility, then the relevant entity must take reasonable steps to facilitate the transfer of the person to a place at which the request may be made, and their return thereafter to the facility.

15-5 Similar provisions should apply to any later request or declaration required by the legislation.

Eligibility assessments

15-6 Where a person receiving relevant services from a relevant entity at a facility wishes to undergo an assessment of their eligibility to access voluntary assisted dying and the entity does not provide access to the request and assessment process at the facility:

(a) if the person is a permanent resident of the facility—

(i) the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by a registered health practitioner who is qualified and willing to undertake an eligibility assessment and whose presence for that purpose is requested by the person or the person's agent; or

(ii) if the relevant practitioner is not available to attend to undertake the assessment at the facility, the relevant entity must take reasonable steps to facilitate the transfer of the person to a place at which the eligibility assessment may be undertaken, and their return thereafter to the facility;

(b) if the person is not a permanent resident of the facility—

(i) the relevant entity must take reasonable steps to facilitate 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

(ii) in circumstances where transfer to a place outside the facility for the purpose of assessment would not be reasonable, the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by a registered health practitioner who is qualified and willing to conduct the assessment.

15-7 For the purpose of these provisions the term 'permanent resident':

(a) refers to a person who resides at the facility as their settled and usual place of abode, being the place where the person regularly or customarily lives;

(b) includes the resident of an aged care facility who has security of tenure by virtue of the *Aged Care Act 1997* (Cth) or on some other basis; and

(c) does not include a person who resides at the facility as a temporary resident, for example as an in-patient at a hospital or the resident of a hospice.

15-8 In determining whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of undergoing an eligibility assessment, regard must be had to whether:

(a) the transfer would be likely to cause serious harm to the person, for example, significant pain or a significant deterioration in their condition;

(b) the transfer would be likely to adversely affect the person's access to voluntary assisted dying; 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;

(c) the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

(d) there is an alternative place reasonably available; for example, whether another facility within a reasonable distance has a suitable place to which to admit the person and can provide the level of care required by the person for the relevant period;

(e) the person would incur financial loss or costs because of the transfer.

15-9 The determination of whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of undergoing an eligibility assessment should be made by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity to decide the reasonableness of the proposed transfer.

15-10 Similar provisions should apply to access to the person's coordinating practitioner when the person wishes to make an administration decision.

Administration of the voluntary assisted dying substance

15-11 Where a person receiving relevant services from an entity at a facility wishes to self-administer or have an authorised practitioner administer a voluntary assisted dying substance and the entity does not provide access to administration of a voluntary assisted dying substance at the facility:

(a) if the person is a permanent resident of the facility, the entity (and any other entity that owns or occupies the facility) must:

(i) allow reasonable access to the facility by the administering practitioner to undertake practitioner administration, together with any person whose presence is required to witness the practitioner administration; and

(ii) not hinder access by the person to the substance required for self-administration;

(b) if the person is not a permanent resident of the facility:

(i) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place outside the entity's facility for the purpose of administration of the voluntary assisted dying substance; or

(ii) in circumstances where transfer to a place outside the facility for the purpose of administration would not be reasonable, the entity (and any other entity that owns or occupies the facility) must allow reasonable access to the facility by the administering practitioner, together with any person whose presence is required to witness the practitioner administration, and not hinder access by the person to the substance required for self-administration.

15-12 In determining whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of administration of the voluntary assisted dying substance, regard must be had to whether:

(a) the transfer would be likely to cause serious harm to the person, for example, significant pain or a significant deterioration in their condition;

(b) the transfer would be likely to adversely affect the person's access to voluntary assisted dying; 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, thereby rendering the person ineligible for authorised practitioner administration;

(c) there is an alternative place reasonably available at which the person can self-administer or receive practitioner administration of the voluntary assisted dying substance.

15-13 The determination of whether it is reasonable for the person to be transferred to a place outside the entity's facility for the purpose of administration of the voluntary assisted dying substance should be made by the coordinating practitioner unless another medical practitioner is agreed to by the person and the entity to decide the reasonableness of the proposed transfer.

Notice that an entity does not provide access to voluntary assisted dying

15-14 A relevant entity that does not provide services associated with access to voluntary assisted dying, such as access to the request and assessment process or access to administration of a voluntary assisted dying substance, at a facility which it operates must:

(a) inform the public, including persons that use the facility or may use the facility in the future, that it does not provide services associated with access to voluntary assisted dying (such as access to the request and assessment process, access to the administration of a voluntary assisted dying substance, or both) at the facility; and

(b) do so in a way that is likely to be brought to the attention of consumers or potential consumers of its services at the facility by, for example, placing the information on its website, in brochures and on signage at the facility.

CHAPTER 16: REVIEW OF CERTAIN DECISIONS BY QCAT

16-1 QCAT should be given jurisdiction to review, on the application of particular persons, a decision of the coordinating practitioner (in a first assessment or final review) or of a consulting practitioner (in a consulting assessment) that the requesting person:

(a) was—or was not—ordinarily resident in Australia for at least three years immediately before making the first request;

(b) was—or was not—ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request;

(c) has—or does not have—decision-making capacity in relation to voluntary assisted dying; or

(d) is—or is not—acting voluntarily and without coercion.

The mechanism for review of decisions by QCAT should have the other features set out in this chapter and included in the draft Bill about making an application for review, the effect of an application for review, what the tribunal may decide and the effect of a tribunal decision, and other procedural matters.

16-2 QCAT should be given the additional resources that are needed to ensure the effective operation of the proposed new jurisdiction under the draft Bill.

CHAPTER 17: COMPLIANCE AND PROTECTION FROM LIABILITY

Criminal offences under the voluntary assisted dying legislation

17-1 It should be an offence for a person, dishonestly or by coercion, to induce another person to:

(a) make or revoke a request for access to voluntary assisted dying, including an administration decision; or

(b) self-administer a voluntary assisted dying substance.

For the purpose of these offences, 'coercion' should be defined to include threats, promises or intimidation of any kind, including by improper use of a position of trust or influence. The offences should be specified as misdemeanours and have a maximum penalty of seven years imprisonment.

17-2 It should be an offence—with a maximum penalty of 100 penalty units—for a person to fail to give a copy of a document or form to the Voluntary Assisted Dying Review Board that the person is required to give under the legislation.

17-3 It should be an offence for a person to:

(a) give information to the Board, in the administration of the legislation, that the person knows is false or misleading in a material particular;

(b) make a statement that the person knows is false or misleading in a material particular in a form or other document required to be made under the legislation; or

(c) otherwise falsify a form or other document required to be made under the legislation.

The offences should be specified as misdemeanours and have a maximum penalty of five years imprisonment.

17-4 Where a voluntary assisted dying substance has been supplied for a person for self-administration, the contact person must:

(a) if the person revokes the self-administration decision—give the substance to an authorised disposer as soon as practicable and in any event within 14 days after the self-administration decision is revoked; and

(b) if the person dies—give any unused or remaining substance to an authorised disposer as soon as practicable and in any event within 14 days after the self-administration decision is revoked.

Failure to do so should be an offence with a maximum penalty of 100 penalty units.

17-5 It should be an offence for a person to administer a voluntary assisted dying substance to another person unless the person is authorised to do so under the provision in Recommendation 10-7 above. The offence should be specified as a crime and have a maximum penalty of 14 years imprisonment.

17-6 A person must not make a record of or disclose personal information that the person obtains, in the course of, or because of, the exercise of a function or power under the legislation, other than:

(a) for a purpose under this legislation;

(b) with the consent of the person to whom the information relates;

(c) in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal; or

(d) as authorised or required by law.

Failure to comply should be an offence with a maximum penalty of 100 penalty units.

For the purpose of this provision, 'personal information' should have the same meaning as under section 12 of the *Information Privacy Act 2009*, but should not include information that is publicly available.

Protections from liability in the voluntary assisted dying legislation

17-7 No civil or criminal liability should attach to any person for an act done or omission made in good faith and without negligence in accordance with, or for the purposes of, this Act.

17-8 Criminal liability should not attach to a person who:

(a) in good faith, does something or omits to do something that assists another person who the person believes on reasonable grounds is requesting access to, or is accessing, voluntary assisted dying in accordance with the legislation; or

(b) is present when another person self-administers or is administered a voluntary assisted dying substance in accordance with the legislation.

17-9 If a health practitioner or ambulance officer, in good faith, does not administer life sustaining treatment to another person in circumstances where:

(a) the other person has not requested the administration of life sustaining treatment; and

(b) the health practitioner or ambulance officer believes on reasonable grounds that the other person is dying after self-administering or being administered a voluntary assisted dying substance in accordance with the legislation,

no civil or criminal liability should attach to the health practitioner or ambulance officer for not administering the life sustaining treatment.

17-10 For the avoidance of doubt, the draft Bill provides that, where relevant in a proceeding, the party alleging that the provision in Recommendation 17-7 above does not apply bears the onus of proving that the person did not do the act or make the omission in good faith in the circumstances covered by the protection. Provision to similar effect should be included for the provisions in Recommendations 17-8 and 17-9 above.

Interaction with the Criminal Code

17-11 For the avoidance of any doubt, the draft Bill provides that a person who does an act or makes an omission in the circumstances mentioned in Recommendations 17-7 to 17-9 above does not commit an offence against sections 300, 302, 303, 305, 306, 307, 309, 310 or 311 of the Criminal Code.

Disciplinary proceedings

17-12 The draft Bill provides that nothing in that part of the Bill prevents:

(a) a person from making a notification about a health practitioner's conduct under the National Law;

(b) a person from making a health service complaint about a person under the *Health Ombudsman Act 2013*; or

(c) the Voluntary Assisted Dying Review Board from referring a matter it identifies to the Health Ombudsman.

Notifications to the Health Ombudsman

17-13 For the avoidance of doubt, in considering:

(a) a notification or a referred matter under the Health Practitioner Regulation National Law (Queensland); or

(b) a complaint under the *Health Ombudsman Act 2013*;

about the professional conduct or performance of a registered health practitioner or a person who provides a health service, regard may be had to whether the practitioner or person contravened a provision of the voluntary assisted dying legislation.

'Health service' for this provision has the meaning given in section 7 of the *Health Ombudsman Act 2013*.

CHAPTER 18: AN OVERSIGHT BODY: THE VOLUNTARY ASSISTED DYING REVIEW BOARD

18-1 An independent Voluntary Assisted Dying Review Board, consisting of at least five but no more than nine members appointed by the Minister and with relevant expertise, experience, knowledge or skills, should be established by the legislation to:

(a) monitor the operation of the Act;

(b) review, for each completed request for voluntary assisted dying, whether or not the following persons complied with the Act:

(i) coordinating practitioners;

(ii) consulting practitioners;

(iii) administering practitioners;

(iv) authorised suppliers;

(v) authorised disposers; and

(vi) contact persons;

(c) refer to the following entities issues identified by the Board in relation to voluntary assisted dying that are relevant to the entities' functions:

(i) the Commissioner of the Police Service;

(ii) the Registrar-General under the *Births, Deaths and Marriages Registration Act 2003*;

(iii) the State Coroner;

(iv) the Health Ombudsman under the *Health Ombudsman Act 2013*;

(v) the chief executive of the Department;

(d) record and keep information prescribed by regulation about requests for, and provision of, voluntary assisted dying;

(e) analyse information given to the Board under the Act and research matters related to the operation of the Act;

(f) provide, on the Board's initiative or on request, information, reports and advice to the Minister or the chief executive of the Department in relation to

the operation of the Act, the Board's functions, or the improvement of the processes and safeguards of voluntary assisted dying;

(g) promote compliance with the Act, including by providing information about the operation of the Act to registered health practitioners and members of the community;

(h) promote continuous improvement in the compassionate, safe and practical operation of the Act; and

(i) consult and engage with the community and any entity the Board considers appropriate in relation to voluntary assisted dying; and

(j) perform any other function given to the Board under the Act.

18-2 The Board and its operation should have the features set out in this chapter and included in the draft Bill, including about its independence, staff and assistance, membership and appointment of members, appointment and roles of the chairperson and a deputy chairperson, general and other powers, annual and other reporting requirements, proceedings and protections from liability.

CHAPTER 19: OTHER MATTERS

Interpreters

19-1 An interpreter for a person requesting access to voluntary assisted dying:

(a) must:

(i) be accredited by a body approved by the chief executive of the Department; or

(ii) have been granted an exemption by the chief executive of the Department; and

(b) must not:

(i) be a family member of the person;

(ii) know or believe that they are a beneficiary under a will of the person or that they may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees as an interpreter);

(iii) be an owner of, or be responsible for the management of, any health facility at which the person is being treated or resides; or

(iv) be a person who is directly involved in providing a health service or personal care service to the person.

19-2 The chief executive of the Department may grant an exemption from the accreditation requirement if satisfied that no accredited interpreter is available in a particular case, and there are exceptional circumstances for granting the exemption.

Regulation making power

19-3 The draft Bill provides that the Governor in Council may make regulations under the Act, including a matter that must be included in an approved form under the Act.

Approved forms

19-4 The draft Bill provides that the chief executive of the Department may approve forms for use under the Act.

Technical errors

19-5 The validity of the request and assessment process under Part 3 or the administration process (consisting of an administration decision and the administration of a voluntary assisted dying substance) under Part 4 of the Act should not be affected by:

(a) any minor or technical error in a form required to be completed;

(b) the failure of a person to provide a form within the time required; or

(c) the failure of a medical practitioner to do an act within the time required for doing the act.

The inclusion of this provision in the draft Bill is not intended to affect the general operation of section 48A of the *Acts Interpretation Act 1954* in that regard.

Review of the Act

19-6 The Minister must review the effectiveness of the Act as soon as practicable after the end of three years after its commencement and:

(a) the review must include a review of the eligibility requirements for access to voluntary assisted dying under the Act; and

(b) as soon as practicable after finishing the review, the Minister must table a report about its outcome in the Legislative Assembly.

Amendment of the guardianship legislation

19-7 The draft Bill amends the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* to include a declaratory provision to the effect that voluntary assisted dying is not a matter to which those Acts apply.

CHAPTER 20: COMMONWEALTH LAWS THAT IMPEDE ACCESS

20-1 The Queensland Government, in consultation with other state governments in which voluntary assisted dying legislation has been enacted, raise for the consideration of senior members of the Commonwealth government, including the ministers responsible for the justice and health portfolios:

(a) the uncertain state of the law concerning the application of Commonwealth carriage service offences for suicide related material to conduct which is authorised by state or territory voluntary assisted dying legislation;

(b) the unintended consequences of the possible application of those laws to lawful voluntary assisted dying in:

(i) deterring health practitioners and health services from using telehealth and other electronic communication to provide information and advice about end of life options and the process of lawful and authorised voluntary assisted dying; and

(ii) denying persons who are dying, particularly persons in rural, regional and remote areas who are too sick to travel or who cannot be readily visited in person by a qualified health practitioner, equal access to lawful and authorised voluntary assisted dying; and

(c) the urgent need to amend the relevant Commonwealth laws to clarify that voluntary assisted dying which is authorised and lawful under state or territory law does not constitute 'suicide' for the purposes of sections 474.29A and 474.29B of the Criminal Code (Cth).

20-2 Pending the amendment of Commonwealth laws in that regard, the Commonwealth Director of Public Prosecutions be asked to consider issuing prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the Criminal Code (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state or territory voluntary assisted dying laws.

20-3 To aid the interpretation of the Commonwealth laws and to avoid their unintended application to lawful and authorised voluntary assisted dying, and to clarify that conduct which is authorised by legislation in Queensland in connection with voluntary assisted dying does not constitute the offence of aiding suicide, the voluntary assisted dying legislation provide:

> For the purposes of the law of the State, a person who dies as a result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act does not die by suicide.

CHAPTER 21: IMPLEMENTATION

21-1 The Queensland Government should establish an implementation taskforce or leadership group which is a multidisciplinary team with expertise in relevant areas such as palliative, disability, mental health and aged care; representatives from peak bodies such as the Australian Medical Association, Royal Australian College of General Practitioners, and other specialist medical colleges; and Aboriginal and Torres Strait Islander representatives. The taskforce should provide advice, leadership and direction on implementation.

21-2 The Queensland Government should ensure that the Voluntary Assisted Dying Review Board has the support and resources required for it to meet its legislated obligations including collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engagement and information sharing with other agencies.

21-3 A Statewide Care Navigator Service should be established to support the voluntary assisted dying scheme in Queensland and to provide services such as:

(a) information, education and support about the voluntary assisted dying process;

(b) helping a person seeking to access voluntary assisted dying to connect with appropriate participating medical practitioners and health services, particularly if their own practitioner is not willing to participate;

(c) helping a person identify appropriate referral pathways;

(d) providing holistic advice and follow-up on appropriate end of life care services, including palliative care and treatment; and

(e) helping persons to access financial support.

21-4 A Statewide Pharmacy Service should be established, suited to Queensland's size and population distribution, and appropriately resourced to facilitate the supply of the voluntary assisted dying substance across Queensland. It should also provide a central source of information about the substance for persons accessing voluntary assisted dying, especially persons who self-administer, and for registered health practitioners.

21-5 The Queensland Government should develop a model for disposal of the voluntary assisted dying substance with particular consideration given to accessibility of voluntary assisted dying by people in rural and remote areas.

21-6 The Queensland Government should ensure that comprehensive mandatory assessment training is developed and available to qualified practitioners prior to full commencement of the legislation. It should also provide information and support for

other health care practitioners, including junior doctors and nurses, who are asked by patients about the scheme or have to provide ongoing support to patients who chose to access it and to their families.

21-7 The Queensland Government should develop a user-friendly ICT system to support the voluntary assisted dying process and the collection of relevant data. It should provide resources to ensure that the ICT system is established early, tested, effective and maintained.

21-8 Appropriately qualified interpreters and speech pathologists should be available to assist in communications between health practitioners and persons seeking access to voluntary assisted dying. They should be skilled and trained in communicating about end of life choices, and specifically briefed about the voluntary assisted dying process before providing communication services about it.

21-9 The Queensland Government should develop policies, procedures and community information to support the implementation of the voluntary assisted dying framework, including health practitioner guidelines, health service provider information, information for persons seeking to access voluntary assisted dying and for the broader community. This should also include adequate resourcing for referral organisations to provide counselling and bereavement support.

21-10 Communities of practice should be established to provide peer support to health practitioners engaged in the voluntary assisted dying process.

21-11 The implementation process should consider the possible implications of the Commonwealth carriage service offences on providing certain services relating to voluntary assisted dying, particularly in rural and remote areas. The Government should seek further legal advice about this issue and develop procedures and processes to guide practitioners and health services about the appropriate use of telehealth, telephone and other electronic services in providing information and advice about voluntary assisted dying.

21-12 The implementation process should include contingency plans in the event that the Commonwealth carriage service offence provisions remain unamended. Participants, including practitioners and the care navigator service, will need to be properly informed about what services can be provided by telehealth, telephone, email and other electronic 'carriage services'.

21-13 The Queensland Civil and Administrative Tribunal should be adequately resourced to deal with applications for review.

21-14 The Queensland Government should develop processes and systems to allow access, upon a patient's request, by qualified practitioners to facilities that do not participate in voluntary assisted dying, or to arrange transfer of patients to other facilities when that is reasonable. The demands on government hospital and health services from transfers should be anticipated and appropriate places made available in hospitals and hospices for persons to undergo assessments and, if authorised, receive administration of voluntary assisted dying substances.

21-15 Any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care and treatment. This should be reflected in all processes associated with the implementation of a voluntary assisted dying scheme in Queensland.

APPENDIX F

Voluntary Assisted Dying Bill 2021

Queensland

Voluntary Assisted Dying Bill 2021

Contents

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Contents

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2021

A Bill

for

An Act about access to voluntary assisted dying and related matters

DRAFT

The Parliament of Queensland enacts—

Part 1 Preliminary

Division 1 Introduction

1 Short title

This Act may be cited as the *Voluntary Assisted Dying Act 2021*.

2 Commencement

(1) Part 8 and section 153 commence 6 months after the date of assent.

(2) The remaining provisions of this Act commence 18 months after the date of assent.

3 Main purposes of Act

The main purposes of this Act 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; and

(b) to establish a lawful process for eligible persons to exercise that option; and

(c) to establish safeguards to—

(i) ensure voluntary assisted dying is accessed only by persons who have been assessed to be eligible; and

(ii) protect vulnerable persons from coercion and exploitation; and

(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 this Act; and

(e) to establish a Voluntary Assisted Dying Review Board and other mechanisms to ensure compliance with this Act.

4 Act binds all persons

This Act binds all persons, including the State.

Division 2 Principles of voluntary assisted dying

5 Principles

The principles that underpin this Act are—

(a) human life is of fundamental importance; and

(b) every person has inherent dignity and should be treated equally and with compassion and respect; and

(c) a person's autonomy, including autonomy in relation to end of life choices, should be respected; and

(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; and

(e) access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland; and

(f) a person should be supported in making informed decisions about end of life choices; and

(g) a person who is vulnerable should be protected from coercion and exploitation; and

(h) a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

Division 3 Interpretation

6 Definitions

The dictionary in schedule 1 defines particular words used in this Act.

Division 4 Other provisions

7 Health care worker not to initiate discussion about voluntary assisted dying

(1) A health care worker must not, in the course of providing a health service or personal care service to a person—

(a) initiate discussion with the person that is in substance about voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to the person.

(2) However, despite subsection (1), a medical practitioner or nurse practitioner may do a thing mentioned in subsection (1)(a) or (b) if, at the same time, the practitioner also informs the person about—

(a) the treatment options available to the person and the likely outcomes of that treatment; and

(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

(3) Nothing in subsection (1) prevents a health care worker from providing information about voluntary assisted dying to a person at the person's request.

(4) In this section—

health care worker means—

(a) a registered health practitioner; or

(b) another person who provides a health service or personal care service.

8 Voluntary assisted dying not suicide

For the purposes of the law of the State, and for the purposes of a contract, deed or other instrument entered into in the State or governed by the law of the State, a person who dies as the result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act—

(a) does not die by suicide; and

(b) is taken to have died from the disease, illness or medical condition mentioned in section 10(1)(a) from which the person suffered.

Part 2 Requirements for access to voluntary assisted dying

9 When person may access voluntary assisted dying

A person may access voluntary assisted dying if—

(a) the person has made a first request; and

(b) the coordinating practitioner for the person has assessed the person as meeting the requirements of a first assessment of the person; and

(c) the consulting practitioner for the person has assessed the person as meeting the requirements of a consulting assessment of the person; and

(d) the person has made a second request; and

(e) the person has made a final request; and

(f) the coordinating practitioner for the person has certified in a final review form that—

(i) the request and assessment process has been completed in accordance with this Act; and

(ii) the practitioner is satisfied of each of the matters mentioned in section 46(3)(b); and

(g) the person has made an administration decision; and

(h) the person has appointed a contact person.

10 Eligibility

(1) A person is eligible for access to voluntary assisted dying if—

(a) the person has been diagnosed with a disease, illness or medical condition that—

(i) is advanced, progressive and will cause death; and

(ii) is expected to cause death within 12 months; and

(iii) is causing suffering that the person considers to be intolerable; and

(b) the person has decision-making capacity in relation to voluntary assisted dying; and

(c) the person is acting voluntarily and without coercion; and

(d) the person is at least 18 years of age; and

(e) 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 3 years immediately before the person makes the first request; or

(iv) has been granted an Australian residency exemption by the chief executive under section 12; and

(f) the person—

(i) has been ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request; or

(ii) has been granted a Queensland residency exemption by the chief executive under section 12.

(2) In this section—

permanent resident means—

(a) the holder of a permanent visa as defined by the *Migration Act 1958* (Cwlth), section 30(1); or

(b) a New Zealand citizen who is the holder of a special category visa as defined by the *Migration Act 1958* (Cwlth), section 32.

suffering, caused by a disease, illness or medical condition, includes—

(a) physical or mental suffering; and

(b) suffering caused by treatment provided for the disease, illness or medical condition.

11 Decision-making capacity

(1) A person has ***decision-making capacity*** in relation to voluntary assisted dying if the person is capable of—

(a) understanding the nature and effect of decisions about access to voluntary assisted dying; and

(b) freely and voluntarily making decisions about access to voluntary assisted dying; and

(c) communicating decisions about access to voluntary assisted dying in some way.

(2) A person is presumed to have decision-making capacity in relation to voluntary assisted dying unless there is evidence to the contrary.

(3) In determining whether or not a person has decision-making capacity in relation to voluntary assisted dying, regard must be had to the following—

(a) a person may have decision-making capacity to make some decisions but not others;

(b) capacity can change or fluctuate and a person may temporarily lose capacity and later regain it;

(c) it should not be presumed that a person does not have decision-making capacity—

(i) because of a personal characteristic such as, for example, age, appearance or language skills; or

(ii) because the person has a disability or an illness; or

(iii) because the person makes a decision with which other people may not agree;

(d) a person is capable of doing a thing mentioned in subsection (1)(a), (b) or (c) if the person is capable of doing the thing with adequate and appropriate support.

Examples of support—

- giving a person information that is tailored to their needs
- giving information to a person in a way that is tailored to their needs
- communicating, or assisting a person to communicate, the person's decision
- giving a person additional time and discussing the matter with the person
- using technology that alleviates the effects of a person's disability

12 Residency exemptions

(1) A person may apply to the chief executive for—

(a) an exemption from the requirements in section 10(1)(e)(i), (ii) and (iii) (an ***Australian residency exemption***); or

(b) an exemption from the requirement in section 10(1)(f)(i) (a ***Queensland residency exemption***).

(2) The chief executive must grant the exemption if satisfied that—

(a) the person has a substantial connection to Queensland; and

Examples—

- a person who is a long term resident of a place close to the Queensland border and who works in Queensland and receives medical treatment in Queensland
- a person who resides outside Queensland but who is a former resident of Queensland and whose family resides in Queensland

(b) there are compassionate grounds for granting the exemption.

13 Disability or mental illness

(1) To remove any doubt, it is declared that a person with a disability or mental illness—

(a) may be eligible under section 10(1)(a); but

(b) is not eligible under section 10(1)(a) only because the person has the disability or mental illness.

(2) In this section—

eligible means eligible for access to voluntary assisted dying.

mental illness see the *Mental Health Act 2016*, section 10.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

Division 1 First request

14 Person may make first request to medical practitioner

(1) A person may make a request under this section (a ***first request***) to a medical practitioner for access to voluntary assisted dying.

(2) The request must be—

(a) clear and unambiguous; and

(b) made by the person personally and not by another person on their behalf.

(3) The person may make the request verbally or by gestures or other means of communication available to the person.

15 No obligation to continue after making first request

(1) The person may decide at any time not to continue the request and assessment process.

(2) The request and assessment process ends if the person decides not to continue the process.

(3) If the request and assessment process ends under subsection (2), the person may begin a new request and assessment process by making a new first request.

16 Medical practitioner to accept or refuse first request

(1) The medical practitioner must refuse the first request if the practitioner is not eligible to act as a coordinating practitioner.

(2) The medical practitioner may refuse the first request if the practitioner—

(a) has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a coordinating practitioner; or

(b) is unavailable or otherwise unable to perform the duties of a coordinating practitioner.

(3) If the medical practitioner accepts the first request, the practitioner must, at the time of informing the person of the practitioner's decision, give the person the approved information.

(4) If the medical practitioner refuses the first request, the practitioner must, at the time of informing the person of their decision—

(a) inform the person that other registered health practitioners, health service providers or services may be able to assist the person with the person's request; and

(b) give the person—

(i) information about a registered health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person with the person's request; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person with the person's request.

(5) The medical practitioner must, within the times mentioned in subsection (6)—

(a) decide whether to accept or refuse the first request; and

(b) inform the person of the decision and, for a decision to refuse the request, the reason for the decision.

(6) For subsection (5) the following times apply—

(a) if the medical practitioner has a conscientious objection to voluntary assisted dying—immediately after the request is made;

(b) in any other case—within 2 business days after the first request is made.

17 Medical practitioner to record first request and acceptance or refusal

The medical practitioner must record in the person's medical record—

(a) the first request; and

(b) the practitioner's decision to accept or refuse the first request; and

(c) if the practitioner's decision is to refuse the first request—the reason for the refusal and the steps taken to comply with section 16(4); and

(d) if the practitioner's decision is to accept the first request—the day on which the person is given the approved information.

18 Medical practitioner becomes coordinating practitioner if first request accepted

If the medical practitioner accepts the first request, the practitioner becomes the coordinating practitioner for the person.

Division 2 First assessment

19 First assessment

(1) The coordinating practitioner for a person must assess whether or not the person is eligible for access to voluntary assisted dying.

(2) An assessment under subsection (1) is a ***first assessment***.

(3) The coordinating practitioner may have regard to any relevant information about the person that has been prepared by, or at the instigation of, another registered health practitioner.

20 Coordinating practitioner to have completed approved training

The coordinating practitioner must not begin the first assessment unless the practitioner has completed the approved training.

21 Referral for determination

(1) Subsection (2) applies if the coordinating practitioner is unable to determine whether or not—

(a) the person has a disease, illness or medical condition that meets the requirements of section 10(1)(a); or

(b) the person has decision-making capacity in relation to voluntary assisted dying.

(2) The coordinating practitioner must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter.

(3) If the coordinating practitioner is unable to determine whether or not the person is acting voluntarily and without coercion as required by section 10(1)(c), the coordinating practitioner must refer the person to another person who has appropriate skills and training to determine the matter.

(4) If the coordinating practitioner makes a referral to a registered health practitioner or other person under subsection (2) or (3) (the ***referee***), the coordinating practitioner may adopt the determination of the referee in relation to the matter in respect of which the referral was made.

(5) The referee must not be—

(a) a family member of the person requesting access to voluntary assisted dying; or

(b) someone who knows or believes that they—

(i) are a beneficiary under a will of the person requesting access to voluntary assisted dying; or

(ii) may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services in connection with the referral.

22 Information to be provided if person assessed as eligible

(1) If the coordinating practitioner is satisfied the person is eligible for access to voluntary assisted dying, the coordinating practitioner must inform the person about the following matters—

(a) the person's diagnosis and prognosis;

(b) the treatment options available to the person and the likely outcomes of that treatment;

(c) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment;

(d) the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing the person's death;

(e) that the expected outcome of self-administering or being administered a substance mentioned in paragraph (d) is death;

(f) the method by which a substance mentioned in paragraph (d) is likely to be self-administered or administered;

(g) the request and assessment process, including the requirement for a second request to be signed in the presence of 2 witnesses;

(h) that, if the person makes an administration decision, the person must appoint a contact person;

(i) that the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;

(j) that, if the person is receiving ongoing health services from another medical practitioner, the person may consider informing the other medical practitioner of the person's request for access to voluntary assisted dying.

(2) Nothing in this section affects any duty a medical practitioner has at common law or under another Act.

23 Outcome of first assessment

(1) If the coordinating practitioner is satisfied that the person—

(a) is eligible for access to voluntary assisted dying; and

(b) understands the information given under section 22(1);

the coordinating practitioner must assess the person as meeting the requirements of the first assessment.

(2) If the coordinating practitioner is not satisfied as to any matter in subsection (1)—

(a) the practitioner must assess the person as not meeting the requirements of a first assessment; and

(b) the request and assessment process ends.

24 Recording of outcome of first assessment

(1) The coordinating practitioner must inform the person of the outcome of the first assessment as soon as practicable after its completion.

(2) Within 2 business days after completing the first assessment, the coordinating practitioner must complete a record of the assessment in the approved form (the ***first assessment record form***) and give a copy of it to the board.

Maximum penalty—100 penalty units.

(3) The first assessment record form—

(a) must include the outcome of the first assessment, including the coordinating practitioner's decision in respect of each of the eligibility criteria; and

(b) may be accompanied by documents supporting the coordinating practitioner's decision in respect of the eligibility criteria.

(4) As soon as practicable after completing the first assessment record form, the coordinating practitioner must give a copy of it, and any documents accompanying it, to the person.

25 Referral for consulting assessment if person assessed as eligible

If the coordinating practitioner assesses the person as meeting the requirements of the first assessment, the practitioner must refer the person to another medical practitioner for a consulting assessment.

Division 3 Consulting assessment

26 Medical practitioner to accept or refuse referral for consulting assessment

(1) This section applies if a person is referred to a medical practitioner for a consulting assessment under section 25, 36 or 47.

(2) The medical practitioner must refuse the referral if the practitioner is not eligible to act as a consulting practitioner.

(3) The medical practitioner may refuse the referral if the practitioner—

(a) has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a consulting practitioner; or

(b) is unavailable or otherwise unable to perform the duties of a consulting practitioner.

(4) The medical practitioner must, within the times mentioned in subsection (5)—

(a) decide whether to accept or refuse the referral; and

(b) inform the person and the coordinating practitioner for the person of the decision and, for a decision to refuse the referral, the reason for the decision.

(5) For subsection (4) the following times apply—

(a) if the medical practitioner has a conscientious objection to voluntary assisted dying—immediately after the referral is made;

(b) in any other case—within 2 business days after the referral is made.

27 Medical practitioner to record referral and acceptance or refusal

The medical practitioner must record the following information in the person's medical record—

(a) the referral;

(b) the practitioner's decision to accept or refuse the referral;

(c) if the practitioner's decision is to refuse the referral, the reason for the refusal.

28 Medical practitioner to notify board of referral

Within 2 business days after deciding to accept or refuse the referral, the medical practitioner must complete a record of the acceptance or refusal of the referral in the approved form and give a copy of it to the board.

Maximum penalty—100 penalty units.

29 Medical practitioner becomes consulting practitioner if referral accepted

If the medical practitioner accepts the referral, the practitioner becomes the consulting practitioner for the person.

30 Consulting assessment

(1) The consulting practitioner must assess whether or not the person is eligible for access to voluntary assisted dying.

(2) An assessment under subsection (1) is a ***consulting assessment***.

(3) For the purposes of subsection (1) the consulting practitioner must, independently of the coordinating practitioner, form the consulting practitioner's own opinions on the matters to be decided.

(4) The consulting practitioner may have regard to any relevant information about the person that has been prepared by, or at the instigation of, another registered health practitioner.

31 Consulting practitioner to have completed approved training

The consulting practitioner must not begin the consulting assessment unless the practitioner has completed the approved training.

32 Referral for determination

(1) Subsection (2) applies if the consulting practitioner is unable to determine whether or not—

(a) the person has a disease, illness or medical condition that meets the requirements of section 10(1)(a); or

(b) the person has decision-making capacity in relation to voluntary assisted dying.

(2) The consulting practitioner must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter.

(3) If the consulting practitioner is unable to determine whether or not the person is acting voluntarily and without coercion as required by section 10(1)(c), the consulting practitioner must refer the person to another person who has appropriate skills and training to determine the matter.

(4) If the consulting practitioner makes a referral to a registered health practitioner or other person under subsection (2) or (3) (the ***referee***), the consulting practitioner may adopt the determination of the referee in relation to the matter in respect of which the referral was made.

(5) The referee must not be—

(a) a family member of the person requesting access to voluntary assisted dying; or

(b) someone who knows or believes that they—

(i) are a beneficiary under a will of the person requesting access to voluntary assisted dying; or

(ii) may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services in connection with the referral.

33 Information to be provided if person assessed as eligible

(1) If the consulting practitioner is satisfied the person is eligible for access to voluntary assisted dying, the consulting practitioner must inform the person about the matters mentioned in section 22(1).

(2) Nothing in this section affects any duty a medical practitioner has at common law or under another Act.

34 Outcome of consulting assessment

(1) If the consulting practitioner is satisfied that the person—

(a) is eligible for access to voluntary assisted dying; and

(b) understands the information given under section 33(1);

the consulting practitioner must assess the person as meeting the requirements of the consulting assessment.

(2) If the consulting practitioner is not satisfied as to any matter in subsection (1), the practitioner must assess the person as not meeting the requirements of the consulting assessment.

35 Recording of outcome of consulting assessment

(1) The consulting practitioner must inform the person and the coordinating practitioner for the person of the outcome of the consulting assessment as soon as practicable after its completion.

(2) Within 2 business days after completing the consulting assessment, the consulting practitioner must complete a record of the assessment in the approved form (the ***consulting assessment record form***) and give a copy of it to the board.

Maximum penalty—100 penalty units.

(3) The consulting assessment record form—

(a) must include the outcome of the consulting assessment, including the consulting practitioner's decision in respect of each of the eligibility criteria; and

(b) may be accompanied by documents supporting the consulting practitioner's decision in respect of the eligibility criteria.

(4) As soon as practicable after completing the consulting assessment record form, the consulting practitioner must give a copy of it, and any documents accompanying it, to the person and the coordinating practitioner for the person.

36 Referral for further consulting assessment if person assessed as ineligible

If the consulting practitioner assesses the person as not meeting the requirements of a consulting assessment, the coordinating practitioner for the person may refer the person to another medical practitioner for a further consulting assessment.

Division 4 Second request

37 Person assessed as eligible may make second request

(1) This section applies if a person has made a first request and has been assessed as meeting the requirements of a first assessment under division 2 and a consulting assessment under division 3.

(2) The person may make another request in writing (the ***second request***) for access to voluntary assisted dying.

(3) The second request must be in the approved form and given to the coordinating practitioner for the person.

(4) The second request must—

(a) specify that the person—

(i) makes it voluntarily and without coercion; and

(ii) understands its nature and effect; and

(b) be signed by the person, or a person mentioned in subsection (5), in the presence of 2 eligible witnesses.

(5) A person may sign the second request on behalf of the person making the request if—

(a) the person making the request is unable to sign the request; and

(b) the person making the request directs the person to sign the request; and

(c) the person signing the request—

(i) is at least 18 years of age; and

(ii) is not a witness to the signing of the request; and

(iii) is not the coordinating practitioner or consulting practitioner for the person making the request.

(6) A person who signs the second request on behalf of the person making the request must do so in the presence of the person making the request.

(7) If the person makes the second request with the assistance of an interpreter, the interpreter must certify on the request that the interpreter provided a true and correct translation of any material translated.

38 Eligibility to witness the signing of second request

(1) A person is eligible to witness the signing of the second request if the person—

(a) is at least 18 years of age; and

(b) is not an ineligible witness.

(2) A person is ineligible to witness the signing of the second request if the person—

(a) knows or believes that the person—

(i) is a beneficiary under a will of the person making the request; or

(ii) may otherwise benefit financially or in any other material way from the death of the person making the request; or

(b) is an owner, or is responsible for the management, of any health facility at which the person making the request is being treated or resides; or

(c) is the coordinating practitioner or consulting practitioner for the person making the request.

39 Certification of witness to signing of second request

(1) Each witness to the signing of the second request must—

(a) certify in writing in the request that—

(i) in the presence of the witness, the person signed the request; and

(ii) the person appeared to sign freely and voluntarily; and

(b) state in the request that the witness is not knowingly ineligible to witness the signing of the second request.

(2) A witness who witnesses the signing of a second request by another person on behalf of the person making the request must—

(a) certify in writing in the request that—

(i) in the presence of the witness, the person making the request appeared to freely and voluntarily direct the other person to sign the request; and

(ii) the other person signed the request in the presence of the person making the request and the witness; and

(b) state in the request that the witness is not knowingly ineligible to witness the signing of the second request.

40 Coordinating practitioner to record second request

If the person gives a second request to the coordinating practitioner for the person, the practitioner must record the following information in the person's medical record—

(a) the date when the second request was made;

(b) the date when the second request was received by the coordinating practitioner.

41 Coordinating practitioner to notify board of second request

Within 2 business days after receiving a second request made by a person, the coordinating practitioner for the person must give a copy of it to the board.

Maximum penalty—100 penalty units.

Division 5 Final request and final review

42 Person may make final request to coordinating practitioner

(1) A person who has made a second request may make a further request to the person's coordinating practitioner for access to voluntary assisted dying (a ***final request***).

(2) The final request must be—

(a) clear and unambiguous; and

(b) made by the person and not by another person on their behalf.

(3) The person may make the final request verbally or by gestures or other means of communication available to the person.

43 When final request may be made

(1) The final request may not be made—

(a) before the end of the designated period, except as provided in subsection (2); and

(b) in any case, until the day after the day on which the consulting assessment that assessed the person as meeting the requirements of a consulting assessment was completed.

(2) The final request may be made before the end of the designated period if—

(a) in the opinion of the coordinating practitioner, the person is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of the designated period; and

(b) the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner for the person as expressed in the consulting assessment.

(3) In this section—

designated period means the period of 9 days from and including the day on which the person made the first request.

44 Coordinating practitioner to record final request

(1) The coordinating practitioner must record the following information in the person's medical record—

(a) the date when the final request was made;

(b) if the final request was made before the end of the designated period, the reason for it being made before the end of that period.

(2) In this section—

designated period see section 43(3).

45 Coordinating practitioner to notify board of final request

Within 2 business days after receiving a final request made by the person, the coordinating practitioner for the person must complete a record of receiving the final request in the approved form and give a copy of it to the board.

Maximum penalty—100 penalty units.

46 Final review by coordinating practitioner on receiving final request

(1) On receiving the final request the coordinating practitioner must—

(a) review the following matters in relation to the person—

(i) the first assessment record form;

(ii) the consulting assessment record form;

(iii) the second request; and

(b) complete the approved form (the ***final review form***) in relation to the person.

(2) When conducting the review, the coordinating practitioner must take account of any decision made by QCAT under part 7 in relation to a decision made in the request and assessment process.

Note—

See section 106 for the effect of a decision by QCAT.

(3) The final review form must certify that—

(a) the request and assessment process has been completed in accordance with this Act; and

(b) the coordinating practitioner is satisfied of each of the following—

(i) the person has decision-making capacity in relation to voluntary assisted dying;

(ii) the person, in requesting access to voluntary assisted dying, is acting voluntarily and without coercion.

(4) As soon as practicable after completing the final review form, the coordinating practitioner must give a copy of it to the person.

(5) Within 2 business days after completing the final review form, the coordinating practitioner must give a copy of it to the board.

Maximum penalty—100 penalty units.

Division 6 Other provisions

47 Transfer of coordinating practitioner's role

(1) The coordinating practitioner for a person requesting access to voluntary assisted dying (the ***original practitioner***) may transfer the role of coordinating practitioner to the consulting practitioner for the person if—

(a) the consulting practitioner has assessed the person as meeting the requirements of a consulting assessment; and

(b) the consulting practitioner accepts the transfer of the role.

(2) The transfer of the role may be—

(a) at the request of the person; or

(b) on the original practitioner's own initiative.

(3) Within 2 business days after being requested by the original practitioner to accept a transfer under subsection (1), the consulting practitioner must inform the original practitioner whether the consulting practitioner accepts or refuses the transfer of the role.

(4) If the consulting practitioner accepts the transfer of the role, the original practitioner must—

(a) inform the person of the transfer; and

(b) record the transfer in the person's medical record; and

(c) within 2 business days after acceptance of the transfer, complete a record of the acceptance of the transfer in the approved form and give a copy of it to the board.

Maximum penalty for paragraph (c)—100 penalty units.

(5) If the consulting practitioner refuses the transfer of the role, the original practitioner may—

(a) refer the person to another medical practitioner for a further consulting assessment; and

(b) transfer the role of coordinating practitioner to that medical practitioner if the practitioner—

(i) accepts the referral for a further consulting assessment; and

(ii) assesses the person as meeting the requirements of a consulting assessment; and

(iii) accepts the transfer of the role.

(6) On acceptance of the referral for a further consulting assessment, the consulting assessment that previously assessed the person as meeting the requirements of a consulting assessment becomes void.

48 No obligation for person to continue after completion of request and assessment process

A person in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

Part 4 Accessing voluntary assisted dying and death

Division 1 Administration of voluntary assisted dying substance

49 Application of division

This division applies if—

(a) a person has made a final request; and

(b) the person's coordinating practitioner has completed the final review form.

50 Administration decision

(1) The person may, in consultation with and on the advice of the coordinating practitioner for the person—

(a) decide to self-administer a voluntary assisted dying substance (a ***self-administration decision***); or

(b) decide that a voluntary assisted dying substance is to be administered to the person by the administering practitioner for the person (a ***practitioner administration decision***).

(2) A practitioner administration decision may only be made if the coordinating practitioner for the person advises the person that self-administration of a voluntary assisted dying substance is inappropriate having regard to any of the following—

(a) the ability of the person to self-administer the substance;

(b) the person's concerns about self-administering the substance;

(c) the method for administering the substance that is suitable for the person.

(3) An administration decision must be—

(a) clear and unambiguous; and

(b) made by the person personally and not by another person on their behalf.

(4) The person may make an administration decision verbally or by gestures or other means of communication available to the person.

(5) If the person makes an administration decision, the coordinating practitioner for the person must record the decision in the person's medical record.

51 Revocation of administration decision

(1) The person may at any time—

(a) revoke a self-administration decision by informing the coordinating practitioner for the person that the person has decided not to self-administer a voluntary assisted dying substance; or

(b) revoke a practitioner administration decision by informing the administering practitioner for the person that the person has decided not to proceed with the administration of a voluntary assisted dying substance.

(2) The person may inform the coordinating practitioner or administering practitioner of the person's decision in writing, verbally or by gestures or other means of communication available to the person.

(3) If the person revokes an administration decision under subsection (1), the coordinating practitioner or administering practitioner who is informed of the person's decision must—

(a) record the revocation in the person's medical record; and

(b) if the practitioner is not the coordinating practitioner for the person, inform the coordinating practitioner of the revocation; and

(c) within 2 business days after the revocation, complete a record of the revocation in the approved form and give a copy of it to the board.

Maximum penalty for paragraph (c)—100 penalty units.

(4) The revocation of an administration decision does not prevent the person from making another administration decision under section 50.

52 Self-administration—authorisations

(1) This section applies if the person makes a self-administration decision.

(2) The coordinating practitioner for the person is authorised to prescribe a voluntary assisted dying substance for the person that is of a sufficient dose to cause death.

(3) Subsection (2) is subject to section 59(6).

(4) The authorised supplier who is given the prescription for the person is authorised to—

(a) possess the voluntary assisted dying substance for the purpose of preparing it and supplying it to a person mentioned in paragraph (c); and

(b) prepare the substance; and

(c) supply the substance to the person, the contact person for the person or an agent of the person.

(5) The person is authorised to—

(a) receive the voluntary assisted dying substance from the authorised supplier, the contact person for the person or an agent of the person; and

(b) possess the substance for the purpose of preparing and self-administering it; and

(c) prepare the substance; and

(d) self-administer the substance.

(6) An agent of the person is authorised to—

(a) receive the voluntary assisted dying substance from an authorised supplier; and

(b) possess the substance for the purpose of supplying it to the person; and

(c) supply the substance to the person.

(7) Another person, requested by the person to prepare the voluntary assisted dying substance for the person, is authorised to—

(a) possess the substance for the purpose of preparing it; and

(b) prepare the substance; and

(c) supply the substance to the person.

Note—

See section 61 for the authorisation of a contact person in the case of a self-administration decision.

53 Practitioner administration—authorisations

(1) This section applies if the person makes a practitioner administration decision.

(2) The coordinating practitioner for the person is authorised to prescribe a voluntary assisted dying substance for the person that is of sufficient dose to cause death.

(3) Subsection (2) is subject to section 59(6).

(4) The authorised supplier who is given the prescription for the person is authorised to—

(a) possess the voluntary assisted dying substance for the purpose of preparing it and supplying it to the administering practitioner for the person; and

(b) prepare the substance; and

(c) supply the substance to the administering practitioner for the person.

(5) The administering practitioner for the person is authorised to—

(a) receive the voluntary assisted dying substance from an authorised supplier; and

(b) possess the substance for the purpose of preparing it and administering it to the person; and

(c) prepare the substance.

(6) The administering practitioner for the person is authorised to administer the voluntary assisted dying substance to the person, in the presence of an eligible witness, if the administering practitioner is satisfied at the time of administration that—

(a) the person has decision-making capacity in relation to voluntary assisted dying; and

(b) the person is acting voluntarily and without coercion.

54 Witness to administration of voluntary assisted dying substance

(1) Another person (the ***witness***) is eligible to witness the administration of a voluntary assisted dying substance to the person if the witness is at least 18 years of age.

(2) The witness must certify in the practitioner administration form for the person that—

(a) the person appeared to be acting voluntarily and without coercion; and

(b) the administering practitioner for the person administered the substance to the person in the presence of the witness.

55 Certification by administering practitioner following administration of voluntary assisted dying substance

(1) This section applies if the administering practitioner for the person administers a voluntary assisted dying substance to the person.

(2) The administering practitioner must certify in writing—

(a) that the person made a practitioner administration decision and did not revoke the decision; and

(b) that the administering practitioner was satisfied at the time of administering the voluntary assisted dying substance to the person—

(i) that the person had decision-making capacity in relation to voluntary assisted dying; and

(ii) that the person was acting voluntarily and without coercion; and

(c) any other matter prescribed by regulation to be certified.

(3) The certificate must be in the approved form (the ***practitioner administration form***) and must include the certificate of the witness required under section 54.

(4) Within 2 business days after administering the voluntary assisted dying substance, the administering practitioner must give a copy of the practitioner administration form to the board.

Maximum penalty—100 penalty units.

56 Transfer of administering practitioner's role

(1) This section applies if—

(a) the person makes a practitioner administration decision; and

(b) the coordinating practitioner for the person prescribes a voluntary assisted dying substance for the person; and

(c) the administering practitioner for the person (the ***original practitioner***) is unable or unwilling for any reason to administer the voluntary assisted dying substance to the person, whether the original practitioner is the coordinating practitioner for the person or a person to whom the role of administering practitioner has been transferred under subsection (2).

(2) The original practitioner must transfer the role of administering practitioner to another person who is eligible to act as an administering practitioner for the person and accepts the transfer of the role.

(3) If a person (the ***new practitioner***) accepts the transfer of the role, the original practitioner must—

(a) inform the person requesting access to voluntary assisted dying of the transfer and the contact details of the new practitioner; and

(b) record the transfer in the person's medical record; and

(c) within 2 business days after the acceptance of the transfer, complete a record of the acceptance of the

transfer in the approved form and give a copy of it to the board.

Maximum penalty for paragraph (c)—100 penalty units.

(4) If the original practitioner has possession of the voluntary assisted dying substance when the role is transferred—

(a) the original practitioner is authorised to supply the substance to the new practitioner; and

(b) the new practitioner is authorised to receive the substance from the original practitioner.

(5) The coordinating practitioner for the person requesting access to voluntary assisted dying remains the coordinating practitioner despite any transfer of the role of administering practitioner under subsection (2).

Division 2 Contact person

57 Application of division

This division applies if a person has made an administration decision.

58 Contact person to be appointed

(1) The person must appoint a contact person.

(2) A person is eligible for appointment as a contact person if the person is at least 18 years of age.

(3) A person cannot be appointed as the contact person unless the person consents to the appointment.

(4) The person may revoke the appointment of the contact person.

(5) If the person revokes the appointment of the contact person—

(a) the person must inform the contact person of the revocation; and

(b) the contact person ceases to be the contact person for the person on being informed under paragraph (a); and

(c) the person must make another appointment under subsection (1).

59 Contact person appointment form

(1) An appointment under section 58(1) must be made in the approved form (the ***contact person appointment form***).

(2) The contact person appointment form must include the following—

(a) the name, date of birth and contact details of the person;

(b) the name and contact details of the coordinating practitioner for the person;

(c) the name, date of birth and contact details of the contact person;

(d) a statement that the contact person consents to the appointment;

(e) a statement that the contact person understands the contact person's role under this Act (including the requirements under section 63 to give the voluntary assisted dying substance, or any unused or remaining substance, to an authorised disposer and the penalties for offences under that section);

(f) if the person was assisted by an interpreter when making the appointment—

(i) the name, contact details and accreditation details of the interpreter; and

(ii) a statement signed by the interpreter certifying that the interpreter provided a true and correct translation of any information translated;

(g) the signature of the contact person and the date when the form was signed;

(h) the signature of the person, or other person who completes the form on behalf of the person, and the date when the form was signed.

(3) At the person's request, another person (the ***second person***) may complete the form on the person's behalf if—

(a) the person is unable to complete the form; and

(b) the second person is at least 18 years of age; and

(c) the second person signs the contact person appointment form in the presence of the person.

(4) The person or the contact person for the person must give the contact person appointment form to the coordinating practitioner for the person.

(5) Within 2 business days after receiving the contact person appointment form, the coordinating practitioner for the person must give a copy of it to the board.

Maximum penalty—100 penalty units.

(6) The coordinating practitioner for a person may not prescribe a voluntary assisted dying substance for the person before the contact person appointment form is given to the coordinating practitioner.

60 Board to give information to contact person

(1) This section applies if the person makes a self-administration decision and appoints a contact person.

(2) Within 2 business days of receiving the contact person appointment form, the board must give the contact person information about—

(a) the requirement to give the voluntary assisted dying substance, or any unused or remaining substance, to an authorised disposer under section 63; and

(b) the support services available to the contact person to assist the contact person to fulfil the requirement.

61 Role of contact person in case of self-administration decision

(1) This section applies if the person makes a self-administration decision.

(2) The contact person for the person is authorised to—

(a) receive the voluntary assisted dying substance from an authorised supplier; and

(b) possess the substance for the purpose of paragraph (c) or (d); and

(c) supply the substance to the person; and

(d) give the substance, or any unused or remaining substance, to an authorised disposer under section 63.

(3) The contact person for the person must inform the coordinating practitioner for the person if the person dies (whether as a result of self-administering the voluntary assisted dying substance or from some other cause), within 2 business days of becoming aware of the death.

(4) The board may contact the contact person to request information.

62 Role of contact person in case of practitioner administration decision

(1) This section applies if the person has made a practitioner administration decision.

(2) The contact person for the person must inform the coordinating practitioner for the person if the person dies as a result of a cause other than the administration of the voluntary assisted dying substance, within 2 business days of becoming aware of the death.

(3) The board may contact the contact person to request information.

63 Contact person to give voluntary assisted dying substance to authorised disposer

(1) Subsection (2) applies if the person revokes a self-administration decision after an authorised supplier has supplied a voluntary assisted dying substance for the person.

(2) The contact person for the person must, as soon as practicable and in any event within 14 days after the day on which the decision is revoked, give the voluntary assisted dying substance to an authorised disposer.

Maximum penalty—100 penalty units.

(3) Subsection (4) applies if the person—

(a) makes a self-administration decision; and

(b) dies after an authorised supplier has supplied a voluntary assisted dying substance for the person.

(4) The contact person for the person must, as soon as practicable and in any event within 14 days after the day on which the person dies, give any unused or remaining substance to an authorised disposer.

Maximum penalty—100 penalty units.

64 Contact person may refuse to continue in role

(1) The contact person for the person may refuse to continue to perform the role of contact person.

(2) If the contact person refuses to continue to perform the role—

(a) the contact person must inform the person of the refusal; and

(b) the contact person ceases to be the contact person for the person on informing the person under paragraph (a); and

(c) the person must make another appointment under section 58.

Division 3 Prescribing, supplying and disposing of voluntary assisted dying substance

65 Information to be given before prescribing voluntary assisted dying substance

(1) The coordinating practitioner for a person who has made a self-administration decision must, before prescribing a voluntary assisted dying substance for the person, inform the person, in writing, of the following—

(a) the S4 substance or S8 substance, or combination of substances, constituting the substance;

(b) that the person is not under any obligation to self-administer the substance;

(c) that the substance must be stored in accordance with requirements prescribed by regulation;

(d) how to prepare and self-administer the substance;

(e) the expected effects of self-administration of the substance;

(f) the period within which the person is likely to die after self-administration of the substance;

(g) the potential risks of self-administration of the substance;

(h) that, if the person decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal;

(i) that, if the person dies, their contact person must give any unused or remaining substance to an authorised disposer for disposal;

(j) the name of the authorised supplier who will be supplying the voluntary assisted dying substance;

(k) the name of 1 or more registered health practitioners or class of registered health practitioners who are authorised disposers.

(2) The coordinating practitioner for a person who has made a practitioner administration decision must, before prescribing a voluntary assisted dying substance for the person, inform the person, in writing, of the following—

(a) the S4 substance or S8 substance, or combination of substances, constituting the substance;

(b) that the person is not under any obligation to have the substance administered to the person;

(c) the method by which the substance will be administered;

(d) the expected effects of administration of the substance;

(e) the period within which the person is likely to die after administration of the substance;

(f) the potential risks of administration of the substance;

(g) that, if the practitioner administration decision is made after the revocation of a self-administration decision, the person's contact person must give any substance received by the person, the contact person or an agent of the contact person to an authorised disposer for disposal;

(h) if the practitioner administration decision is made after the revocation of a self-administration decision—the name of 1 or more registered health practitioners or class of registered health practitioners who are authorised disposers.

66 Prescription for voluntary assisted dying substance

(1) This section applies if the coordinating practitioner for a person prescribes a voluntary assisted dying substance for the person.

(2) The prescription issued by the coordinating practitioner must include—

(a) a statement that clearly indicates it is for a voluntary assisted dying substance; and

(b) a statement—

(i) certifying that the request and assessment process has been completed in relation to the person in accordance with this Act; and

(ii) certifying that the person has made an administration decision and specifying whether the decision is a self-administration decision or practitioner administration decision; and

(c) details of the substance and the maximum amount of the substance authorised by the prescription; and

(d) the person's name and telephone number.

(3) The prescription may not provide for the voluntary assisted dying substance to be supplied on more than 1 occasion.

(4) The coordinating practitioner must give the prescription directly to an authorised supplier.

67 Other requirements for prescribing

A regulation may prescribe other requirements with which a coordinating practitioner must comply in relation to prescribing a voluntary assisted dying substance.

68 Coordinating practitioner to notify board of administration decision and prescription of voluntary assisted dying substance

Within 2 business days after prescribing a voluntary assisted dying substance for a person, the person's coordinating practitioner must complete, and give a copy to the board of, a record in the approved form stating—

(a) the person's administration decision; and

(b) that the practitioner has prescribed a voluntary assisted dying substance for the person.

Maximum penalty—100 penalty units.

69 Authorised supplier to authenticate prescription

An authorised supplier who is given a prescription for a voluntary assisted dying substance must not supply the substance in accordance with the prescription unless the authorised supplier has confirmed—

(a) the authenticity of the prescription; and

(b) the identity of the person who issued the prescription; and

(c) the identity of the person to whom the substance is to be supplied.

70 Information to be given when supplying voluntary assisted dying substance

(1) This section applies if an authorised supplier supplies a voluntary assisted dying substance to a person, the contact person for a person or an agent of a person following a self-administration decision of the person.

(2) The authorised supplier must, when supplying the voluntary assisted dying substance, inform the recipient, in writing, of the following—

(a) that the person is not under any obligation to self-administer the substance;

(b) the S4 substance or S8 substance, or combination of substances, constituting the substance;

(c) how to prepare and self-administer the substance;

(d) that the substance must be stored in accordance with requirements prescribed by regulation;

(e) the expected effects of self-administration of the substance;

(f) the period within which the person is likely to die after self-administration of the substance;

(g) the potential risks of self-administration of the substance;

(h) that, if the person decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal;

(i) that, if the person dies, their contact person must give any unused or remaining substance to an authorised disposer for disposal.

71 Labelling requirements for voluntary assisted dying substance

An authorised supplier who supplies a voluntary assisted dying substance must comply with labelling requirements prescribed by regulation.

72 Authorised supplier to record and notify of supply

(1) An authorised supplier who supplies a voluntary assisted dying substance must complete a record of the supply in the approved form (the ***authorised supply form***).

(2) The authorised supply form must include the following—

(a) the name, date of birth and contact details of the person;

(b) the name and contact details of the authorised supplier;

(c) a statement that the voluntary assisted dying substance was supplied;

(d) a statement that the requirements under sections 69, 70 and 71 were complied with.

(3) Within 2 business days after supplying the voluntary assisted dying substance, the authorised supplier must give a copy of the completed authorised supply form to the board.

Maximum penalty—100 penalty units.

73 Other requirements for supplying

A regulation may prescribe other requirements with which an authorised supplier must comply in relation to supplying a voluntary assisted dying substance.

74 Storage of voluntary assisted dying substance

A person who receives a voluntary assisted dying substance must store the substance in accordance with the requirements prescribed by regulation.

75 Disposal of voluntary assisted dying substance

(1) This section applies if a voluntary assisted dying substance, or any unused or remaining substance, is given to an authorised disposer by the contact person for a person.

(2) The authorised disposer is authorised to—

(a) possess the voluntary assisted dying substance or unused or remaining substance for the purpose of disposing of it; and

(b) dispose of the substance.

(3) The authorised disposer must dispose of the voluntary assisted dying substance or unused or remaining substance as soon as practicable after receiving it.

76 Authorised disposer to record and notify of disposal

(1) An authorised disposer who disposes of a voluntary assisted dying substance or unused or remaining substance must complete a record of the disposal in the approved form (the ***authorised disposal form***).

(2) Within 2 business days after disposing of the voluntary assisted dying substance or unused or remaining substance, the authorised disposer must give a copy of the completed authorised disposal form to the board.

Maximum penalty—100 penalty units.

77 Disposal of voluntary assisted dying substance by administering practitioner

(1) Subsections (2) and (3) apply if—

(a) a person who has made a practitioner administration decision revokes the decision; and

(b) the administering practitioner for the person has possession of the voluntary assisted dying substance when the decision is revoked.

(2) The administering practitioner is authorised to—

(a) possess the voluntary assisted dying substance for the purpose of disposing of it; and

(b) dispose of the substance.

(3) The administering practitioner must dispose of the voluntary assisted dying substance as soon as practicable after the practitioner administration decision is revoked.

(4) Subsections (5) and (6) apply if—

(a) a person who has made a practitioner administration decision dies (whether or not after being administered the voluntary assisted dying substance); and

(b) the administering practitioner for the person has possession of any unused or remaining substance.

(5) The administering practitioner is authorised to—

(a) possess the unused or remaining substance for the purpose of disposing of it; and

(b) dispose of the unused or remaining substance.

(6) The administering practitioner must dispose of the unused or remaining substance as soon as practicable after the person's death.

78 Administering practitioner to record and notify of disposal

(1) An administering practitioner for a person who disposes of a voluntary assisted dying substance or unused or remaining substance must complete a record of the disposal in the approved form (the ***practitioner disposal form***).

(2) Within 2 business days after disposing of the voluntary assisted dying substance or unused or remaining substance, the administering practitioner must give a copy of the completed practitioner disposal form to the board.

Maximum penalty—100 penalty units.

79 Other requirements for disposal

A regulation may prescribe other requirements with which an authorised disposer or administering practitioner must comply in relation to disposing of a voluntary assisted dying substance or unused or remaining substance.

Division 4 Other provisions

80 Notification of death

(1) The coordinating practitioner and administering practitioner for a person must each, within 2 business days after becoming aware that the person has died (whether or not after self-administering or being administered a voluntary assisted dying substance), notify the board in the approved form of the person's death.

Maximum penalty—100 penalty units.

(2) Subsection (1) does not apply if the administering practitioner for a person gives the board a copy of a practitioner administration form in relation to the person under section 55.

81 Cause of death certificate

(1) This section applies if a medical practitioner who is required to give a cause of death certificate for a person knows or reasonably believes that the person self-administered, or was administered, a voluntary assisted dying substance under this Act.

(2) The medical practitioner must, within 2 business days after becoming aware that the person has died, notify the board, in the approved form, of the person's death, unless the medical practitioner is the coordinating practitioner or administering practitioner for the person.

(3) The medical practitioner—

(a) must state in the cause of death certificate for the person that the cause of death of the person was the disease, illness or medical condition mentioned in section 10(1)(a) from which the person suffered; and

(b) must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

(4) In this section—

cause of death certificate see the *Births, Deaths and Marriages Registration Act 2003*, section 30(2)(a).

Part 5 Eligibility requirements for health practitioners

82 Eligibility to act as coordinating practitioner or consulting practitioner

(1) A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a person requesting access to voluntary assisted dying if—

(a) the medical practitioner—

(i) holds specialist registration and has practised for at least 1 year as the holder of that registration; or

(ii) holds general registration and has practised for at least 5 years as the holder of that registration; or

(iii) holds specialist registration and has practised for at least 5 years as the holder of general registration; or

(iv) is an overseas-trained specialist who holds limited registration or provisional registration; and

(b) the medical practitioner meets the approved medical practitioner requirements; and

(c) the medical practitioner is not a family member of the person requesting access to voluntary assisted dying; and

(d) the medical practitioner does not know or believe that the practitioner—

(i) is a beneficiary under a will of the person requesting access to voluntary assisted dying; or

(ii) may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the person.

(2) In this section—

general registration means general registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession.

limited registration means limited registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession.

provisional registration means provisional registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession.

specialist registration means specialist registration under the Health Practitioner Regulation National Law (Queensland) in the medical profession in a recognised speciality.

83 Eligibility to act as administering practitioner

A person is eligible to act as an administering practitioner for a person requesting access to voluntary assisted dying if—

(a) the person is—

(i) a medical practitioner who is eligible to act as a coordinating practitioner for the person requesting access to voluntary assisted dying under section 82(1); or

(ii) a nurse practitioner who meets the approved nurse practitioner requirements; or

(iii) a nurse who has practised in the nursing profession for at least 5 years and meets the approved nurse requirements; and

(b) the person has completed the approved training; and

(c) the person is not a family member of the person requesting access to voluntary assisted dying; and

(d) the person does not know or believe that they—

(i) are a beneficiary under a will of the person requesting access to voluntary assisted dying; or

(ii) may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services as the administering practitioner for the person.

Part 6 Participation

Division 1 Conscientious objection

84 Registered health practitioner with conscientious objection

(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—

(a) provide information to another person about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) participate in an administration decision;

(d) prescribe, supply or administer a voluntary assisted dying substance;

(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

(2) A registered health practitioner who, because of a conscientious objection, refuses to do a thing mentioned in subsection (1) for a person seeking information or assistance about voluntary assisted dying, must—

(a) inform the person that other health practitioners, health service providers or services may be able to assist the person; and

(b) give the person—

(i) information about a health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and

contact details) about a health practitioner, health service provider or service who may be able to assist the person.

85 Speech pathologist with conscientious objection

(1) A speech pathologist who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—

(a) provide information to another person about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) participate in an administration decision;

(d) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

(2) A speech pathologist who, because of a conscientious objection, refuses to do a thing mentioned in subsection (1) for an employer or for any other person who has requested speech pathology services in relation to voluntary assisted dying—

(a) must inform the employer or other person of the speech pathologist's conscientious objection; and

(b) must inform the employer or other person of another speech pathologist or speech pathology service who, in the speech pathologist's belief, is likely to be able to assist in providing the speech pathology services requested; and

(c) must not intentionally impede the person's access to speech pathology services in relation to voluntary assisted dying.

(3) Subsection (4) applies if—

(a) a speech pathologist is employed or otherwise engaged by a health service provider; and

(b) the speech pathologist knows, or ought reasonably to know, the health service provider provides, or is likely to provide, services relating to voluntary assisted dying.

(4) The speech pathologist must—

(a) inform the health service provider of the speech pathologist's conscientious objection to voluntary assisted dying; and

(b) discuss with the health service provider how they can practise in accordance with their beliefs without placing a burden on their colleagues or compromising a person's access to voluntary assisted dying under this Act.

(5) In this section—

speech pathologist means a person who is eligible for practising membership of The Speech Pathology Association of Australia Limited ACN 008 393 440.

Division 2 Participation by entities

Subdivision 1 Preliminary

86 Definitions for division

In this division—

deciding practitioner, for a decision about the transfer of a person, means—

(a) the coordinating practitioner for the person; or

(b) if a different medical practitioner is chosen by the person and the relevant entity from which the person is receiving relevant services at a facility, to make the decision—that practitioner.

facility means—

(a) a private hospital; or

(b) a hospice; or

(c) a public sector hospital; or

(d) a nursing home, hostel or other facility at which accommodation, nursing or personal care is provided to persons who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care; or

(e) a residential aged care facility.

permanent resident see section 89.

relevant entity see section 87.

relevant service see section 88.

residential aged care means personal care or nursing care, or both personal care and nursing care, that is provided to a person in a residential facility in which the person is also provided with accommodation that includes—

(a) staffing to meet the nursing and personal care needs of the person; and

(b) meals and cleaning services; and

(c) furnishings, furniture and equipment for the provision of that care and accommodation.

residential aged care facility means a facility at which residential aged care is provided, whether or not the care is provided by an entity that is an approved provider under the *Aged Care Quality and Safety Commission Act 2018* (Cwlth).

residential facility does not include—

(a) a private home; or

(b) a hospital or psychiatric facility; or

(c) a facility that primarily provides care to people who are not frail and aged.

87 Meaning of *relevant entity*

A ***relevant entity*** is an entity, other than an individual, that provides a relevant service.

88 Meaning of *relevant service*

A ***relevant service*** is a health service, residential aged care or a personal care service.

89 Meaning of *permanent resident*

(1) A person is a ***permanent resident*** at a facility if the facility is the person's settled and usual place of abode where the person regularly or customarily lives.

(2) Also, a person is a ***permanent resident*** at a facility that is a residential aged care facility if the person has security of tenure at the facility under the *Aged Care Act 1997* (Cwlth) or on some other basis.

(3) A person is not a permanent resident at a facility if the person resides at the facility temporarily.

Examples—

- an in-patient of a hospital
- a resident of a hospice

Subdivision 2 Information about voluntary assisted dying

90 Access to information about voluntary assisted dying

(1) This section applies if—

(a) a person is receiving relevant services from a relevant entity at a facility; and

(b) the person asks the entity for information about voluntary assisted dying; and

(c) the entity does not provide at the facility, to persons to whom relevant services are provided, the information that has been requested.

(2) The relevant entity and any other entity that owns or occupies the facility—

(a) must not hinder the person's access at the facility to information about voluntary assisted dying; and

(b) must allow reasonable access to the person at the facility by each person who—

(i) is a registered health practitioner or a member or employee of an official voluntary assisted dying care navigator service; and

(ii) is seeking the access to provide the requested information to the person about voluntary assisted dying.

Subdivision 3 Access to voluntary assisted dying

91 Application of subdivision

This subdivision applies if a person is receiving relevant services from a relevant entity at a facility.

92 First requests and final requests

(1) This section applies if—

(a) the person or the person's agent advises the relevant entity that the person wishes to make a first request or final request (each a ***relevant request***); and

(b) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) The relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a medical practitioner—

(a) whose presence is requested by the person; and

(b) who—

(i) for a first request—is eligible to act as a coordinating practitioner; or

(ii) for a final request—is the coordinating practitioner for the person.

(3) If the requested medical practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made to—

(a) the requested medical practitioner; or

(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

93 Second requests

(1) This section applies if—

(a) the person or the person's agent advises the relevant entity that the person wishes to make a second request; and

(b) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) The relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by—

(a) the coordinating practitioner for the person; and

(b) 2 persons who are eligible to witness the signing of a second request by the person.

(3) If the coordinating practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the

transfer of the person to and from a place where the person's second request may be made to—

(a) the coordinating practitioner; or

(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

94 First assessments

(1) This section applies if—

(a) the person has made a first request; and

(b) the person or the person's agent advises the relevant entity that the person wishes to undergo a first assessment; and

(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the facility—

(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person to assess the person; and

(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by—

(i) the relevant practitioner; or

(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by a relevant practitioner for the person; or

(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person;

Examples of serious harm—

- significant pain
- a significant deterioration in the person's condition

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;

Examples of adverse effects—

- the transfer would likely result in a loss of decision-making capacity of the person
- pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

(d) whether the place to which the person is proposed to be transferred is available to receive the person;

(e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section—

relevant practitioner, for a person, means—

(a) the coordinating practitioner for the person; or

(b) a registered health practitioner to whom the coordinating practitioner for the person has referred a matter under section 21.

95 Consulting assessments

(1) This section applies if—

(a) the person has undergone a first assessment; and

(b) the person or the person's agent advises the relevant entity that the person wishes to undergo a consulting assessment; and

(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the facility—

(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person to assess the person; and

(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by—

(i) the relevant practitioner; or

(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by a relevant practitioner for the person; or

(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person;

Examples of serious harm—

- significant pain
- a significant deterioration in the person's condition

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;

Examples of adverse effects—

- the transfer would likely result in a loss of decision-making capacity of the person
- pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

(d) whether the place to which the person is proposed to be transferred is available to receive the person;

(e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section—

relevant practitioner, for a person, means—

(a) the consulting practitioner for the person; or

(b) a registered health practitioner to whom the consulting practitioner for the person has referred a matter under section 32.

96 Administration decisions

(1) This section applies if—

(a) the person has made a final request; and

(b) the person or the person's agent advises the relevant entity that the person wishes to make an administration decision; and

(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to a person's coordinating practitioner to enable an administration decision to be made.

(2) If the person is a permanent resident at the facility—

(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating practitioner for the person to consult with and advise the person in making the administration decision; and

(b) if the coordinating practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's administration decision may be made in consultation with, and on the advice of—

(i) the coordinating practitioner; or

(ii) another medical practitioner who is eligible and willing to act as the coordinating practitioner for the person.

(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's administration decision may be made in consultation with, and on the advice of, the coordinating practitioner for the person; or

(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating practitioner for the person.

(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person;

Examples of serious harm—

- significant pain
- a significant deterioration in the person's condition

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;

Examples of adverse effects—

- the transfer would likely result in a loss of decision-making capacity of the person
- pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

(d) whether the place to which the person is proposed to be transferred is available to receive the person;

(e) whether the person would incur financial loss or costs because of the transfer.

97 Administration of voluntary assisted dying substance

(1) This section applies if—

(a) the person has made an administration decision; and

(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have an administering practitioner administer a voluntary assisted dying substance to the person; and

(c) the relevant entity does not provide, to persons to whom relevant services are provided at the facility, access to the administration of a voluntary assisted dying substance at the facility.

(2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must—

(a) if the person has made a practitioner administration decision—

(i) allow reasonable access to the person at the facility by the administering practitioner for the person to administer a voluntary assisted dying substance to the person; and

(ii) allow reasonable access to the person at the facility by an eligible witness to the administration of the voluntary assisted dying substance by the administering practitioner for the person; or

(b) if the person has made a self-administration decision—not hinder access by the person to a voluntary assisted dying substance.

(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance; or

(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the facility.

(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person;

Examples of serious harm—

- significant pain
- a significant deterioration in the person's condition

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;

Examples of adverse effects—

- the transfer would likely result in a loss of decision-making capacity of the person

- pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person

(c) whether the place to which the person is proposed to be transferred is available to receive the person.

Subdivision 4 Information about non-availability of voluntary assisted dying

98 Relevant entities to inform public of non-availability of voluntary assisted dying

(1) This section applies to a relevant entity that does not provide, at a facility at which the entity provides relevant services, services associated with voluntary assisted dying, such as access to the request and assessment process or access to the administration of a voluntary assisted dying substance.

(2) The relevant entity must publish information about the fact the entity does not provide those services at the facility.

(3) The relevant entity must publish the information in a way in which it is likely that persons who receive the services of the entity at the facility, or may in future receive the services of the entity at the facility, become aware of the information.

Examples of ways of publishing information—

- printing the information in brochures about the relevant entity
- placing the information on the relevant entity's website
- displaying the information on signs at the facility

Part 7 Review by QCAT

Division 1 Preliminary

99 Reviewable decisions

The following decisions are reviewable under this part—

(a) a decision of a coordinating practitioner, in a first assessment of a person requesting access to voluntary assisted dying, whether or not the person—

(i) has been ordinarily resident in Australia for at least 3 years immediately before the person made the person's first request; or

(ii) has been ordinarily resident in Queensland for at least 12 months immediately before the person made the person's first request; or

(iii) has decision-making capacity in relation to voluntary assisted dying; or

(iv) is acting voluntarily and without coercion; or

(b) a decision of a consulting practitioner, in a consulting assessment of a person requesting access to voluntary assisted dying, whether or not the person—

(i) has been ordinarily resident in Australia for at least 3 years immediately before the person made the person's first request; or

(ii) has been ordinarily resident in Queensland for at least 12 months immediately before the person made the person's first request; or

(iii) has decision-making capacity in relation to voluntary assisted dying; or

(iv) is acting voluntarily and without coercion; or

(c) a decision of a coordinating practitioner, in a final review of a person requesting access to voluntary assisted dying, whether or not the person—

(i) has decision-making capacity in relation to voluntary assisted dying; or

(ii) is acting voluntarily and without coercion.

100 Who is an *eligible person*

An ***eligible person***, for a reviewable decision, is—

(a) a person who is the subject of the decision; or

(b) an agent of a person mentioned in paragraph (a); or

(c) any other person who has a sufficient and genuine interest in the rights and interests of a person mentioned in paragraph (a) in relation to voluntary assisted dying.

101 Relationship with QCAT Act

The following provisions of the QCAT Act do not apply in relation to proceedings under this part—

(a) section 21(2) and (4);

(b) sections 22 and 23;

(c) section 24(1) and (2);

(d) section 33(3) and (4);

(e) chapter 3.

Division 2 Application and review

102 Right of review of particular decisions

An eligible person for a reviewable decision may apply to QCAT for a review of the decision.

103 Making an application

(1) The application must be made within 5 business days after the relevant day for the reviewable decision.

(2) In this section—

relevant day, for a reviewable decision, means—

(a) for a reviewable decision mentioned in section 99(a)—the later of the following days—

(i) the day the first assessment record form was given to the person requesting access to voluntary assisted dying;

(ii) the day the eligible person making the application becomes aware of the reviewable decision; or

(b) for a reviewable decision mentioned in section 99(b)—the later of the following days—

(i) the day the consulting assessment record form was given to the person requesting access to voluntary assisted dying;

(ii) the day the eligible person making the application becomes aware of the reviewable decision; or

(c) if the reviewable decision was made under section 99(c)—the later of the following days—

(i) the day the final review form was given to the person requesting access to voluntary assisted dying;

(ii) the day the eligible person making the application becomes aware of the reviewable decision.

104 Effect of application

When the application is made—

(a) if the request and assessment process in relation to the person requesting access to voluntary assisted dying has not been completed—

(i) the request and assessment process is suspended; and

(ii) no further step in the process may be taken until the application for review is finalised; or

(b) if the request and assessment process in relation to the person requesting access to voluntary assisted dying has been completed—

(i) the process for accessing voluntary assisted dying under part 4 is suspended; and

(ii) no further step under that part (including the prescription, supply or administration of a voluntary assisted dying substance) may be taken in relation to the person until the application for review is finalised.

105 Decision of QCAT

In a proceeding for a review of the reviewable decision, QCAT may decide—

(a) if the application for review was about the person's Australian residency—

(i) that at the time of making the first request, the person had been ordinarily resident in Australia for at least 3 years immediately before that time; or

(ii) that at the time of making the first request, the person had not been ordinarily resident in Australia for at least 3 years immediately before that time; or

(b) if the application for review was about the person's Queensland residency—

(i) that at the time of making the first request, the person had been ordinarily resident in Queensland for at least 12 months immediately before that time; or

(ii) that at the time of making the first request, the person had not been ordinarily resident in Queensland for at least 12 months immediately before that time; or

(c) if the application for review was about the person's decision-making capacity—

(i) that the person does have decision-making capacity in relation to voluntary assisted dying; or

(ii) that the person does not have decision-making capacity in relation to voluntary assisted dying; or

(d) if the application was about whether the person is acting voluntarily and without coercion—

(i) that the person is acting voluntarily and without coercion; or

(ii) that the person is not acting voluntarily and without coercion.

106 Effect of decision

(1) If QCAT makes a decision mentioned in section 105(a)(i), (b)(i), (c)(i) or (d)(i) on a review of a reviewable decision about a person requesting access to voluntary assisted dying—

(a) section 104 ceases to apply; and

(b) if the reviewable decision is a decision of a coordinating practitioner mentioned in section 99(a) or (c) and QCAT's decision sets aside the reviewable decision—QCAT's decision is taken to be the decision of the coordinating practitioner, except for the purposes of an appeal under the QCAT Act, chapter 2, part 8; and

(c) if the reviewable decision is a decision of a consulting practitioner mentioned in section 99(b) and QCAT's decision sets aside the reviewable decision—QCAT's decision is taken to be the decision of the consulting practitioner, except for the purposes of an appeal under the QCAT Act, chapter 2, part 8.

(2) Subsection (1) only applies if QCAT does not, in addition to making a decision under section 105(a)(i), (b)(i), (c)(i) or (d)(i), make a decision in the same proceeding under section 105(a)(ii), (b)(ii), (c)(ii) or (d)(ii).

(3) If QCAT makes a decision mentioned in section 105(a)(ii), (b)(ii), (c)(ii) or (d)(ii) on a review of a reviewable decision in relation to a person requesting access to voluntary assisted dying—

(a) the person is taken to be ineligible for access to voluntary assisted dying for the purposes of the request and assessment process in relation to the person; and

(b) if the request and assessment process in relation to the person had not been completed when the application for the review was made—the request and assessment process ends; and

(c) if the request and assessment process in relation to the person had been completed when the application for review was made—

(i) the process for accessing voluntary assisted dying under part 4 ends; and

(ii) no step under that part (including the prescription, supply or administration of a voluntary assisted dying substance) is to be taken in relation to the person.

Division 3 Procedural provisions

107 Parties to proceeding

For the QCAT Act, section 40(1)(e), each of the following persons is a party to a review of a reviewable decision about a person requesting access to voluntary assisted dying—

(a) if the person is not the applicant—the person;

(b) if the reviewable decision is a decision mentioned in section 99(b)—the coordinating practitioner for the person.

108 Notice of proceeding

(1) This section applies if an application for review of a reviewable decision about a person requesting access to voluntary assisted dying is accepted by the principal registrar.

(2) Within 2 business days after receiving the application the principal registrar must give a copy of the application to—

(a) each party to the proceeding; and

(b) if there is a consulting practitioner for the person and the consulting practitioner is not a party—the consulting practitioner; and

(c) any other person to whom QCAT directs a copy of the application be given.

109 Coordinating practitioner or consulting practitioner to assist QCAT

(1) Subsection (2) applies if the principal registrar gives a coordinating practitioner or consulting practitioner for a person requesting access to voluntary assisted dying a copy of an application for review of a reviewable decision about the person.

(2) The principal registrar must also give the coordinating practitioner or consulting practitioner a notice requiring the practitioner to give QCAT any documents in the practitioner's possession or under the practitioner's control that are relevant to the review.

Examples of documents—

- a first assessment record form and any accompanying documents
- a consulting assessment record form and any accompanying documents
- a final review form

(3) Within 2 business days after receiving the notice the coordinating practitioner or consulting practitioner must comply with the notice.

110 Notice of decision

(1) This section applies if—

(a) there is a consulting practitioner for a person requesting access to voluntary assisted dying; and

(b) the consulting practitioner is not a party to the review of a reviewable decision about the person.

(2) For the QCAT Act, section 121(1)(b), QCAT must give its final decision in the proceeding for the review of the reviewable decision about the person to the consulting practitioner for the person as soon as reasonably practicable after making the decision.

111 Members constituting QCAT

(1) For the review of a reviewable decision QCAT must be constituted by at least 1 member who is a legally qualified member.

(2) In this section—

legally qualified member has the meaning given by the QCAT Act.

member has the meaning given by the QCAT Act.

112 Hearings must be held in private

A hearing of a review of a reviewable decision must be held in private.

113 Application taken to be withdrawn if person dies

(1) This section applies if the person the subject of a review of a reviewable decision dies.

(2) The application is taken to be withdrawn.

(3) The principal registrar must, as soon as reasonably practicable after becoming aware that the person has died, give notice of the withdrawal to—

(a) each person who received a copy of the application; and

(b) any other person to whom QCAT directs notice be given.

Division 4 Other provisions

114 Coordinating practitioner must give copy of QCAT's decision to board

(1) This section applies if a coordinating practitioner for a person requesting access to voluntary assisted dying receives a final decision of QCAT in a proceeding for the review of a reviewable decision about the person.

(2) Within 2 business days after receiving the final decision the coordinating practitioner must give a copy of it to the board.

Maximum penalty—100 penalty units.

115 Coordinating practitioner may refuse to continue in role

(1) This section applies if—

(a) a decision of QCAT is substituted for a decision of a coordinating practitioner for a person requesting access to voluntary assisted dying under section 106(1)(b); and

(b) the decision of QCAT is about—

(i) whether the person has or does not have decision-making capacity in relation to voluntary assisted dying; or

(ii) whether the person is or is not acting voluntarily and without coercion.

(2) The coordinating practitioner may refuse to continue to perform the role of coordinating practitioner.

(3) A coordinating practitioner who refuses to continue to perform the role of coordinating practitioner must transfer the role of coordinating practitioner to—

(a) if there is a consulting practitioner for the person—that person; or

(b) otherwise—another medical practitioner who is eligible to act as a coordinating practitioner.

Part 8 Voluntary Assisted Dying Review Board

Division 1 Establishment, functions and powers

116 Establishment

The Voluntary Assisted Dying Review Board is established.

117 Functions

(1) The board has the following functions—

(a) to monitor the operation of this Act;

(b) to review, for each completed request for voluntary assisted dying, whether or not the following persons complied with this Act—

(i) coordinating practitioners;

(ii) consulting practitioners;

(iii) administering practitioners;

(iv) authorised suppliers;

(v) authorised disposers;

(vi) contact persons;

(c) to refer to the following entities issues identified by the board in relation to voluntary assisted dying that are relevant to the functions of the entities—

(i) the commissioner of police;

(ii) the registrar-general;

(iii) the State Coroner;

(iv) the health ombudsman;

(v) the chief executive;

(d) to record and keep information prescribed by regulation about requests for, and provision of, voluntary assisted dying;

(e) to analyse information given to the board under this Act and research matters related to the operation of this Act;

(f) to provide, on the board's own initiative or on request, information, reports and advice to the Minister or the chief executive in relation to—

(i) the operation of this Act; or

(ii) the board's functions; or

(iii) the improvement of the processes and safeguards of voluntary assisted dying;

(g) to promote compliance with this Act, including by providing information about the operation of this Act to registered health practitioners and members of the community;

(h) to promote continuous improvement in the compassionate, safe and practical operation of this Act;

(i) to consult and engage with the community and any entity the board considers appropriate in relation to voluntary assisted dying;

(j) any other function given to the board under this Act.

(2) For subsection (1)(b), a person's request for voluntary assisted dying is ***completed*** if—

(a) the person has died; or

(b) the request has been discontinued.

118 Powers

(1) The board may do anything necessary or convenient to be done in the performance of its functions.

(2) Without limiting subsection (1), the board may collect, use and disclose information given to the board under this Act for the purpose of carrying out the board's functions.

119 Board must act independently and in public interest

(1) In performing its functions, the board must act independently and in the public interest.

(2) Without limiting subsection (1), the board is not subject to direction by anyone, including the Minister, about how it performs its functions.

120 Administrative support for board

The chief executive must ensure the board has the administrative support services reasonably required for the board to perform its functions effectively and efficiently.

Division 2 Membership

121 Members of board

The board consists of at least 5 but not more than 9 members appointed by the Minister.

122 Chairperson

(1) The Minister must appoint a member of the board to be the chairperson of the board.

(2) The chairperson is responsible for leading and directing the activities of the board to ensure the board performs its functions appropriately.

(3) The chairperson holds office for the term stated in the person's instrument of appointment as chairperson.

(4) A vacancy in the office of chairperson arises if the person holding the office—

(a) resigns office by signed notice given to the Minister; or

(b) ceases to be a member.

(5) A person may be reappointed as chairperson.

123 Deputy chairperson

(1) The Minister may appoint a member of the board to be the deputy chairperson of the board.

(2) The deputy chairperson is to act as chairperson—

(a) during a vacancy in the office of the chairperson; and

(b) during all periods when the chairperson is absent from duty or for another reason cannot perform the duties of the office.

(3) The deputy chairperson holds office for the term stated in the person's instrument of appointment as deputy chairperson.

(4) A vacancy in the office of deputy chairperson arises if the person holding the office—

(a) resigns office by signed notice given to the Minister; or

(b) ceases to be a member.

(5) A person may be reappointed as deputy chairperson.

124 Appointment of members

(1) The Minister may appoint a person as a member only if satisfied the person—

(a) has expertise in—

(i) medicine; or

(ii) nursing; or

(iii) pharmacy; or

(iv) psychology; or

(v) social work; or

(vi) ethics; or

(vii) law; or

(viii) another area the Minister considers relevant to the performance of the board's functions; or

(b) is otherwise, because of the person's experience, knowledge or skills, likely to make a valuable contribution to the work of the board.

(2) The Minister must ensure the membership of the board—

(a) includes persons with a range of experience, knowledge and skills relevant to the board's functions; and

(b) takes into account the social, cultural and geographic characteristics of the Queensland community; and

(c) does not include a majority of persons who are public service employees.

(3) A person may not be appointed as a member if the person—

(a) is an insolvent under administration under the Corporations Act, section 9; or

(b) has a conviction, other than a spent conviction, for an indictable offence; or

(c) is a member of the Legislative Assembly.

(4) In this section—

spent conviction means a conviction—

(a) for which the rehabilitation period under the *Criminal Law (Rehabilitation of Offenders) Act 1986* has expired under the Act; and

(b) that is not revived as prescribed by section 11 of that Act.

125 Conditions of appointment

(1) A member is to be paid the remuneration and allowances decided by the Minister.

(2) For matters not provided for by this Act, a member holds office on the terms and conditions decided by the Minister.

126 Term of appointment

(1) A member is appointed for the term, of not more than 3 years, stated in the member's instrument of appointment.

(2) A member may be reappointed.

127 Vacation of office

(1) The office of a member becomes vacant if—

(a) the member—

(i) completes the member's term of office and is not reappointed; or

(ii) resigns from office by signed notice given to the Minister; or

(iii) becomes ineligible for appointment under section 124(3); or

(b) the Minister ends the member's appointment under subsection (2).

(2) The Minister may, by signed notice given to a member, terminate the member's appointment if the Minister is satisfied the member is incapable of satisfactorily performing the member's functions.

Division 3 Proceedings

128 Conduct of meetings

(1) Subject to this division, the board may conduct its business, including its meetings, in the way it considers appropriate.

(2) The board may hold meetings, or allow members to take part in meetings, by using any technology allowing reasonably contemporaneous and continuous communication between persons taking part in the meeting.

(3) A member who takes part in a meeting under subsection (2) is taken to be present at the meeting.

(4) A question at a meeting is to be decided by a majority of the votes of the members present at the meeting.

(5) If the votes are equal, the member presiding has a casting vote.

(6) A resolution is a valid resolution of the board, even though it is not passed at a meeting of the board, if—

(a) at least half of the members have given written agreement to the resolution; and

(b) notice of the resolution is given under procedures approved by the board.

129 Minutes and other records

The board must keep—

(a) minutes of its meetings; and

(b) a record of its decisions and resolutions.

130 Quorum

A quorum for a meeting of the board is at least half of the members of the board.

131 Presiding at meetings

(1) The chairperson is to preside at all meetings at which the chairperson is present.

(2) If the chairperson is not present at a meeting, the deputy chairperson is to preside.

(3) If neither the chairperson nor the deputy chairperson is present at a meeting, the board member chosen by the members present is to preside.

132 Committees

The board may establish committees to assist in the performance of its functions.

133 Disclosure of interests

(1) This section applies if—

(a) a member has a direct or indirect interest in a matter being considered, or about to be considered, at a meeting; and

(b) the interest could conflict with the proper performance of the member's duties about the consideration of the matter.

(2) As soon as practicable after the relevant facts come to the member's knowledge, the member must disclose the nature of the interest at a meeting.

(3) Particulars of the disclosure must be recorded by the board in a register of interests kept for the purpose.

(4) Unless the board directs otherwise, the member must not—

(a) be present when the board considers the matter; or

(b) take part in a decision of the board about the matter.

(5) The member must not be present when the board is considering whether to give a direction under subsection (4).

(6) A contravention of this section does not invalidate a decision of the board.

(7) However, the board must reconsider a decision it has made about a matter if the board becomes aware that—

(a) the member contravened subsection (4)(a) in relation to the board's consideration of the matter before the board made the decision; or

(b) the member contravened subsection (4)(b) in relation to the decision.

Division 4 Reporting

134 Annual report

(1) The board must, within 3 months after the end of each financial year, give the Minister a report (an ***annual report***) in relation to the performance of the board's functions during the financial year.

(2) The annual report must include—

(a) the number of completed requests for voluntary assisted dying the board has reviewed under section 117(1)(b); and

(b) the number of referrals, if any, the board has made to other entities under section 117(1)(c); and

(c) recommendations of the board relevant to the performance of its functions, including, for example, recommendations about systemic matters in voluntary assisted dying or the improvement of voluntary assisted dying; and

(d) a summary, in de-identified form, of the information required to be recorded and kept by the board under section 117(1)(d).

(3) The Minister must table a copy of the report in the Legislative Assembly within 14 sitting days after receiving it.

135 Report to Minister or chief executive on board's functions

(1) The board may, and must on request, provide the Minister or the chief executive with a report about the board's functions.

(2) Subsection (1) applies despite section 119(2).

(3) A copy of a report provided to the Minister under this section must be tabled by the Minister in the Legislative Assembly within 14 sitting days after receiving it.

136 Reports not to include personal information

An annual report or a report under section 135 must not include personal information about an individual unless the information was provided to the board for the purpose of publication.

Division 5 Miscellaneous

137 Assistance to the board

(1) The board may, with the chief executive's approval, engage persons with suitable qualifications and experience to help the board in performing its functions.

(2) The engagement may be in an honorary capacity or for remuneration.

(3) A person engaged by the board under this section may attend the board's meetings and participate in the board's deliberations, but may not vote at the meetings.

138 Request for information by the board

To help in performing its functions, the board may consult with, and ask for information from, other entities.

139 Protection from liability for giving information

(1) This section applies if a person, acting honestly, gives information under section 138.

(2) The person is not liable, civilly, criminally or under an administrative process, for giving the information.

(3) Also, merely because the person gives the information, the person cannot be held to have—

(a) breached any code of professional etiquette or ethics; or

(b) departed from accepted standards of professional conduct.

(4) Without limiting subsections (2) and (3)—

(a) in a proceeding for defamation, the person has a defence of absolute privilege for publishing the information; and

(b) if the person would otherwise be required to maintain confidentiality about the information under an Act, oath or rule of law or practice, the person—

(i) does not contravene the Act, oath or rule of law or practice by giving the information; and

(ii) is not liable to disciplinary action for giving the information.

Part 9 Offences

140 Unauthorised administration of voluntary assisted dying substance

(1) A person must not administer a voluntary assisted dying substance to another person unless the person is authorised to do so under section 53(6).

Maximum penalty—14 years imprisonment.

(2) A person does not commit an offence against subsection (1) if the person administers a medicine to another person under the *Medicines and Poisons Act 2019*.

(3) An offence against subsection (1) is a crime.

(4) In this section—

medicine see the *Medicines and Poisons Act 2019*, section 11.

141 Inducing a person to request, or revoke request for, voluntary assisted dying

(1) A person must not, dishonestly or by coercion, induce another person to make, or revoke, a request for access to voluntary assisted dying.

Maximum penalty—7 years imprisonment.

(2) An offence against subsection (1) is a misdemeanour.

(3) In this section—

request for access to voluntary assisted dying means—

(a) a first request; or

(b) a second request; or

(c) a final request; or

(d) an administration decision.

142 Inducing self-administration of voluntary assisted dying substance

(1) A person must not, dishonestly or by coercion, induce another person to self-administer a voluntary assisted dying substance.

Maximum penalty—7 years imprisonment.

(2) An offence against subsection (1) is a misdemeanour.

143 Giving board false or misleading information

(1) A person must not, in relation to the administration of this Act, give the board information the person knows to be false or misleading in a material particular.

Maximum penalty—5 years imprisonment.

(2) An offence against subsection (1) is a misdemeanour.

(3) Subsection (1) does not apply to a person if the person, when giving information in a document—

(a) tells the board, to the best of the person's ability, how the document is false or misleading; and

(b) if the person has, or can reasonably obtain, the correct information—gives the correct information.

144 Making false or misleading statement

(1) A person must not make a statement in a form or other document required to be made under this Act that the person knows to be false or misleading in a material particular.

Maximum penalty—5 years imprisonment.

(2) An offence against subsection (1) is a misdemeanour.

145 Falsifying documents

(1) A person must not falsify a form or other document required to be made under this Act.

Maximum penalty—5 years imprisonment.

(2) An offence against subsection (1) is a misdemeanour.

146 Personal information not to be recorded or disclosed

(1) This section applies to a person who obtains personal information in the course of, or because of, the exercise of a function or power under this Act.

(2) The person must not—

(a) make a record of the personal information; or

(b) disclose the personal information to a person.

Maximum penalty—100 penalty units.

(3) However, subsection (2) does not apply if the record is made, or the personal information is disclosed—

(a) for a purpose under this Act; or

(b) with the consent of the person to whom the personal information relates; or

(c) in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal; or

(d) as authorised or required by law.

Part 10 Protection from liability

147 Protection for persons assisting access to voluntary assisted dying or present when substance administered

(1) Criminal liability does not attach to a person only because—

(a) the person, in good faith, does an act or makes an omission that assists another person who the person believes on reasonable grounds is requesting access to or accessing voluntary assisted dying in accordance with this Act; or

(b) the person is present when another person self-administers or is administered a voluntary assisted dying substance under this Act.

(2) To remove any doubt, it is declared that a person who does an act, or makes an omission, mentioned in subsection (1)(a) or (b) does not commit an offence against the Criminal Code, section 300, 302, 303, 305, 306, 307, 309, 310 or 311.

(3) If a question arises in a proceeding as to whether subsection (1)(a) prevents liability for an act or omission attaching to a person, the party alleging that subsection (1)(a) does not prevent liability attaching to the person bears the onus of proving the person did not do the act or make the omission in good faith in the circumstances mentioned in subsection (1)(a).

148 Protection for persons acting under Act

(1) No civil or criminal liability attaches to a person for an act done or omission made in good faith and without negligence in accordance with, or for the purposes of, this Act.

(2) To remove any doubt, it is declared that a person who does an act, or makes an omission, mentioned in subsection (1) does not commit an offence against the Criminal Code, section 300, 302, 303, 305, 306, 307, 309, 310 or 311.

(3) If a question arises in a proceeding as to whether subsection (1) prevents liability for an act or omission attaching to a person, the party alleging that subsection (1) does not prevent liability attaching to the person bears the onus of proving the person did not do the act or make the omission in good faith in the circumstances mentioned in subsection (1).

149 Protection for health practitioners and ambulance officers

(1) This section applies if a protected person, in good faith, does not administer life sustaining treatment to another person in circumstances where—

(a) the other person has not requested the administration of life sustaining treatment; and

(b) the protected person believes on reasonable grounds that the other person is dying after self-administering or being administered a voluntary assisted dying substance in accordance with this Act.

(2) No civil or criminal liability attaches to the protected person for not administering the life sustaining treatment.

(3) To remove any doubt, it is declared that a person who does an act, or makes an omission, mentioned in subsection (1) does not commit an offence against the Criminal Code, section 300, 302, 303, 305, 306, 307, 309, 310 or 311.

(4) If a question arises in a proceeding as to whether subsection (1) prevents liability for an act or omission attaching to a person, the party alleging that subsection (1) does not prevent liability attaching to the person bears the onus of proving the person did not do the act or make the omission in good faith in the circumstances mentioned in subsection (1).

(5) In this section—

ambulance officer see the *Ambulance Service Act 1991*, schedule 1.

protected person means—

(a) a registered health practitioner; or

(b) a student under the Health Practitioner Regulation National Law (Queensland); or

(c) an ambulance officer.

150 Nothing affects disciplinary proceedings, complaints or referrals

Nothing in this part prevents—

(a) the making of a mandatory notification or voluntary notification about a person under the Health Practitioner Regulation National Law (Queensland); or

(b) the making of a health service complaint about a person under the *Health Ombudsman Act 2013*; or

(c) the referral of an issue to the health ombudsman under section 117(1)(c)(iv).

Part 11 Miscellaneous

151 Functions and powers of inspectors

(1) The functions of an inspector under the *Medicines and Poisons Act 2019*, section 130, also include to investigate and enforce compliance with this Act (the ***further function***).

(2) For the performance of the further function by an inspector—

(a) the inspector may exercise the inspector's powers under the applied provisions of the *Medicines and Poisons Act 2019*; and

(b) chapter 5, part 5, divisions 1 and 2 apply in relation to the exercise or purported exercise of a power under paragraph (a); and

(c) a reference in the applied provisions of that Act to an offence against that Act is taken to be a reference to an offence against this Act.

(3) In this section—

applied provisions means the following provisions of the *Medicines and Poisons Act 2019*—

(a) section 140(1)(a), (b) and (c) and (3) to (6);

(b) chapter 5, part 3, division 2;

(c) chapter 5, part 3, division 4 and part 4.

inspector means a person who holds office under the *Medicines and Poisons Act 2019*, chapter 5, part 2, as an inspector.

152 Compliance with this Act relevant to professional conduct or performance

(1) In considering a matter under an Act about a relevant person's professional conduct or performance, regard may be had to whether the person contravened a section of this Act.

(2) The matters to which subsection (1) applies include matters arising in—

(a) a notification under the Health Practitioner Regulation National Law (Queensland); or

(b) a complaint under the *Health Ombudsman Act 2013*; or

(c) a referred matter under the Health Practitioner Regulation National Law (Queensland).

(3) In this section—

relevant person means—

(a) a registered health practitioner; or

(b) a health service provider.

153 Protection from liability for members and persons helping board perform functions

(1) A member of the board or a person engaged to help in the performance of the board's functions is not civilly liable for

an act done, or omission made, honestly and without negligence under this Act.

(2) If subsection (1) prevents a civil liability attaching to a member of the board or other person, the liability attaches instead to the State.

(3) Subsection (1) does not apply to a member of the board or other person who is a State employee.

Note—

For protection from civil liability in relation to State employees—see the *Public Service Act 2008*, section 26C.

(4) In this section—

State employee means a person who is a State employee within the meaning of the *Public Service Act 2008*, section 26B(4).

154 Review of Act

(1) The Minister must review the effectiveness of this Act as soon as practicable after the end of 3 years after the commencement.

(2) The review must include a review of the eligibility criteria.

(3) As soon as practicable after finishing the review, the Minister must table a report about its outcome in the Legislative Assembly.

155 Technical error not to invalidate processes

(1) The validity of the request and assessment process or the administration process is not affected by—

(a) any minor or technical error in a form required to be completed under part 3 or 4; or

(b) the failure of a person to provide a form within the time required under part 3 or 4; or

(c) the failure of a medical practitioner to do an act within the time required under part 3 or 4 for doing the act.

(2) In this section—

administration process means the process that consists of the following steps—

(a) an administration decision;

(b) an administration or self-administration of a voluntary assisted dying substance.

(3) This section is in addition to, and does not limit, the *Acts Interpretation Act 1954*, section 48A.

156 Official voluntary assisted dying care navigator service

(1) The chief executive may approve a service to be an official voluntary assisted dying care navigator service for this Act.

(2) The purpose of an official voluntary assisted dying care navigator service is to provide support, assistance and information to people relating to voluntary assisted dying.

(3) The chief executive must publish an approval under subsection (1) on the department's website.

157 Interpreters

(1) An interpreter for a person requesting access to voluntary assisted dying—

(a) must be either—

(i) accredited by a body approved by the chief executive; or

(ii) have been granted an exemption by the chief executive under subsection (2); and

(b) must not—

(i) be a family member of the person; or

(ii) know or believe that they are a beneficiary under a will of the person or that they may otherwise benefit financially or in any other material way from the death of the person other than by

receiving reasonable fees for the provision of services as an interpreter; or

(iii) be an owner of, or be responsible for the management of, any health facility at which the person is being treated or resides; or

(iv) be a person who is directly involved in providing a health service or personal care service to the person.

(2) The chief executive may grant an interpreter an exemption from the accreditation requirement in subsection (1)(a)(i) if satisfied that—

(a) no accredited interpreter is available in a particular case; and

(b) there are exceptional circumstances for granting the exemption.

158 Authorised suppliers

(1) The chief executive may authorise an appropriately qualified registered health practitioner, or person in a class of registered health practitioners, to supply a voluntary assisted dying substance under this Act.

(2) The chief executive must, on request, give a person who is acting as a coordinating practitioner the name of 1 or more registered health practitioners or class of registered health practitioners who are authorised under subsection (1).

159 Authorised disposers

(1) The chief executive may authorise an appropriately qualified registered health practitioner, or person in a class of registered health practitioners, to dispose of a voluntary assisted dying substance under this Act.

(2) The chief executive must, on request, give a person who is acting as a coordinating practitioner the name of 1 or more

registered health practitioners or class of registered health practitioners who are authorised under subsection (1).

160 Voluntary assisted dying substance

The chief executive may approve an S4 substance or S8 substance, or a combination of those substances, for use under this Act for the purpose of causing a person's death.

161 Approved medical practitioner requirements

(1) The chief executive must approve medical practitioner requirements for the purposes of section 82(1)(b).

(2) The chief executive must publish the approved medical practitioner requirements on the department's website.

162 Approved nurse practitioner requirements

(1) The chief executive must approve nurse practitioner requirements for the purposes of section 83(a)(ii).

(2) The chief executive must publish the approved nurse practitioner requirements on the department's website.

163 Approved nurse requirements

(1) The chief executive must approve nurse requirements for the purposes of section 83(a)(iii).

(2) The chief executive must publish the approved nurse requirements on the department's website.

164 Approved information

(1) The chief executive must approve information for the purposes of section 16(3).

(2) The chief executive must publish the approved information on the department's website.

165 Approved training

(1) The chief executive must approve training for the purposes of sections 20, 31 and 83(b).

(2) The approved training may provide for the following matters—

(a) the operation of this Act in relation to medical practitioners, nurse practitioners and nurses, including the functions of coordinating practitioners, consulting practitioners and administering practitioners;

(b) assessing whether or not a person meets the eligibility criteria;

(c) identifying and assessing risk factors for abuse or coercion;

(d) other matters relating to the operation of this Act.

(3) The chief executive must publish the approval on the department's website.

166 Approved forms

The chief executive may approve forms for use under this Act.

167 Regulation-making power

(1) The Governor in Council may make regulations under this Act.

(2) A regulation may prescribe a matter that must be included in an approved form under this Act.

Part 12 Acts amended

Division 1 Amendment of Coroners Act 2003

168 Act amended

This division amends the *Coroners Act 2003*.

169 Amendment of s 8 (*Reportable death* defined)

(1) Section 8—

insert—

(4A) Despite subsections (1) to (3), the death of a person who has self-administered, or been administered, a voluntary assisted dying substance under the *Voluntary Assisted Dying Act 2021* is not a reportable death.

(2) Section 8(4A) and (5)—

renumber as section 8(5) and (6).

Division 2 Amendment of Guardianship and Administration Act 2000

170 Act amended

This division amends the *Guardianship and Administration Act 2000*.

171 Insertion of new s 250C

Chapter 11, part 4A—

insert—

250C Voluntary assisted dying

Voluntary assisted dying under the *Voluntary Assisted Dying Act 2021* is not a matter to which this Act applies.

Division 3 Amendment of Medicines and Poisons Act 2019

172 Act amended

This division amends the *Medicines and Poisons Act 2019*.

173 Amendment of s 50 (Persons authorised under other laws)

(1) Section 50(1), 'This section'—

omit, insert—

Subsection (2)

(2) Section 50—

insert—

(4) Also, a person does not commit an offence against this Act to the extent the person acts under an authorisation for the person under the *Voluntary Assisted Dying Act 2021*.

Division 4 Amendment of Powers of Attorney Act 1998

174 Act amended

This division amends the *Powers of Attorney Act 1998*.

175 Insertion of new s 159

Chapter 8—

insert—

159 Voluntary assisted dying

Voluntary assisted dying under the *Voluntary Assisted Dying Act 2021* is not a matter to which this Act applies.

Schedule 1 Dictionary

section 6

administer, a voluntary assisted dying substance, means to introduce the substance into the body of a person by any means.

administering practitioner, for a person, means—

(a) the coordinating practitioner for the person; or

(b) a person to whom the role of administering practitioner is transferred under section 56.

administration decision means a self-administration decision or a practitioner administration decision.

annual report see section 134.

approved information means information approved under section 164.

approved medical practitioner requirements means the requirements approved under section 161.

approved nurse practitioner requirements means the requirements approved under section 162.

approved nurse requirements means the requirements approved under section 163.

approved training means the training approved under section 165.

Australian residency exemption see section 12(1)(a).

authorised disposer means a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive under section 159.

authorised supplier means a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive under section 158.

board means the Voluntary Assisted Dying Review Board established under section 116.

coercion includes intimidation or a threat or promise, including by an improper use of a position of trust or influence.

consulting assessment see section 30(2).

consulting assessment record form see section 35(2).

consulting practitioner, for a person, means a medical practitioner who accepts a referral to conduct a consulting assessment of the person.

contact details, in relation to a person, includes the address, telephone number and email address of the person.

contact person, for a person requesting access to voluntary assisted dying, means the person appointed under section 58(1) for the person.

contact person appointment form see section 59(1).

coordinating practitioner, for a person, means a medical practitioner who accepts the person's first request.

deciding practitioner, for part 6, division 2, see section 86.

decision-making capacity, in relation to voluntary assisted dying, see section 11.

disability see the *Disability Services Act 2006*, section 11.

eligibility criteria means the criteria set out in section 10(1).

eligible person, for a reviewable decision, for part 7, see section 100.

eligible witness—

(a) to witness a second request—means a person eligible under section 38(1) to witness the request; or

(b) to witness the administration of a voluntary assisted dying substance—means a person eligible under section 54 to witness the administration.

facility, for part 6, division 2, see section 86.

family member, of a person, means—

(a) the person's spouse; or

(b) the person's parent, grandparent, sibling, child or grandchild; or

(c) a person who, under Aboriginal tradition or Torres Strait Island custom, is regarded as a person mentioned in paragraph (b).

final request see section 42(1).

final review means a review conducted under section 46 by the coordinating practitioner for a person.

final review form see section 46(1)(b).

first assessment see section 19(2).

first assessment record form see section 24(2).

first request see section 14(1).

health ombudsman means the health ombudsman under the *Health Ombudsman Act 2013*.

health service see the *Health Ombudsman Act 2013*, section 7.

health service provider see the *Health Ombudsman Act 2013*, section 8.

member means a member of the board.

nurse means a person registered under the Health Practitioner Regulation National Law (Queensland)—

(a) to practise in the nursing profession, other than as a student; and

(b) in the registered nurses division of that profession.

nurse practitioner means a person registered under the Health Practitioner Regulation National Law (Queensland) to practise in the nursing profession whose registration under that Law is endorsed as nurse practitioner.

official voluntary assisted dying care navigator service means a service approved under section 156.

palliative care and treatment means care and treatment that—

(a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting; and

(b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering in order to improve their comfort and quality of life.

permanent resident, for part 6, division 2, see section 86.

personal care service means assistance or support provided by a person to another person under a contract of employment or a contract for services, including—

(a) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals; and

(b) assistance for persons with mobility problems; and

(c) assistance for persons who are mobile but require some form of assistance or supervision; and

(d) assistance or supervision in administering medicine; and

(e) the provision of substantial emotional support.

personal information—

(a) means information or an opinion, including information or an opinion forming part of a database, whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion; but

(b) does not include information that is publicly available.

Poisons Standard means the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* (Cwlth), section 52A(1).

practitioner administration decision see section 50(1)(b).

practitioner administration form see section 55(3).

prepare, a voluntary assisted dying substance, means to do anything necessary to ensure that the substance is in a form suitable for administration and includes to decant, dilute, dissolve, reconstitute, colour or flavour the substance.

prescribe, a voluntary assisted dying substance, means to issue a prescription for the substance.

prescription means a document that—

(a) is written or electronic; and

(b) sets out the particulars of a voluntary assisted dying substance that is to be self-administered by, or administered to, the person named in the document; and

(c) is issued to authorise the substance to be supplied for one of the purposes mentioned in paragraph (b); and

(d) complies with requirements prescribed by regulation in relation to prescriptions under this Act.

principal registrar has the meaning given in the QCAT Act.

private hospital see the *Private Health Facilities Act 1999*, section 9.

public sector hospital see the *Hospital and Health Boards Act 2011*, schedule 2.

Queensland residency exemption see section 12(1)(b).

registered health practitioner means a person registered under the Health Practitioner Regulation National Law (Queensland) to practise a health profession, other than as a student.

registrar-general means the registrar-general under the *Births, Deaths and Marriages Registration Act 2003*.

relevant entity, for part 6, division 2, see section 86.

relevant service, for part 6, division 2, see section 86.

request and assessment process means the process that consists of the following steps—

(a) a first request;

(b) a first assessment;

(c) a consulting assessment;

(d) a second request;

(e) a final request;

(f) a final review.

residential aged care, for part 6, division 2, see section 86.

residential aged care facility, for part 6, division 2, see section 86.

residential facility, for part 6, division 2, see section 86.

reviewable decision means a decision mentioned in section 99.

S4 substance means a substance listed in the Poisons Standard, schedule 4.

S8 substance means a substance listed in the Poisons Standard, schedule 8.

second request see section 37(2).

self-administration decision see section 50(1)(a).

unused or remaining substance means any of the voluntary assisted dying substance supplied for a person that remains unused or remaining after the person's death.

voluntary assisted dying means the administration of a voluntary assisted dying substance and includes steps reasonably related to that administration.

voluntary assisted dying substance means a substance approved by the chief executive under section 160.

Queensland
Law Reform Commission