



**A legal framework for voluntary  
assisted dying**

Consultation Paper



Queensland  
Law Reform Commission

**A legal framework for voluntary  
assisted dying**

Consultation Paper

WP No 79  
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## SUBMISSIONS

You are invited to make a written submission on the issues raised in this Consultation Paper. Submissions should be sent to:

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**Closing date: 27 November 2020**

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\* Until 14 September 2020.

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## Abbreviations and Glossary

<b>AHPRA</b>	Australian Health Practitioner Regulation Agency, which administers the National Health Practitioner Regulation Law in force in each Australian state and territory
<b>AMA</b>	Australian Medical Association
<b><i>Belgian Euthanasia Act 2002</i></b>	Unofficial English translation by DyingForChoice.com (July 2018) < <a href="https://dyingforchoice.com/docs/Belgium_Euthanasia_Act_as-at_July_2018.pdf">https://dyingforchoice.com/docs/Belgium_Euthanasia_Act_as-at_July_2018.pdf</a> >
<b>Board</b>	As context requires: <ul style="list-style-type: none"> <li>• In Victoria, the Voluntary Assisted Dying Review Board, established under section 92 of the <i>Voluntary Assisted Dying Act 2017</i> (Vic); and</li> <li>• In Western Australia, the Voluntary Assisted Dying Board, established under section 116 of the <i>Voluntary Assisted Dying Act 2019</i> (WA) (and which is to commence operation on a day to be fixed by proclamation).</li> </ul>
<b>HR Act</b>	<i>Human Rights Act 2019</i> (Qld)
<b><i>Luxembourg Law on Euthanasia and Assisted Suicide 2009</i></b>	English translation published in Ministry of Health et al (Luxembourg), <i>Euthanasia and assisted suicide: Law of 16 March 2009—25 questions 25 answers</i> (June 2010), Appendix 1
<b>MBA</b>	Medical Board of Australia
<b>Qld Parliamentary Committee Report No 33 (2020)</b>	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Aged care, end-of-life and palliative care</i> (Report No 33, March 2020)
<b>Qld Parliamentary Committee Report No 34 (2020)</b>	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Voluntary assisted dying</i> (Report No 34, March 2020)
<b><i>The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001</i></b>	English translation published in Regional Euthanasia Review Committees (The Netherlands), <i>Euthanasia Code 2018: Review procedures in practice</i> (April 2018) Annexe
<b>the Parliamentary Committee</b>	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
<b>VCAT</b>	Victorian Civil and Administrative Tribunal
<b>Vic Guidance for Health Practitioners (2019)</b>	Victoria, Department of Health and Human Services, <i>Voluntary assisted dying: Guidance for health practitioners</i> (July 2019)



<b>Vic Ministerial Advisory Panel Final Report (2017)</b>	Victorian Voluntary Assisted Dying Ministerial Advisory Panel, <i>Final Report of the Ministerial Advisory Panel on Voluntary Assisted Dying</i> (Final Report, Department of Health and Human Services, July 2017)
<b>Vic Parliamentary Committee Final Report (2016)</b>	Legislative Council, Legal and Social Issues Committee, Parliament of Victoria, <i>Inquiry into end of life choices</i> (Final Report, June 2016)
<b>Victorian Ministerial Advisory Panel</b>	Victorian Voluntary Assisted Dying Ministerial Advisory Panel
<b><i>Voluntary Assisted Dying Act 2019 (WA)</i></b>	References to this Act are to the Act as passed
<b>Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020)</b>	Voluntary Assisted Dying Review Board, <i>Report of operations: January–June 2020</i> (Safer Care Victoria, August 2020)
<b>Voluntary Assisted Dying Review Board Report of Operations June–December 2019 (2020)</b>	Voluntary Assisted Dying Review Board, <i>Report of operations: June–December 2019</i> (Safer Care Victoria, February 2020)
<b>W&amp;W Model</b>	<p>Professors Ben White and Lindy Willmott, Submission No 1199 to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying</i> (24 April 2014) attachment 'Voluntary Assisted Dying Bill 2019' and 'Explanatory Notes'.</p> <p>The W&amp;W Model is set out in Qld Parliamentary Committee Report No 34 (March 2020) app A.</p>
<b>WA Joint Select Committee on End of Life Choices Report (2018)</b>	Western Australian Joint Select Committee on End of Life Choices, Parliament of Western Australia, <i>My Life, My Choice, Report of the Joint Select Committee on End of Life Choices</i> (Report, August 2018)
<b>WA Ministerial Expert Panel Final Report (2019)</b>	Western Australian Ministerial Expert Panel on Voluntary Assisted Dying, <i>Final Report of the Ministerial Expert Panel on Voluntary Assisted Dying</i> (Final Report, Department of Health, 2019)
<b>Western Australian Ministerial Expert Panel</b>	Western Australian Ministerial Expert Panel on Voluntary Assisted Dying



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# Consultation questions and proposals

The Commission seeks your views on the following questions (Q) and proposals (P):

## **CHAPTER 3: PRINCIPLES**

- Q-1** What principles should guide the Commission's approach to developing voluntary assisted dying legislation?
- Q-2** Should the draft legislation include a statement of principles:
- (a) that aids in the interpretation of the legislation?
  - (b) to which a person must have regard when exercising a power or performing a function under the legislation (as in Victoria and Western Australia)?
- Q-3** If yes to Q-2(b), what would be the practical, and possibly unintended, consequences of requiring such persons to have regard to each of the principles?
- Q-4** If yes to Q-2(a) or (b) or both, what should the principles be? For example, should the statement of principles include some or all of the principles contained in:
- (a) section 5(1) of the *Voluntary Assisted Dying Act 2017* (Vic);
  - (b) section 4(1) of the *Voluntary Assisted Dying Act 2019* (WA); or
  - (c) clause 5 of the W&W Model?

## **CHAPTER 4: ELIGIBILITY CRITERIA FOR ACCESS TO VOLUNTARY ASSISTED DYING**

- Q-5** Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that:
- (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)?
- Q-6** Should the eligibility criteria for a person to access voluntary assisted dying expressly state that a person is not eligible only because they:
- (a) have a disability; or
  - (b) are diagnosed with a mental illness?

- Q-7** Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that is expected to cause death within a specific timeframe?
- Q-8** If yes to Q-7, what should the timeframe be? Should there 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 case of a disease, illness or medical condition that is neurodegenerative (as in Victoria and Western Australia)?
- Q-9** Should the eligibility criteria for a person to access voluntary assisted dying require that the person must 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)?
- P-1** The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be aged 18 years or more.
- Q-10** Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be:
- (a) an Australian citizen or permanent resident; and
  - (b) ordinarily resident in Queensland?
- Q-11** If yes to Q-10(b), should that requirement also specify that, at the time of making the first request to access voluntary assisted dying, the person must have been ordinarily resident in Queensland for a minimum period? If so, what period should that be?
- P-2** The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be acting voluntarily and without coercion.
- P-3** The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must have decision-making capacity in relation to voluntary assisted dying.
- Q-12** Should 'decision-making capacity' be defined in the same terms as the definition of 'capacity' in the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*, or in similar terms to the definitions of 'decision-making capacity' in the voluntary assisted dying legislation in Victoria and Western Australia? Why or why not?

**Q-13** What should be the position if a person who has started the process of accessing voluntary assisted dying loses, or is at risk of losing, their decision-making capacity in relation to voluntary assisted dying before they complete the process?

For example:

- (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?

*Note: see also [6.16] ff and Q-20 and Q-21 below as to waiting periods.*

- (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?

**Q-14** Should the eligibility criteria for a person to access voluntary assisted dying require that the person's request for voluntary assisted dying be enduring?

**CHAPTER 5: INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING**

**Q-15** Should the draft legislation provide that a health practitioner is prohibited from initiating a discussion about voluntary assisted dying as an end of life option?

**Q-16** If yes to Q-15, should there be an exception to the prohibition if, at the same time, the practitioner informs the person about 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 (as in Western Australia)?

**CHAPTER 6: THE VOLUNTARY ASSISTED DYING PROCESS**

Requesting access to voluntary assisted dying

*Witnessing requirements for the written declaration*

**Q-17** Should the draft legislation provide that the person who makes a written declaration must sign the written declaration in the presence of:

- (a) two witnesses (as in Western Australia); or

(b) two witnesses and the coordinating practitioner (as in Victoria)?

**Q-18** Should the draft legislation provide that a person is not eligible to witness a written declaration if they:

- (a) are under 18 years (as in Victoria and Western Australia);
- (b) know or believe that they:
  - (i) are a beneficiary under a will of the person making the declaration (as in Victoria and Western Australia);
  - (ii) may otherwise benefit financially or in any other material way from the death of the person making the declaration (as in Victoria and Western Australia);
- (c) are an owner of, or are responsible for the day-to-day operation of, any health facility at which the person making the declaration is being treated or resides (as in Victoria);
- (d) are directly involved in providing health services or professional care services to the person making the declaration (as in Victoria);
- (e) are the coordinating practitioner or consulting practitioner for the person making the declaration (as in Western Australia);
- (f) are a family member of the person making the declaration (as in Western Australia)?

**Q-19** Alternatively to Q-18(f), should the draft legislation provide that not more than one witness may be a family member of the person making the declaration (as in Victoria)?

#### **Waiting periods**

**Q-20** Should the draft legislation include provisions about the prescribed period that must elapse between a person's first request and final request for access to voluntary assisted dying, in similar terms to the legislation in Victoria and Western Australia?

**Q-21** If yes to Q-20, should the draft legislation provide that the final request can be made before the end of the prescribed period if:

- (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?

**Eligibility assessments*****Requirement for the eligibility assessments to be independent***

**Q-22** Should the draft legislation 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:

- (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 assessments must be independent of each other?

***Requirements for referral of certain matters to a specialist or another person***

**Q-23** Should the draft legislation provide that, if the coordinating practitioner or consulting practitioner:

- (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)?

***Other requirements***

**Q-24** Should the draft legislation provide (as in Western Australia) that the coordinating practitioner, the consulting practitioner, any health practitioner (or other person) to whom the person is referred for a determination of whether the person meets particular eligibility requirements, or the administering practitioner must not:

- (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?

#### **Review of certain decisions by Tribunal**

**Q-25** Should the draft legislation provide for an eligible applicant to apply to the Queensland Civil and Administrative Tribunal for review of a decision of a coordinating practitioner or a consulting practitioner that the person who is the subject of the decision:

- (a) is or is not ordinarily resident in the State (as in Victoria);
- (b) at the time of making the first request, was or was not ordinarily resident in the State for a specified minimum period (as in Victoria and Western Australia);
- (c) has or does not have decision-making capacity in relation to voluntary assisted dying (as in Victoria and Western Australia);
- (d) is or is not acting voluntarily and without coercion (as in Western Australia)?

**Q-26** If yes to Q-25, should an application for review be able to be made by:

- (a) the person who is the subject of the decision;
- (b) an agent of the person who is the subject of the decision; or
- (c) another person who the tribunal is satisfied has a special interest in the medical care and treatment of the person?

#### **Reporting requirements for health practitioners**

**Q-27** At what points during the request and assessment process should the coordinating practitioner or consulting practitioner be required to report to an independent oversight body? For example, should it be required to report to an independent oversight body:

- (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);
- (d) at some other time (and, if so, when)?

**Additional approval process**

**Q-28** Is it 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)?

**Administration of the voluntary assisted dying substance*****Self-administration or practitioner administration***

**Q-29** Should the draft legislation 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)?

**Q-30** Alternatively to Q-29, should the draft legislation provide (as in Western Australia) that:

- (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; or
  - (iii) the method for administering the substance that is suitable for the person?

***Requirements for self-administration***

**Q-31** Should the draft legislation provide that the coordinating practitioner or another health practitioner must be present when the person self-administers the voluntary assisted dying substance?

***Requirements for practitioner administration***

**Q-32** Should the draft legislation provide that a witness, who is independent of the administering practitioner, must be present when the practitioner administers the voluntary assisted dying substance?

**Community, cultural and linguistic considerations*****Requirements for interpreters to be accredited and impartial***

**Q-33** Should the draft legislation provide that an interpreter who assists a person in requesting or accessing voluntary assisted dying must be accredited and impartial, in similar terms to the legislation in Victoria and Western Australia?

**Procedural requirements**

**Q-34** Are there any other issues relating to these or other procedural matters that you wish to comment on?

**CHAPTER 7: QUALIFICATIONS AND TRAINING OF HEALTH PRACTITIONERS****Minimum qualification and experience requirements of coordinating and consulting practitioners**

**Q-35** Should the draft legislation provide that only a medical practitioner can act as a coordinating practitioner or a consulting practitioner and assess the person's eligibility for access to voluntary assisted dying?

**Q-36** Should the draft legislation 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?

**Q-37** If yes to Q-36, what should the minimum qualification and experience requirements be? For example, should it be a requirement that either the coordinating practitioner or the consulting practitioner must:

- (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 cause the death of the person being assessed (as in Victoria)?

**Role of other health practitioners**

**Q-38** Should the draft legislation provide that the voluntary assisted dying substance can be administered by:

- (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)?



**Mandatory assessment training**

**Q-39** Should the draft legislation require health practitioners to complete approved training before they can assess a person's eligibility for access to voluntary assisted dying?

**CHAPTER 8: CONSCIENTIOUS OBJECTION**

**Q-40** Should the draft legislation 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:

- (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)?

**Q-41** Should a registered medical practitioner who has a conscientious objection to voluntary assisted dying be required to refer a person elsewhere or to transfer their care?

**Q-42** Should the draft legislation make provision for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility? If so, should the entity be required to:

- (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?

**CHAPTER 9: OVERSIGHT, REPORTING AND COMPLIANCE**

**Q-43** Should the draft legislation provide for an independent oversight body with responsibility for monitoring compliance with the legislation?

**Q-44** If yes to Q-43, should the oversight body have some or all of the functions and powers conferred on:

- (a) the Voluntary Assisted Dying Review Board under the *Voluntary Assisted Dying Act 2017* (Vic); or

- (b) the Voluntary Assisted Dying Board under the *Voluntary Assisted Dying Act 2019* (WA)?

**Q-45** Should notifications to the Health Ombudsman of concerns about health practitioners' professional conduct relating to voluntary assisted dying:

- (a) be dealt with by specific provisions in the draft legislation, as in Victoria, which provide for mandatory and voluntary notification in particular circumstances; or
- (b) as in Western Australia, be governed by existing law under the Health Practitioner Regulation National Law (Queensland) which states when mandatory notification is required and voluntary notification is permitted?

**Q-46** Should the draft legislation include specific criminal offences related to non-compliance with the legislation, similar to those in the *Voluntary Assisted Dying Act 2017* (Vic) or the *Voluntary Assisted Dying Act 2019* (WA)?

**Q-47** Should the draft legislation 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 *Voluntary Assisted Dying Act 2017* (Vic)?

**Q-48** Should there be a statutory requirement for review of the operation and effectiveness of the legislation?

#### **CHAPTER 10: OTHER MATTERS**

**Q-49** How should the death of a person who has accessed voluntary assisted dying be treated for the purposes of the *Births, Deaths and Marriages Registration Act 2003* and the *Coroners Act 2003*?

**Q-50** What key issues or considerations should be taken into account in the implementation of voluntary assisted dying legislation in Queensland?

# Chapter 1

## Background

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### INTRODUCTION

1.1 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. While these people may receive palliative care or a range of other supports, the options available to them if they wish to end their life are limited to the refusal of medical treatment, the refusal of food, the refusal of hydration, palliative sedation and suicide.<sup>1</sup> The ability to seek assistance from a health practitioner when exercising these options is constrained by restrictions on what health practitioners can legally provide to their patients.<sup>2</sup>

1.2 Voluntary assisted dying allows people, in certain circumstances, to exercise greater choice over the timing and manner of their death.

1.3 Voluntary assisted dying is a very complex and deeply personal issue that requires the balancing of a range of competing considerations, including respecting human rights and the dignity and autonomy of individuals, while also taking into account the need for safeguards to protect individuals who might be vulnerable to coercion or exploitation.

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<sup>1</sup> Qld Parliamentary Committee Report No 34 (2020) 4. See further Qld Parliamentary Committee Report No 33 (2020) [21.3]–[21.4.2], in relation to the legal status of the refusal of medical treatment, the refusal of food, the refusal of hydration and palliative sedation as part of end of life care. Attempted suicide is not unlawful in Queensland although it is a crime for a person to procure, aid or counsel another person to kill himself or herself: Criminal Code (Qld) s 311.

<sup>2</sup> Qld Parliamentary Committee Report No 34 (2020) 4. See further Qld Parliamentary Committee Report No 33 (2020) [21.5.1]–[21.5.4].

## TERMS OF REFERENCE

1.4 On 21 May 2020, the Acting Attorney-General and Minister for Justice and Acting Leader of the House, gave the Commission terms of reference to develop 'an appropriate scheme for voluntary assisted dying and to prepare draft voluntary assisted dying legislation to give effect to its recommendations'.<sup>3</sup> It further provides:

### 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.

1.5 In preparing draft legislation, the Commission is also to have regard to the following:

- 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;

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<sup>3</sup> The full terms of reference are set out in Appendix A below. The terms of reference required the Commission to commence the review on 1 July 2020.

- F. Legislative and regulatory arrangements in other Australian and international jurisdictions.

1.6 The Commission is required to provide its final report for the review and draft legislation by 1 March 2021.

## THE SCOPE OF THE COMMISSION'S REVIEW

1.7 As the terms of reference make clear, the Commission is not asked to consider the desirability or otherwise of introducing voluntary assisted dying legislation in Queensland.

1.8 As can be seen from the following section, a recent Parliamentary inquiry has already determined that the majority of the Queensland community, including health practitioners, is supportive of the introduction of voluntary assisted dying legislation in Queensland.

1.9 The scope of the Commission's reference is limited to developing an appropriate legal framework for voluntary assisted dying.

## THE PARLIAMENTARY COMMITTEE INQUIRY

1.10 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').<sup>4</sup>

1.11 The Parliamentary Committee's terms of reference required it to report to the Legislative Assembly on:<sup>5</sup>

- 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.

1.12 The Parliamentary Committee conducted extensive consultation and research in relation to the various matters covered by its inquiry.<sup>6</sup>

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<sup>4</sup> Qld Parliamentary Committee Report No 34 (2020) 1.

<sup>5</sup> Ibid 1–2.

<sup>6</sup> The Parliamentary Committee's consultation activities for the inquiry included the release of an issues paper on 'aged care, end-of-life, palliative care and voluntary assisted dying'. The issues paper posed 38 questions, nine of which related to voluntary assisted dying. The Parliamentary Committee accepted 4719 written submissions for the inquiry, conducted 34 public and private hearings and briefings and heard evidence from 502 invited witnesses: *ibid* 2–3. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary Assisted Dying* (Issues Paper No 3, 2019).

1.13 In March 2020, the Parliamentary Committee tabled separate reports on aged care, end of life and palliative care<sup>7</sup> and on voluntary assisted dying.<sup>8</sup>

1.14 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’.<sup>9</sup>

1.15 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’.<sup>10</sup>

1.16 The Parliamentary Committee, by majority, made 21 recommendations in relation to voluntary assisted dying.<sup>11</sup>

1.17 The Parliamentary Committee’s principal recommendation was that the Queensland Government use the model draft legislation submitted to the inquiry by Professors Ben White and Lindy Willmott (the ‘W&W Model’)<sup>12</sup> as ‘the basis for a legislative scheme for voluntary assisted dying’.<sup>13</sup>

1.18 Its other recommendations related to specific aspects of the proposed new voluntary assisted dying framework, including the criteria for eligibility for access to

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7 Qld Parliamentary Committee Report No 33 (2020).

8 Qld Parliamentary Committee Report No 34 (2020).

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

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

11 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. See also n 14 below.

12 The W&W 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 W&W 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’.

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

voluntary assisted dying,<sup>14</sup> 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.

## Palliative care

1.19 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 inquiry. Many referred to the benefit of palliative treatment as a part of end of life care for patients.<sup>15</sup>

1.20 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’.<sup>16</sup>

## VOLUNTARY ASSISTED DYING IN OTHER JURISDICTIONS

1.21 In Australia, two jurisdictions—Victoria and Western Australia—have enacted voluntary assisted dying legislation. Voluntary assisted dying legislation has also been enacted in a number of overseas jurisdictions.

1.22 A comparison of the voluntary assisted dying legislation in selected jurisdictions, including Victoria and Western Australia, is set out in the table in Appendix C below.

## Victoria

1.23 Victoria was the first Australian State to enact voluntary assisted dying legislation. The *Voluntary Assisted Dying Act 2017 (Vic)* commenced on 19 June 2019, following an 18 month implementation period.<sup>17</sup>

1.24 The introduction of that 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

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<sup>14</sup> While the Parliamentary Committee recommended that the voluntary assisted dying legislation should limit eligibility to a person with decision-making capacity, it also recommended further research into improving end of life options for people who do not have decision-making capacity, particularly in relation to Advance Health Directives: 127, Recs 6, 7. In a statement of reservation, Michael Berkman MP also supported further research into improving end of life options for minors who are terminally ill: Qld Parliamentary Committee Report No 34 (2020) 199–200.

<sup>15</sup> See especially Qld Parliamentary Committee Report No 34 (2020) [7], 106–8.

<sup>16</sup> 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).

<sup>17</sup> 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. In Victoria, the Voluntary Assisted Dying Review Board has reported that in the period between the Act’s commencement on 19 June 2019 and 30 June 2020, 348 people were assessed for eligibility to access voluntary assisted dying, 272 eligible applicants applied for a voluntary assisted dying permit, 231 voluntary assisted dying permits were issued and 124 people died from taking the voluntary assisted dying substance: Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 3.

voluntary assisted dying legislation and proposed a legislative framework for voluntary assisted dying for capable adults in certain circumstances.<sup>18</sup>

1.25 In response, the Victorian Government announced that it would introduce voluntary assisted dying legislation and established the Victorian Ministerial Advisory Panel to develop a ‘compassionate and safe’ legislative framework using the framework proposed by the Committee as the starting point.<sup>19</sup>

1.26 The Panel consulted widely on the development of a ‘compassionate, safe and practical’ voluntary assisted dying legislative framework.<sup>20</sup> In July 2017, it released its final report, which contained 66 recommendations for a voluntary assisted dying legislative framework for Victoria.<sup>21</sup> The Panel subsequently contributed to the drafting of the Voluntary Assisted Dying Bill 2017 (Vic), which implemented the Panel’s recommendations.<sup>22</sup>

1.27 A diagrammatic overview of the voluntary assisted dying process in Victoria is set out in Appendix B below.

## Western Australia

1.28 In Western Australia, the *Voluntary Assisted Dying Act 2019* (WA) was passed and received Royal Assent on 19 December 2019. The operative provisions of the Act are to commence upon proclamation which is scheduled for mid-2021. This delayed commencement is to allow an 18 month period for the implementation of the voluntary assisted dying scheme.<sup>23</sup>

1.29 As in Victoria, the Western Australian legislation was enacted following 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*.<sup>24</sup> That report made

<sup>18</sup> Vic Parliamentary Committee Final Report (2016) xxvii, xxxiv–xxxviii, Rec 49 and Annex 1.

<sup>19</sup> Vic Ministerial Advisory Panel Final Report (2017) 5, 33, 35.

<sup>20</sup> In January 2017, the Vic Ministerial Advisory Panel released a discussion paper on voluntary assisted dying, which received 176 written submissions: Victorian Voluntary Assisted Dying Ministerial Advisory Panel, *Discussion Paper of the Ministerial Advisory Panel on Voluntary Assisted Dying* (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.

<sup>21</sup> Vic Ministerial Advisory Panel Final Report (2017) 22–32.

<sup>22</sup> M O’Connor et al, ‘Documenting the process of developing the Victorian voluntary assisted dying legislation’ (2018) 42 *Australian Health Review* 621, 624.

<sup>23</sup> Department of Health (WA), ‘Voluntary Assisted Dying’ (3 April 2020) <<https://ww2.health.wa.gov.au/voluntaryassisteddying>>. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (WA) 1.

<sup>24</sup> WA Joint Select Committee on End of Life Choices Report (2018).



24 recommendations to improve the way the Western Australian health system delivers end of life and palliative care, including the introduction of 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 development of legislation for voluntary assisted dying.<sup>25</sup>

1.30 The Western Australian Ministerial Expert Panel was subsequently appointed to provide advice to assist in the development and implementation of the new legislation. Its role did not extend to drafting the legislation or focussing on the detail of its implementation.<sup>26</sup>

1.31 The focus of the Panel's work was on the Joint Select Committee's recommendations and proposed legislative framework. It also examined the approach taken under the *Voluntary Assisted Dying Act 2017* (Vic), and used it as a basis for the design of the new legislation, with modifications in respect of some elements of the Victorian legislation.<sup>27</sup>

1.32 Following an extensive consultation process, the Panel delivered its final report, with recommendations on the elements of the proposed voluntary assisted dying legislation, in June 2019.<sup>28</sup>

1.33 A diagram giving an overview of the voluntary assisted dying process in Western Australia is set out in Appendix B below.

## Legislative developments in other Australian jurisdictions

1.34 In 1995, the Northern Territory enacted the *Rights of the Terminally Ill Act 1995* (NT) to allow an eligible terminally ill adult to request assistance from a qualified medical practitioner to voluntarily end their own life. 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 with respect to the territories by enacting the *Euthanasia Laws Act 1997* (Cth).<sup>29</sup>

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25 Ibid [7.89], Recs 19–24.

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

27 Ibid.

28 Ibid xi–xxiv, 2.

29 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 relating to advance care planning and palliative care. It noted that, until s 23(1A)–(1B) of the *Australian Capital Territory (Self-Government) 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](https://www.parliament.act.gov.au/data/assets/pdf_file/0004/1334992/9th-EOLC-Report.pdf)>.

1.35 In recent years, voluntary assisted dying legislation has also been proposed, but not enacted, in New South Wales<sup>30</sup> and South Australia.<sup>31</sup> In late August 2020, the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) was introduced, as a Private Member's Bill, in the Legislative Council of Tasmania.<sup>32</sup>

### Overseas jurisdictions

1.36 Some overseas jurisdictions have passed voluntary assisted dying legislation, 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 of America.<sup>33</sup>

1.37 New Zealand has also passed an Act to regulate and permit voluntary assisted dying in certain circumstances, the commencement of which is subject to a referendum to be held on the same day as the New Zealand general election on 17 October 2020.<sup>34</sup>

## THE COMMISSION'S APPROACH

1.38 Voluntary assisted dying legislation will add to existing end of life decision-making options and frameworks. It will provide a limited but important option for people who are dying and suffering to exercise some choice over the timing and manner of their death.

1.39 The Commission identifies, in Chapter 3 below, a number of guiding principles to inform its review, including the desirability of achieving reasonable consistency with comparative legislation in other jurisdictions.

1.40 The Commission takes the legislation in Victoria and Western Australia as its starting point and model in developing draft legislation for Queensland.

1.41 The legislation in those jurisdictions was developed and enacted recently and so reflects a contemporary Australian approach. It also takes into account the national health care regulatory framework. Research and experience in overseas jurisdictions will also inform the Commission's consideration. However, caution is

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<sup>30</sup> 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.

<sup>31</sup> 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.

<sup>32</sup> The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) was introduced in the Legislative Council on 27 August 2020 by the Hon MV Gaffney.

<sup>33</sup> 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.

<sup>34</sup> *End of Life Choice Act 2019* (NZ) (as enacted, not commenced). See also New Zealand Government, End of Life Choice referendum (2020) <<https://www.referendums.govt.nz/endoflifechoice/index.html>>.

required in drawing comparisons and guidance from legislation adopted in jurisdictions with different legal and health care systems.

1.42 This is generally consistent with the approach adopted by the Parliamentary Committee,<sup>35</sup> and the W&W Model submitted to that Committee.<sup>36</sup>

1.43 It is also important to ensure that the draft legislation is well adapted to Queensland's specific needs. Queensland's cultural and geographic diversity, for example, may have an impact on access to end of life care and voluntary assisted dying in rural, regional and remote areas and by Aboriginal and Torres Strait Islander people.

1.44 Any legislative framework for voluntary assisted dying will be complex and will require appropriate safeguards to protect vulnerable people. The Victorian and Western Australia legislation share a number of features which are also likely to be reflected in any legislation the Commission recommends.

1.45 Core elements include:

- eligibility requirements that limit access to competent adults with a diagnosed disease, illness or medical condition that is advanced and progressive, will cause death, and involves intolerable suffering;
- limitations on access to voluntary assisted dying based on the adults' voluntary and enduring requests;
- independent assessment of eligibility by two suitably qualified and experienced medical practitioners;
- the right of conscientious objection by health practitioners;
- providing for self-administration of a voluntary assisted dying substance or, in limited circumstances, administration by a medical practitioner;
- oversight provisions including reporting obligations, monitoring by a review board, and tribunal review of certain decisions; and
- a period after enactment but before commencement of the legislation to prepare for implementation.

## TERMINOLOGY

1.46 Different terms are used to refer to the act of consensually ending a person's life. For the purpose of this review, the Commission uses the term 'voluntary assisted dying' to refer to the administration of medication by the person or by a medical practitioner with the purpose of bringing about the person's death, on the basis of the

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<sup>35</sup> The Parliamentary Committee took Victoria and Western Australia as the starting point of their consideration of provisions for voluntary assisted dying legislation: see, eg, Qld Parliamentary Committee Report No 34 (2020) 112.

<sup>36</sup> The W&W Model also took the Victorian legislation as the starting point. It was submitted to the Parliamentary Committee prior to the introduction of the Voluntary Assisted Dying Bill 2017 (WA) in Western Australia.

person's voluntary request and in accordance with the requirements of the relevant legislation.

1.47 Other terms that are sometimes used in this context include euthanasia, assisted suicide, and medically assisted or physician assisted suicide.

1.48 'Euthanasia' is a general term capable of encompassing many practices. It broadly refers to the act of deliberately ending a person's life for the purpose of ending intolerable physical or mental pain or suffering.<sup>37</sup> It can refer to acts that are:<sup>38</sup>

- either—
  - passive (where medical treatment is withheld or withdrawn); or
  - active (where medical intervention takes place);
- and either—
  - voluntary (at the person's request); or
  - involuntary (not at the person's request).

1.49 Voluntary assisted dying is an active and voluntary practice.

1.50 'Assisted suicide' refers to circumstances in which the person causes their own death after being provided with the means or knowledge to do so by another person. 'Medically assisted' or 'physician assisted' suicide is where the person providing that assistance is a medical practitioner. For example, a medical practitioner may prescribe the medication, but the person administers it themselves.<sup>39</sup> This is distinguished from passive practices not intentionally directed toward causing death, such as withholding or withdrawing life-sustaining medical treatment.<sup>40</sup>

1.51 A list of Abbreviations and Glossary of terms commonly used in this paper is set out at the beginning of the paper.

## STRUCTURE OF THIS PAPER

1.52 Chapter 2 provides an overview of the voluntary assisted dying process in Victoria and Western Australia.

1.53 Chapter 3 considers the guiding principles the Commission may use in its approach to developing draft voluntary assisted dying legislation. It also considers

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<sup>37</sup> 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.

<sup>38</sup> Australian Human Rights Commission, *Euthanasia, human rights and the law* (Issues Paper, May 2016) 3.

<sup>39</sup> See, eg, 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, 481. See also Qld Parliamentary Committee Report No 34 (2020) [3.1], 12.

<sup>40</sup> See, eg, AMA, *Position Statement: Euthanasia and Physician Assisted Suicide* (2016) note 2, [2.2].

whether the draft legislation should include a statement of principles to aid the interpretation or operation of the legislation or both.

1.54 Chapter 4 considers eligibility criteria for access to voluntary assisted dying under the draft legislation.

1.55 Chapter 5 discusses whether medical practitioners and other health practitioners should be prohibited from initiating a discussion about voluntary assisted dying in certain circumstances.

1.56 Chapter 6 raises various issues in relation to the voluntary assisted dying process.

1.57 Chapter 7 discusses minimum qualification requirements for health practitioners who may participate in the voluntary assisted dying process.

1.58 Chapter 8 discusses a health practitioner's conscientious objection to participating in voluntary assisted dying.

1.59 Chapter 9 considers the inclusion of oversight measures in the voluntary assisted dying legislative framework.

1.60 Chapter 10 deals with consequential matters arising from the development of draft voluntary assisted dying legislation.

1.61 Appendix A sets out the Commission's terms of reference.

1.62 Appendix B contains detailed diagrams of the voluntary assisted dying process in Victoria and in Western Australia.

1.63 Appendix C is a comparative table of voluntary assisted dying legislation in Victoria, Western Australia and several overseas jurisdictions.

## **MAKING A SUBMISSION**

1.64 This paper seeks feedback on key issues relevant to developing an appropriate legislative framework for voluntary assisted dying and asks respondents to address specific questions about those issues in their response. A list of all of the questions is set out at pages i to x above.

1.65 The Commission invites written submissions in response to the questions set out in this paper by **27 November 2020**.

1.66 As mentioned above, the terms of reference require the Commission to recommend the 'best legal framework' for voluntary assisted dying legislation in Queensland; the question of whether or not such legislation should be introduced is outside the scope of the Commission's review.

1.67 Information about how to make a written submission is set out at the beginning of the paper.



## Chapter 2

# Overview of the voluntary assisted dying process in Victoria and Western Australia

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### INTRODUCTION

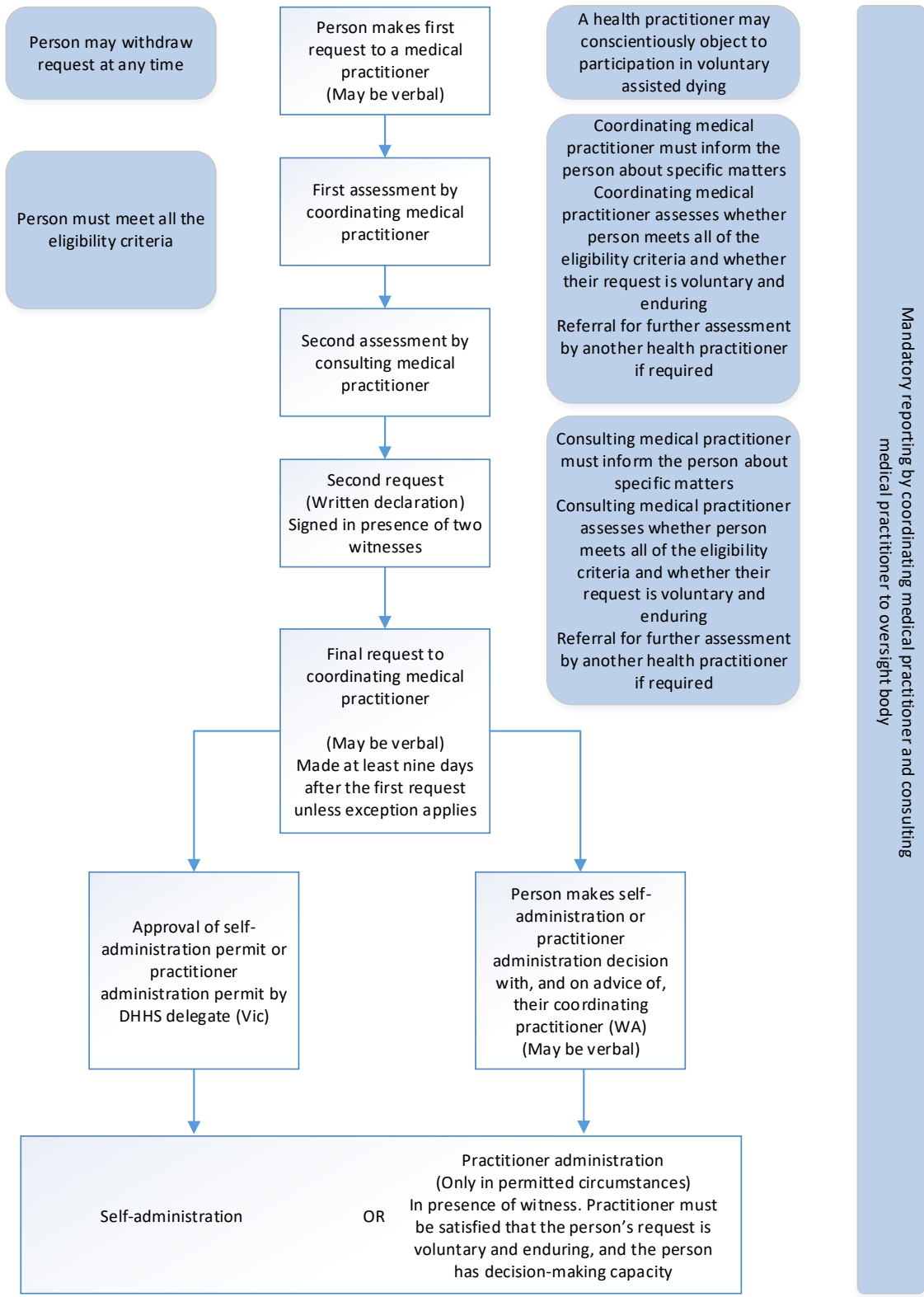
2.1 The voluntary assisted dying process is similar in Victoria and Western Australia. In each jurisdiction, the process has a number of safeguards to protect the vulnerable and ensure that the person's decision to access voluntary assisted dying is voluntary and enduring. In particular, the process includes requirements for:

- the person to make three requests for access to voluntary assisted dying, one of which must be a written declaration signed in the presence of two witnesses, and for a waiting period between the first and final request;
- two medical practitioners to assess the person's eligibility for access to voluntary assisted dying; and
- participating medical practitioners to report to an independent board that monitors the voluntary assisted dying process.

2.2 The following diagram provides a high-level overview of the voluntary assisted dying process in Victoria and Western Australia.<sup>1</sup>

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<sup>1</sup> Appendix B below contains detailed diagrams of the voluntary assisted dying process in Victoria and Western Australia.





## FIRST REQUEST

2.3 The person may make a first request to a medical practitioner for access to voluntary assisted dying.<sup>2</sup>

2.4 The request must be ‘clear and unambiguous’,<sup>3</sup> and made by the person themselves.<sup>4</sup> 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.<sup>5</sup>

2.5 The request may be made verbally or by other means of communication, such as gestures.<sup>6</sup>

2.6 The person is under no obligation to continue after making the first request and can decide to end the process at any time.<sup>7</sup> This ‘reflects the voluntary nature of voluntary assisted dying, and that in order for the process to continue, the person’s choice to participate is paramount’.<sup>8</sup>

## ELIGIBILITY ASSESSMENTS

2.7 Two medical practitioners—known as the coordinating practitioner and the consulting practitioner<sup>9</sup>—must each assess the person and be satisfied that they are eligible for access to voluntary assisted dying.<sup>10</sup>

<sup>2</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 11; *Voluntary Assisted Dying Act 2019* (WA) s 18. The request must be initiated by the person: see further the discussion of initiating a discussion about voluntary assisted dying in Chapter 5 below.

<sup>3</sup> A request for access to voluntary assisted dying must be clear and unambiguous as it must be able to be distinguished from a request for information about voluntary assisted dying: Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 5; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 7.

<sup>4</sup> In Victoria, the legislation states that the request ‘must be made ...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. See *Voluntary Assisted Dying Act 2017* (Vic) s 11(2)(b); *Voluntary Assisted Dying Act 2019* (WA) s 18(2)(b)–(c).

<sup>5</sup> 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>>.

<sup>6</sup> The person may be assisted in making a request by a qualified interpreter or speech pathologist: see Department of Health & Human Services (Vic), ‘Community information about voluntary assisted dying’ (April 2019) <<https://www2.health.vic.gov.au/Api/downloadmedia/%7B16E71848-1A55-4FA4-B5C5-293D659F62A3%7D>>.

<sup>7</sup> If the person has ended the process, they can commence a fresh request and assessment process by making a new first request: *Voluntary Assisted Dying Act 2017* (Vic) s 12; *Voluntary Assisted Dying Act 2019* (WA) s 19.

<sup>8</sup> Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 8.

<sup>9</sup> In Victoria, the relevant terms are ‘coordinating medical practitioner’ and ‘consulting medical practitioner’, respectively.

<sup>10</sup> *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. See also the discussions of eligibility criteria for access to voluntary assisted dying and eligibility assessments in Chapters 4 and 6 below, respectively.

## The role of the coordinating practitioner and the consulting practitioner

2.8 The medical practitioner who accepts the person's first request for access to voluntary assisted dying becomes the 'coordinating practitioner' and is responsible for conducting the first eligibility assessment (the 'coordinating assessment').<sup>11</sup>

2.9 If the coordinating practitioner determines that the person is ineligible for access to voluntary assisted dying, the request and assessment process ends.<sup>12</sup> However, if the coordinating practitioner determines that the person is eligible for access to voluntary assisted dying, they must refer the patient to another medical practitioner for a second assessment.<sup>13</sup>

2.10 The medical practitioner who accepts the referral becomes the 'consulting practitioner' and is responsible for conducting the second eligibility assessment (the 'consulting assessment').<sup>14</sup> If the consulting practitioner assesses the person as ineligible, the coordinating practitioner may refer the person to another medical practitioner for another consulting assessment.<sup>15</sup>

2.11 Medical practitioners may refuse a request or referral if they have a conscientious objection to voluntary assisted dying or if they are not able to perform the duties of a coordinating practitioner or consulting practitioner due to unavailability (or, in Western Australia, some other reason). They must refuse if they do not meet the minimum qualification and experience requirements in the legislation.<sup>16</sup> The medical practitioner must inform the person of their acceptance or refusal of the first request or the referral within:<sup>17</sup>

- seven days of receiving the request (Victoria); or

<sup>11</sup> In Victoria, the medical practitioner must record their acceptance of the first request in the person's medical record. In Western Australia, the medical practitioner must record their acceptance or refusal (and the reasons for refusal) in the person's medical record, and notify the Board within two business days of their acceptance or refusal: *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'co-ordinating medical practitioner'), 14–16; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'coordinating practitioner'), 21–24.

<sup>12</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 20(2); *Voluntary Assisted Dying Act 2019* (WA) s 28(2).

<sup>13</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 22; *Voluntary Assisted Dying Act 2019* (WA) s 30.

<sup>14</sup> In Victoria, a medical practitioner who receives a referral must notify the coordinating practitioner of their acceptance or refusal. In Western Australia, the medical practitioner must record their acceptance or refusal (and the reasons for refusal) in the person's medical record, and notify the Board within two business days after deciding to accept or refuse the referral: *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'consulting medical practitioner'), 23–25; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'consulting practitioner'), 31–35. The consulting assessment must be independent of the first assessment: see Chapter 6 below in relation to the requirement for the eligibility assessments to be independent.

<sup>15</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 31; *Voluntary Assisted Dying Act 2019* (WA) s 41.

<sup>16</sup> See further the discussion of minimum qualification and experience requirements of coordinating and consulting practitioners in Chapter 7 below.

<sup>17</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 13, 23; *Voluntary Assisted Dying Act 2019* (WA) ss 20, 31. In Western Australia, if the medical practitioner accepts or refuses the request they must give the person the information approved by the CEO of the Department of Health for the purposes of this section: s 20(4)(b), (5)(b). 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': Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 8.

- two business days of receiving the request, or immediately if the practitioner has a conscientious objection (Western Australia).

2.12 The coordinating practitioner and the consulting practitioner must each complete the approved training before they can begin the assessment.<sup>18</sup>

### Referral of certain matters

2.13 If either the coordinating practitioner or the consulting practitioner is not able to determine certain matters—including whether the person has a disease, illness or medical condition that meets the eligibility criteria, or has decision-making capacity in relation to voluntary assisted dying—they must refer the person to another practitioner with appropriate skills and training to make that determination. The coordinating or consulting practitioner may adopt the determination of the person they referred the matter to in relation to that particular criterion.<sup>19</sup>

### Outcome of assessment

2.14 The coordinating practitioner and the consulting practitioner must assess the person as eligible for access to voluntary assisted dying if they are satisfied of each of the following matters:<sup>20</sup>

- the person is diagnosed with a (or, in Western Australia, 'at least [one]') disease, illness or medical condition that:
  - is advanced, progressive and will cause death (and, in Victoria, is incurable);
  - is expected to cause death (or, in Western Australia, will on the balance of probabilities cause death) within six months, or 12 months if the disease, illness or medical condition is neurodegenerative; and
  - is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;
- the person is aged 18 years or more;
- the person:
  - is an Australian citizen or permanent resident; and
  - has been ordinarily resident in the State for at least 12 months at the time of making the first request for access to voluntary assisted dying (and, in Victoria, must be ordinarily resident in the State);

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<sup>18</sup> See further the discussion of mandatory assessment training in Chapter 7 below.

<sup>19</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 18, 27; *Voluntary Assisted Dying Act 2019* (WA) ss 26, 37. See further the discussion of requirements for referral of certain matters in Chapter 6 below.

<sup>20</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 9, 20, 29; *Voluntary Assisted Dying Act 2019* (WA) ss 16, 28, 39. See further the discussion of eligibility criteria for access to voluntary assisted dying in Chapter 4 below.

- the person has decision-making capacity in relation to voluntary assisted dying;
- the person is acting voluntarily and without coercion;
- the person's request for access to voluntary assisted dying is enduring; and
- the person understands the information that the practitioner is required to give to the person if they are assessed as eligible.<sup>21</sup>

2.15 There is no requirement for a person to receive counselling as a condition of their eligibility for access to voluntary assisted dying.

2.16 If an assessment has been completed, the coordinating practitioner or consulting practitioner (as relevant) must notify the person of the outcome of the assessment and must complete either a first assessment report form or a consulting assessment report form and give a copy of it to the Board.<sup>22</sup>

2.17 The legislation also provides a mechanism for eligible applicants to apply to a relevant tribunal for the review and determination of certain decisions of a coordinating practitioner or a consulting practitioner.<sup>23</sup>

## **INFORMATION TO BE GIVEN TO THE PERSON IF THEY ARE ASSESSED AS ELIGIBLE**

2.18 If the coordinating practitioner is satisfied that the person requesting access to voluntary assisted dying meets all the eligibility criteria, then the practitioner must inform the person of the following matters:<sup>24</sup>

- the person's diagnosis and prognosis;
- the treatment and palliative care options available to the person, and the likely outcomes of that treatment or care;
- 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 voluntary assisted dying substance is death;
- in Western Australia only, the method by which the voluntary assisted dying substance is likely to be self-administered or administered, the request and

<sup>21</sup> See below under the heading 'information to be given to the person if they are assessed as eligible'.

<sup>22</sup> A report must be made whether the person was assessed as eligible or ineligible for access to voluntary assisted dying and must be provided to the Board within seven days (Victoria), or within two business days (Western Australia) of the relevant eligibility assessment being completed. The consulting practitioner must also give a copy of the consulting assessment report to the coordinating practitioner (and, in Western Australia, to the person): *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definitions of 'Board', 'first assessment report form' and 'consulting assessment report form'), 21, 30, sch 1, Forms 1–2; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definitions of 'Board', 'first assessment report form' and 'consulting assessment report form') 29, 40.

<sup>23</sup> See the discussion of a review of certain decisions by a Tribunal in Chapter 6 below.

<sup>24</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 19(1); *Voluntary Assisted Dying Act 2019* (WA) s 27(1).

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 to access voluntary assisted dying.

2.19 In addition, the coordinating practitioner must, if the person consents, take all reasonable steps to fully explain to another person, all of the relevant clinical guidelines and a plan about the administration of the voluntary assisted dying substance.<sup>25</sup>

2.20 Following referral to and assessment by a consulting practitioner, if the consulting practitioner is also satisfied that the person requesting access to voluntary assisted dying meets all the eligibility criteria, they must also inform the person of the matters listed at [2.18] above.<sup>26</sup>

2.21 The requirement that both the coordinating practitioner and consulting practitioner provide the person with this information ensures that the person's decision is properly informed.<sup>27</sup>

2.22 These provisions do not affect any duty that a registered medical practitioner has at common law or under any other enactment.<sup>28</sup>

## SECOND REQUEST

2.23 If the coordinating practitioner and consulting practitioner have each assessed the person as eligible for access to voluntary assisted dying, the person may make a second request for access to voluntary assisted dying.<sup>29</sup>

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<sup>25</sup> *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.

<sup>26</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 28(1); *Voluntary Assisted Dying Act 2019* (WA) s 38(1).

<sup>27</sup> Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2952 (J Hennessey, Minister for Health); Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 10.

<sup>28</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 19(3), 28(2); *Voluntary Assisted Dying Act 2019* (WA) ss 27(3), 38(2). 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': Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) 7, 10; Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 10, 13.

<sup>29</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 34(1); *Voluntary Assisted Dying Act 2019* (WA) s 42(1).

2.24 The second request must be a written declaration made in the approved form and must specify that the person:<sup>30</sup>

- makes the declaration voluntarily and without coercion; and
- understands the nature and effect of the declaration.

2.25 The written declaration must be signed by the person in the presence of two witnesses (and, in Victoria, the coordinating practitioner).<sup>31</sup>

## FINAL REQUEST AND REVIEW

2.26 If the person has made a written declaration, they may make a final request for access to voluntary assisted dying, subject to the requirement in relation to waiting periods, discussed below.<sup>32</sup> The 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 legislation in Western Australia also provides that the request must be 'clear and unambiguous'.<sup>33</sup>

2.27 Once the final request is made, the coordinating practitioner must review the first assessment report form, all consulting assessment report forms and the written declaration,<sup>34</sup> complete the final review form and give a copy of it to the Board.<sup>35</sup> The coordinating practitioner must certify that the request and assessment process has been completed in accordance with the legislation.<sup>36</sup>

2.28 The request and assessment process is not invalidated by any technical error in a form.<sup>37</sup>

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<sup>30</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of 'written declaration'), 34, sch 1, Form 3; *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'written declaration'), 42. See also Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 15, stating that 'the purpose of the declaration is to reflect the voluntary and enduring nature of the patient's request for access to voluntary assisted dying'.

<sup>31</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 34(2)(b); *Voluntary Assisted Dying Act 2019* (WA) s 42(3)(b). See further the discussion of witnessing requirements for the written declaration in Chapter 6 below. If the person is unable to sign the written declaration, another person can do so at their direction: see further [6.105] below.

<sup>32</sup> See [2.30]–[2.31], and [6.16] ff below.

<sup>33</sup> In Victoria, the legislation states that the request 'must be made ... 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 37; *Voluntary Assisted Dying Act 2019* (WA) ss 47, 158(2).

<sup>34</sup> In Victoria, the coordinating practitioner must also review the contact person appointment form: see [2.38] n 53 below.

<sup>35</sup> *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.

<sup>36</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 41(1)(c); *Voluntary Assisted Dying Act 2019* (WA) s 52(3)(d).

<sup>37</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 42; *Voluntary Assisted Dying Act 2019* (WA) s 52.

2.29 There is no obligation for a person to continue the process after the completion of the final review. The person may decide at any time not to take any further step in relation to access to voluntary assisted dying.<sup>38</sup>

## WAITING PERIODS

2.30 Generally, a person's final request for access to voluntary assisted dying must be made at least nine days after the day on which they made the first request.<sup>39</sup> However, that requirement does not apply if the coordinating and consulting medical practitioners both consider that the person is 'likely' to die (and, in Western Australia, to lose decision-making capacity in relation to voluntary assisted dying) within that period of time.<sup>40</sup>

2.31 In any case, the person's final request must be made at least one day after the day on which the consulting assessment was completed.<sup>41</sup> Therefore, the minimum time over which the request and assessment process for access to voluntary assisted dying can be completed is two days.

## ADDITIONAL APPROVAL PROCESS IN VICTORIA

2.32 In Victoria, after the request and assessment process is completed, the coordinating medical practitioner must apply to the Secretary of the Department of Health and Human Services for the approval of a voluntary assisted dying permit, which may be either a self-administration permit or a practitioner administration permit.<sup>42</sup> The application must be made in the approved form, and the Secretary must determine the application within three business days.<sup>43</sup>

2.33 In Western Australia, there is no requirement for a permit. After the request and assessment process is completed, 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.<sup>44</sup> An administration decision must be clear and unambiguous and made to

<sup>38</sup> *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.

<sup>39</sup> *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 on which the person makes the first request is not included as one of the nine days, meaning that the final request can 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 can 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).

<sup>40</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 38(2); *Voluntary Assisted Dying Act 2019* (WA) s 48(3).

<sup>41</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 38(1)(b); *Voluntary Assisted Dying Act 2019* (WA) s 48(2)(b).

<sup>42</sup> There are two types of voluntary assisted dying permits; that is, self-administration permits or practitioner administration permits.

<sup>43</sup> *Voluntary Assisted Dying Act 2019* (Vic) ss 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) s 7, sch 1, Forms 1–2.

<sup>44</sup> *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definitions of 'administration decision', 'self-administration decision' and 'practitioner administration decision'), 56.

the coordinating practitioner by the person,<sup>45</sup> and 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.<sup>46</sup>

## ADMINISTRATION OF THE VOLUNTARY ASSISTED DYING SUBSTANCE

2.34 The voluntary assisted dying substance may be administered by the person taking the medication themselves (self-administration) or by a health practitioner administering it to the person (practitioner administration). Self-administration is the primary or default method. Practitioner administration is permitted only if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance (Victoria), or if self-administration is clinically inappropriate (Western Australia).<sup>47</sup>

2.35 If a self-administration permit has been approved (Victoria) or a self-administration decision has been made (Western Australia), the person can self-administer the substance.<sup>48</sup>

2.36 If a practitioner administration permit has been approved (Victoria), or a practitioner administration decision has been made (Western Australia), the coordinating practitioner (or, in Western Australia, the administering practitioner)<sup>49</sup> can administer the voluntary assisted dying substance to the person if they are satisfied, at the time of the administration, that the person has decision-making capacity in relation to voluntary assisted dying, the person is acting voluntarily and without coercion, and the person's request is enduring.<sup>50</sup> The administration of the voluntary assisted dying substance must occur in the presence of a witness.<sup>51</sup>

2.37 The legislation in Victoria and Western Australia contains a number of provisions regulating the safe management of the voluntary assisted dying substance—particularly in relation to self-administration—including how the

<sup>45</sup> It must be made in person before the coordinating practitioner (although, if that is not practicable, it may be made by audiovisual communication).

<sup>46</sup> *Voluntary Assisted Dying Act 2019* (WA) ss 56(5), 60.

<sup>47</sup> See further the discussion of self-administration or practitioner administration in Chapter 6 below.

<sup>48</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 45; *Voluntary Assisted Dying Act 2019* (WA) s 58. See further the discussion of the requirements for self-administration in Chapter 6 below.

<sup>49</sup> In Western Australia, the coordinating practitioner can transfer the role of administering the voluntary assisted dying substance to another medical practitioner who is eligible to act as a coordinating practitioner, or to a suitably qualified nurse practitioner (the 'administering practitioner'): *Voluntary Assisted Dying Act 2019* (WA) ss 54, 63.

In Victoria, the coordinating practitioner is always responsible for administering the voluntary assisted dying substance. However, 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.

<sup>50</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 46; *Voluntary Assisted Dying Act 2019* (WA) ss 59, 61.

<sup>51</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 46, 64–66; *Voluntary Assisted Dying Act 2019* (WA) ss 59, 61–62. See further the discussion of the requirements for practitioner administration in Chapter 6 below.



substance is prescribed, dispensed, labelled, stored and, in the event that it is not used, returned and disposed of.<sup>52</sup>

2.38 For example, there are requirements for the person to appoint a contact person, who is responsible for returning any unused voluntary assisted dying substance. This may occur, for example, if the person dies without taking the substance. The contact person must be 18 years or more, agree to take on the role and be appointed using the approved form.<sup>53</sup>

2.39 The coordinating practitioner is required on prescribing the voluntary assisted dying substance, and the pharmacist is required on dispensing the substance, to inform the person of particular matters related to the safe use, storage and return of the substance. The coordinating practitioner and the pharmacist must also inform the person that the person is not under any obligation to use the voluntary assisted dying substance.<sup>54</sup>

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<sup>52</sup> *Voluntary Assisted Dying Act 2017* (Vic) pt 5 div 1; *Voluntary Assisted Dying Act 2019* (WA) pt 4 div 4.

<sup>53</sup> The contact person is also a point of contact for the Board to request information from. In Victoria, the person must appoint a contact person after a final request has been made (regardless of whether the person will seek a self-administration permit or a practitioner permit). In Western Australia, the person must appoint a contact person only if they have made a self-administration decision: *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definitions of 'contact person' and 'contact person appointment form'), 39–40, 41(1)(a), 47(2)(d)–(e), 48(2)(d)–(e), sch 1, Form 4; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definitions of 'contact person' and 'contact person appointment form'), 64–68, 150.

<sup>54</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 57–58; *Voluntary Assisted Dying Act 2019* (WA) ss 69, 72. In Victoria, the medication can only be dispensed by the Voluntary Assisted Dying Statewide Pharmacy Service. The Statewide Pharmacy Service is based in the Alfred Hospital in Melbourne, but delivers the medication free of charge to the person anywhere in Victoria and is required to provide instructions and education regarding the safe administration, storage and return of the medication: Department of Health & Human Services (Vic), 'What process do my doctor and I need to follow' (2020) <<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/process-to-follow>>.



# Chapter 3

## Principles

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### INTRODUCTION

3.1 This chapter considers the guiding principles the Commission may use in its approach to developing draft voluntary assisted dying legislation. It also raises for consideration the question whether the draft legislation should include a statement of principles to aid the interpretation or operation of the legislation or both.

### THE COMMISSION'S GUIDING PRINCIPLES

3.2 The Commission has identified some guiding principles which may help inform its recommendations about the draft legislation:

- 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;
- 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.

3.3 If these principles were to be distilled to a few words, as was done by the Victorian Ministerial Advisory Panel,<sup>1</sup> the Commission aims to develop draft legislation that is *compassionate, safe and practical*. This includes the need for legislation that can be reasonably understood by those who may wish to use it and by those who have to 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.

### Consultation question

**Q-1 What principles should guide the Commission’s approach to developing voluntary assisted dying legislation?**

## RELEVANT HUMAN RIGHTS AND PROFESSIONAL ETHICS

### The *Human Rights Act 2019*

3.4 The *Human Rights Act 2019* (‘HR Act’) provides important guidance for the development of legislation in Queensland. It gives statutory expression to a number of fundamental personal rights that may be relevant in the present context, including:<sup>2</sup>

- 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.

3.5 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.<sup>3</sup>

<sup>1</sup> See, eg, Vic Ministerial Advisory Panel Final Report (2017) 10–11, 12 which refers to a ‘safe and compassionate’ voluntary assisted dying framework ‘that can be applied and understood by people and health practitioners in a range of clinical settings’ and ‘that embeds safeguards, checks and balances’.

<sup>2</sup> *Human Rights Act 2019* (Qld) ss 15–17, 20, 25(a), 29(1), 37(1).

<sup>3</sup> *Human Rights Act 2019* (Qld) ss 26(1)–(2), 27–28.

3.6 These rights are all based on international human rights instruments<sup>4</sup> and are similar to those included in human rights legislation in the Australian Capital Territory and Victoria.<sup>5</sup>

3.7 Underlying these rights are the core principles of equality and respect for the inherent dignity of every individual. They inform a number of the considerations that are outlined in the discussion beginning at [3.16] below.

3.8 The rights under the HR Act are not absolute. They must be balanced with other rights and interests. The rights may be subject to limits, but only to those that are 'reasonable' and 'can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom'.<sup>6</sup> The factors that may be relevant in deciding whether a limit is reasonable and justifiable are:<sup>7</sup>

- (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).

### Professional ethics and good medical practice

3.9 As indicated by the terms of reference, voluntary assisted dying legislation should also take into account relevant ethical and professional standards that apply to health practitioners.<sup>8</sup>

3.10 Four key principles are commonly recognised in medical ethics:<sup>9</sup>

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<sup>4</sup> Explanatory Notes, Human Rights Bill 2018 (Qld) 3–5. See *International Covenant on Civil and Political Rights* and, in relation to the right to health services, *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), 16 December 1966.

<sup>5</sup> See *Human Rights Act 2004* (ACT); *Charter of Human Rights and Responsibilities Act 2006* (Vic).

<sup>6</sup> *Human Rights Act 2019* (Qld) s 13(1).

<sup>7</sup> *Human Rights Act 2019* (Qld) s 13(2).

<sup>8</sup> Terms of reference para 4.

<sup>9</sup> TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013) 13, 106–7, 150, 153, 202–3, 249–50; KJ Breen et al, *Good Medical Practice: Professionalism, Ethics and Law* (Cambridge University Press, 2010) [1.4].

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

3.11 Other core values of medical practice, which have particular significance in end of life care, include:<sup>10</sup>

- compassion—the importance of empathy and 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.

3.12 In responding to the needs of a terminally ill patient, these principles require doctors not to deny the patient access to available pain relief and palliative care.<sup>11</sup> In the context of end of life care, doctors ‘do not have a duty to try to prolong life at all cost’,<sup>12</sup> and should ‘try to ensure that death occurs with comfort and dignity’.<sup>13</sup>

3.13 Health practitioners are subject to a comprehensive legal and regulatory framework.<sup>14</sup> One of the obligations of a registered health practitioner is to comply with professional standards, including codes of ethics and conduct.<sup>15</sup> This includes the MBA’s code of conduct for doctors which sets out core standards for good

<sup>10</sup> Breen et al, above n 9, [1.5.1], [1.5.4], [1.6]. See also TE Quill and CK Cassel, ‘Nonabandonment: A Central Obligation for Physicians’ (1995) 122(5) *Annals of Internal Medicine* 368.

<sup>11</sup> Breen et al, above n 9, [22.8].

<sup>12</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.13.4].

<sup>13</sup> AMA, *Code of Ethics* (2016) [2.1.14].

<sup>14</sup> See further [7.5]–[7.7] and [9.36]–[9.40] below.

<sup>15</sup> 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.

medical practice.<sup>16</sup> The code is consistent with the principles above and emphasises that good medical practice is ‘patient-centred’.<sup>17</sup> Patient-centred care includes:<sup>18</sup>

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

3.14 The ethical principles applying to health practitioners inform a number of the considerations discussed at [3.16] below.

3.15 Ethical standards provide general guidance, rather than absolute or rigid rules. They change over time with shifting community attitudes and are to be interpreted in light of prevailing circumstances.<sup>19</sup>

### Key themes and considerations

3.16 The matters outlined at [3.4]–[3.15] above provide a framework for considering the principles that may guide the Commission’s development of draft voluntary assisted dying legislation. They also inform consideration of the question of what, if any, principles should be included in the draft legislation to aid its interpretation or operation or both. There are agreements, tensions and balances in any consideration of such principles. Some key themes and considerations that emerge from this framework are outlined below.

#### *The fundamental value of human life*

3.17 The fundamental and inherent value of every human life is not questioned. The right to life is recognised as the most basic and supreme human right.<sup>20</sup> It is protected by criminal laws that prohibit unlawful killing. Upholding the value of human life is also a cornerstone of medical practice.

3.18 The right to life is not, however, absolute. The HR Act protects a person from arbitrary deprivation of life—not all acts that end in death will infringe this right.<sup>21</sup> Overseas experience suggests 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.<sup>22</sup>

<sup>16</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [1.1]. See also AMA, *Code of Ethics* (2016).

<sup>17</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [2.1]. See also [3.1], [4.2].

<sup>18</sup> 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>>.

<sup>19</sup> Breen et al, above n 9, [1.7], [1.10].

<sup>20</sup> 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].

<sup>21</sup> 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>>.

<sup>22</sup> See, eg, *Carter v Canada (Attorney-General)* [2012] BCSC 886 (Smith J), upheld in *Carter v Canada (Attorney-General)* [2015] 1 SCR 331.

3.19 It is important to avoid making 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.<sup>23</sup> It is focused on giving people, in certain limited circumstances, a degree of choice and control over the timing and manner of their death.

3.20 There are divergent views about whether voluntary assisted dying is ethical.<sup>24</sup> There are other end of life practices, such as the withdrawal or withholding of life-sustaining treatment in certain circumstances, that are likely to have the secondary consequence of hastening death. In the balance between the principles of non-maleficence and beneficence, the cessation of unendurable pain and suffering through death may for some people constitute a benefit, rather than a harm.<sup>25</sup>

### **Respect for individual autonomy**

3.21 The principle of individual autonomy reflects the value of human dignity and is a central value in contemporary liberal democracy. It relates to:<sup>26</sup>

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

3.22 The HR Act provides that every person has the 'right to liberty and security'.<sup>27</sup> This might reflect the principle that a person should be protected from arbitrary limits by the State on their individual freedom and interference with their bodily integrity. It includes concerns about both physical and psychological integrity.<sup>28</sup> Elsewhere, the right to liberty and security has been held to encompass concerns about quality of life and non-interference with personal medical decisions including voluntary assisted dying.<sup>29</sup>

<sup>23</sup> 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).

<sup>24</sup> See, eg, AMA, *Position Statement: Euthanasia and Physician Assisted Suicide* (2016) [3.2].

<sup>25</sup> See, eg, Beauchamp and Childress, above n 9, 182–3.

<sup>26</sup> See, eg, 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, 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.

<sup>27</sup> *Human Rights Act 2019* (Qld) s 29(1).

<sup>28</sup> 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).

<sup>29</sup> *Carter v Canada (Attorney-General)* [2015] 1 SCR 331, 365–6, 368–71; *Carter v Canada (Attorney-General)* [2012] BCSC 886, [1291]–[1304] (Smith J).



3.23 Patient autonomy has also become a central feature of medical practice.<sup>30</sup> Providing good patient care includes '[r]ecognising and respecting patients' rights to make their own decisions'.<sup>31</sup> This includes the right to refuse medical treatment.

3.24 The principle of autonomy recognises that people who are dying and suffering serious pain or distress should have some control over the timing and manner of their death. Since death is part of life, choices about the manner and timing of death 'are, for many people, part of what is involved in taking responsibility for their lives' and, thereby, exercising their autonomy.<sup>32</sup>

3.25 The principle of autonomy is not, however, 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 / protecting vulnerable people***

3.26 It is important to balance the right of a person who is dying to access voluntary assisted dying with the need for appropriate safeguards to protect individuals and the wider community.

3.27 Safeguards are necessary to ensure that people who might be vulnerable to coercion or undue influence are protected. It is important to ensure that decisions to request or access assisted dying are voluntary and not, for example, the result of undue pressure.

### ***Informed decision-making***

3.28 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.

3.29 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.<sup>33</sup> It is also expressly 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'.<sup>34</sup>

3.30 Informed consent ensures the person's decision is voluntary. It involves providing information in a way the person can understand.<sup>35</sup> It also emphasises the

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<sup>30</sup> See, eg, Breen et al, above n 9, [1.8].

<sup>31</sup> 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 9, [1.4].

<sup>32</sup> Stanford Encyclopedia of Philosophy, *Voluntary Euthanasia* (6 January 2020) [3] <<https://plato.stanford.edu/entries/euthanasia-voluntary/>>.

<sup>33</sup> See, eg, *Rogers v Whitaker* (1992) 175 CLR 479, 489; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102-103; 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].

<sup>34</sup> *Human Rights Act 2019* (Qld) s 17.

<sup>35</sup> See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.5.1].

importance of ensuring the person understands all the available options. If a decision is not properly informed, it will not necessarily reflect the person's truly voluntary choice.

### **Equality and non-discrimination**

3.31 The HR Act recognises the right to recognition and equality before the law.<sup>36</sup> This recognises that all people have the same rights and deserve the same level of respect. It requires laws and policies to 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.<sup>37</sup> Principles of non-discrimination are also recognised under anti-discrimination and other rights-based legislation.<sup>38</sup>

3.32 Equality rights are relevant to questions about access to voluntary assisted dying. 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.

3.33 The HR Act specifically recognises the right to access health services without discrimination.<sup>39</sup> Access to high quality health services is also recognised as part of the national framework of health care regulation.<sup>40</sup> This may present particular challenges for people living in rural, regional and remote areas of Queensland.

### **Privacy and communication**

3.34 The 'right to privacy' should also be considered. The HR Act requires that a person's privacy not be unlawfully or arbitrarily interfered with. The right to privacy protects a variety of interests. They include the protection of personal information and data collection. They also extend to a person's private life and protection from interference with the person's physical and mental integrity.<sup>41</sup>

<sup>36</sup> *Human Rights Act 2019* (Qld) s 15.

<sup>37</sup> See, eg, Law Council of Australia, *Policy Statement: Rule of Law Principles* (March 2011) [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.

<sup>38</sup> 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 11 sch 1 pt 1, item 2.

<sup>39</sup> *Human Rights Act 2019* (Qld) s 37(1). See also TC Beirne School of Law, *Human Rights Act 2019 (Qld): A Guide to Rights Interpretation* (February 2020) 81. 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.

<sup>40</sup> Office of the Health Ombudsman (Queensland), *Your healthcare rights* (2020) <<https://www.oho.qld.gov.au/health-consumers/healthcare-rights/>>; 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/>>.

<sup>41</sup> *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/>>.

3.35 Privacy laws impose information privacy obligations on public entities, health service providers and some private organisations.<sup>42</sup> Patient confidentiality also forms part of a health practitioner's ethical responsibilities.<sup>43</sup>

3.36 Good medical practice recognises the importance of open dialogue between the health practitioner and patient, and meeting the patient's individual language, cultural and communication needs.<sup>44</sup> In the context of end of life care, '[d]octors have a vital role in assisting the community to deal with the reality of death and its consequences'.<sup>45</sup>

### **Freedom of conscience**

3.37 Respect for the right of individuals to make decisions about the manner and timing of their death must be balanced against the right of others to freedom of conscience.

3.38 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 observance or practice.<sup>46</sup> This suggests that a person is not required to carry out an act that is contrary to their beliefs.<sup>47</sup>

3.39 The right of health practitioners to conscientiously object to participation in medical treatments or procedures is reflected in other legislation<sup>48</sup> and is recognised in health practitioners' codes of ethics.<sup>49</sup>

3.40 Some health practitioners may conscientiously object to participating in voluntary assisted dying. The right to freedom of conscience is not, however, absolute. The principle of non-abandonment, for example, suggests that a health practitioner who conscientiously objects may still have obligations to ensure their patient is referred to another practitioner or service.<sup>50</sup>

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42 See the *Privacy Act 1988* (Cth); and *Information Privacy Act 2009* (Qld).

43 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.4]; AMA, *Code of Ethics* (2016) [3.2.3], [3.4].

44 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [4.3].

45 Ibid [3.12].

46 *Human Rights Act 2019* (Qld) s 20.

47 See, eg, Willmott and White, above n 26, 492.

48 See the *Termination of Pregnancy Act 2018* (Qld) s 8.

49 See, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.4.6].

50 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.

### **Clarity of the law**

3.41 As a general principle, legislation should be ‘unambiguous and drafted in a sufficiently clear and precise way’.<sup>51</sup> The community is ‘the ultimate user of a law’.<sup>52</sup>

3.42 It is especially important that individuals who may wish to use voluntary assisted dying legislation, their families and carers, health practitioners and health services are able to understand the legislation. The issues involved in end of life care and decisions mean that any voluntary assisted dying legislation is likely to be complex. To the extent possible, however, the legislation should be structured and expressed in terms that will enable its requirements and processes to be communicated effectively. Community engagement and education are likely to be of particular importance in ensuring the Queensland framework is practical.<sup>53</sup>

### **Reasonable consistency with other jurisdictions and adaptation to Queensland**

3.43 Voluntary assisted dying legislation has been introduced in two other Australian jurisdictions. Although there are differences, there are also many similarities between those two legislative schemes.

3.44 It is desirable for the legislation in Queensland to achieve reasonable consistency with the approaches taken in other jurisdictions, while being adapted to the particular features of the State. This recognises both the national nature of the health care regulatory framework, as well as the challenges posed by Queensland’s geography and the spread of population in regional and remote areas, its public and private health systems and the availability of, and accessibility to, suitably qualified medical practitioners.

## **WHETHER THE LEGISLATION SHOULD INCLUDE A SET OF PRINCIPLES**

### **Victoria and Western Australia**

3.45 Both the *Voluntary Assisted Dying Act 2017* (Vic) and the *Voluntary Assisted Dying Act 2019* (WA) include a statement of legislative principles. The principles are intended to underpin the interpretation and operation of the legislation.<sup>54</sup>

3.46 The principles in the Western Australian legislation are based on those contained in the *Voluntary Assisted Dying Act 2017* (Vic). With some drafting differences and additions in the Western Australian legislation, they are in the same terms in both Acts.

<sup>51</sup> *Legislative Standards Act 1992* (Qld) s 4(3)(k). Section 4 of that Act sets out what are known as the ‘fundamental legislative principles’.

<sup>52</sup> 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.

<sup>53</sup> 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’.

<sup>54</sup> 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.

3.47 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 underlining appearing only in the Western Australian legislation):<sup>55</sup>

	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 <u>high quality care 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)
• a person should be encouraged to openly discuss death and dying, and the person’s preferences and values <u>regarding their care, treatment and end of life</u> 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 <u>and end of life, irrespective of where the person lives in [the State] and having regard to the person’s culture and language</u> ;	s 5(1)(h)	s 4(1)(h)
• <u>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</u> ;	—	s 4(1)(i)
• there is a need to protect persons who may be subject to abuse <u>or coercion</u> ;	s 5(1)(i)	s 4(1)(j)
• all persons, including health practitioners, have the right to be shown respect for their culture, <u>religion</u> , beliefs, values and personal characteristics.	s 5(1)(j)	s 4(1)(k)

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In Victoria, the principles in *Voluntary Assisted Dying Act 2017* (Vic) ss 5(1)(f)–(i) refer to ‘individuals’ rather than ‘persons’.

3.48 In contrast with the Victorian legislation, the Western Australian legislative principles include additional references to equality of access, particularly for people in regional areas. In particular, the legislation provides that:<sup>56</sup>

- 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.

3.49 It was observed in submissions to the Western Australian Ministerial Expert Panel that equality of access 'may be impacted by disability, age, geographical location [or] language'.<sup>57</sup>

### Overseas jurisdictions

3.50 The voluntary assisted dying legislation in overseas jurisdictions does not generally include statements of guiding principles. Some Acts include a statement of purposes or declarations which refer, in broad terms, to relevant principles. For example, in New Jersey, the 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'.<sup>58</sup>

### Queensland

3.51 The Parliamentary Committee's Issues Paper did not include a specific question about whether voluntary assisted dying legislation should be informed by or include particular principles. However, many responses to the question whether there should be voluntary assisted dying legislation, and what features any such legislation should have, referred to principles or values, including variously:<sup>59</sup>

- 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;

<sup>56</sup> *Voluntary Assisted Dying Act 2019* (WA) s 4(1)(h), (i).

<sup>57</sup> WA Ministerial Expert Panel Final Report (2019) 11. The expert panel recommended the following principle:  
People are entitled to genuine choices regarding their treatment and care; [and] this should be regardless of their geographic location and take into account their ability as well as individual cultural and linguistic needs: at 12.

<sup>58</sup> *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:16 2(a), (c)(3).

<sup>59</sup> See, eg, Submissions 219, 263, 277, 278, 282, 387, 399, 439, 719, 876, 1209 to the Parliamentary Committee.

- the protection of vulnerable people and not devaluing others' lives;
- medical ethics principles; and
- transparency and clarity.

3.52 Some respondents to the Parliamentary Committee's Issues Paper expressed views that voluntary assisted dying legislation should be 'values-based'<sup>60</sup> or informed by principles<sup>61</sup> such as autonomy, protecting the vulnerable, and reducing human suffering.

3.53 The W&W Model suggests that a person should 'have regard to' the following broad principles under the legislation:<sup>62</sup>

- (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.

3.54 In Victoria and Western Australia, and under the W&W 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, including the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*.<sup>63</sup> An entity who performs a function or exercises a power under those Acts, such as an attorney or guardian, is required to apply the General Principles in making

<sup>60</sup> See, eg, Submissions 1199, 1201, 1206 to the Parliamentary Committee.

<sup>61</sup> See, eg, Submissions 189, 1200 to the Parliamentary Committee.

<sup>62</sup> W&W Model cl 5, which provides that '[a] person exercising a power or performing a function or duty under this Act must have regard to' those principles.

<sup>63</sup> See *Guardianship and Administration Act 2000* (Qld) s 11(1), sch 1; and *Powers of Attorney Act 1998* (Qld) s 76, sch 1.

See also, eg, *Mental Health Act 2016* (Qld) s 5; *Domestic and Family Violence Protection Act 2012* (Qld) s 4(1)-(2). Each of those Acts provides that the stated principles apply to the 'administration' of the Act. Cf, eg, *Disability Services Act 2006* (Qld) ss 17, 19(1)-(2), which provides that particular entities are 'encouraged' to apply or have regard to the stated principles.

decisions under the legislation.<sup>64</sup> This provides a ground upon which those decisions might be challenged.<sup>65</sup>

### Consultation questions

- Q-2 Should the draft legislation include a statement of principles:**
- (a) that aids in the interpretation of the legislation?**
  - (b) to which a person must have regard when exercising a power or performing a function under the legislation (as in Victoria and Western Australia)?**
- Q-3 If yes to Q-2(b), what would be the practical, and possibly unintended, consequences of requiring such persons to have regard to each of the principles?**
- Q-4 If yes to Q-2(a) or (b) or both, what should the principles be? For example, should the statement of principles include some or all of the principles contained in:**
- (a) section 5(1) of the *Voluntary Assisted Dying Act 2017* (Vic);**
  - (b) section 4(1) of the *Voluntary Assisted Dying Act 2019* (WA); or**
  - (c) clause 5 of the W&W Model?**

<sup>64</sup> *Guardianship and Administration Act 2000* (Qld) ss 11(1), 34(1), sch 1; *Powers of Attorney Act 1998* (Qld) s 76, sch 1. Those provisions are repealed and replaced with amendments by the *Guardianship and Other Legislation Amendment Act 2019* (Qld) ss 7, 8, 19, 43, 56, 69, 80 (not yet commenced).

<sup>65</sup> 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 9 below.



# Chapter 4

## Eligibility criteria for access to voluntary assisted dying

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## INTRODUCTION

4.1 The terms of reference require the Commission to have regard to a number of specific matters including identifying ‘the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland’ and ‘identifying who can access voluntary assisted dying’.<sup>1</sup>

4.2 This chapter considers eligibility criteria for access to voluntary assisted dying.

4.3 For a person to be eligible for access to voluntary assisted dying in Victoria and Western Australia:<sup>2</sup>

- the person must be diagnosed with a disease, illness or medical condition (or, in Western Australia, ‘at least [one] disease, illness or medical condition’) that:
  - is advanced, progressive and will cause death (and, in Victoria, is incurable);
  - is expected to cause death (or in Western Australia will, on the balance of probabilities, cause death) within six months, or within 12 months if the disease, illness or medical condition is neurodegenerative; and
  - is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;
- the person must be aged 18 years or more;
- the person must:
  - be an Australian citizen or permanent resident;
  - have been ordinarily resident in the State for at least 12 months at the time of making their first request for access to voluntary assisted dying (and, in Victoria, must be ordinarily resident in the State);
- the person must be acting voluntarily and without coercion;<sup>3</sup>
- the person must have decision-making capacity in relation to voluntary assisted dying; and

<sup>1</sup> Terms of reference paras 1, 2.

<sup>2</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 9(1), (4), 20(1)(a), (c)–(d), 29(1)(a), (c)–(d); *Voluntary Assisted Dying Act 2019* (WA) s 16(1), and see ss 28, 39. Additionally, the person must understand the information that the coordinating and consulting practitioners are required to provide them with if they are assessed as eligible: see further the discussion of outcome of assessments, and information to be given to the person if they are assessed as eligible in Chapter 2 above.

<sup>3</sup> In Victoria, this is not included as an eligibility criterion. However, the coordinating practitioner and consulting practitioner must each be satisfied that the person ‘is acting voluntarily and without coercion’ in order to assess the person as eligible for access to voluntary assisted dying: *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(c); 29(1)(c). In contrast, in Western Australia, this is one of the eligibility criteria: *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(e).

- the person's request for access to voluntary assisted dying must be enduring.<sup>4</sup>

## ELIGIBLE DISEASE, ILLNESS OR MEDICAL CONDITION

4.4 One of the eligibility criteria for access to voluntary assisted dying in Victoria and Western Australia is that the person must be diagnosed with a 'disease, illness or medical condition' that is 'advanced, progressive and will cause death'. In Victoria, the legislation also requires that the disease, illness or medical condition is 'incurable'.<sup>5</sup>

4.5 This criterion—together with the criteria relating to the timeframe until death and the level of suffering caused—reflects the policy that voluntary assisted dying:<sup>6</sup>

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.

4.6 A person will meet these eligibility criteria for access to voluntary assisted dying in Victoria and Western Australia only if they are diagnosed with a terminal disease, illness or medical condition that is expected to cause death within six months (or 12 months, in the case of a neurodegenerative disease, illness or medical condition) and that is causing intolerable suffering.<sup>7</sup>

4.7 Whether a person has an eligible disease, illness or medical condition:<sup>8</sup>

will be determined on a clinical basis by the medical practitioner based on an individual's particular circumstances, including their overall condition and their comorbidities.

4.8 The Voluntary Assisted Dying Review Board has reported that, since the commencement of voluntary assisted dying in Victoria, 78 per cent of applicants who had a permit issued and subsequently died had a malignancy diagnosis, and 22 per cent had a non-malignant diagnosis.<sup>9</sup>

<sup>4</sup> In Victoria, this is not included as an eligibility criterion. However, the coordinating and consulting practitioner must each be satisfied that the person's request 'is enduring' in order to assess the person as eligible: *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(d); 29(1)(d). In contrast, in Western Australia, this is one of the eligibility criteria: *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(f).

<sup>5</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(i)–(ii); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c)(i).

<sup>6</sup> Vic Ministerial Advisory Panel Final Report (2017) 70, quoting Vic Parliamentary Committee Final Report (2016) 237 (and see [8.6.4]). See also Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019 5134 (RH Cook, Minister for Health), noting that voluntary assisted dying 'is a choice for those who are going to die, for whom death is inevitable and imminent'.

<sup>7</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d), (4); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c).

<sup>8</sup> Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health). See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5.

Whether the disease, illness or medical condition is causing intolerable suffering is, however, a subjective element to be determined by the patient: see [4.47] below.

<sup>9</sup> Of the malignancy group, 17% had a primary lung malignancy, 15% had primary breast malignancy, 11% had other gastrointestinal tract malignancy and 10% had primary pancreatic malignancy. Of the non-malignant group, 15% had a neurodegenerative disease and 7% had other diseases such as pulmonary fibrosis, cardiomyopathy or chronic obstructive pulmonary disease: Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 10.

4.9 In overseas jurisdictions, the main diseases, illnesses and medical conditions for accessing voluntary assisted dying are cancers, neurodegenerative diseases and chronic heart and respiratory diseases.<sup>10</sup>

4.10 The Parliamentary Committee recommended that any scheme 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 will cause death.<sup>11</sup>

4.11 Like Victoria, the W&W Model provides that the person must be diagnosed with a medical condition that is incurable and is advanced, progressive and will cause death.<sup>12</sup>

### **Advanced, progressive and will cause death**

4.12 The requirement that the person must be diagnosed with a ‘disease, illness or medical condition’ that is ‘advanced, progressive and will cause death’ was recommended by the Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel.<sup>13</sup>

4.13 The terms ‘advanced and progressive’ make it clear that the disease, illness or medical condition must be ‘very serious and on a deteriorating trajectory’,<sup>14</sup> such that ‘the person is not going to recover and instead will continue to decline’.<sup>15</sup>

4.14 The words ‘will cause death’ make it clear that the disease, illness or medical condition must be terminal.<sup>16</sup>

4.15 The Victorian Ministerial Advisory Panel considered that the formulation ‘advanced, progressive and will cause death’ is more clear and precise than

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10 See, eg, 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, *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.

11 Qld Parliamentary Committee Report No 34 (2020) 120, Rec 4.

12 W&W Model cl 9(e)(i)–(ii).

13 Vic Ministerial Advisory Panel Final Report (2017) 52, Rec 2; WA Ministerial Expert Panel Final Report (2019) 34, Rec 7.

14 WA Ministerial Expert Panel Final Report (2019) 34.

15 Vic Ministerial Advisory Panel Final Report (2017) 69. See also Vic Guidance for Health Practitioners (2019) 37, noting that:

‘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.

16 WA Ministerial Expert Panel Final Report (2019) 34.

terminology used in overseas jurisdictions (such as ‘serious’<sup>17</sup> or ‘terminal’<sup>18</sup>) and reflects contemporary healthcare terminology used and understood in Australia.<sup>19</sup> The Panel also considered that:<sup>20</sup>

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.

4.16 The Western Australian Joint Select Committee on End of Life Choices recommended that the legislation should define an eligible condition to mean an advanced and progressive ‘terminal’, ‘chronic’ or ‘neurodegenerative’ illness or disease.<sup>21</sup> However, the Western Australian Ministerial Expert Panel considered that it ‘is not helpful’ and ‘may cause undue concern’ for the eligibility criteria to refer to ‘specific disease types’. Instead, it recommended the Victorian formulation of ‘an illness, disease or medical condition that is advanced, progressive and will cause death’.<sup>22</sup> This is intended to capture terminal, chronic and neurodegenerative diseases, illnesses and medical conditions.

## Incurable

4.17 In Victoria, the legislation also requires that the disease, illness or medical condition must be ‘incurable’.<sup>23</sup> This was recommended by the Victorian Ministerial Advisory Panel, which explained that it chose to retain ‘incurable’ as the term:<sup>24</sup>

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

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17 See Vic Ministerial Advisory Panel Final Report (2017) 67, in which the Panel expressed the view that the word ‘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’.

18 For example, it was 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: Vic Ministerial Advisory Panel Final Report (2017) 70. See also WA Ministerial Expert Panel Final Report (2019) 33.

19 Vic Ministerial Advisory Panel Final Report (2017) 66–70.

20 Ibid 68.

21 WA Joint Select Committee on End of Life Choices Report (2018) [7.89], Rec 24. See also [7.30].

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

23 *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(i).

24 Vic Ministerial Advisory Panel Final Report (2017) 67. See also Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) 3.

aims to manage the symptoms of the medical condition to promote the person's quality of life and ensure their comfort.

4.18 However, it was explained that this does not require that all treatment options to manage the person's symptoms have been exhausted or proven futile. 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.<sup>25</sup>

### Mental illness or disability

4.19 The legislation in Victoria and Western Australia expressly provides that a person is not eligible to access voluntary assisted dying only because they are diagnosed with a mental illness, or because they have a disability.<sup>26</sup>

4.20 This makes it clear that a mental illness or disability is not an eligible disease, illness or medical condition for the purposes of accessing voluntary assisted dying.<sup>27</sup> However, having a mental illness or disability does not exclude a person from accessing voluntary assisted dying if they satisfy all of the eligibility criteria.<sup>28</sup> It was explained, for example, that:<sup>29</sup>

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.

4.21 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 of the eligibility criteria.<sup>30</sup>

<sup>25</sup> See Vic Ministerial Advisory Panel Final Report (2017) 67; Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3–4; Vic Guidance for Health Practitioners (2019) 37.

<sup>26</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(2), (3); *Voluntary Assisted Dying Act 2019* (WA) s 16(2). Similarly, see *End of Life Choice Act 2019* (NZ) s 5(2)(a)–(b) (as enacted, not commenced). That Act also provides that a person is not an eligible person by reason only that they are 'of advanced age': s 5(2)(c).

<sup>27</sup> See Vic Ministerial Advisory Panel Final Report (2017) 68, 80–82, 83–5, Recs 5, 6; Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (J Hennessy, Minister for Health); WA Ministerial Expert Panel Final Report (2019) 40, Rec 10.

<sup>28</sup> See n 27 above. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 4; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 6.

It was noted that there are strong safeguards in relation to 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. See further the discussion of requirements for referral of certain matters in Chapter 6 below.

<sup>29</sup> Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (J Hennessy, Minister for Health).

<sup>30</sup> 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, in relation to the right to recognition and equality before the law.

4.22 In Queensland, the Parliamentary Committee similarly considered that:<sup>31</sup>

people should not be automatically excluded from voluntary assisted dying simply 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.

4.23 It recommended that any voluntary assisted dying scheme in Queensland should provide that:<sup>32</sup>

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.

4.24 The W&W Model does not contain any provisions similar to those in the Victorian and Western Australian legislation which specify that a person is not eligible only because they have a mental illness or disability.

## Overseas jurisdictions

4.25 Like Victoria and Western Australia, state legislation in the United States of America limits eligibility for access to voluntary assisted dying to a person with a terminal disease, illness or medical condition where death is imminent. The person must be diagnosed with a terminal disease or illness that is 'incurable and irreversible' and will 'result in' or 'produce' death.<sup>33</sup>

4.26 The federal legislation in Canada requires the person to have a 'grievous and irremediable medical condition', which is defined to mean, among other things, that the person has a 'serious and incurable' illness, disease or disability and that they are 'in an advanced state of irreversible decline in capability'.<sup>34</sup> The legislation

<sup>31</sup> Qld Parliamentary Committee Report No 34 (2020) 133.

<sup>32</sup> Ibid Rec 10.

<sup>33</sup> 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 require 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'.

Legislation in New Zealand limits eligibility for access to voluntary assisted dying to a person who 'suffers from a terminal illness that is likely to end the person's life' and 'is in an advanced state of irreversible decline in physical capability': *End of Life Choice Act 2019* (NZ) s 5(1)(c), (d) (as enacted, not commenced).

<sup>34</sup> *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(1)(c), (2)(a)–(b), (d). Cf *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, s 26(4)–(5), which requires that the person must suffer from a 'serious and incurable' illness and 'be in an advanced state of irreversible decline in capability'.

does not currently exclude mental illness from being an eligible condition, although an amendment to this effect has been proposed.<sup>35</sup>

4.27 Unlike Victoria and Western Australia, the legislation in Belgium and the Netherlands does not require the person to have a terminal disease, illness or medical condition.<sup>36</sup> Access to voluntary assisted dying may be sought on the basis of mental or psychological suffering alone.<sup>37</sup>

### Consultation questions

**Q-5 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that:**

- (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)?**

**Q-6 Should the eligibility criteria for a person to access voluntary assisted dying expressly state that a person is not eligible only because they:**

- (a) have a disability; or**
- (b) are diagnosed with a mental illness?**

<sup>35</sup> Mental illness alone is unlikely to meet the eligibility criteria, including the requirement that natural death must be reasonably foreseeable. However, s 241(2)(d) of the federal legislation was held to be inoperative in *Truchon v Attorney General of Canada* [2019] QCCS 3792. Consequently, a Bill has been introduced to, among other things, amend the eligibility criteria by stating that mental illness is not an illness, disease or disability for the purpose of determining eligibility for medical assistance in dying: An Act to Amend the Criminal Code (medical assistance in dying), Canada, Bill C-7, 2020 Preamble, cl 1(2). See also 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) 26, 29; and [4.43]–[4.44] below.

<sup>36</sup> In Belgium, the person must 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': *Belgian Euthanasia Act 2002* art 3(1).

In the Netherlands, the physician must be satisfied, among other things, simply that 'the patient's suffering is unbearable, with no prospect of improvement': *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(b). See also Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) 9.

Cf *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(1)(3), which requires that the person is in a 'terminal medical situation', and 'shows constant and unbearable physical or mental suffering without prospects of improvement, resulting from an accidental or pathological disorder'.

<sup>37</sup> In 2018, there were 6126 notifications of euthanasia in the Netherlands. 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 also 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.



## TIMEFRAME UNTIL DEATH

4.28 In Victoria and Western Australia, a person is eligible to access voluntary assisted dying only if they have an eligible disease, illness or medical condition that is expected to cause death within six months, or 12 months in the case of a disease, illness or medical condition that is neurodegenerative.<sup>38</sup>

4.29 Whether a disease, illness or medical condition will cause death and the time within which it is expected to cause death:<sup>39</sup>

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.

4.30 In Victoria, guidance for health practitioners explains that:<sup>40</sup>

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.

... 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.

4.31 The Victorian Parliamentary Committee and Western Australian Joint Select Committee considered that voluntary assisted dying legislation should not include a specific timeframe.

4.32 The Victorian Parliamentary Committee considered that voluntary assisted dying should be accessible to those who are 'at the end of life (final weeks or months of life)' and that 'empowering doctors to make this assessment is preferable to allocating an arbitrary time limit'.<sup>41</sup>

4.33 The Western Australian Joint Select 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'.<sup>42</sup>

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<sup>38</sup> The precise wording varies. The legislation in Victoria provides that the disease, illness or medical condition is 'expected to cause death'; in Western Australia, the legislation provides that it 'will, on the balance of probabilities, cause death': *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iii), (4); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c)(ii).

<sup>39</sup> Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) 3–4. See also Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 5.

<sup>40</sup> Vic Guidance for Health Practitioners (2019) 38.

<sup>41</sup> Vic Parliamentary Committee Final Report (2016) 223–4, Rec 49.

<sup>42</sup> 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, should be sufficient without a prescribed timeline until death': 213–14, Finding 50. It recommended that the legislation should require that 'death be *reasonably foreseeable* as a consequence of the condition' (emphasis in original): 214, Rec 22.

4.34 However, the inclusion of a specific timeframe was recommended by the Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel.<sup>43</sup> It was considered to be an important additional safeguard to ensure that voluntary assisted dying is:<sup>44</sup>

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.

4.35 It was also considered that the inclusion of a specific timeframe would provide clarity and guidance for the community and medical practitioners about who is eligible to access voluntary assisted dying and will ensure consistency of approach in implementation.<sup>45</sup>

4.36 The Victorian Ministerial Advisory Panel and Western Australian Ministerial Expert Panel recommended that the specific timeframe should be 12 months. This timeframe was considered to be consistent with current healthcare practice and the end of life and palliative care framework in Australia.<sup>46</sup> It was also considered that a 12 month timeframe 'is more likely to encompass the clinical trajectories of neurodegenerative diseases, such as motor neurone disease'.<sup>47</sup>

4.37 The Western Australian Ministerial Expert Panel did not consider that there should be more than one timeframe, for example, of six months for some conditions and 12 months for others. In its view, 'it is difficult and potentially discriminatory to weight the suffering of one terminal diagnosis above other terminal diagnoses'.<sup>48</sup>

4.38 As introduced, the Victorian Voluntary Assisted Dying Bill 2017 provided for a single timeframe of 12 months.<sup>49</sup> However, during its passage through the Legislative Council, the Bill was amended to reduce the timeframe to six months, in order to strengthen the safeguard that voluntary assisted dying should be limited to the end of life, and to insert a new provision extending the timeframe to 12 months for those diagnosed with a neurodegenerative condition.<sup>50</sup>

<sup>43</sup> Vic Ministerial Advisory Panel Final Report (2017) 52, 71–4, Rec 2; WA Ministerial Expert Panel Final Report (2019) 37–9, Rec 9.

<sup>44</sup> WA Ministerial Expert Panel Final Report (2019) 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.

<sup>45</sup> Vic Ministerial Advisory Panel Final Report (2017) 71–2; WA Ministerial Expert Panel Final Report (2019) 37–8.

<sup>46</sup> 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 <<https://www.safetyandquality.gov.au/our-work/comprehensive-care/end-life-care/national-consensus-statement>>.

<sup>47</sup> Vic Ministerial Advisory Panel Final Report (July 2017) 73. The Panel stated 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': 72.

<sup>48</sup> WA Ministerial Expert Panel Final Report (2019) 39.

<sup>49</sup> Voluntary Assisted Dying Bill 2017 (Vic) s 9(1)(d)(iii) (as introduced).

<sup>50</sup> Victoria, *Parliamentary Debates*, Legislative Council, 16 November 2017, 6097–8 (G Jennings, Special Minister of State) and 21 November 2017, 6216 (G Jennings, Special Minister of State), 6239.

4.39 An approach consistent with the legislation in Victoria was adopted in the Western Australian legislation.<sup>51</sup>

4.40 In Queensland, the Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland:<sup>52</sup>

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

4.41 The W&W Model does not impose a specific timeframe within which a person must be expected to die. It was considered that a time limit is arbitrary.<sup>53</sup>

### Overseas jurisdictions

4.42 State legislation in the United States of America requires that the person must be diagnosed with a terminal disease or illness that will, within reasonable medical judgment, result in death within six months.<sup>54</sup> It has been noted that in some states, this timeframe relates to administrative and funding requirements in relation to access to hospice care.<sup>55</sup>

4.43 The federal legislation in Canada required that a person's natural death must have 'become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining'.<sup>56</sup>

4.44 However, in the 2019 case of *Truchon v Attorney General of Canada*, that provision was held to be contrary to the *Canadian Charter of Rights and Freedoms* and declared inoperative.<sup>57</sup> In 2020, the Government introduced a Bill that proposes to amend the Criminal Code by repealing the requirement for the person's natural

51 Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health).

52 Qld Parliamentary Committee Report No 34 (2020) 120, Rec 5.

53 W&W Model, Explanatory Notes 3. It also notes that 'not imposing a time limit avoids [the need for] a registered medical practitioner ... to engage in the difficult task of determining prognosis and timing of death'.

54 See, eg, the definitions of 'terminal disease', 'terminal illness' or 'terminally ill' in *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.1(q); *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); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L-1; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140(2)(M); *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:16-3; *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.800.1.01(12); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5281(10); *Washington Death with Dignity Act*, RCW § 70.245.010(13).

Legislation in New Zealand limits access to voluntary assisted dying to a person who 'suffers from a terminal illness that is likely to end the person's life within 6 months': *End of Life Choice Act 2019* (NZ) s 5(1)(c) (as enacted, not commenced).

55 Vic Ministerial Advisory Panel Final Report (2017) 72; Western Australian Ministerial Expert Panel on Voluntary Assisted Dying, *Discussion Paper of the Ministerial Expert Panel on Voluntary Assisted Dying* (Discussion Paper, Department of Health (Western Australia), March 2019) 28.

56 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2 (2)(d).

57 [2019] QCCS 3792. Section 26(3) of the *Quebec Act respecting end-of-life-care*, RSQ, c S-32.001 was also declared inoperative. That provision required, among other things, that a person must be 'at the end of life' to access medical aid in dying.

death to be reasonably foreseeable and inserting additional safeguards that apply for individuals whose death is not reasonably foreseeable.<sup>58</sup>

4.45 The legislation in Belgium, the Netherlands and Luxembourg does not include any specific timeframes until death.

### Consultation questions

**Q-7 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that is expected to cause death within a specific timeframe?**

**Q-8 If yes to Q-7, what should the timeframe be? Should there 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 case of a disease, illness or medical condition that is neurodegenerative (as in Victoria and Western Australia)?**

### LEVEL OF SUFFERING CAUSED BY THE DISEASE, ILLNESS OR MEDICAL CONDITION

4.46 In Victoria and Western Australia, 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'.<sup>59</sup> This reflects the policy that:<sup>60</sup>

voluntary assisted dying legislation should provide an option for a small number of people whose pain and suffering cannot be relieved in a manner they deem tolerable to control the timing and manner of their death.

4.47 The extent to which the person's suffering may be relieved or is tolerable is a subjective assessment to be determined by the person themselves.<sup>61</sup> This recognises the person's autonomy and is consistent with a person-centred approach

<sup>58</sup> An Act to amend the Criminal Code (medical assistance in dying), Canada, Bill C-7, 2020 cl 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 43-1-C7-E, Library of Parliament, Canada, 27 March 2020) 5, 6–9.

<sup>59</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iv); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c)(iii).

<sup>60</sup> Vic Ministerial Advisory Panel Final Report (2017) 75, noting that a core value of end of life care is 'the alleviation of pain and suffering for those who are unwell'.

<sup>61</sup> Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (J Hennessy, Minister for Health); Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 5.

to care.<sup>62</sup> It also recognises that ‘a person’s experience of the nature and intensity of their suffering is entirely subjective’.<sup>63</sup>

4.48 The Victorian guidance for health practitioners explains that:<sup>64</sup>

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 tolerate. If the suffering is linked to the medical condition, then this eligibility criterion is met.

4.49 ‘Suffering’ is not limited to the physical symptoms of a person’s disease, illness or medical condition, such as pain. It can also include ‘non-physical aspects such as loss of function, control and enjoyment of life’.<sup>65</sup> It has been observed that:<sup>66</sup>

A person’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.

4.50 The Victorian Voluntary Assisted Dying Review Board reported that:<sup>67</sup>

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.

4.51 The Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel considered that the eligibility criteria should not incorporate a higher threshold in relation to the level of suffering by requiring, for example, that the suffering is ‘enduring and unbearable’ or ‘grievous and irremediable’. It was

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62 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.

63 Vic Ministerial Advisory Panel Final Report (2017) 76.

64 Vic Guidance for Health Practitioners (2019) 39.

65 Vic Ministerial Advisory Panel Final Report (2017) 76. See also Vic Guidance for Health Practitioners (2019) 39, noting that ‘[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’.

66 Vic Ministerial Advisory Panel Final Report (2017) 77.

67 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 9. This is consistent with data collected in the United States of America. In Oregon, data in relation to the reasons why people request voluntary assisted dying have been collected since 1998. Over that time, 90.2% of people who accessed voluntary assisted dying cited concerns about losing autonomy, 89.3% about decreased ability to engage in activities that make life enjoyable, and 74% about loss of dignity. Other end of life concerns included being a burden on family, friend or caregivers (46.7%), losing control of bodily functions (43.9%), inadequate pain control or concern about inadequate pain control (26.6%) and financial implications of treatment (4.3%). The categories are not mutually exclusive: Oregon Health Authority, Public Health Division, Center for Health Statistics, *Oregon Death with Dignity Act 2019 Data Summary* (Report, 2020) 12, 13 Table 1.

considered that the inclusion of such terms is unnecessary and could ‘potentially compromise the compassionate intention of the legislation’.<sup>68</sup>

4.52 As in Victoria and Western Australia, 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’.<sup>69</sup>

4.53 The W&W Model provides that the person must be diagnosed with a medical condition that is causing ‘intolerable and enduring suffering’, which is to be determined by the person themselves.<sup>70</sup> It was noted that ‘intolerable and enduring’ is a higher threshold than in the Victorian and Western Australian legislation but is consistent with some overseas jurisdictions.<sup>71</sup> Unlike Victoria and Western Australia, the W&W Model does not include a time limit within which death must be expected to occur.

### Overseas jurisdictions

4.54 In Belgium, the person must be experiencing ‘constant and unbearable’ physical or mental suffering that ‘cannot be alleviated’.<sup>72</sup> In Luxembourg and the Netherlands, the person’s suffering must be ‘unbearable’ and without prospects of improvement.<sup>73</sup> In Canada, the person must be suffering ‘enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under

<sup>68</sup> WA Ministerial Expert Panel Final Report (2019) 35. The Panel also noted that the addition of such terms ‘implies that the person needs to prove the severity of their suffering’ and could ‘lead to a possible interpretation that there should be an objective determination of the nature of the suffering’: 34–5.

See also Vic Ministerial Advisory Panel Final Report (2017) 79, noting that the word ‘suffering’, on its own, denotes a sufficiently high threshold for eligibility to access voluntary assisted dying, 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 to access voluntary assisted dying.

<sup>69</sup> Qld Parliamentary Committee Report No 34 (2020) 120, Rec 4.

<sup>70</sup> W&W Model cll 9(e)(iii), 10(2)(a). Clause 10(2) provides that:

- (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.

<sup>71</sup> W&W Model, Explanatory Notes 4. See also 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, noting that:

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.

<sup>72</sup> *Belgian Euthanasia Act 2002* art 3(1).

<sup>73</sup> *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(1)(3); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(b). Whether a patient’s suffering is unbearable is ‘to a large extent a subjective and personal question from the patient’, whereas the question of prospects of improvement is one of a medical nature: 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) 15. See also Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2008: Review Procedures in Practice* (2018) [3.3].

conditions that they consider acceptable'.<sup>74</sup> Unlike Victoria and Western Australia, these jurisdictions do not include a specific timeframe within which death must be expected to occur.

4.55 State legislation in the United States of America requires only that the person has a terminal disease or illness that will cause death within six months; there is no additional requirement in relation to the person's level of suffering.<sup>75</sup>

## Consultation question

**Q-9 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must 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)?**

## AGE

4.56 In Victoria and Western Australia, 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.<sup>76</sup> In Australia, this is generally the age at which a person is regarded at law as an adult.<sup>77</sup> This age limit was also recommended by the Parliamentary Committee and adopted in the W&W Model.<sup>78</sup>

4.57 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.

4.58 In contrast, access to voluntary assisted dying by children is sometimes permitted in Belgium and the Netherlands. The legislation in those jurisdictions includes additional safeguards for children; for example, requirements to have

<sup>74</sup> *Canada Criminal Code*, RSC 1985, c C-46, s 241.2 (2)(c). See also *Quebec Act respecting end-of-life care*, RSQ, c S-32.001, s 26(6), which requires that the person must experience 'constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable'.

<sup>75</sup> See the legislation cited at n 54 above.

<sup>76</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(a); *Voluntary Assisted Dying Act 2019* (WA) s 16(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).

<sup>77</sup> *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.

<sup>78</sup> Qld Parliamentary Committee Report No 34 (2020) 117, Rec 2; W&W Model cl 9(a).

parental involvement or consent, to meet narrower medical criteria, or to be examined by a child psychologist or psychiatrist to ensure capacity.<sup>79</sup>

4.59 In Canada, where access is presently limited to adults, further studies are being undertaken about access to voluntary assisted dying by children.<sup>80</sup>

4.60 In Victoria and Western Australia, the policy reasons for limiting access to voluntary assisted dying to persons who are at least 18 years included the following:<sup>81</sup>

- 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.
- The age limit is consistent with the expectation of autonomy for adults, and with the approach in most other jurisdictions.
- The decision to access voluntary assisted dying is complex, 'requiring a person to have a well-developed capacity for abstract reasoning—a capacity that young people develop at different ages'.<sup>82</sup>
- Adults are presumed to have capacity to consent to medical treatment. A person under 18 years could have capacity to consent to some medical treatment but might not have capacity to make decisions about more complex medical treatments. This age limit provides a safeguard by protecting children who may lack the maturity, capacity or experience to make this complex decision.
- Children are considered to be more vulnerable than adults. In the context of human rights, an age limit directly discriminates against children. However, for the purposes of permitting access to voluntary assisted dying, it is

<sup>79</sup> See *Belgian Euthanasia Act 2002* arts 3(1), (2)(7); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(2)–(4). In the Netherlands, the child must be at least 12 years of age and must be 'deemed to be capable of making a reasonable appraisal of his own interests'. In Belgium, a child may access voluntary assisted dying if they are an 'emancipated minor' or a minor with 'the capacity for discernment'. The law in Belgium was passed in 2002 but amended in 2014 to include unemancipated children. See further, as to emancipation, N Francis, *Use of lawful voluntary assisted dying by minors: Worldwide evidence* (11 September 2020) 9 <<https://www.dyingforchoice.com/resources/fact-files/use-vad-minors-rare-worldwide-report>>.

<sup>80</sup> Canadian 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); Special Joint Committee on Physician Assisted Dying, Parliament of Canada, *Medical Assistance in Dying: A Patient-Centred Approach* (Report, February 2016) 20–21, Rec 6; Council of Canadian Academies, The Expert Panel Working Group on MAID for Mature Minors, *The State of Knowledge on Medical Assistance in Dying for Mature Minors* (2018); Canada, *Parliamentary Debates*, House of Commons, 26 February 2020, 1619 (D Lametti, Minister of Justice).

<sup>81</sup> 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; WA Ministerial Expert Panel Final Report (2019) 20. 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.

<sup>82</sup> Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2947 (J Hennessey, Minister for Health).



justifiable as equality of access must be balanced against the need to protect children from potential abuse.

- Children have the right to protection of their best interests. It is unclear whether this could extend to medical treatment to bring about a terminally ill child's death. Access to voluntary assisted dying 'might not be in their best interests due to their particular vulnerabilities'.<sup>83</sup>

4.61 Other matters that have been raised about the inclusion or exclusion of children from access to voluntary assisted dying (including those identified by submitters to the Parliamentary Committee and in Canadian studies) include the following:<sup>84</sup>

- There is a need for further scientific, evidence-based research on this topic, including consultation with children.
- Children experience similar physical and psychological symptoms to adults at the end of life and should not be forced to endure suffering.
- Children may be vulnerable and in need of protection, but it is also important to respect their rights and autonomy and to protect them from exclusion.
- Chronological age should not be the sole ground for predicting or assessing capacity. This approach may be 'arbitrary' or 'discriminatory', may impact on the rights of children and does not recognise that some children do have the capacity to make decisions about health care, including at the end of life. On the other hand, there is a need for a clear cut-off and there are difficulties associated with assessing the capacity of children.
- Children often rely, at least to some extent, on guidance from family and others, and may be influenced by other factors or perceptions, potentially reducing their ability to make an autonomous decision.
- Legislation permitting access to voluntary assisted dying for children could include additional safeguards to balance the needs for protection and access, such as requiring that there be additional or specialist medical involvement (including in relation to the assessment of capacity), or parental and family involvement, and requiring that particular or additional medical criteria be met (although these measures may themselves raise complex issues).
- It is important, regardless of the legality of voluntary assisted dying, that there is adequate access to paediatric palliative care.

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<sup>83</sup> Ibid 2948. It was also considered that it is of 'fundamental importance' that a person makes their own decision to access voluntary assisted dying, and that options such as permitting substitute decision-making by a child's parent could not sufficiently protect children, including from potential abuse: *ibid*.

<sup>84</sup> See generally, eg, Council of Canadian Academies, The Expert Panel Working Group on MAID for Mature Minors, *The State of Knowledge on Medical Assistance in Dying for Mature Minors* (2018) chs 5–7; Special Joint Committee on Physician Assisted Dying, Parliament of Canada, *Medical Assistance in Dying: A Patient-Centred Approach* (Report, February 2016) 19–21, Rec 6; Qld Parliamentary Committee Report No 34 (2020) 115–17.

- In jurisdictions where it is permitted, there are very few instances of children accessing voluntary assisted dying.<sup>85</sup>

### Consent by children to medical treatment in Australia

4.62 Generally, an adult may consent to medical treatment if they are competent, and their consent is informed and voluntary.<sup>86</sup>

4.63 In some circumstances, a child can give consent to medical treatment if they have the capacity to do so. A child is ‘capable of giving informed consent when [the child] “achieves a sufficient understanding and intelligence to enable [the child] to understand fully what is proposed”’.<sup>87</sup> A child who meets this standard is commonly referred to as ‘Gillick competent’.

4.64 A child who does not have the capacity to consent to medical treatment cannot give a valid consent.<sup>88</sup> In some circumstances, the parent of the child can give consent to medical treatment on the child’s behalf. However, consent to some types of medical treatment is outside the scope of parental decision-making authority. In those circumstances, the Supreme Court, by an order made in its *parens patriae* jurisdiction, may authorise the treatment.<sup>89</sup> In making such an order, the Court must act in the best interests of the child.<sup>90</sup>

4.65 Queensland Health guidelines explain that, in making decisions about the withdrawal or withholding of medical treatment for children, ‘there is a shift from the principle of patient autonomy to that of upholding the best interests of the child’. A

<sup>85</sup> See, eg, Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) [4.2]; Council of Canadian Academies, The Expert Panel Working Group on MAID for Mature Minors, *The State of Knowledge on Medical Assistance in Dying for Mature Minors* (2018) 109–110, 111, 113; N Francis, *Use of lawful voluntary assisted dying by minors: Worldwide evidence* (11 September 2020) 5–6, 10 <<https://www.dyingforchoice.com/resources/fact-files/use-vad-minors-rare-worldwide-report>>.

The latter report indicates that, between 2003 and 2019, there have been 14 reported instances involving a child in the Netherlands and eight in Belgium (five relating to emancipated minors and three relating to unemancipated minors with capacity for discernment). It was suggested that this ‘in part reflects the low rate of terminal illness and otherwise severe conditions at young ages compared with more advanced ages’.

In Canada, research conducted in 2016 about the number of discussions or requests relating to voluntary assisted dying with people under the age of 18 demonstrated that, if legalised, the actual number of requests from that age group is ‘likely to be small’, although might increase. (It was also noted that a greater number of requests come from parents on behalf of minors).

<sup>86</sup> See further [4.128] ff below.

<sup>87</sup> *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).

<sup>88</sup> See, eg, *Re A* (1993) 16 Fam LR 715, 719 and *Re Alex* (2004) 180 FLR 89, 529–30, [155]–[156], 531 [168], citing *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and *Marion’s Case* (1992) 175 CLR 218, 231–2.

<sup>89</sup> For example, as to termination of a child’s pregnancy, see *Queensland v B* [2008] 2 Qd R 562, [17]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [20], [30]–[33].

<sup>90</sup> *Marion’s Case* (1992) 175 CLR 218, 259–60, 269–70; *Queensland v Nolan* [2002] 1 Qd R 454, 455 [7], cited in, eg, *Queensland v B* [2008] 2 Qd R 562, [3], [17] and *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [18]. See also LexisNexis Australia, *Halsbury’s Laws of Australia* [205-2140] (9 January 2020).

Gillick competent child may consent to life-sustaining treatment but (unlike adults) cannot refuse life-sustaining treatment that would be in their best interests.<sup>91</sup>

4.66 A Gillick competent child may be able to give valid consent to the withholding or withdrawal of life-sustaining measures, but Queensland Health guidelines explain that ‘the gravity of the situation must involve a higher test of “maturity to understand the nature and effect of the decision”’ and that ‘this area of decision-making is profoundly difficult and involves complex interactions to establish what is in the best interests of the child’. As a result, the policy implemented by Queensland Health is that parents must have involvement in discussions and decisions about life-sustaining measures.<sup>92</sup>

### **The Commission’s preliminary view**

4.67 The Commission’s preliminary view is 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.

4.68 The Commission considers that there is value in the approach, which has been taken in most other jurisdictions, including Victoria and Western Australia, of enacting a scheme for voluntary assisted dying that applies to adults.

4.69 The Commission also recognises that there is a need in the future to further explore the application of that scheme, with modifications, to children.

4.70 Children have much in common with adults. They are entitled to respect for their autonomy and to have access to lawful medical options, although they may also have greater vulnerabilities and consequently a greater need for protection. Further, like adults, children become ill and experience significant suffering, and some of those children make or participate in significant medical decisions.

4.71 However, there is a lack of scientific, evidence-based research and other information in this area to inform policy considerations about access to voluntary assisted dying by children. In particular, there would be benefit in future consultation being undertaken by child health and other relevant experts with children and with 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.

4.72 Further, this topic raises broader issues about the law governing consent to medical treatment by children, which are outside the scope of this reference.

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<sup>91</sup> Queensland Government, Implementation Guidelines, *End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from patients under the age of 18 years, Part 1: Legal Framework, Clinical Considerations and Decision-making Framework* (version 2.4, 27 February 2017) 34, 39.

<sup>92</sup> *Ibid* 45, 46.

## Proposal

**P-1 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be aged 18 years or more.**

## RESIDENCY

### Victoria

4.73 In Victoria, the eligibility criteria for access to voluntary assisted dying include a residency requirement. This is intended to prevent a person who is a non-resident from travelling to that jurisdiction for the purpose of accessing voluntary assisted dying.<sup>93</sup>

4.74 To satisfy this requirement, the person must:<sup>94</sup>

- be an Australian citizen or permanent resident;
- be ordinarily resident in Victoria; and
- at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months.<sup>95</sup>

4.75 The Victorian Ministerial Advisory Panel recommended that the eligibility criteria should include a requirement that a person be an Australian citizen or permanent resident and be ordinarily resident in Victoria. However, the Panel did not recommend a minimum length of time that a person must be ordinarily resident in Victoria. It noted that there is no minimum period of residency required by the legislation in most other jurisdictions and considered that such a requirement would be administratively burdensome and onerous for the dying and suffering person.<sup>96</sup>

4.76 As a result, the Voluntary Assisted Dying Bill 2017 (Vic) originally did not include the requirement that, at the time of making the request, the person must have been ordinarily resident in Victoria for at least 12 months. However, during its passage in the Legislative Council, the Bill was amended to include the time-based requirement in response to uncertainty about the meaning of ordinary residence and

<sup>93</sup> Victoria, *Parliamentary Debates*, Legislative Council, 14 November 2017, 5818 (G Jennings, Special Minister of State).

<sup>94</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(b).

<sup>95</sup> 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).

<sup>96</sup> Vic Ministerial Advisory Panel Final Report (2017) 52, 57, Rec 2.

concerns about non-residents travelling to Victoria to access voluntary assisted dying.<sup>97</sup>

### **‘Ordinarily resident’**

4.77 The Victorian Civil and Administrative Tribunal (‘VCAT’) recently considered the ‘ordinarily resident’ requirement of the *Voluntary Assisted Dying Act 2017* (Vic) and held that whether a person is ‘ordinarily resident’ in Victoria is a matter of fact and degree.<sup>98</sup> The Tribunal explained that:<sup>99</sup>

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.

### **Western Australia**

4.78 The Western Australian legislation also includes a residency requirement in its eligibility criteria. It provides that the person must:<sup>100</sup>

- 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.

4.79 The Western Australian Ministerial Expert Panel considered that the need to have been ordinarily resident in Western Australia for at least 12 months prior to the first request would set clear parameters for the coordinating practitioner (who assesses eligibility), ensure that access is limited to those ordinarily resident in Western Australia and be consistent with the approach taken in Victoria.<sup>101</sup>

### **Queensland**

4.80 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should limit eligibility to Australian citizens or permanent residents who are ordinarily resident in Queensland (and not include a

<sup>97</sup> The amendments were passed in Committee. See Victoria, *Parliamentary Debates*, Legislative Council, 14 November 2017, 5818 and 16 November 2017, 6097 (G Jennings, Special Minister of State).

<sup>98</sup> *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).

<sup>99</sup> *Ibid* [83]–[88].

<sup>100</sup> *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(b).

<sup>101</sup> 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.

minimum timeframe).<sup>102</sup> This is consistent with the approach in the W&W Model, which requires only that a person must be ordinarily resident in the jurisdiction:<sup>103</sup>

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.

### Overseas jurisdictions

4.81 In California, Colorado, Hawaii, Oregon and Washington, the legislation requires that the person is resident in the State but does not prescribe a minimum length of time for being a resident.<sup>104</sup> The legislation specifies various factors that will be taken to demonstrate residency, such as possession of a driver licence in that State.<sup>105</sup>

4.82 To access assisted dying in Canada, the person must either be eligible for health services funded by a government in Canada or be a person who would be eligible for such services but for any applicable minimum period of residence or waiting period.<sup>106</sup>

4.83 Voluntary assisted dying legislation in Europe does not impose express residency requirements. However, guidance material explains that the legislation in Luxembourg envisages that ‘the treating doctor must have treated the patient continuously and for a sufficiently long time’ in order to satisfy various requirements of the legislation, including the conduct of several interviews with the patient about their condition and request.<sup>107</sup>

### Consultation questions

**Q-10 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be:**

<sup>102</sup> Qld Parliamentary Committee Report No 34 (2020) 118, Rec 3.

<sup>103</sup> W&W Model cl 9(b), Explanatory Notes 3.

<sup>104</sup> *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; *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800.101(11), 127.860.3.10; *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(11), 70.245.130.

<sup>105</sup> See, eg, *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.860.3.10(1)–(4), which provides that factors demonstrating residency in Oregon include, but are not limited to, possession of an Oregon driver licence, being registered to vote in Oregon, evidence of owning or leasing property in Oregon, or filing an Oregon tax return for the most recent tax year. Similar provision is made in the legislation in California, Colorado, Hawaii and Washington: see n 104 above.

<sup>106</sup> *Canada Criminal Code*, RSC 1985, C-46, s 241.2(1)(a).

<sup>107</sup> 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) 26.

- (a) an Australian citizen or permanent resident; and
- (b) ordinarily resident in Queensland?

**Q-11** If yes to Q-10(b), should that requirement also specify that, at the time of making the first request to access voluntary assisted dying, the person must have been ordinarily resident in Queensland for a minimum period? If so, what period should that be?

## VOLUNTARY AND WITHOUT COERCION

### Victoria and Western Australia

4.84 In Western Australia, the eligibility criteria that must be met for a person to access voluntary assisted dying include that ‘the person is acting voluntarily and without coercion’.<sup>108</sup> It was explained that ‘[t]his reflects a fundamental concept in the [legislation] that participation in voluntary assisted dying must be completely voluntary in all respects’.<sup>109</sup>

4.85 In Victoria, the voluntariness of the person’s request is not included as one of the eligibility criteria. However, when assessing whether the person is eligible for access to voluntary assisted dying, the coordinating practitioner and consulting practitioner must each be satisfied that (among other things) the person meets the eligibility criteria and ‘is acting voluntarily and without coercion’.<sup>110</sup>

4.86 In both jurisdictions, a person must be acting voluntarily and without coercion at each stage of the voluntary assisted dying process, including at the time of the first and second assessments by the coordinating practitioner and consulting practitioner, at the time of the person’s final request and (if applicable) at the time that a practitioner administers the substance.<sup>111</sup>

<sup>108</sup> *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), 52(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).

<sup>109</sup> 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).

<sup>110</sup> *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).

<sup>111</sup> *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). 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.

4.87 A request for voluntary assisted dying must be made by the person ‘personally’ (in Victoria) or ‘in person’ (in Western Australia),<sup>112</sup> and the process of assessing a person’s eligibility for voluntary assisted dying occurs in stages.<sup>113</sup> This reflects that a request to access voluntary assisted dying must be the person’s own choice.

4.88 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, discussion with the family. Health practitioners are advised to allow sufficient 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.<sup>114</sup>

4.89 As discussed later in this chapter, an additional eligibility requirement is that the person has decision-making capacity. This is also to be assessed at each stage of the process.

4.90 It was explained that 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 voluntary assisted dying process remains voluntary and to protect people from coercion or abuse.<sup>115</sup> The Victorian Ministerial Advisory 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’.<sup>116</sup>

## Queensland

4.91 The W&W Model includes, as one of the eligibility criteria for access to voluntary assisted dying, that a person’s decision must be ‘made voluntarily and without coercion’.<sup>117</sup> This is consistent with the drafting approach in Western Australia.<sup>118</sup>

4.92 The Parliamentary Committee did not make any express recommendation about an eligibility requirement for the person to be acting voluntarily. However, it

<sup>112</sup> *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).

<sup>113</sup> See especially *Voluntary Assisted Dying Act 2017* (Vic) ss 16, 20, 25, 29, 34, 41; *Voluntary Assisted Dying Act 2019* (WA) ss 24, 28, 35, 39, 42, 51. See also Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2944–5 (J Hennessey, Minister for Health); Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137, 5138 (RH Cook, Minister for Health).

<sup>114</sup> Vic Guidance for Health Practitioners (2019) [2.4].

<sup>115</sup> 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).

<sup>116</sup> Vic Ministerial Advisory Panel Final Report (2017) 58. See further [4.100] ff below.

<sup>117</sup> W&W Model cl 9(d)(ii).

<sup>118</sup> See [4.84] above. See also, as to how voluntariness might be incorporated into the meaning of decision-making capacity, [4.110] ff below.



noted in general terms the importance of a ‘staged process’ of ongoing assessment of a person’s request and their decision-making capacity,<sup>119</sup> which may also be relevant to ensuring that a person’s decision is voluntary and free of coercion.

4.93 In some other legislation, such as the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*, one of the requirements that must be met for a person to have ‘capacity’ to make a decision for a matter is that the person is capable of ‘freely and voluntarily making decisions about the matter’. This is considered to be an important safeguard.<sup>120</sup>

## Overseas jurisdictions

4.94 Overseas jurisdictions also require a person’s decision to be voluntary. In Canada, the legislation provides that a person may access voluntary assisted dying if ‘they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure’.<sup>121</sup> Similarly, the legislation in some European countries requires that a person’s request is voluntary and well-considered.<sup>122</sup> In the United States of America, legislation in relevant jurisdictions requires that a person has made a request voluntarily<sup>123</sup> or has ‘voluntarily expressed a wish’ to access voluntary assisted dying.<sup>124</sup>

4.95 In New Zealand, the eligibility criteria do not refer to the voluntary nature of the request for assisted dying. However, provision is included for the medical practitioner to ‘do their best’ to ensure the person ‘expresses their wish free from pressure from any other person’, and to take no further action to provide assisted dying to the person if they suspect on reasonable grounds that the person is not expressing their wish free from such pressure.<sup>125</sup>

119 Qld Parliamentary Committee Report No 34 (2020) [8.2.4], [9].

120 *Guardianship and Administration Act 2000* (Qld) s 3 sch 4 (definition of ‘capacity’, para (b)); *Powers of Attorney Act 1998* (Qld) s 3 sch 3 (definition of ‘capacity’, para (b)). See also [4.113], [4.116] below.

121 *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(1)(d).

122 See *Belgian Euthanasia Act 2002* art 3(1); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* arts 1, 2(1); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(a). The Belgian and Luxembourg provisions also require that the person’s request ‘does not result from external pressure’.

123 *District of Columbia Death with Dignity Act 2016*, DC Code § 7-661.03(a)(1)(C); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a)(5)(D).

124 *California End of Life Option Act 2015*, Cal Health and Safety Code §§ 443.2(a)(2), 443.5(a)(1)(C), (4); *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25-48-103(1)(c), 25-48-106(1)(a), (g); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L–2, 327L–4(a)(1); *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.4, 2140.6(A), (E); *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann, C.26:16-4(c), C.26:16-6(a)(1), C.26:16-7(c); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.805.2.01(1), 127.815.3.01(1)(a); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.020(1), 70.245.040(1)(a). In those jurisdictions, the relevant medical practitioner is to assess whether the person’s request was made voluntarily and (in California, Colorado and Maine) confirm that the request did not arise from coercion or undue influence.

125 *End of Life Choice Act 2019* (NZ) ss 11(2)(h), 24(a) (as enacted, not commenced).

## The Commission's preliminary view

4.96 The Commission's preliminary view is that the draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be acting voluntarily and without coercion.<sup>126</sup>

4.97 This is a fundamental safeguard in any voluntary assisted dying scheme. In conjunction with the remaining eligibility criteria and the other safeguards operating within the scheme, it protects individual autonomy and ensures that access to voluntary assisted dying in Queensland is appropriately regulated.

4.98 Other features of the voluntary assisted dying scheme could also safeguard against coercion or undue influence and help protect vulnerable individuals from abuse.

4.99 These safeguards might include limitations on the circumstances in which a discussion about voluntary assisted dying may be initiated, clear 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, explicit provision that a person may change their mind at any time, and comprehensive educational campaigns targeted at both the public and registered health practitioners.<sup>127</sup>

## Proposal

**P-2 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be acting voluntarily and without coercion.**

## DECISION-MAKING CAPACITY

### Victoria and Western Australia

4.100 In Victoria and Western Australia, one of the eligibility criteria for a person to access voluntary assisted dying is that the person has 'decision-making capacity in relation to voluntary assisted dying'.<sup>128</sup>

4.101 The Victorian Ministerial Advisory Panel stated that, practically, a requirement that a person has decision-making capacity creates a 'clear and

<sup>126</sup> In plain English, the term 'voluntary' refers to something that is done 'of one's own accord or by free choice': *Macquarie Dictionary* (online at 8 September 2020) 'voluntary'. 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': *Australian Law Dictionary* (Oxford University Press, 3rd ed, 2018, online) 'voluntariness'.

<sup>127</sup> 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.

<sup>128</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(c); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(d). This eligibility requirement is also reflected in other provisions of the legislation: see [4.107] below.

enforceable line’ regarding who can access voluntary assisted dying.<sup>129</sup> The Panel also explained the importance of this requirement as a safeguard:<sup>130</sup>

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’.

4.102 Similarly, the Western Australian Ministerial Expert 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’.<sup>131</sup>

4.103 In Victoria and Western Australia, 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.<sup>132</sup> The definition of ‘decision-making capacity’ is similar in both jurisdictions:<sup>133</sup>

#### Victoria

- understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision; and
- retain that information to the extent necessary to make the decision; and
- use or weigh that information as part of the process of making the decision; and
- communicate the decision and the person’s views and needs as to the decision in some way, including by speech, gestures or other means.

#### Western Australia

- 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 matters involved in a voluntary assisted dying decision; and
- understand the effect of a voluntary assisted dying decision; and
- weigh up the factors referred to in [the preceding three points] for the purposes of making a voluntary assisted dying decision; and
- communicate a voluntary assisted dying decision in some way.

129 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’.

130 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/>>. See also [4.90] above.

131 WA Ministerial Expert Panel Final Report (2019) 105, see also 25. See generally Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5138 (RH Cook, Minister for Health).

132 *Voluntary Assisted Dying Act 2017* (Vic) s 4(2); *Voluntary Assisted Dying Act 2019* (WA) s 6(3).

133 *Voluntary Assisted Dying Act 2017* (Vic) s 4(1); *Voluntary Assisted Dying Act 2019* (WA) s 6(2). 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).

4.104 The legislation in Victoria includes additional statements about decision-making capacity. In particular, it provides that, in determining whether a person has decision-making capacity, regard must be had to the following:<sup>134</sup>

- 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 on the basis of their appearance or because they make a decision that others consider unwise; and
- a person has decision-making capacity if it is possible for that person to make a decision with ‘practicable and appropriate support’.

4.105 The approach taken in Victoria and Western Australia draws on legislation relating to medical treatment, guardianship and administration, and mental health. In Western Australia, the definition of ‘decision-making capacity’ mirrors the approach in the *Mental Health Act 2014* (WA).<sup>135</sup> In Victoria, the definition of ‘decision-making capacity’, including the additional relevant statements about that matter, mirrors the definition of that term in the *Medical Treatment Planning and Decisions Act 2016* (Vic).<sup>136</sup> The Victorian Ministerial Advisory 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’.<sup>137</sup>

4.106 Guidance for health practitioners in Victoria explains that, when assessing a person’s decision-making capacity in relation to voluntary assisted dying, a medical practitioner should provide the patient with 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 provide reasons for their chosen option.<sup>138</sup>

<sup>134</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 4(4). Reasonable steps must be taken ‘to conduct the assessment at a time and in an environment in which the person’s decision-making capacity can be most accurately assessed’: s 4(5). See also s 4(3) as to the provision of information ‘in a way that is appropriate to the person’s circumstances, whether by using modified language, visual aids or any other means’.

<sup>135</sup> *Mental Health Act 2014* (WA) s 15(1). That Act also provides that a decision ‘must be made freely and voluntarily’ and includes a presumption of capacity: ss 13(1), 15(2).

<sup>136</sup> *Medical Treatment Planning and Decisions Act 2016* (Vic) s 4. 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.  
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.

<sup>137</sup> Vic Ministerial Advisory Panel Final Report (2017) 60, Rec 3. See generally WA Ministerial Expert Panel Final Report (2019) 22–3.

<sup>138</sup> 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.

4.107 In both jurisdictions, a person must have decision-making capacity for voluntary assisted dying at each stage of the voluntary assisted dying process. In addition to assessment of decision-making capacity by the coordinating practitioner and consulting practitioner at the time of the coordinating assessment and consulting assessment, a person must have decision-making capacity at the time of making their final request and (if applicable) at the time that a practitioner administers the substance.<sup>139</sup> In Western Australia, the nine day waiting period that is usually required between a person's first and final requests for access to voluntary assisted dying may be reduced if it is likely that the person will lose decision-making capacity within that period of time.<sup>140</sup>

## Queensland

4.108 The Parliamentary Committee recommended that a voluntary assisted dying scheme in Queensland should limit eligibility to people with decision-making capacity. It also recommended that any such 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 in relation to ensuring advance health directives are fit for purpose and effective'.<sup>141</sup>

4.109 Like Victoria and Western Australia, one of the eligibility criteria for access to voluntary assisted dying in the W&W Model is that 'the person must have decision-making capacity in relation to voluntary assisted dying'. It also provides that a person is presumed to have decision-making capacity and defines 'decision-making capacity' in the same terms as the legislation in Victoria.<sup>142</sup>

4.110 The W&W Model notes that definitions of 'capacity' or 'decision-making capacity' vary between jurisdictions and that the approach may need to be adjusted

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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) at n 134 above.

<sup>139</sup> *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). 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 in relation to 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 in relation to 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).

The person or other eligible applicant may apply to VCAT (in Victoria) or the State Administrative Tribunal (in Western Australia) for review of a coordinating practitioner's or consulting practitioner's decision that the person does or does not have decision-making capacity in relation to 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).

<sup>140</sup> *Voluntary Assisted Dying Act 2019* (WA) s 48(3). In Victoria and Western Australia, the waiting period can also be waived if it is likely that the person will die within that period of time: see the discussion of waiting periods in Chapter 6 below.

<sup>141</sup> Qld Parliamentary Committee Report No 34 (2020) 127, Recs 6, 7. See further [4.127] below.

<sup>142</sup> W&W Model cl 7, 9(c). The definition mirrors s 4(1) of the *Voluntary Assisted Dying Act 2017* (Vic) but does not include the additional matters in s 4(3)–(5) of that Act.

to reflect those differences. For example, it was noted that the test for capacity in the *Guardianship and Administration Act 2000* includes a requirement that a person is able to decide 'freely and voluntarily', but that in the W&W Model this requirement is dealt with separately in the eligibility criteria.<sup>143</sup>

### Other legislation

4.111 In Queensland, there are other specific laws that relate to decision-making capacity, including particularly the *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998*<sup>144</sup> and the *Mental Health Act 2016*.

4.112 Under those Acts, an adult is presumed to have capacity.<sup>145</sup> They each define capacity as having certain features, including that the adult is capable of understanding the relevant information or the nature and effect of a decision, and is able to make and communicate a decision. An additional feature of capacity under the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* is that the adult is capable of making a decision freely and voluntarily.<sup>146</sup>

4.113 Specifically, the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* define 'capacity' as follows:<sup>147</sup>

**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

<sup>143</sup> W&W Model, Explanatory Notes 7. See also [4.93] above and [4.112] ff below. This is consistent with the approach in Victoria and Western Australia: see [4.84]–[4.85] above.

<sup>144</sup> The *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) (referred to as Queensland's guardianship laws) create a statutory framework for substitute decision-making for people with impaired capacity. The former Act prevails in the event of any inconsistency between them: *Powers of Attorney Act 1998* (Qld) s 6A(4).

<sup>145</sup> See *Guardianship and Administration Act 2000* (Qld) ss 7(a), 11, 34(1), sch 1 pt 1 item 1; *Mental Health Act 2016* (Qld) ss 5(b), 7; *Powers of Attorney Act 1998* (Qld) s 76, sch 1 pt 1 item 1.

<sup>146</sup> *Guardianship and Administration Act 2000* (Qld) s 3 sch 4 (definition of 'capacity'); *Mental Health Act 2016* (Qld) s 14(1)–(2); *Powers of Attorney Act 1998* (Qld) s 3 sch 3 (definition of 'capacity').

<sup>147</sup> As to 'matters', see [4.121] below. Cf *Mental Health Act 2016* (Qld) s 14(1)–(3) (Meaning of capacity to consent to be treated):

- (1) A person has **capacity** to consent to be treated if the person—
  - (a) is capable of understanding, in general terms—
    - (i) that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing; and
    - (ii) the nature and purpose of the treatment for the illness; and
    - (iii) the benefits and risks of the treatment, and alternatives to the treatment; and
    - (iv) the consequences of not receiving the treatment; and
  - (b) is capable of making a decision about the treatment and communicating the decision in some way.
- (2) A person may have **capacity** to consent to be treated even though the person decides not to receive treatment.
- (3) A person may be supported by another person in understanding the matters mentioned in subsection (1)(a) and making a decision about the treatment.

- (c) communicating the decisions in some way.

4.114 The *Guardianship and Administration Act 2000* was recently amended, with effect from 30 November 2020, to require the Minister to publish guidelines to help people who undertake assessments of an adult's capacity under Queensland's guardianship laws.<sup>148</sup>

4.115 In a previous review, this Commission concluded that the definition of 'capacity' in the *Guardianship and Administration Act 2000* is appropriate. However, in relation to paragraph (a) of the definition, the Commission expressed the view that it would be helpful for guidelines about assessing capacity to provide information and advice about how this aspect of the definition is to be applied, including that:<sup>149</sup>

- The process of understanding covers the abilities to understand and retain the information relevant to the decision (including its likely consequences) and to use or weigh that information in the process of making the decision;
- The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or of failing to make the decision;
- A person is not to be regarded as unable to understand the information relevant to a decision if he or she is able to understand an explanation of it given to the person in a way that is appropriate to his or her circumstances (using simple language, visual aids or any other means); and
- The fact that a person is able to retain the information relevant to a decision for a short period only does not, of itself, prevent the person from being regarded as able to make the decision.

4.116 The Commission also concluded that the element of voluntariness in paragraph (b) of the definition should be retained as part of the definition of 'capacity', concluding that it is 'an important legislative safeguard' in that an adult's ability to

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<sup>148</sup> *Guardianship and Administration Act 2000* (Qld) s 250, to be inserted by the *Guardianship and Administration and Other Legislation Amendment Act 2019* (Qld) s 41 (commencing 30 November 2020). The guidelines will include principles to apply when assessing an adult's capacity to make decisions, and information and advice that will provide practicable guidance about making these assessments. This reflects a recommendation made by this Commission in its previous review of Queensland's guardianship laws: see Explanatory Notes, *Guardianship and Administration and Other Legislation Amendment Bill 2018* (Qld) 2, 7; QLRC, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) vol 1, Recs 7-11 to 7-13.

More generally, the *Guardianship and Administration and Other Legislation Amendment Act 2019* (Qld) makes a range of amendments to the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld), including (among other things) amendment of the general principles and clarification of matters related to the making of enduring documents.

See generally, Queensland Government, *Changes to guardianship laws and forms* (31 July 2020) <[https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/guardianship-changes?utm\\_term=0\\_1f2427372b-c32a2b4cd5-228749365&utm\\_medium=email&utm\\_source=QLS%20Master%20List&utm\\_campaign=c32a2b4cd5-qls-update-29april2020\\_COPY\\_01](https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/guardianship-changes?utm_term=0_1f2427372b-c32a2b4cd5-228749365&utm_medium=email&utm_source=QLS%20Master%20List&utm_campaign=c32a2b4cd5-qls-update-29april2020_COPY_01)>.

<sup>149</sup> QLRC, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) vol 1, [7.162]–[7.166], Recs 7-8, 7-11, 7-16.

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’.<sup>150</sup>

4.117 In relation to paragraph (c) of the definition of capacity, the *Guardianship and Administration Act 2000* provides separately that, ‘[i]n 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’.<sup>151</sup>

4.118 The *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998* and the *Mental Health Act 2016* also contain other relevant principles and statements about capacity and associated issues. For example, in general terms:<sup>152</sup>

- a person should be assisted to achieve their maximum potential and be self-reliant, and is to be enabled or encouraged to take part in decision-making to the greatest extent practicable;
- a person should be given adequate and appropriate information and support to enable them to exercise their rights, or to make a decision, and a person’s views, wishes and preferences must be sought and taken into account;
- people have the right to make decisions with which others may not agree and, in relation to treatment, may have the capacity to consent to treatment even if they decide not to receive it.

4.119 The *Guardianship and Administration Act 2000* additionally notes, for example, that a person’s capacity may differ according to the nature and extent of an impairment, the type of decision to be made (including its complexity) and the support that can be provided by the person’s existing support network.

### ***Decision-making for people with impaired capacity***

4.120 The *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* together establish a scheme by which (among other things):<sup>153</sup>

- 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).

<sup>150</sup> Ibid vol 1, [7.208]–[7.212].

<sup>151</sup> *Guardianship and Administration Act 2000* (Qld) s 146(3). The Commission recommended that the definition of capacity include a reference to this section, and considered that guidelines about capacity ‘should provide information and advice about practical steps that may be taken to assist and support the person to communicate his or her decisions’: see QLRC, *A Review of Queensland’s Guardianship Laws*, Report No 67 (2010) vol 1, [7.229]–[7.233], Recs 7-9, 7-11.

<sup>152</sup> See generally *Guardianship and Administration Act 2000* (Qld) ss 5, 11, 34(1), sch 1 pt 1; *Mental Health Act 2016* (Qld) ss 5, 14(2)–(3); *Powers of Attorney Act 1998* (Qld) s 76, sch 1 pt 1.

<sup>153</sup> *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’).



4.121 Those Acts apply to particular types of ‘matters’ for which an adult might have impaired capacity.<sup>154</sup> One of those matters relates to an adult’s ‘health care’,<sup>155</sup> which includes the diagnosis, maintenance or treatment of a physical or mental condition. Health care also includes the withholding or withdrawal of a life-sustaining measure<sup>156</sup> if commencing or continuing that measure would be inconsistent with good medical practice.<sup>157</sup>

4.122 Under the *Powers of Attorney Act 1998*, an adult who has capacity may make an ‘advance health directive’ in which they may give directions about their future health care that will operate, where relevant, at any time when that adult has impaired capacity. This may include a direction requiring, in the circumstances specified in the directive, that a life-sustaining measure be withheld or withdrawn.<sup>158</sup> However, section 36(2) of that Act provides that such a direction cannot operate unless:

- (a) 1 of the following applies—
  - (i) the principal has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a doctor treating the principal and another doctor, the principal may reasonably be expected to die within 1 year;
  - (ii) the principal is in a persistent vegetative state, that is, the principal has a condition involving severe and irreversible brain damage which, however, allows some or all of the principal’s vital bodily functions to continue, including, for example, heart beat or breathing;
  - (iii) the principal is permanently unconscious, that is, the principal has a condition involving brain damage so severe that there is no reasonable prospect of the principal regaining consciousness;

<sup>154</sup> Generally, a ‘matter’ under these Acts includes a ‘financial matter’ (which is a matter relating to an adult’s financial or property matters, such as accommodation expenses, mortgages and investments), and a ‘personal matter’ (which is a matter, other than particular ‘special’ matters, that relates to an adult’s care, such as their health care, education and employment). A ‘health matter’ is a type of personal matter that relates to health care, other than ‘special health care’. See generally *Guardianship and Administration Act 2000* (Qld) sch 2; *Powers of Attorney Act 1998* (Qld) sch 2.

<sup>155</sup> *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.

<sup>156</sup> A ‘life-sustaining measure’ is health care ‘that is intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation’. It includes cardiopulmonary resuscitation, assisted ventilation, and artificial nutrition and hydration. It does not include a blood transfusion. See *Guardianship and Administration Act 2000* (Qld) sch 2 item 5A; *Powers of Attorney Act 1998* (Qld) sch 2 item 5A.

<sup>157</sup> The term ‘good medical practice’ refers to good medical practice for the medical profession in Australia, having regard to the recognised ethical standards, medical standards, and practices and procedures of the medical profession in Australia: *Guardianship and Administration Act 2000* (Qld) sch 2 item 5B; *Powers of Attorney Act 1998* (Qld) sch 2 item 5B.

<sup>158</sup> *Powers of Attorney Act 1998* (Qld) s 35(1)(a), (2)(b), 36(1), 42(1). An adult may also, by way of an advance health directive, appoint a person to make decisions about a health matter in the event that their directions are inadequate: ss 35(1)(c), 36(3), 41, 42(2) See also [4.124] below. See generally Queensland Government, *Advance health directive* (17 January 2018) <<https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/advance-health-directive>>.

*Note*—This is sometimes referred to as ‘a coma’.

- (iv) the principal has an illness or injury of such severity that there is no reasonable prospect that the principal will recover to the extent that the principal’s life can be sustained without the continued application of life-sustaining measures; and
- (b) for a direction to withhold or withdraw artificial nutrition or artificial hydration—the commencement or continuation of the measure would be inconsistent with good medical practice; and
- (c) the principal has no reasonable prospect of regaining capacity for health matters.

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4.123 More generally, a health provider who is providing an adult with health care will not be liable for failing to follow a direction in the adult’s advance health directive if they have reasonable grounds to believe that the direction is ‘uncertain or inconsistent with good medical practice’, or that ‘circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate’.<sup>159</sup>

4.124 Alternatively, if an adult has impaired capacity and has not given an applicable direction in a valid advance health directive, these Acts provide, where necessary, for relevant decisions for the adult to be made by another person. The other person may be appointed by the adult under an enduring document made at an earlier time when the adult had capacity, or otherwise may be appointed pursuant to these Acts.<sup>160</sup>

4.125 A person may be appointed to make decisions about an adult’s health care. This may include consenting to the withholding or withdrawal of a life-sustaining measure from the adult, but that consent will operate only in circumstances where the adult’s health provider reasonably considers that commencing or continuing the measure would be ‘inconsistent with good medical practice’.<sup>161</sup>

<sup>159</sup> *Powers of Attorney Act 1998* (Qld) s 103(1)–(2). If the advance health directive appoints another person as an attorney, a health provider will have reasonable grounds for believing that a direction is uncertain only if, among other things, the provider has consulted the attorney about that direction: s 103(3). See also 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) [1.5.5].

<sup>160</sup> *Guardianship and Administration Act 2000* (Qld) ss 12(1), 66; *Powers of Attorney Act 1998* (Qld) s 32, 33(3)–(4), 35(1)(c), (3). An enduring document is an enduring power of attorney or an advance health directive: *Powers of Attorney Act 1998* (Qld) s 28. As to appointment by way of an enduring power of attorney, see generally Queensland Government, *Power of attorney* (20 November 2017) <<https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/power-of-attorney>>.

<sup>161</sup> *Guardianship and Administration Act 2000* (Qld) s 66A. Therefore, if the adult’s health provider considers that the commencement or continuation of the life-sustaining measure is *not* ‘inconsistent with good medical practice’, an appointed person’s consent to withhold or withdraw that measure cannot operate. It has been stated that ‘[t]his means that if the health professional believes the life-sustaining treatment should continue because it is good clinical practice, then the substitute decision-maker’s decision to withhold or withdraw the treatment will be overruled’: see QUT, End of Life Law in Australia, *Can a substitute decision-maker’s decision be overridden?* (13 March 2020) <<https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws?a=548735#548735>>.

4.126 Except in limited circumstances, health care for which consent is given under those Acts by another person cannot be provided to the adult if the health provider knows (or ought reasonably to know) that the adult objects to the health care.<sup>162</sup>

4.127 Amendments to this scheme have previously been recommended, including omission of section 36(2) of the *Powers of Attorney Act 1998*.<sup>163</sup> The Parliamentary Committee recommended that the Queensland Government further consider those previous recommendations for reform. It expressed the view that ‘a patient’s autonomy is paramount, and a directive made in a valid advance health directive to withdraw or withhold life sustaining treatment ... should not be subject to legislative restrictions’, and recommended that ‘the Government ensure that patients’ directions to withdraw or withhold life-sustaining treatment are followed in accordance with their advance health directive’.<sup>164</sup>

### **Consent to medical treatment**

4.128 Under the common law, a health practitioner is ordinarily required to obtain consent from the person before performing surgery or providing medical treatment.<sup>165</sup>

4.129 A person must have the requisite capacity to consent. There is a presumption, which may be rebutted, that an adult has capacity to give or refuse consent.<sup>166</sup> The consent must also be voluntary and specific to the proposed treatment; it is not true consent if it is obtained by fraud or coercion. In particular, the person must be informed in broad terms of the nature of the proposed procedure or treatment.<sup>167</sup>

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In making decisions about an adult’s health care, a person must exercise their power ‘in the way least restrictive of the adult’s rights’ and only if that exercise of power ‘is necessary and appropriate to maintain or promote the adult’s health or wellbeing’ or ‘is, in all the circumstances, in the adult’s best interests’: ss 11, 34(2), sch 1 item 12.

<sup>162</sup> *Guardianship and Administration Act 2000* (Qld) s 67. The term ‘object’ is defined to mean that the adult indicates they do not wish to have the health care, or that the adult previously indicated in similar circumstances that they did not then wish to have the health care, and has not since indicated otherwise: *Guardianship and Administration Act 2000* (Qld) s 3 sch 4 (definition of ‘object’). See also, as to urgent health care, s 63.

A life-sustaining measure may be withheld or withdrawn without consent in urgent circumstances provided that particular criteria are met, but this also does not apply if the practitioner knows that the adult objects: *Guardianship and Administration Act 2000* (Qld) s 63A.

<sup>163</sup> QLRC, *A Review of Queensland’s Guardianship Laws*, Report No 68 (2010) vol 2, Rec 11-3. It was also recommended that, in relation to the withdrawal or withholding of life-sustaining treatment, the concept of the commencement or continuation of the measure being ‘inconsistent with good medical practice’ should be amended to address the practical impacts of the limitation: see generally ch 11.

<sup>164</sup> Qld Parliamentary Committee Report No 33 (2020) [21.4.1], 410, 421–2, Rec 76.

<sup>165</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 489; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102–103; LexisNexis Australia, *Halsbury’s Laws of Australia* [280–3000] (10 February 2016). There are exceptions, for example, in emergencies. Consent can be in writing, oral or implied. Providing treatment without obtaining valid consent may amount to trespass or a criminal offence.

<sup>166</sup> See, eg, *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112–13. See generally Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.7].

<sup>167</sup> *Chatterton v Gerson* [1981] QB 432, 442–3; *Rogers v Whitaker* (1992) 175 CLR 479, 489–90; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113–14; LexisNexis Australia, *Halsbury’s Laws of Australia* [280-3000] (10 February 2016). See generally Queensland Health, Clinical Excellence Division, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017) [1.2].

4.130 In the context of end of life care, guidelines by Queensland Health explain that, ‘where patients have capacity to make decisions about their own health care, the situation is governed by common law principles’, and that ‘the guardianship laws are activated when a person loses capacity for decision-making’. In particular, it notes that the legislative framework for the withdrawal or withholding of life-sustaining measures is triggered by the question whether the adult has capacity, within the meaning of the guardianship laws, to make decisions about health matters. These guidelines also state that, in a clinical assessment of capacity, a patient may be regarded as having decision-making capacity if they understand the medical situation and the nature of the required decision, can use or weigh the relevant information in making a decision, can communicate a decision, and can communicate that decision voluntarily. If a patient has decision-making capacity, they can make decisions about their own health care. A patient who has capacity can also refuse treatment or request that it be withdrawn, even if this will cause the patient to die or cause their death to happen sooner.<sup>168</sup>

### Overseas jurisdictions

4.131 Overseas jurisdictions with voluntary assisted dying legislation also require the person to have decision-making capacity.

4.132 In New Zealand, similar to the Australian jurisdictions, legislation provides that a person must be ‘competent to make an informed decision about assisted dying’ to be eligible for assisted dying. This means that the person is able to understand, retain and use relevant information in making the decision and to communicate their decision in some way.<sup>169</sup>

4.133 In Canada and relevant jurisdictions of the United States of America, a person is required to be ‘capable’ or ‘competent’ or to have ‘capacity’. In most of those jurisdictions, this is defined in broad terms to mean that the person is able to make and communicate health care decisions.<sup>170</sup>

4.134 In Belgium, Luxembourg and the Netherlands, the legislation requires that a person seeking access to assisted dying is ‘capable’ or ‘decisionally competent’. In

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Additionally, failure to provide adequate information to enable a patient to make an informed decision, such as information about the material risks associated with the procedure, may give rise to liability in negligence: see generally *Rogers v Whitaker* (1992) 175 CLR 479, 489, 490, citing *F v R* (1983) 33 SASR 189, 192–3; LexisNexis Australia, *Halsbury’s Laws of Australia* [280–3500] (10 February 2016).

<sup>168</sup> 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].

<sup>169</sup> *End of Life Choice Act 2019* (NZ) ss 5(1)(f), (6) (as enacted, not commenced).

<sup>170</sup> *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(e), 443.2(a), 443.5(a)(1)(A)(i); *Colorado End of Life Options Act 2016*, Colo Rev Stat §§ 25-48-102(10), 25-48-103(1)(b), 25-48-106(1)(a); *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7-661.01(2), 7-661.03(a)(1)(B); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L–1 (definition of ‘capable’), 327L–2, 327L–4(a)(1); *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.2(C), 2140.4, 2140.6(A); *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann C.26:16-3 (definition of ‘capable’), C.26:16-4(b), C.26:16-6(a)(1), C.26:16-7(c); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.800, 1.01(3), 127.805.2.01(1), 127.815.3.01(1)(a); *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann §§ 5281(2), 5283(a)(5)(B); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.010(3), 70.245.020(1), 70.245.040(1)(a). The legislation in California and Hawaii additionally defines ‘capacity’ or ‘capable’, respectively, to mean that the person is able to understand the risks, benefits and alternatives.

addition, in limited circumstances, a person who is no longer able to express their 'will' or 'wishes' is permitted to access assisted dying if that person had, at an earlier time when they were capable or competent, made an advance directive that assisted dying should be performed.<sup>171</sup>

4.135 For example, in Belgium and Luxembourg, a competent adult (and in Belgium, a competent emancipated minor) may make a written advance directive about the circumstances under which a physician may perform euthanasia. Generally, a physician may provide euthanasia in accordance with that directive if:<sup>172</sup>

- the patient is suffering from a serious or severe and incurable disorder, caused by an illness or an accident;
- the patient is unconscious;
- the patient's condition or situation is irreversible given the current state of medical science; and
- the physician has complied with other conditions and procedures, including consulting with a second independent physician, the patient's health care team, persons nominated in the advance directive and the patient's relatives.

4.136 An advance directive must be registered with the relevant national body. In Luxembourg, doctors must obtain information from this body about whether a person has registered an advance directive, and that body is obliged to request confirmation of the person's wishes every five years. In Belgium, an advance directive is valid only if it was drafted or confirmed no more than five years before the person's loss of ability to express their wishes. An advance directive may be amended or withdrawn at any time, and in Luxembourg euthanasia may not occur if a physician becomes aware that a patient subsequently withdrew their request for euthanasia.<sup>173</sup>

## The Commission's preliminary view

4.137 The Commission's preliminary view is that the draft legislation should provide that for a person to be eligible for access to voluntary assisted dying, the person must have decision-making capacity in relation to voluntary assisted dying.

<sup>171</sup> *Belgian Euthanasia Act 2002* arts 3(1), 4; *Luxembourg Law on Euthanasia and Assisted Suicide 2009* arts 2(1), 4; *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(a), (2). The code of practice for the Netherlands legislation explains that the statutory requirement for the person's request to be 'voluntary' requires that the patient is 'decisionally competent': Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) [3.2].

<sup>172</sup> *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.

In the Netherlands, a person who is 16 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. The physician must apply the same 'due care criteria' that operate in relation to 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].

<sup>173</sup> *Belgian Euthanasia Act 2002* art 4; *Luxembourg Law on Euthanasia and Suicide 2009* art 4.

4.138 This eligibility requirement is a fundamental safeguard in any voluntary assisted dying scheme. In particular, this requirement protects individual autonomy and, in conjunction with other requirements, provides protection for people who might be vulnerable to coercion or abuse.

4.139 There are some people who will not have decision-making capacity for voluntary assisted dying. In the Commission's view, they should not be eligible.

4.140 There are other people who may have decision-making capacity when they first request access to voluntary assisted dying but will lose or be at risk of losing that capacity, for example, because of their disease, illness or medical condition, or the medication that is being taken.

4.141 In some circumstances, those scenarios could be addressed by reducing the usual waiting period between a person's first and final requests for access to voluntary assisted dying. However, some may regard this as an unsatisfactory solution. The rate at which capacity deteriorates can be unpredictable and the extent of its deterioration may be difficult to measure on a day-to-day basis. Other circumstances, such as a complete loss of capacity before finalisation of the request and assessment process, are not addressed by such provisions.

### Proposal and consultation questions

**P-3** The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must have decision-making capacity in relation to voluntary assisted dying.

**Q-12** Should 'decision-making capacity' be defined in the same terms as the definition of 'capacity' in the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*, or in similar terms to the definitions of 'decision-making capacity' in the voluntary assisted dying legislation in Victoria and Western Australia? Why or why not?

**Q-13** What should be the position if a person who has started the process of accessing voluntary assisted dying loses, or is at risk of losing, their decision-making capacity in relation to voluntary assisted dying before they complete the process?

For example:

- (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?

*Note: see also [6.16] ff and Q-20 and Q-21 below as to waiting periods.*

- (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?**

## ENDURING REQUEST

4.142 The legislation in Victoria and Western Australia requires that a person's request for access to voluntary assisted dying be 'enduring'.

4.143 This is a fundamental safeguard to protect persons seeking to access voluntary assisted dying. It is intended to ensure that the person's request is well-considered, and more than a passing, short-term reaction to their suffering.

4.144 Accordingly, most voluntary assisted dying schemes ensure the enduring nature of a person's wish to die by one or more of various legislative measures. These include making durability of the request an express criterion of eligibility to access the scheme or a part of the eligibility assessment process, or through providing safeguarding mechanisms such as the need to make multiple requests spread out over specified intervals.<sup>174</sup>

4.145 In Western Australia, the eligibility criteria include a requirement that 'the person's request for access to voluntary assisted dying is enduring'.<sup>175</sup> This is determined as part of the assessment of whether the person meets all the eligibility criteria undertaken by the coordinating practitioner and, separately, by the consulting practitioner in the voluntary assisted dying process.<sup>176</sup>

4.146 The Victorian legislation does not include an enduring request as an eligibility criterion. However, the durability of the person's request is an element of the assessment process. The coordinating practitioner, as part of their initial assessment, and the consulting practitioner, as part of their consulting assessment, must assess the person as eligible to access the scheme if satisfied that the person meets the eligibility criteria and, among other things, 'the person's request for access to voluntary assisted dying is enduring'.<sup>177</sup>

4.147 In Victoria and Western Australia, the durability of the request must be attested to at each relevant stage of the process, including at the time of the person's final request and (if applicable) at the time that a practitioner administers the

<sup>174</sup> 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.

<sup>175</sup> *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(f). See also Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 5–6 in which it is noted that this 'reflects that in order for the process to continue, the person's choice to continue is paramount'.

<sup>176</sup> See *Voluntary Assisted Dying Act 2019* (WA) ss 24(1)–(2), 28(1), 35(1)–(2), 39(1).

<sup>177</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 20(1)(d), 29(1)(d).

substance.<sup>178</sup> It is also reflected in the request procedure. The person must make three separate requests, with the final request preceded by a written declaration.<sup>179</sup> The first request and final request must be at least nine days apart.<sup>180</sup>

## Queensland

4.148 The Parliamentary Committee did not make any specific comment or recommendation regarding the durability or continuity of a person's request, as part of either the eligibility criteria or the assessment process for voluntary assisted dying. However, the W&W Model includes the requirement that the request be enduring as part of the eligibility criteria to access the scheme.<sup>181</sup> It also provides for the making of three requests, the final request occurring no less than nine days after the first request and in clear and unambiguous terms.<sup>182</sup>

## Overseas jurisdictions

4.149 The approach to ensuring that a person's wish to access assisted dying is enduring varies in overseas jurisdictions.

4.150 The legislation in most European jurisdictions expressly provide for the durability of the request. In the Netherlands, the attending physician must be satisfied that the patient's request is 'well considered';<sup>183</sup> in Belgium the request must be well-considered and repeated;<sup>184</sup> and in Luxembourg, the physician must ensure that the patient's request is made 'after reflection and, if necessary, repeated'.<sup>185</sup>

4.151 The Belgian and Luxembourg legislation further safeguards the durability of the request by requiring that the physician must have several conversations with the patient over a reasonable period of time, taking into account the progress of the patient's condition, to be certain of the durable nature of the request.<sup>186</sup>

4.152 In Canada and relevant jurisdictions in the United States of America, the durability of the person's request is not a condition of eligibility or a requirement of

<sup>178</sup> In addition to the first and second assessments, see: *Voluntary Assisted Dying Act 2017* (Vic) ss 41(1), 46(c)(iv), 47(3)(b), 48(3)(c), 64(1)(c), 65(2)(a)(iii), 66(1)(d); *Voluntary Assisted Dying Act 2019* (WA) ss 51(1), (3)(d), (f), 55(b)(iii), 59(5)(c), 61(2)(b)(iii), 62(3)(a).

<sup>179</sup> As to the final request and written declaration, see *Voluntary Assisted Dying Act 2017* (Vic) ss 34(1), 37(1); *Voluntary Assisted Dying Act 2019* (WA) ss 42(1), 47(1).

<sup>180</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 38; *Voluntary Assisted Dying Act 2019* (WA) s 48.

<sup>181</sup> W&W Model cl 9(d)(i).

<sup>182</sup> W&W Model cll 11, 27, 30, 33.

<sup>183</sup> *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2(1)(a).

<sup>184</sup> *Belgian Euthanasia Act 2002* art 3(1).

<sup>185</sup> *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(1)(2).

<sup>186</sup> *Belgian Act on Euthanasia 2002* art 3(2). See also art 3(3). The *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(2)(2) states that the doctor must hold several interviews with the patient, at reasonable intervals having regard to the evolution of the patient's condition, to ensure the persistence of the patient's physical or mental suffering and recently expressed or reiterated wish to die.

Similarly, legislation in New Zealand provides that the attending medical practitioner must communicate with the person about the wish for assistance to die at intervals determined by the progress of the person's terminal illness: *End of Life Choice Act 2019* (NZ) s 11(2)(b) (as enacted, not commenced); see also ss 12–19.



the assessment process. However, the voluntary assisted dying process in those jurisdictions seeks to ensure the request is lasting and continuous principally through the use of a waiting period.<sup>187</sup>

### Consultation question

**Q-14 Should the eligibility criteria for a person to access voluntary assisted dying require that the person's request for voluntary assisted dying be enduring?**

<sup>187</sup>

In Canada, there must be at least 10 clear days between making the request and the day on which the assistance in dying is provided. Further, immediately prior to the assistance being given, the person must again expressly consent to receiving assistance. However, the timeframe can be shorter in circumstances where the person's death, or the loss of their capacity to provide informed consent, is imminent: *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3)(g), (h). State legislation in the United States of America generally includes a waiting period of 15 days between the first and second oral request, except for Hawaii which requires a longer waiting time: see, eg, *Oregon Death with Dignity Act 1997*, Or Rev Stat, § 127.840.3.06; *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L-2(1), 327L-9, 327L-11 (20 days). See also the references in n 25 in Chapter 6 below.



# Chapter 5

## Initiating a discussion about voluntary assisted dying

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### INTRODUCTION

5.1 The terms of reference require the Commission to have regard to a number of specific matters, including ‘the legal and ethical obligations of treating health practitioners’ and ‘appropriate safeguards and protections, including for treating health practitioners’.<sup>1</sup>

5.2 This chapter discusses the issue of whether medical and other health practitioners should be prohibited from initiating a discussion about voluntary assisted dying in certain circumstances.

### INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING

#### Victoria

5.3 In Victoria, section 8 of the *Voluntary Assisted Dying Act 2017* (Vic) provides that a registered health practitioner,<sup>2</sup> in the course of providing health services or

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1 Terms of reference paras 4, 5.

2 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: 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.

professional care services<sup>3</sup> to a person, is prohibited from initiating a discussion about voluntary assisted dying, or in substance suggesting voluntary assisted dying to the person.<sup>4</sup> It further provides that the prohibition does not prevent a registered health practitioner from providing information about voluntary assisted dying to a person at the person's request.<sup>5</sup>

5.4 A contravention of the prohibition is to be regarded as unprofessional conduct under the Health Practitioner Regulation National Law.<sup>6</sup> This may have potentially serious consequences for the practitioner, including the suspension, or cancellation of, or imposition of conditions on, the practitioner's registration.<sup>7</sup>

5.5 Section 8 is based on the recommendations of the Victorian Ministerial Advisory Panel that 'a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship',<sup>8</sup> and that 'a request for ... information about voluntary assisted dying can only be initiated by the person'.<sup>9</sup>

5.6 The aim of the provision is to ensure that a person is not coerced or unduly influenced into accessing voluntary assisted dying.<sup>10</sup> In this regard, the Panel explained that:<sup>11</sup>

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.

5.7 In Victoria, guidance for health practitioners on voluntary assisted dying explains how the provision is to be applied in practice, with examples of patient

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3 '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').

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

5 *Voluntary Assisted Dying Act 2017* (Vic) s 8(2).

6 *Voluntary Assisted Dying Act 2017* (Vic) s 8(3). See the discussion of the National Health Practitioner Regulation Law at [9.36] ff below in relation to concerns about health practitioners' conduct.

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

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

9 *Ibid* Rec 7.

10 *Ibid* 91.

11 *Ibid* 15.

utterances that would and would not constitute patient requests for information or access to voluntary assisted dying:<sup>12</sup>

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?'

5.8 The Victorian prohibition is included as a safeguard in the legislation to reduce the possibility of coercion or undue influence. However, some commentators have raised concerns that the prohibition has implications for practitioners and patients and presents a significant barrier for access to voluntary assisted dying.<sup>13</sup>

5.9 From a policy perspective, several commentators have suggested that the prohibition does not align with the underlying goal of respecting a person's autonomy to make end of life choices and the provision of high quality health care.<sup>14</sup>

5.10 It has also been suggested that the prohibition conflicts with health practitioners' professional obligations to present and discuss all the relevant end of life options to their patients, and may undermine the therapeutic relationship between the practitioner and the person:<sup>15</sup>

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.

5.11 Another practical issue that has been raised is the potential uncertainty for health practitioners in determining whether, in some cases, a person has raised voluntary assisted dying sufficiently for the health practitioner to be able to specifically discuss it with the person.<sup>16</sup>

<sup>12</sup> Vic Guidance for Health Practitioners (2019) 13. The guidance also provides some specific examples of what does, and does not, constitute a request for information about or access to voluntary assisted dying: 14.

<sup>13</sup> C Johnston and J Cameron, 'Discussing voluntary assisted dying', (2018) 26 *Journal of Law and Medicine* 454, 463; 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>>; 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, 541.

<sup>14</sup> 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, 439–40; Johnston and Cameron, above n 13, 462–3; McDougall and Pratt, above n 13; L Willmott et al, 'Restricting conversations about voluntary assisted dying: implications for clinical practice' (2020) 10 *BMJ Supportive & Palliative Care* 105.

<sup>15</sup> Johnston and Cameron, above n 13, 462. See also McDougall and Pratt, above n 13.

<sup>16</sup> Platt, above n 13, 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. See also [5.7] above, in relation to the guidance for health practitioners on voluntary assisted dying published by the Victorian Department of Health and Human Services. It has been suggested that, in lieu of initiating a discussion, a health practitioner could direct a person to additional source of information, such as the Department of Health and Human Resources end of life webpage: Moore, Hempton and Kendal, 67–8.

5.12 In addition, if a person is unaware of the prohibition on medical practitioners initiating a discussion about voluntary assisted dying, they may assume that it is not an available option for them:<sup>17</sup>

While the prohibition may achieve its intention of preventing people from accessing voluntary assisted dying as a result of coercion or undue influence by a health practitioner, it is likely that this will be achieved through the exclusion of a cohort of people who may have been interested but were never made aware that this was an option for them.

5.13 It has also been suggested that the presence of numerous other safeguards in the request and assessment process for voluntary assisted dying to ensure voluntariness makes it unnecessary to have a prohibition against health practitioners initiating a discussion with patients.<sup>18</sup>

## Western Australia

5.14 In considering a proposed framework for the Western Australian legislation, the Western Australian Ministerial Expert Panel did not support the Victorian prohibition. This was on the basis that health practitioners have a professional obligation to ensure that their patients are fully informed about their end of life choices, including voluntary assisted dying, and should not be restricted in their ability to have those comprehensive end of life discussions.<sup>19</sup> Instead, it recommended that health practitioners should '[be] able to appropriately raise the topic of voluntary assisted dying with a patient'.<sup>20</sup> This was intended to ensure that 'people can make fully informed decisions at end of life', and that 'access to voluntary assisted dying is not impeded by a health practitioner not discussing what would be a legal option at end of life for some people'.<sup>21</sup>

5.15 In keeping with that recommendation, the Voluntary Assisted Dying Bill 2019 (WA) did not originally include any prohibition on the introduction of voluntary assisted dying. When the Bill was introduced, it was noted that:<sup>22</sup>

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.

<sup>17</sup> Johnston and Cameron, above n 13, 463. See also McDougall and Pratt, above n 13. 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 16, 68.

<sup>18</sup> Moore, Hempton and Kendal, above n 16, 67. In Victoria and Western Australia, such safeguards include that: the request must be initiated by the person themselves; the person must make a number of separate requests at prescribed intervals; voluntariness is assessed as part of two separate assessments by independent medical practitioners; the person must be fully informed about voluntary assisted dying and treatment and palliative care options and outcomes; and the person may withdraw from the voluntary assisted dying process at any time.

<sup>19</sup> WA Ministerial Expert Panel Final Report (2019) 31.

<sup>20</sup> Ibid Rec 6.

<sup>21</sup> Ibid 31.

<sup>22</sup> 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).

5.16 However, during the parliamentary debates, the Bill was amended to include a new clause that was enacted as section 10 of the *Voluntary Assisted Dying Act 2019* (WA). When introducing the new provision, it was explained that:<sup>23</sup>

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. As with all other elements of health care, medical practitioners will make a reasoned judgement about whether it is appropriate to inform this patient at this time about their choice to consider requesting voluntary assisted dying. 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.

5.17 Like Victoria, section 10 of the *Voluntary Assisted Dying Act 2019* (WA) prohibits the initiation of a discussion about voluntary assisted dying by a registered health practitioner (unless the practitioner is providing information about voluntary assisted dying to the person at their request).<sup>24</sup> A contravention of the prohibition constitutes unprofessional conduct under the Health Practitioner Regulation National Law (Western Australia).<sup>25</sup>

5.18 However, unlike Victoria, section 10 also provides that the 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:<sup>26</sup>

<sup>23</sup> Western Australia, *Parliamentary Debates*, Legislative Council, 21 November 2019, 9121–2 (S Dawson, Minister for Environment).

<sup>24</sup> *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 another 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: 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, and includes a service provided to a person at a hospital or any other place. 'Professional care services' is defined in s 5 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* section 3.

<sup>25</sup> *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 Act, which generally 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).

<sup>26</sup> *Voluntary Assisted Dying Act 2019* (WA) s 10(3).

- (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.

5.19 This additional provision preserves the ability of a medical practitioner or a nurse practitioner who is providing health or professional care services to a person 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. Other health care workers, however, will still be subject to the prohibition.

### Queensland

5.20 In Queensland, the Parliamentary Committee recommended that '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'.<sup>27</sup>

5.21 By comparison, the W&W Model does not prohibit the initiation of a discussion about voluntary assisted dying by a health practitioner, as in Victoria. It was considered that such a prohibition would impede the frank discussions between the practitioner and their patient that are needed for safe and high quality end of life care.<sup>28</sup>

### Overseas jurisdictions

5.22 In overseas jurisdictions that regulate voluntary assisted dying, health practitioners are not prohibited from initiating a discussion about the topic. In Vermont, it is recognised that patients have a right to be informed of all therapeutic options at the end of their life. In Canada, medical practitioners who introduce the subject of medical assistance in dying are protected. In European jurisdictions, there are no restrictions on who can introduce voluntary assisted dying.<sup>29</sup>

### Consultation questions

**Q-15 Should the draft legislation provide that a health practitioner is prohibited from initiating a discussion about voluntary assisted dying as an end of life option?**

<sup>27</sup> Qld Parliamentary Committee Report No 34 (2020) 141, Rec 16.

<sup>28</sup> W&W Model, Explanatory Notes 6, referring to the discussion of s 8 of the *Victorian Assisted Dying Act 2017* (Vic) in Johnston and Cameron, above n 13, 456.

<sup>29</sup> See Johnston and Cameron, above n 13, 456, discussing various statutes including *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5282; *Canada Criminal Code*, RSC 1985, c C-46, ss 241(2), (5.1); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* s 2; *Belgian Euthanasia Act 2002* art 3(1).



**Q-16** If yes to Q-15, should there be an exception to the prohibition if, at the same time, the practitioner informs the person about 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 (as in Western Australia)?



# Chapter 6

## The voluntary assisted dying process

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### INTRODUCTION

6.1 This chapter discusses selected issues in relation to the voluntary assisted dying process. It is intended to be read together with the general overview of the process in Victoria and Western Australia in Chapter 2 above.

### REQUESTING ACCESS TO VOLUNTARY ASSISTED DYING

6.2 In Victoria and Western Australia, the person must make three requests for access to voluntary assisted dying. The first and final request may be made verbally. However, the second request must be a written declaration.<sup>1</sup>

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<sup>1</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 11, 34, 37; *Voluntary Assisted Dying Act 2019* (WA) ss 18, 42, 47. The first and final requests can also be made by gestures or other means of communication.

6.3 The requirement for a staged request process ensures that the person's request for voluntary assisted dying is voluntary, considered and enduring, and was recommended by both the Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel.<sup>2</sup> It was considered that the requirement for the second request to be a written declaration formalises the request after the person has been fully informed and assessed as eligible.<sup>3</sup>

6.4 The W&W Model also requires the person to make three requests, the second of which must be a written declaration.<sup>4</sup>

### Witnessing requirements for the written declaration

6.5 The written declaration must be signed by the person in the presence of two witnesses. In Victoria, the coordinating practitioner must also be present.<sup>5</sup>

6.6 The requirement for two independent witnesses is 'a safeguard for people who may be vulnerable to abuse and coercion'.<sup>6</sup> Among other things, the witnesses must certify that the person making the declaration appeared to freely and voluntarily sign the declaration. In Victoria, the witnesses must also certify that, at the time of signing, the person appeared to have decision-making capacity in relation to voluntary assisted dying and appeared to understand the nature and effect of making the declaration.<sup>7</sup>

6.7 The witnesses to the written declaration must each be 18 years or more and must not be an ineligible witness. A person is ineligible to be a witness if the person:<sup>8</sup>

- knows or believes they:
  - are a beneficiary under a will of the person making the declaration (Victoria and Western Australia); or

<sup>2</sup> Vic Ministerial Advisory Panel Final Report (2017) 112–14, Recs 19, 20; WA Ministerial Expert Panel Final Report (2019) 67, Rec 18.

<sup>3</sup> WA Ministerial Expert Panel Final Report (2019) 67, Rec 18.

<sup>4</sup> W&W Model cll 11, 27, 30.

<sup>5</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 34(2)(b), (3)–(4), 36(3); *Voluntary Assisted Dying Act 2019* (WA) s 42(3)(b), (4)–(5). If the person is unable to sign the written declaration, another person can do so at their direction: see further [6.105] below.

<sup>6</sup> Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 12; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 15, stating that '[t]he purpose of the two witnesses is to provide independent verification that the written declaration was signed freely and voluntarily by the [person]', and also noting that the purpose of the written declaration 'is to reflect the voluntary and enduring nature of the [person's] request for access to voluntary assisted dying'.

<sup>7</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 36(1)(a); *Voluntary Assisted Dying Act 2019* (WA) s 44(2)(a). See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 15.

<sup>8</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 35(1)–(2); *Voluntary Assisted Dying Act 2019* (WA) s 43. See also *Voluntary Assisted Dying Act 2017* (Vic) s 3 (definitions of 'health facility', 'health service' and 'professional care services'); *Voluntary Assisted Dying Act 2019* (WA) s 5 (definitions of 'health service' and 'professional care services').

- may otherwise benefit financially or in any other material way from the death of the person making the declaration (Victoria and Western Australia);
- 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);
- is directly involved in providing health services or professional care services to the person making the declaration (Victoria); or
- is the coordinating practitioner or consulting practitioner for the person making the declaration (Western Australia).

6.8 Additionally, in Western Australia, a family member of the person making the declaration cannot be a witness to the written declaration.<sup>9</sup> In Victoria, not more than one witness may be a family member of the person making the written declaration.<sup>10</sup>

6.9 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.<sup>11</sup>

6.10 The requirements in relation to who can be a witness to the written declaration are 'aimed at ensuring witnesses do not have a conflict of interest in witnessing the declaration'.<sup>12</sup>

6.11 In recommending those provisions, the Victorian Ministerial Advisory Panel considered that:<sup>13</sup>

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.

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<sup>9</sup> *Voluntary Assisted Dying Act 2019* (WA) s 43(2)(b).

<sup>10</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 35(3).

<sup>11</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of 'family member'); *Voluntary Assisted Dying Act 2019* (WA) s 5 (definition of 'family member').

<sup>12</sup> Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) 12; Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 15.

<sup>13</sup> Vic Ministerial Advisory Panel Final Report (2017) 127, Recs 26, 27.

6.12 The Victorian Ministerial Advisory Panel also recommended that the written declaration should be signed and witnessed in the presence of the coordinating practitioner. It considered that this:<sup>14</sup>

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.

6.13 The witnessing requirements in Western Australia implement the recommendations of the Western Australian Ministerial Expert Panel, which stated:<sup>15</sup>

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.

6.14 In particular, the Western Australian Ministerial Expert 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:<sup>16</sup>

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.

6.15 The witnessing requirements for the written declaration in the W&W Model are substantially the same as the requirements in the Victorian legislation.<sup>17</sup>

### Consultation questions

**Q-17 Should the draft legislation provide that the person who makes a written declaration must sign the written declaration in the presence of:**

- (a) two witnesses (as in Western Australia); or**
- (b) two witnesses and the coordinating practitioner (as in Victoria)?**

**Q-18 Should the draft legislation provide that a person is not eligible to witness a written declaration if they:**

<sup>14</sup> Ibid 127, Rec 26.

<sup>15</sup> WA Ministerial Expert Panel Final Report (2019) 67, Rec 18.

<sup>16</sup> Ibid 67.

<sup>17</sup> W&W Model cl 27–9.

- (a) are under 18 years (as in Victoria and Western Australia);**
- (b) know or believe that they:**
  - (i) are a beneficiary under a will of the person making the declaration (as in Victoria and Western Australia);**
  - (ii) may otherwise benefit financially or in any other material way from the death of the person making the declaration (as in Victoria and Western Australia);**
- (c) are an owner of, or are responsible for the day-to-day operation of, any health facility at which the person making the declaration is being treated or resides (as in Victoria);**
- (d) are directly involved in providing health services or professional care services to the person making the declaration (as in Victoria);**
- (e) are the coordinating practitioner or consulting practitioner for the person making the declaration (as in Western Australia);**
- (f) are a family member of the person making the declaration (as in Western Australia)?**

**Q-19 Alternatively to Q-18(f), should the draft legislation provide that not more than one witness may be a family member of the person making the declaration (as in Victoria)?**

## **WAITING PERIODS**

6.16 The legislation in Victoria and Western Australia generally requires that there be a period of at least nine days between a person's first and final requests for access to voluntary assisted dying.<sup>18</sup> However, that does not apply if it is likely that the person will die or, in Western Australia only, will lose decision-making capacity in relation to voluntary assisted dying, within that period of time. In any case, the person must make their final request at least one day after the day on which the consulting assessment was completed.<sup>19</sup>

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<sup>18</sup> In Victoria, since June 2019, it is reported that '25 per cent of applicants have progressed between their first and last request within 11 days and 50 per cent within 19 days': see further [6.118] below.

<sup>19</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 38; *Voluntary Assisted Dying Act 2019* (WA) s 48. See also the discussion of waiting periods in Chapter 2 above.

6.17 The W&W Model contains a similar provision to Victoria, including provision for a reduced timeframe in circumstances where the person is likely to die (but not where the person is likely to lose decision-making capacity).<sup>20</sup>

6.18 Waiting periods are included as a means of ensuring that the process of accessing voluntary assisted dying is not rushed, that people have time to reflect and make a well-considered decision, and that a person's decision to access voluntary assisted dying is enduring. A waiting period of around nine days was considered to represent an appropriate balance between the need to ensure a person's decision is well-considered and to avoid 'unnecessarily prolonging' that person's suffering.<sup>21</sup>

6.19 In Victoria, it was acknowledged that where a person's death is imminent the imposition of 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':<sup>22</sup>

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.

6.20 In contrast, the Western Australian Ministerial Expert Panel recommended that the waiting period should be reduced if a person is likely to lose decision-making capacity, explaining that this decision was 'based on the increased suffering the person could experience though 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.<sup>23</sup>

6.21 In some cases, a person may have decision-making capacity in relation to voluntary assisted dying at the time of making their first request, but be at risk of losing that capacity with time due to the nature of their disease, illness or medical condition, the medication they are taking, or their closeness to death.<sup>24</sup> An ability to reduce the waiting period in these circumstances provides a mechanism for a person to complete the voluntary assisted dying process before they lose decision-making capacity.

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<sup>20</sup> W&W Model cl 33. This provision requires the final request to be made immediately before the person is provided access to voluntary assisted dying. It was explained that '[t]his ensures it is a contemporaneous request by a person with capacity who is acting freely and voluntarily in requesting access to voluntary assisted dying': W&W Model, Explanatory Notes 7.

<sup>21</sup> 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.

<sup>22</sup> Vic Ministerial Advisory Panel Final Report (2017) 124, Rec 24.

<sup>23</sup> WA Ministerial Expert Panel Final Report (2019) 71, Rec 20.

<sup>24</sup> Ibid 24.



6.22 State legislation in the United States of America and the federal legislation in Canada also includes waiting periods.<sup>25</sup> The federal legislation in Canada provides that there must be ‘10 clear days’ between a person’s written request and the day on which assisted dying is provided, or any shorter period if the person’s death or loss of capacity to provide informed consent is imminent.<sup>26</sup>

## Consultation questions

**Q-20** Should the draft legislation include provisions about the prescribed period that must elapse between a person’s first request and final request for access to voluntary assisted dying, in similar terms to the legislation in Victoria and Western Australia?

**Q-21** If yes to Q-20, should the draft legislation provide that the final request can be made before the end of the prescribed period if:

- (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?

## ELIGIBILITY ASSESSMENTS

6.23 In Victoria and Western Australia, the coordinating practitioner and the consulting practitioner must each assess whether the person meets the eligibility criteria and is eligible for access to voluntary assisted dying.<sup>27</sup> The requirement for

<sup>25</sup> State legislation in the United States of America includes a waiting period of 15 days (except for Hawaii, which has a waiting period of 20 days). Some legislation (in District of Columbia, Hawaii, Maine, Oregon, and Washington) provides for an additional waiting period of 48 hours 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: *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.3(a); *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-104(1); *District of Columbia Death with Dignity Act 2016*, DC Code § 7-661.02(a); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat §§ 327L-2, 327L-9, 327L-11; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann §§ 2140.11, 2140.13; *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:16-10(a); *Oregon Death with Dignity Act 1997*, Or Rev Stat §§ 127.840.3.06, 127.850.3.08; *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann § 5283(a)(1); *Washington Death with Dignity Act 2008*, RCW §§ 70.245.090, 70.245.110.

In contrast, the legislation in Belgium, Luxembourg and the Netherlands does not include a specific waiting period but provides, variously, that the person’s request must be ‘well considered’ or made ‘after reflection’: *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).

<sup>26</sup> *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3)(g). In Canada, it is proposed to remove the waiting period in cases where a person’s natural death is reasonably foreseeable, as individuals in that situation have already given their request careful consideration and the waiting period ‘unnecessarily prolongs suffering’. There are concerns about removing the waiting period. For example, it is argued that statistics about applicants for assisted dying who subsequently have a change of mind ‘demonstrate a need for a period of reflection’: An Act to amend the Criminal Code (medical assistance in dying), Canada, Bill C-7, 2020 cl 1(3), (5), (7); 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], [3.4].

<sup>27</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 6(b), 9, 16, 20(1)(a)–(d), 25, 29(1)(a), (c)–(d); *Voluntary Assisted Dying Act 2019* (WA) ss 15(b), 16, 24, 28(1)(a), 35, 39. See further the discussions of eligibility assessments in Chapter 2 above and eligibility criteria in Chapter 4 above.

two medical practitioners to independently assess the person's eligibility for access to voluntary assisted dying is considered to be a 'fundamental safeguard'.<sup>28</sup> It is also consistent with the legislation in overseas jurisdictions.<sup>29</sup>

### Requirement for the eligibility assessments to be independent

6.24 The consulting assessment must be done, independently of the coordinating assessment, against the eligibility criteria.<sup>30</sup> 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 of the requirements for access to voluntary assisted dying.<sup>31</sup>

6.25 The legislation in Western Australia states that the consulting practitioner 'must make a decision in respect of each of the eligibility criteria' and 'must independently of the coordinating practitioner form their own opinions on the matters to be decided'. However, the legislation states that this does not prevent 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'.<sup>32</sup>

6.26 In Victoria, guidance for health practitioners explains that:<sup>33</sup>

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.

6.27 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should include, among other things, 'the requirement that two independent medical practitioners assess any person wishing to access

<sup>28</sup> 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)); Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 8.

<sup>29</sup> For example, state legislation in the United States of America 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 *California End of Life Option Act 2015*, Cal Health and Safety Code § 443.1(f), (j), (m); *Colorado End of Life Options Act 2016*, Colo Rev Stat § 25-48-102(3), (9); *District of Columbia Death with Dignity Act 2016*, DC Code § 7-661.2.(3), (12); *Hawaii Our Care Our Choice Act 2018*, Haw Rev Stat § 327L-1; *Maine Death with Dignity Act 2019*, Me Rev Stat Ann § 2140.2(D), (H); *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019*, NJ Stat Ann § 26:16-3(3); *Oregon Death with Dignity Act 1997*, Or Rev Stat § 127.800.1.01(4), (8); *Washington Death with Dignity Act 2008*, RCW § 70.245.010(4), (8). See also *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).

<sup>30</sup> Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 8; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 11.

<sup>31</sup> *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). See further the discussions of eligibility assessments in Chapter 2 above and eligibility criteria in Chapter 4 above.

<sup>32</sup> *Voluntary Assisted Dying Act 2019* (WA) s 35. The legislation similarly provides that the coordinating practitioner 'must make a decision in respect of each of the eligibility criteria' and that 'nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner': s 24.

<sup>33</sup> Vic Guidance for Health Practitioners (2019) [2.8].

voluntary assisted dying'. It noted that 'the protection of vulnerable people from coercion is a critical issue for the design of any voluntary assisted dying scheme'.<sup>34</sup>

6.28 The W&W Model requires two medical practitioners to each assess the person's eligibility. Unlike Victoria and Western Australia, it also expressly provides that the two medical practitioners who undertake the assessments 'must be independent of each other'. This means that one medical practitioner must not be employed by or working under the supervision of the other medical practitioner, and that the medical practitioners must not be family members.<sup>35</sup>

6.29 The Western Australian Ministerial Expert Panel observed that, during consultation, 'points were raised in relation to the independence of the assessing practitioners'. It noted that:<sup>36</sup>

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.

6.30 Medical practitioners are subject to professional obligations and must comply with professional standards, including codes of ethics, codes of conduct, policies and guidelines.<sup>37</sup> Good medical practice involves recognising and resolving conflicts of interest in the best interests of the patient:<sup>38</sup>

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.

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<sup>34</sup> Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

<sup>35</sup> W&W Model cl 12. 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 first practitioner: *Belgian Euthanasia Act 2002* art 3(2); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(2)(3).

<sup>36</sup> WA Ministerial Expert Panel Final Report (2019) 65. See further Western Australia, Legislative Assembly, *Parliamentary Debates*, 5 September 2019, 6613–14 (RH Cook, Minister for Health), explaining that the legislation requires two independent assessments (as opposed to two independent practitioners). During the parliamentary debates, the concerns of the Western Australian Ministerial Expert Panel were referred to. However, it was noted that the legislation does not, for example, preclude practitioners who work in the same practice from being the coordinating practitioner and consulting practitioner, and that such a requirement may cause accessibility issues in rural, regional and remote areas where there may be only one practice: 6613–14.

<sup>37</sup> 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.

<sup>38</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [10.12].

## Requirements for referral of certain matters

6.31 If the coordinating practitioner or consulting practitioner is not able to determine whether the person has decision-making capacity in relation to voluntary assisted dying, they must refer the person to a registered health practitioner with appropriate skills and training to determine the matter. This may, for example, be a psychiatrist or neuropsychologist in the case of a person with a mental illness.<sup>39</sup>

6.32 If the coordinating practitioner or consulting practitioner is not able 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:<sup>40</sup>

- in Victoria—a specialist medical practitioner who has appropriate skills and training in that disease, illness or medical condition;
- in Western Australia—a registered health practitioner with appropriate skills and training to make a determination in relation to the matter.

6.33 Additionally, 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 a determination in relation to the matter'.<sup>41</sup> 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.<sup>42</sup>

6.34 The coordinating practitioner or consulting practitioner may adopt the determination of the health practitioner (or other person) to whom they referred the person in relation to the particular criterion.<sup>43</sup>

6.35 The ability to seek a further medical opinion 'ensures that the patient has access to the highest standard of assessment in the voluntary dying process' and is

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39 *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 also 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'.

40 *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).

41 *Voluntary Assisted Dying Act 2019* (WA) ss 26(3), 37(3).

42 Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 10.

43 *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.

consistent with current medical practice.<sup>44</sup> The Victorian Ministerial Advisory Panel noted that medical practitioners:<sup>45</sup>

have professional obligations to act within their scope of practice. 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.

6.36 In Victoria, there is an additional requirement for the coordinating practitioner to make a referral in cases where the person has a neurodegenerative disease, illness or medical condition that is expected to cause death within six to 12 months. The coordinating practitioner must refer the person 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, and must adopt the specialist's determination.<sup>46</sup> There is no equivalent requirement for consulting practitioners.

6.37 This additional requirement was not recommended by the Victorian Ministerial Advisory Panel or included in the Voluntary Assisted Dying Bill 2017 (Vic) as introduced into Parliament but was the subject of an amendment during the parliamentary debates.<sup>47</sup> The Victorian guidance for health practitioners explains 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'.<sup>48</sup>

6.38 The W&W Model provides that, if either the coordinating practitioner or the consulting practitioner is unable to determine whether the person requesting access to voluntary assisted dying 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.<sup>49</sup>

## Other requirements

6.39 The legislation in Western Australia 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:<sup>50</sup>

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44 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 10.

45 Vic Ministerial Advisory Panel Final Report (2017) 103.

46 *Voluntary Assisted Dying Act 2017* (Vic) s 18(4)–(6).

47 Victoria, *Parliamentary Debates*, Legislative Council, 21 November 2017, 6274–75 (G Jennings, Special Minister for State), 6277–78.

48 Vic Guidance for Health Practitioners (2019) 31. See also [4.30] above.

49 W&W Model cll 17, 22.

50 *Voluntary Assisted Dying Act 2019* (WA) ss 17(2)(b)–(c), 37(5), 54(1)(c)–(d).

- are a family member of the person;<sup>51</sup> 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.<sup>52</sup>

6.40 Those requirements were not recommended by the Western Australian Ministerial Expert Panel or included in the Bill as introduced into Parliament, but were the subject of amendment during the parliamentary debates. They were included to ensure that medical practitioners providing voluntary assisted dying are independent of the person and reflect good medical practice.<sup>53</sup>

6.41 There are no equivalent requirements included in the Victorian legislation. However, as explained above, health practitioners are subject to professional obligations, including to avoid conflicts of interest.<sup>54</sup>

### Consultation questions

**Q-22 Should the draft legislation 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:**

- (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 assessments must be independent of each other?

**Q-23 Should the draft legislation provide that, if the coordinating practitioner or consulting practitioner:**

- (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);

<sup>51</sup> See [6.9] above for the definition of 'family member'.

<sup>52</sup> Other than by receiving reasonable fees for the provision of their services; for example, as the coordinating practitioner or consulting practitioner for the person.

<sup>53</sup> Western Australia, Legislative Assembly, *Parliamentary Debates*, 10 December 2019, 9961, 9975 (RH Cook, Minister for Health).

<sup>54</sup> See [6.30] above. In some overseas jurisdictions, the legislation provides that the consulting practitioner must be independent of the patient: *Belgian Euthanasia Act 2002* art 3(2); *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 2(2)(3).

- (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)?

**Q-24** Should the draft legislation provide (as in Western Australia) that the coordinating practitioner, the consulting practitioner, any health practitioner (or other person) to whom the person is referred for a determination of whether the person meets particular eligibility requirements, or the administering practitioner must not:

- (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?

## REVIEW OF CERTAIN DECISIONS BY TRIBUNAL

6.42 An eligible applicant may apply to the relevant tribunal for review of a decision of a coordinating practitioner or a consulting practitioner that the person:<sup>55</sup>

- 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).

<sup>55</sup>

In Victoria, the relevant tribunal is the Victorian Civil and Administrative Tribunal ('VCAT'); in Western Australia, the relevant tribunal is the State Administrative Tribunal ('SAT'): *Voluntary Assisted Dying Act 2017* (Vic) s 68; *Voluntary Assisted Dying Act 2019* (WA) ss 5 (definition of 'Tribunal'), 84. As to the powers of the tribunal to determine those matters and make any necessary interim orders see *Voluntary Assisted Dying Act 2017* (Vic) ss 72, 74; *Voluntary Assisted Dying Act 2019* (WA) ss 88, 98.

6.43 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.<sup>56</sup>

6.44 If an application for review is made, the request and assessment process is suspended, and no further step is to be taken until the review application is determined.<sup>57</sup>

### Consultation questions

**Q-25** Should the draft legislation provide for an eligible applicant to apply to the Queensland Civil and Administrative Tribunal for review of a decision of a coordinating practitioner or a consulting practitioner that the person who is the subject of the decision:

- (a) is or is not ordinarily resident in the State (as in Victoria);
- (b) at the time of making the first request, was or was not ordinarily resident in the State for a specified minimum period (as in Victoria and Western Australia);
- (c) has or does not have decision-making capacity in relation to voluntary assisted dying (as in Victoria and Western Australia);
- (d) is or is not acting voluntarily and without coercion (as in Western Australia)?

**Q-26** If yes to Q-25, should an application for review be able to be made by:

- (a) the person who is the subject of the decision;
- (b) an agent of the person who is the subject of the decision; or
- (c) another person who the tribunal is satisfied has a special interest in the medical care and treatment of the person?

### REPORTING REQUIREMENTS FOR HEALTH PRACTITIONERS

6.45 At various stages in the voluntary assisted dying process, the coordinating practitioner and the consulting practitioner are required to report to an independent board that monitors the voluntary assisted dying process. In Victoria and Western Australia, the Board conducts a review to ensure that the legislation is being complied with and the correct process is being followed in relation to each case of voluntary

<sup>56</sup> *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).

<sup>57</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 70; *Voluntary Assisted Dying Act 2019* (WA) s 86.



assisted dying. Reporting requirements also assist the Board in maintaining statistics of participation in voluntary assisted dying.<sup>58</sup>

6.46 In particular, in both Victoria and Western Australia, reports must be provided in the approved forms to notify the Board:

- of the outcome of eligibility assessments that have been conducted in relation to the person (the ‘first assessment report form’ and the ‘consulting assessment report form’);<sup>59</sup> and
- that the final review has been completed (the ‘final review form’).<sup>60</sup>

6.47 Those reports must be provided to the Board within seven days (Victoria) or two business days (Western Australia) of the eligibility assessment or the final review (as relevant) being completed.

6.48 In Victoria, the coordinating practitioner is required to provide a copy of all the required forms completed in relation to the request and assessment together with the final review form. This includes a copy of the written declaration, and the form appointing the contact person.<sup>61</sup>

6.49 In Western Australia, the coordinating practitioner and, where relevant, the consulting practitioner are required to notify the Board progressively at each step of the voluntary assisted dying process.<sup>62</sup> For example, the written declaration and the contact person appointment form must be provided to the Board within two business days of the coordinating practitioner receiving them.<sup>63</sup> In addition:

- the medical practitioner to whom a person makes a first request must notify the Board that the person has made the first request within two business days after deciding to accept or refuse the request;<sup>64</sup>

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58 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 11.

59 *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).

60 *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).

61 *Voluntary Assisted Dying Act 2017* (Vic) ss 3(1) (definition of ‘final review form’), 41(2). A consulting practitioner must also notify the Board of the outcome of the consulting assessment within seven days of completing it: s 30.

62 It also expressly requires medical practitioners to record matters in the medical record for the person: *Voluntary Assisted Dying Act 2019* (WA) ss 21, 32, 45, 49, 56(5), 57(3)(a), 63(3)(b), 157(4)(b).

63 *Voluntary Assisted Dying Act 2019* (WA) ss 46, 66. If the person has made a self-administration decision, a copy of the administration decision and prescription form and the contact appointment form must be provided within two business days after prescribing a voluntary assisted dying substance: s 60.

64 *Voluntary Assisted Dying Act 2019* (WA) s 22. There is no such requirement in Victoria.

- the medical practitioner to whom a person is referred for a consulting assessment must notify the Board of a referral within two business days after deciding to accept or refuse the referral;<sup>65</sup>
- the coordinating practitioner must give the Board a copy of the administration decision and prescription form within two business days after prescribing a voluntary assisted dying substance.<sup>66</sup>

6.50 In both Victoria and Western Australia, if the voluntary assisted dying substance is administered by a practitioner, the practitioner must notify the Board within seven days (Victoria) or two business days (Western Australia) of the substance being administered to a person.<sup>67</sup>

6.51 The legislation in both Victoria and Western Australia provides that the request and assessment process is not invalidated by any minor or technical error in a form.<sup>68</sup>

6.52 In Victoria, the Voluntary Assisted Dying Portal has been established to enable medical practitioners to submit the required forms and evidence to the Voluntary Assisted Dying Review Board online.<sup>69</sup>

6.53 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 voluntary assisted dying 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.<sup>70</sup> The Board reported that, between January and June 2020, 99 per cent of cases were compliant.<sup>71</sup>

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65 *Voluntary Assisted Dying Act 2019* (WA) s 33. There is no such requirement in Victoria.

66 *Voluntary Assisted Dying Act 2019* (WA) s 60. There is no equivalent provision in Victoria. As previously explained, the legislation in Victoria requires the coordinating practitioner to obtain a self-administration permit or a practitioner administration permit. See further the discussion of the additional approval process in Victoria in Chapter 2 above.

67 *Voluntary Assisted Dying Act 2017* (Vic) s 66 (2), sch 1, Form 8; *Voluntary Assisted Dying Act 2019* (WA) s 61(3), (4).

68 *Voluntary Assisted Dying Act 2017* (Vic) s 42; *Voluntary Assisted Dying Act 2019* (WA) s 52. This makes it clear that a technical error on a form, such as a spelling error 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': Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) 15; Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 17.

69 Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 2, 4. The Board has reported that it has received some feedback from medical practitioners that the portal is difficult to use and that it would 'continue to improve the portal to make the process of applying easier wherever possible': 8.

70 *Ibid* 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'.

71 *Ibid* 15, noting 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 *Voluntary Assisted Dying Act 2017* (Vic). The Board referred the matter to the AHPRA.

6.54 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should have 'thorough documentation and reporting requirements'.<sup>72</sup>

6.55 The W&W 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.<sup>73</sup> The coordinating practitioner must also report to the Board in the approved form within 14 days of providing access to voluntary assisted dying. This final report is to be provided together with relevant documentation, including the written declaration, the eligibility assessment reports, and a record of the first and final request.<sup>74</sup>

### Consultation question

**Q-27 At what points during the request and assessment process should the coordinating practitioner or consulting practitioner be required to report to an independent oversight body? For example, should it be required to report to an independent oversight body:**

- (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);**
- (d) at some other time (and, if so, when)?**

### ADDITIONAL APPROVAL PROCESS

6.56 In Victoria, the coordinating practitioner must apply to the Secretary of the Department of Health and Human Services for a voluntary assisted dying permit after the request and assessment process is complete, and before the voluntary assisted dying substance can be prescribed and administered. The Secretary must be satisfied that all the pre-conditions in the legislation have been met and that the request and assessment process has been completed, and must determine the application within three business days.<sup>75</sup>

6.57 The Victorian Voluntary Assisted Dying Review Board reported that, between 1 January and 30 June 2020, 145 permits were issued, and 68 per cent of

<sup>72</sup> Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

<sup>73</sup> W&W Model cl 25.

<sup>74</sup> W&W Model cl 37.

<sup>75</sup> Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 4, 12. See further the discussion of the additional approval process in Victoria in Chapter 2 above.

permits were issued within two business days. Twenty-one permits were initially not issued due to administrative errors in the prescribing of the voluntary assisted dying substance (in 20 cases) and insufficient evidence of the applicant's eligibility (in one case). However, all 21 were resubmitted and subsequently approved after errors were corrected or further evidence was provided.<sup>76</sup>

6.58 The requirement for a permit was recommended by the Victorian Ministerial Advisory Panel.<sup>77</sup> 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'.<sup>78</sup> It also 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'.<sup>79</sup> 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.<sup>80</sup>

6.59 However, some concerns have been expressed that 'a further [three] day delay for consideration by the Secretary may cause hardship for a terminally ill [person] who is suffering and unnecessarily impede access to [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'.<sup>81</sup>

6.60 There is no requirement for a permit in Western Australia, or in any overseas jurisdictions. The position is similar under the W&W Model. As previously explained, in Western Australia the person may make an administration decision in consultation with, and on the advice of, their coordinating practitioner.<sup>82</sup>

<sup>76</sup> Ibid 12. Further, it was reported that, in 42% of cases, the voluntary assisted dying substance was dispensed within two business days of a request by the applicant.

<sup>77</sup> Vic Ministerial Advisory Panel Final Report (2017) 133–4, Rec 31.

<sup>78</sup> Ibid 133.

<sup>79</sup> Ibid 141. See also 134.

<sup>80</sup> 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.

<sup>81</sup> 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 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, 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.

<sup>82</sup> See further the discussion of the additional approval process in Victoria in Chapter 2 above.

6.61 In Western Australia, it was considered that this requirement is an additional 'bureaucratic' layer that 'does not confer additional protection'.<sup>83</sup>

6.62 The Western Australian Ministerial Expert 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 of life options open to patients', such as to receive terminal sedation, or to refuse artificial food and hydration.<sup>84</sup>

6.63 The Panel also considered that the authorisation for prescription of voluntary assisted dying medication could be managed through existing mechanisms in the *Medicines and Poisons Act 2014* (WA), including notification or authorisation requirements, without the need for a permit.<sup>85</sup>

6.64 The W&W Model does not include a requirement for the approval of a permit.

### Consultation question

**Q-28 Is it 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)?**

## ADMINISTRATION OF THE VOLUNTARY ASSISTED DYING SUBSTANCE

### Self-administration or practitioner administration

6.65 Self-administration of the voluntary assisted dying substance is the default method in Victoria and the primary method in Western Australia; practitioner administration is permitted only in limited circumstances.

6.66 In Victoria, practitioner administration is permitted only if the person is physically incapable of self-administering or digesting the substance.<sup>86</sup>

6.67 In Western Australia, the person may decide, in consultation with and on the advice of their coordinating practitioner, whether the voluntary assisted dying

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<sup>83</sup> Western Australia, *Parliamentary Debates*, Legislative Council, 22 November 2019, 9181 (S Dawson, Minister for Environment).

<sup>84</sup> 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.

<sup>85</sup> WA Ministerial Expert Panel Final Report (2019) 72–3, Recs 21, 22. See also Western Australia, *Parliamentary Debates*, Legislative Council, 22 November 2019, 9181 (S Dawson, Minister for Environment).

<sup>86</sup> *Voluntary Assisted Dying Act 2019* (Vic) ss 47(1), 48(1), (3)(a).

substance will be self-administered or practitioner administered.<sup>87</sup> However, a practitioner administration decision can only be made if the coordinating practitioner advises that self-administration is inappropriate, having regard to one or more of the following considerations:<sup>88</sup>

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

6.68 Those provisions implement the recommendations of, respectively, the Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel. They considered that self-administration should be the primary method, noting that it is 'a powerful safeguard to ensure voluntary assisted dying is in fact voluntary',<sup>89</sup> and 'demonstrates that the person is acting autonomously'.<sup>90</sup>

6.69 However, they also considered that there will be circumstances where self-administration is either not possible or clinically inappropriate, and that it would be unfair or discriminatory to preclude a person from accessing voluntary assisted dying because of this. They therefore recommended that practitioner administration should be permitted in the limited circumstances noted above, subject to additional safeguards to ensure that the person's decision is voluntary.<sup>91</sup>

6.70 Approaches in overseas jurisdictions vary. In some jurisdictions the voluntary assisted dying substance must be self-administered,<sup>92</sup> in some it must be

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<sup>87</sup> *Voluntary Assisted Dying Act 2019 (WA)* s 56(1). Shared decision-making is consistent with good medical practice. See MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) [3.3], which provides that '[m]aking decisions about healthcare is the shared responsibility of the doctor and the patient'.

<sup>88</sup> *Voluntary Assisted Dying Act 2019 (WA)* s 56(2). See further Western Australia, Legislative Assembly, *Parliamentary Debates*, 17 September 2019, 6794 ff (RH Cook, Minister for Health).

<sup>89</sup> Vic Ministerial Advisory Panel Final Report (2017) 141.

<sup>90</sup> WA Ministerial Expert Panel Final Report (2019) 78.

<sup>91</sup> Vic Ministerial Advisory Panel Final Report (2017) 137–43, Recs 36, 37; WA Ministerial Expert Panel Final Report (2019) 78–9, Rec 23.

<sup>92</sup> This is the case in the state legislation in the United States of America: *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.

practitioner administered,<sup>93</sup> and in others the person may request either.<sup>94</sup> Data from overseas jurisdictions show that, when given the choice of self-administration or practitioner administration, the majority of people opt for practitioner administration.<sup>95</sup>

6.71 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 better suited to the person.<sup>96</sup>

6.72 The W&W Model enables the person to choose either practitioner administration or self-administration.<sup>97</sup> It was considered that this promotes the value of autonomy.<sup>98</sup>

### Requirements for self-administration

6.73 If a self-administration permit has been approved (Victoria) or a self-administration decision has been made (Western Australia), the voluntary assisted dying substance can be prescribed and supplied to the person, and the person can receive, possess, prepare and self-administer the substance.<sup>99</sup>

6.74 The legislation in Victoria and Western Australia does not require the coordinating practitioner or another health practitioner to be present when the person self-administers the voluntary assisted dying substance, although it also does not preclude them from being present.

6.75 The person has autonomy to choose the manner and timing of their death. The person may choose to have their family members, friends, carer or support person with them. They may also choose to have the coordinating practitioner or another health practitioner present, if they agree.<sup>100</sup>

<sup>93</sup> This is the case in Belgium and Quebec: *Belgian Euthanasia Act 2002* art 2; *Quebec Act respecting end-of-life care*, RSQ, c S-32.0001, s 3(6).

<sup>94</sup> This is the case in the *Canada Criminal Code*, the Netherlands, and Luxembourg: *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). It is also the model in the *End of Life Choice Act 2019* (NZ) s 19(2)(a) (as enacted, not commenced).

<sup>95</sup> For example, of 6126 cases in the Netherlands in 2018, 96.2% were terminations of life on request (practitioner administration), 3.4% were of assisted suicide (self-administration) and 0.3% involved a combination of the two: Regional Euthanasia Review Committees, *Annual Report 2018* (April 2019) 11, 13. In Canada, of 5631 cases of medical assistance in dying in 2019, there were 'fewer than 7' reported cases of self-administration. However, it was noted that in some Canadian jurisdictions health institutions and regulatory bodies have 'developed policies that discourage self-administration' because of concerns about the ability of the person to effectively self-administer the medications, and the complications that may arise: Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (2020) 19.

<sup>96</sup> Qld Parliamentary Committee Report No 34 (2020) [9.4], Rec 12.

<sup>97</sup> W&W Model cl 6, 31, 34.

<sup>98</sup> W&W Model, Explanatory Notes 2.

<sup>99</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 45; *Voluntary Assisted Dying Act 2019* (WA) s 58.

<sup>100</sup> Vic Ministerial Advisory Panel Final Report (2017) 137, Rec 34; WA Ministerial Expert Panel Final Report (2019) 78. See also Vic Guidance for Health Practitioners (2019) [5.1], noting that:

6.76 Educational material prepared by the Victorian Government informs the person that they may want to have a health practitioner with them to make sure they are comfortable during the dying process, and explains that they must arrange this with their health practitioner.<sup>101</sup>

6.77 If a health practitioner is present, they can provide the person with treatment to make them comfortable and respond to any unexpected events. The Victorian guidance states that:<sup>102</sup>

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.

6.78 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'.<sup>103</sup>

6.79 If the person becomes unable to self-administer (for example, if they are unable to digest, swallow, or physically take the voluntary assisted dying substance), no one else can help them take the substance.<sup>104</sup>

6.80 In Victoria, if the person deteriorates after a self-administration permit has been approved and becomes physically incapable of self-administration, they must ask the coordinating practitioner to apply for a practitioner administration permit.<sup>105</sup>

6.81 In Western Australia, if the person has made a self-administration decision and becomes unable to self-administer, they may revoke the decision and make a

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Often patients nearing the end of their life are in a health service and the attendance of a health practitioner may be easily arranged. 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.

<sup>101</sup> Department of Health & Human Services (Vic), 'Preparing to take the medications' (August 2019) <<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>>.

<sup>102</sup> Vic Guidance for Health Practitioners (2019) [5.1]. See also [5.2], noting that '[h]ealth practitioners are also under no obligation to attempt life-sustaining measures unless the patient requests this'.

<sup>103</sup> Vic Guidance for Health Practitioners (2019) [5.2].

<sup>104</sup> 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: *Voluntary Assisted Dying Act 2017* (Vic) s 84; *Voluntary Assisted Dying Act 2019* (WA) s 99. A health practitioner can administer the voluntary assisted dying substance only if the requirements under the legislation for practitioner administration have been complied with and they are authorised to do so; that is, if a practitioner permit has been approved (Victoria), or a practitioner administration decision has been made (Western Australia). See further the discussion of the additional approval process in Victoria in Chapter 2 above.

<sup>105</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 53.



practitioner administration decision.<sup>106</sup> It has been noted that the Western Australian approach ‘grants more discretion to the person and their doctor about how voluntary assisted dying is provided’.<sup>107</sup>

6.82 In the first year of operation of voluntary assisted dying in Victoria, the voluntary assisted dying substance was self-administered in 104 cases and practitioner administered in 20 cases.<sup>108</sup>

6.83 Data from overseas jurisdictions show that a number of people choose to have a health practitioner present during self-administration.<sup>109</sup> Data also show that there are some cases where complications arise during self-administration.<sup>110</sup>

6.84 Unlike Victoria and Western Australia, the W&W Model provides that self-administration must always occur under medical supervision; that is, the medical practitioner must be present while the person self-administers the voluntary assisted dying substance.<sup>111</sup>

6.85 The authors of the W&W Model acknowledged that this approach has some disadvantages, including:<sup>112</sup>

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.

<sup>106</sup> *Voluntary Assisted Dying Act 2019* (WA) s 57. The coordinating practitioner or administering practitioner who is informed of the patient’s decision must record the revocation in the person’s medical record and, within two business days after revocation, complete the approved form and give a copy of it to the Board. If the practitioner is not the coordinating practitioner, they must inform the coordinating practitioner of the revocation. In relation to the role of an administering practitioner, see [6.91] ff below.

<sup>107</sup> 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>>.

<sup>108</sup> Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020). It is not known in how many cases of self-administration that a health practitioner was present, or whether any complications or unexpected events arose.

<sup>109</sup> For example, of 188 cases in Oregon in 2019, the prescribing physician was present when the medication was ingested in 36 cases, another provider was present in 25 cases, a volunteer was present in 53 cases, no provider or volunteer was present in 14 cases, and 60 cases were unknown: Oregon Health Authority, *Oregon Death with Dignity Act 2019 Data Summary* (February 2020) 12.

<sup>110</sup> For example, of the 1657 cases of medical assistance in dying in Oregon from 1998 to 2019, it was reported that there were no complications in 707 cases, compared to 30 cases where there was difficulty ingesting or regurgitation, two cases where there were seizures, 15 cases with other complications, and 93 cases that were unknown: *ibid*.

<sup>111</sup> W&W Model cl 6(2), (3), Explanatory Notes 2.

<sup>112</sup> W&W Model, Explanatory Notes 2.

6.86 However, they considered that there may be ways to address some of these concerns,<sup>113</sup> and that the benefits of this approach outweighed its disadvantages. In particular, they considered that requiring medical supervision:<sup>114</sup>

- only disadvantages those who would specifically want to self-administer and do not want medical supervision;<sup>115</sup>
- prioritises and enhances the safety and quality of voluntary assisted dying for the person;<sup>116</sup> and
- 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.<sup>117</sup>

6.87 The Western Australian Ministerial Expert Panel also observed that:<sup>118</sup>

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.

6.88 However, it ultimately concluded that ‘the presence of a health practitioner should be a decision between the practitioner and the person’, noting that some people ‘may wish for complete independence and privacy at this time’.<sup>119</sup>

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113 Ibid 2. For example, it was noted that permitting nurse practitioners to provide voluntary assisted dying has been one response to address access issues in rural and remote areas. See further the discussion of the role of other health practitioners in Chapter 7 below.

114 Ibid 2–3.

115 It was noted that it is likely that many people would choose practitioner administration or to have a practitioner present at the time of self-administration. It was also noted that medical supervision ‘could be done unobtrusively by the medical practitioner so as to respect the person’s wishes about how their death occurs’: *ibid.* See also Onwuteaka-Philipsen, Willmott and White, above n 81, 439, commenting that:

While self-administration promotes autonomy to the extent that patients are completely in control of the timing of their death and do not have to work around the convenience of a medical practitioner, we argue that allowing a choice of method promotes patient autonomy to a greater degree.

116 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’: W&W Model, Explanatory Notes 2, referring to 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 American Medical Association* 79, 86. See also Onwuteaka-Philipsen, Willmott and White, above n 81, 439.

117 It was noted that this would avoid having to replicate the provisions in Victoria and Western Australia that regulate the safe management of the voluntary assisted dying substance in relation to self-administration: W&W Model, Explanatory Notes 3.

118 WA Ministerial Expert Panel Final Report (2019) 78, noting that:

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 is provided and to reduce any perceived risk of assisted dying medications being present in the community (notes omitted).

119 *Ibid.*

6.89 The Panel 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'.<sup>120</sup>

6.90 One member of the Parliamentary Committee noted in a statement of reservation 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]'. That member 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'.<sup>121</sup>

### Requirements for practitioner administration

6.91 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.<sup>122</sup> 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 medical practitioner or suitably qualified nurse practitioner who is eligible for this role.<sup>123</sup>

6.92 If a practitioner administration permit has been approved (Victoria) or a practitioner administration decision has been made (Western Australia), the voluntary assisted dying substance can be prescribed for the person and supplied to the coordinating practitioner or administering practitioner.<sup>124</sup>

6.93 In Victoria, after the practitioner administration permit has been approved, the person may make a request for the coordinating practitioner to administer the

<sup>120</sup> Ibid 77, referring to 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>>; 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, 551; 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>>.

<sup>121</sup> Qld Parliamentary Committee Report No 34 (2020) 202 (Michael Berkman MP) (emphasis in original).

<sup>122</sup> *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.

<sup>123</sup> *Voluntary Assisted Dying Act 2019* (WA) ss 54, 63. The coordinating practitioner can transfer the role of administering the voluntary assisted dying substance to another medical practitioner who is eligible to act as a coordinating practitioner or a nurse practitioner (who has at least two years' experience and meets the approved requirements) and who accepts the transfer of the role: ss 5 (definition of 'administering practitioner'), 63(2).

<sup>124</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 46(a); *Voluntary Assisted Dying Act 2019* (WA) s 59.

substance. The administration request must be made personally and may be made verbally or by other means of communication available to the person.<sup>125</sup>

6.94 In Western Australia, the administering practitioner is authorised to administer the voluntary assisted dying substance if the person has made a practitioner administration decision, and it has not been revoked. The practitioner administration decision must be clear and unambiguous, made by the person to the coordinating practitioner, and recorded in the person's medical record. It may be made verbally or in another way (for example, by gestures).<sup>126</sup>

6.95 The coordinating practitioner (in Victoria) or the administering practitioner (in Western Australia) can administer the voluntary assisted dying substance only if they are satisfied that, at the time of administration, the person has decision-making capacity in relation to voluntary assisted dying, is acting voluntarily and without coercion, and that their request is enduring.<sup>127</sup>

6.96 It is also a requirement that a witness must be present to certify that the person appeared to have decision-making capacity in relation to voluntary assisted dying, is acting voluntarily and without coercion, and that their request is enduring. The witness must also state that the voluntary assisted dying substance was administered.<sup>128</sup>

6.97 The witness must be 18 years or over. They may be a family member, friend or carer of the person. However, the witness must be independent of the coordinating practitioner (Victoria) or the administering practitioner (Western Australia).<sup>129</sup>

6.98 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.<sup>130</sup> In Western Australia, the legislation 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.<sup>131</sup>

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125 *Voluntary Assisted Dying Act 2017* (Vic) ss 46(b), 64(1)–(3).

126 *Voluntary Assisted Dying Act 2019* (WA) ss 56(1)(b), (3)–(5), 59(1), (5).

127 *Voluntary Assisted Dying Act 2017* (Vic) ss 46(c)(i)–(iv), 64(5), 66(1); *Voluntary Assisted Dying Act 2019* (WA) ss 59(5), 61(2). In Victoria, the coordinating practitioner must also be satisfied that the person is physically incapable of self-administering or digesting the voluntary assisted dying substance.

128 *Voluntary Assisted Dying Act 2017* (Vic) ss 46(b)–(c)(v), 64(1)(d), (4), 65; *Voluntary Assisted Dying Act 2019* (WA) ss 59(5), 62(3). In Western Australia, the witness is required to certify that the person's request to access voluntary assisted dying appeared to be 'free, voluntary and enduring'. In Victoria, the legislation provides that a witness must be present both at the time the person makes the request and when the voluntary assisted dying substance is administered. The substance must be administered immediately after the request is made. In Western Australia, the legislation provides that the witness must be present when the practitioner administers the substance.

129 *Voluntary Assisted Dying Act 2017* (Vic) s 65(1); *Voluntary Assisted Dying Act 2019* (WA) s 62(1)–(2).

130 Vic Guidance for Health Practitioners (2019) 61.

131 *Voluntary Assisted Dying Act 2019* (WA) s 62(1)(b), (2).

6.99 The requirement for the witness to be independent is to ensure ‘that the witness to the request for administration and the [coordinating practitioner] do not have a conflict of interest’.<sup>132</sup> It was considered that:<sup>133</sup>

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.

6.100 The W&W Model also provides for a final check at the time of administration that the person’s request is made voluntarily and without coercion and is enduring, and that the person has decision-making capacity in relation to voluntary assisted dying.<sup>134</sup> This occurs when the person makes their final request for access to voluntary assisted dying.<sup>135</sup> That request must be made in the presence of a witness and occur ‘immediately before’ the substance is administered.<sup>136</sup>

### Consultation questions

**Q-29 Should the draft legislation 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)?**

**Q-30 Alternatively to Q-29, should the draft legislation provide (as in Western Australia) that:**

- (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:**

<sup>132</sup> Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 23.

<sup>133</sup> Vic Ministerial Advisory Panel Final Report (2017) 143.

<sup>134</sup> W&W Model cll 30(1)(b)–(d), (5), 33(3), 34. The coordinating practitioner must be satisfied of those matters. They 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 the making of the final request: cl 30 (1)(a), (e).

<sup>135</sup> W&W Model cll 30(1), 34. The final request for access to voluntary assisted dying must be clear and unambiguous and made by the person personally. It may be made verbally or by gestures or other means of communication available to the person. The final request must specify whether the person requests practitioner administration or supervised self-administration: cll 30(2)–(3), 31.

<sup>136</sup> W&W Model cll 30(4), 32, 33(3). The witness must be 18 years or more and must not be employed by or working under the supervision of the coordinating practitioner, or a family member of the coordinating 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.

- (i) the ability of the person to self-administer the substance;
- (ii) the person's concerns about self-administering the substance; or
- (iii) the method for administering the substance that is suitable for the person?

**Q-31 Should the draft legislation provide that the coordinating practitioner or another health practitioner must be present when the person self-administers the voluntary assisted dying substance?**

**Q-32 Should the draft legislation provide that a witness, who is independent of the administering practitioner, must be present when the practitioner administers the voluntary assisted dying substance?**

## COMMUNITY, CULTURAL AND LINGUISTIC CONSIDERATIONS

6.101 The Victorian Ministerial Advisory Panel and the Western Australian Ministerial Expert Panel each emphasised the importance of ensuring voluntary assisted dying is accessible to culturally and linguistically diverse communities, and those with alternative communication or other needs.<sup>137</sup>

6.102 They each noted that information about voluntary assisted dying should be available to people in a manner and language they understand, and that is culturally appropriate.<sup>138</sup> In Victoria, the Statewide Voluntary Assisted Dying Care Navigator Service has been established to provide information and support to the community and health services.<sup>139</sup> The Western Australian Ministerial Expert Panel recommended that a system of care navigators should also be established in Western Australia.<sup>140</sup>

6.103 The legislation in Victoria and Western Australia also supports access to voluntary assisted dying for people who are from culturally and linguistically diverse backgrounds, and people who require alternative means of communication using interpreters.<sup>141</sup>

<sup>137</sup> Vic Ministerial Advisory Panel Final Report (2017) 84, 96–7, Rec 11; WA Ministerial Expert Panel Final Report (2019) 44, 46, 48.

<sup>138</sup> Vic Ministerial Advisory Panel Final Report (2017) 83, 96; WA Ministerial Expert Panel Final Report (2019) Rec 11, recommending that:

The 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.

<sup>139</sup> Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 5.

<sup>140</sup> WA Ministerial Expert Panel Final Report (2019) 48, Rec 12.

<sup>141</sup> Vic Ministerial Advisory Panel Final Report (2017) 84, 96–7, Rec 11; WA Ministerial Expert Panel Final Report (2019) 46, Rec 11, noting that 'the use of qualified interpreters or other communication methods that meet the needs of the person being assessed are essential to achieving equity of access'.

6.104 People from culturally diverse backgrounds may ask for or require an interpreter to be present to interpret discussions about voluntary assisted dying, including to assist the person to make a request for access to voluntary assisted dying, or to assist the person and the medical practitioner during the eligibility assessment. Further, people with disabilities or medical conditions that make communication difficult may be assisted by a qualified speech pathologist.<sup>142</sup>

6.105 If the person making the written declaration is unable to sign the declaration, another person may sign it on their behalf, provided that they do so at the direction, and in the presence of, the person making the declaration.<sup>143</sup> This is to account for individuals who may not be capable of writing, due to physical, linguistic or other barriers.<sup>144</sup>

6.106 If an interpreter is used by the person to make the written declaration, the interpreter must certify that they provided a true and correct translation of any material translated.<sup>145</sup>

6.107 The legislation in Western Australia also provides that, if an interpreter provides assistance throughout the process, for example during an eligibility assessment, this must be recorded, together with the interpreter's name, contact details and accreditation details, and included in the approved forms provided to the Board.<sup>146</sup>

6.108 This is not required by the legislation in Victoria, except in relation to the written declaration and the form appointing the contact person.<sup>147</sup> However, the Victorian guidance for health practitioners states, in relation to eligibility assessments, that '[t]he use (and identity) of an interpreter or other health practitioner such as a speech pathologist should always be documented'.<sup>148</sup>

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142 Vic Guidance for Health Practitioners (2019) 15.

143 The person signing on their behalf must be 18 years or more and must not be a witness to the signing of the declaration. The legislation in Western Australia also expressly provides that the coordinating practitioner or consulting practitioner must not sign the declaration for the person: *Voluntary Assisted Dying Act 2017* (Vic) s 34(2)(b), (3)–(4); *Voluntary Assisted Dying Act 2019* (WA) s 42(3)(b), (4)–(5).

144 Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 15.

145 *Voluntary Assisted Dying Act 2017* (Vic) s 34(5); *Voluntary Assisted Dying Act 2019* (WA) s 42(6).

146 *Voluntary Assisted Dying Act 2019* (WA) ss 29(4)(b)(vi), (j), 40(4)(l), 42(3)(c)(ii), (6), 50(2)(f), 51(3)(e), 57(4)(f), 60(2)(g), 66(1)(f). In relation to the approved forms to be provided to the Board, see [6.46] ff above.

147 *Voluntary Assisted Dying Act 2017* (Vic) ss 34(5), 40(5), sch 1, Forms 3, 4.

148 Vic Guidance for Health Practitioners (2019) 32.

## Requirements for interpreters or speech pathologists to be accredited and impartial

6.109 In Victoria and Western Australia, an interpreter or speech pathologist who assists a person in relation to requesting access to or accessing voluntary assisted dying:<sup>149</sup>

- must be accredited by a prescribed body (Victoria), or by a body approved by the Secretary of the Department of Health (Western Australia);<sup>150</sup> and
- must not:
  - be a family member of the person; or
  - believe or have knowledge 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 day-to-day management and operation of, any health facility at which the person is being treated or resides;<sup>151</sup> or
  - be a person who is directly involved in providing health services or professional care services to the person.

6.110 These 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’.<sup>152</sup>

6.111 However, some concerns have been expressed that the requirement for interpreters to be accredited professionals may be onerous in practice.<sup>153</sup>

<sup>149</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 115; *Voluntary Assisted Dying Act 2019* (WA) s 162(1), (2)(a), (b). In Western Australia, the requirements also apply to an interpreter who is assisting in a proceeding for a review of certain decisions by the State Administrative Tribunal: s 162(1), (2)(c).

<sup>150</sup> The prescribed bodies in Victoria are the National Accreditation Authority for Translators and Interpreters Limited, and Speech Pathology Australia: *Voluntary Assisted Dying Act 2017* (Vic) s 115(a); *Voluntary Assisted Dying Regulations 2018* (Vic) reg 11.

<sup>151</sup> In relation to the meaning of ‘health facility’, see: *Voluntary Assisted Dying Act 2017* (Vic) s 3(1) (definition of ‘health facility’) and *Medical Treatment Planning and Decisions Act 2016* (Vic) s 3(1) (definition of ‘health facility’); *Voluntary Assisted Dying Act 2019* (WA) s 162(1) (definition of ‘health facility’). A health facility may be, for example, a hospital, premises where residential care is provided, or premises, other than a private residence, where personal care or nursing care are provided to a person with a disability.

<sup>152</sup> Explanatory Memorandum, *Voluntary Assisted Dying Bill 2019* (WA) 48. See also Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) 35. See also Vic Ministerial Advisory Panel Final Report (2017) 96, noting that ‘[t]he use of accredited interpreters is an important safeguard in ensuring the interpretation is independent and that the person is acting voluntarily’; 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’.

<sup>153</sup> White et al, above n 81, 442.



6.112 The W&W Model does not contain any provisions in relation to the requirements for interpreters. It notes that the Bill should include 'provisions regulating the use of interpreters'.<sup>154</sup>

### Consultation question

**Q-33 Should the draft legislation provide that an interpreter who assists a person in requesting or accessing voluntary assisted dying must be accredited and impartial, in similar terms to the legislation in Victoria and Western Australia?**

### PROCEDURAL REQUIREMENTS

6.113 The legislation in Victoria and Western Australia contains, respectively, 68 and 102 safeguards.<sup>155</sup> These procedural requirements have been included to protect the vulnerable and ensure that the person's decision for access to voluntary assisted dying is voluntary and enduring, that only people who meet the eligibility criteria are able to access voluntary assisted dying, and that the legislation is complied with.

6.114 However, some commentators have expressed concerns that these procedural requirements, taken as a whole, may be a barrier to accessing voluntary assisted dying.<sup>156</sup>

6.115 Some have noted that a person who is eligible for access to voluntary assisted dying 'may find the process overwhelming and too difficult to navigate', that the stress involved in navigating the process might 'intensify the person's suffering', or that some people 'might die (or lose capacity)' before they can complete the process. It has also been noted that onerous administrative requirements may mean that few medical practitioners will choose to participate in voluntary assisted dying.<sup>157</sup> For these reasons, it has been observed that:<sup>158</sup>

while the policy goals of safeguarding the vulnerable and the community, and respecting all human life are advanced by the rigorous [voluntary assisted dying] process, its many stages and complexity may pose a risk to access and undermine the policy goals of respecting autonomy and alleviating suffering.

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154 W&W Model pt 9.

155 See further Vic Ministerial Advisory Panel Final Report (2017) 181–83, app 3, Section A: Safeguards and jurisdictional comparison; and Western Australia Government, 'Voluntary Assisted Dying Bill 2019 (August): Summary of Safeguards' <<https://www.parliament.wa.gov.au/publications/tables/papers.nsf/displaypaper/4013204c4272e00709c300b0482584820008706e/%24file/tp-3204.pdf>>.

156 White et al, above n 81, 442–3; 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>>.

157 White et al, above n 81, 442–3; McDougall and Pratt, above n 156.

158 White et al, above n 81, 443.

6.116 As noted above, in Victoria the Statewide Voluntary Assisted Dying Care Navigator Service has been established to assist people who need support in obtaining information about or access to voluntary assisted dying, and a similar care navigator service has been recommended in Western Australia.<sup>159</sup>

6.117 The Voluntary Assisted Dying Review Board reported that it received some feedback from medical practitioners that the overall process is ‘complex and time consuming’. However, it observed that voluntary assisted dying ‘is not an emergency procedure’; it is ‘a serious matter’ that ‘takes time and requires thoughtful planning’.<sup>160</sup>

6.118 The Board reported that most applications for access to voluntary assisted dying took a few weeks:<sup>161</sup>

Since June 2019, 25 per cent of applicants have progressed between their first and last request within 11 days and 50 per cent within 19 days.

6.119 It observed that ‘[t]here are occasions when the person applying for voluntary assisted dying dies before the process is complete’, and noted that:<sup>162</sup>

There are several reasons why this might occur. It could be due to delays in finding a medical practitioner to assess the applicant, because it takes time to gather all the necessary evidence, or because the process was started too late in the applicant’s life.

6.120 While the voluntary assisted dying process in Queensland must necessarily incorporate safeguards, the Commission considers that the process should be as simple as possible for those seeking to access voluntary assisted dying. The Commission aims to develop legislation that is compassionate, safe and practical.

### Consultation question

**Q-34 Are there any other issues relating to these or other procedural matters that you wish to comment on?**

<sup>159</sup> See [6.102] above.

<sup>160</sup> Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 2, 8, 10. Further, between 1 January and 30 June 2020, 68% of permits were issued within two business days of submission of the required forms and evidence and, in 42% of cases, the voluntary assisted dying substance was dispensed within two business days of a request by the applicant: 12.

<sup>161</sup> Ibid 4, 10.

<sup>162</sup> Ibid 10.

# Chapter 7

## Qualifications and training of health practitioners

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### INTRODUCTION

7.1 There are two key roles for medical practitioners under voluntary assisted dying legislation in Victoria and Western Australia; namely, the coordinating practitioner and the consulting practitioner.

7.2 The coordinating practitioner is responsible for conducting the first eligibility assessment (the coordinating assessment), and the consulting practitioner is responsible for conducting the second eligibility assessment (the consulting assessment). The coordinating practitioner is also responsible for coordinating the request and assessment process and prescribing the voluntary assisted dying substance.<sup>1</sup>

7.3 If practitioner administration is permitted, the coordinating practitioner has the role of administering the voluntary assisted dying substance. In Western Australia, this role can be carried out by a coordinating practitioner or another suitably qualified medical practitioner or nurse practitioner (in the capacity of an 'administering practitioner').<sup>2</sup>

7.4 Only health practitioners who meet the minimum qualification and training requirements set out in the legislation can be a coordinating practitioner or a consulting practitioner, or an administering practitioner. They are also required to complete the training approved under the legislation.

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<sup>1</sup> See generally Chapter 2 above.

<sup>2</sup> *Voluntary Assisted Dying Act 2019* (WA) ss 54, 63. See further the discussion of practitioner administration in Chapter 6 above.

## REGULATION OF HEALTH PRACTITIONERS

7.5 The Health Practitioner Regulation National Law establishes a national registration and accreditation scheme for the regulation of health practitioners, which includes medical practitioners and nurses.<sup>3</sup> There are different types of registration to reflect different levels of training and expertise and to recognise specialists.<sup>4</sup>

7.6 Registered health practitioners must comply with relevant registration and accreditation standards, professional standards (including codes of ethics, codes of conduct and competency standards), policies and guidelines.<sup>5</sup>

7.7 Health practitioners are also required to undergo a process of 'credentialing', and the definition of their scope of clinical practice, as part of a wider organisational quality and risk management system.<sup>6</sup>

## MINIMUM QUALIFICATION AND EXPERIENCE REQUIREMENTS OF COORDINATING PRACTITIONERS AND CONSULTING PRACTITIONERS

7.8 In Victoria and Western Australia, a medical practitioner must not accept a request or referral to be a coordinating practitioner or consulting practitioner unless they meet the minimum qualification and experience requirements set out in the voluntary assisted dying legislation.<sup>7</sup> This is to ensure that 'only registered medical

<sup>3</sup> Health Practitioner Regulation National Law (Queensland) ss 3, 5 (definitions of 'health practitioner', 'health profession' and 'registered health practitioner'), pts 4–7. In Queensland, the National Law is implemented under the Health Practitioner Regulation National Law (Queensland): *Health Practitioner Regulation National Law Act 2009* (Qld) s 4. 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. The National Law also establishes AHPRA, which is required to work with National Boards to establish and manage the registration and accreditation scheme.

<sup>4</sup> See, eg, AHPRA Medical Board, 'Registration' (30 October 2019) <<https://www.medicalboard.gov.au/Registration.aspx>>.

<sup>5</sup> 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.

<sup>6</sup> 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. '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'. 'Scope of clinical practice' means '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': 70 (definition of 'credentialing'), 75 (definition of 'scope of clinical practice'). See also, 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) 53 (definition of 'credentialing'), 55 (definition of 'scope of clinical practice').

<sup>7</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 13(2), 23(2)–(6); *Voluntary Assisted Dying Act 2019* (WA) ss 17, 20(3), 31(3).

practitioners with considerable experience and relevant expertise may undertake assessments against the eligibility criteria for access to voluntary assisted dying'.<sup>8</sup>

7.9 The minimum qualification and experience requirements vary between the jurisdictions.

## Victoria

7.10 In Victoria, the legislation requires that each coordinating practitioner and consulting practitioner must:<sup>9</sup>

- hold a fellowship with a specialist medical college;<sup>10</sup> or
- be a vocationally registered general practitioner.<sup>11</sup>

7.11 Additionally, the legislation requires that either the coordinating practitioner or the consulting practitioner must:<sup>12</sup>

- have a minimum of five years of post-fellowship or post-vocational registration practise experience; and
- have relevant expertise and experience in the disease, illness or medical condition expected to cause the person's death.

7.12 Those provisions implement the recommendations of the Victorian Ministerial Advisory Panel, which considered that:<sup>13</sup>

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.

<sup>8</sup> Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 9. See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 7, making a similar statement.

<sup>9</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 10(1).

<sup>10</sup> 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.

<sup>11</sup> '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) s 3F. The *Health Insurance Act 1973* (Cth) establishes Medicare. 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' (1 October 2019) <<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](https://files.gpa.net.au/resources/QPA_Vocationally_registered_GPs.pdf)>.

<sup>12</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 10(2)–(3).

<sup>13</sup> Vic Ministerial Advisory Panel Final Report (2017) 103, Rec 14. The Panel also noted 'the importance of ensuring that only appropriately qualified medical practitioners are involved' in voluntary assisted dying, given that it will be a new practice.

7.13 However, some concern has been expressed that these requirements—in particular, the requirements mentioned at [7.11] above—may have an impact on accessibility to voluntary assisted dying, especially in rural, regional and remote areas.<sup>14</sup> 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’.<sup>15</sup>

7.14 The Victorian guidance for health practitioners explains, in relation to the requirements mentioned at [7.11] above, that ‘one of the medical practitioners may fulfil both these requirements, or they may each fulfil one’. It also explains that in order 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’.<sup>16</sup> It has been noted that this may be interpreted to mean that ‘[p]alliative care specialists and geriatricians are not categorised as specialists in patients with cancer’.<sup>17</sup>

7.15 The Voluntary Assisted Dying Review Board reported that, in the first six months of operation, 134 medical practitioners had registered in the Voluntary Assisted Dying Portal and 33 per cent of trained practitioners were located outside of metro Melbourne.<sup>18</sup> 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 scheme. It also noted that the Statewide Voluntary Assisted Dying Care Navigator Service, which provides assistance in connecting people who wish to access voluntary assisted dying with participating medical practitioners, ‘is expanding with a focus on developing regional networks’.<sup>19</sup>

<sup>14</sup> 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://bmcmethics.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.

<sup>15</sup> 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>>.

<sup>16</sup> Vic Guidance for Health Practitioners (2019) 5.

<sup>17</sup> Platt, above n 14, 537 (note omitted). Cf Vic Ministerial Advisory Panel Final Report (2017) 103.

<sup>18</sup> 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.

<sup>19</sup> 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>>.

7.16 In its most recent report covering the period from January to June 2020, the Board reported that the number of medical practitioners trained and registered in the portal had increased to 175 (a 30 per cent increase from the first six months), and that 37 per cent were now located in regional and rural Victoria.<sup>20</sup>

7.17 It also reported that, of the medical practitioners who have completed the training and are registered in the portal:<sup>21</sup>

- 50 per cent are general practitioners;
- 16 per cent specialise in oncology;
- 5 per cent specialise in neurology; and
- 3 per cent specialise in palliative medicine.

7.18 The W&W Model includes minimum qualification requirements in substantially the same terms as the Victorian legislation, except for the requirement that one of the medical practitioners must have relevant expertise in the person's disease, illness or medical condition.<sup>22</sup>

## Western Australia

7.19 The legislation in Western Australia provides that a medical practitioner is eligible to act as a coordinating practitioner or a consulting practitioner for a person if they:<sup>23</sup>

- hold specialist registration and have practised as a registered specialist for at least one year;<sup>24</sup>

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<sup>20</sup> Voluntary Assisted Dying Review Board Report of Operations January–June 2020 (2020) 7.

<sup>21</sup> Ibid.

<sup>22</sup> W&W Model cl 13. The authors of this model have suggested amending the wording to provide that either the coordinating practitioner or each consulting practitioner 'must have relevant experience *in treating or managing* the medical condition expected to cause the death of the person being assessed'. They considered that this retains the 'policy goal that at least one of the registered medical practitioners has particular experience with the person's medical condition', but 'is intended to reflect that general practitioners and palliative care physicians may have such experience': W&W Model, Explanatory Notes 6.

<sup>23</sup> *Voluntary Assisted Dying Act 2019* (WA) s 17.

<sup>24</sup> General registration may be granted to Australian and New Zealand medical graduates, medical practitioners who have previously held general registration in Australia, international medical graduates in the competent authority pathway, or international medical graduates with the Australian Medical Council certificate: see AHPRA Medical Board, 'General Registration' (27 August 2018) <<https://www.medicalboard.gov.au/Registration/Types/General-Registration.aspx>>.

- hold general registration and have practised as a generally registered medical practitioner for ten or more years;<sup>25</sup> or
- are an overseas-trained specialist who holds limited or provisional registration.<sup>26</sup>

7.20 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, it is not known whether any additional requirements will be approved.<sup>27</sup>

7.21 Unlike Victoria, the legislation in Western Australia 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'. Either the coordinating practitioner or the consulting practitioner, or both, can be a general practitioner (although they must have practised as a generally registered medical practitioner for ten or more years).

7.22 Those legislative requirements generally reflect the recommendations of the Western Australian Ministerial Expert Panel.<sup>28</sup> The Panel considered adopting the Victorian minimum qualification 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'.<sup>29</sup> At the same time,

<sup>25</sup> Specialist registration is available to medical practitioners who have been assessed by an Australian Medical Council accredited specialist college as being eligible for fellowship. Fellowship is not a pre-requisite for specialist registration. The Ministerial Council has approved a list of specialties, fields of specialty practice and specialist titles: AHPRA Medical Board, 'Specialist Registration' (26 February 2018) <<https://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>>. Relevantly for voluntary assisted dying this includes specialist palliative medicine physicians, specialist geriatricians, specialist medical oncologists, specialist neurologists and specialist general practitioners: MBA, *List of specialties, fields of specialty practice and related specialist titles* (1 June 2018). 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)*.

<sup>26</sup> Limited registration is available to medical practitioners whose medical qualifications are from a medical school outside of Australia or New Zealand: AHPRA Medical Board, 'Limited registration' (31 January 2018) <<https://www.medicalboard.gov.au/Registration/Types/Limited-Registration.aspx>>. Provisional registration applies to people who are qualified for general registration and who are also required to complete a period of approved supervised practice in Australia before becoming eligible for general registration: AHPRA Medical Board, 'Provisional registration' (27 August 2018) <<https://www.medicalboard.gov.au/Registration/Types/Provisional-Registration.aspx>>.

<sup>27</sup> 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>>.

<sup>28</sup> WA Ministerial Expert Panel Final Report (2019) Rec 15. However, in relation to overseas-trained medical specialists on a limited or provisional registration, the Panel recommended that they should be able to be a coordinating practitioner or a consulting practitioner only if there is no local provider who meets the other requirements and if: (a) they work in a gazetted Area of Need or as a sponsored provider within a health service in Western Australia; (b) they have undergone a formal assessment by the relevant Australian College; (c) the relevant College has approved their specialist pathway and supervision program; (d) they have five years' experience as a specialist consultant; and (e) they have completed 12 months working in a supervised position within Western Australia.

<sup>29</sup> WA Ministerial Expert Panel Final Report (2019) 58.



it considered the need to 'ensure that there is appropriate access to voluntary assisted dying across the geographically diverse state of Western Australia'.<sup>30</sup> It concluded that:<sup>31</sup>

a requirement 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.

7.23 The Panel also noted that:<sup>32</sup>

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.

## Overseas jurisdictions

7.24 The legislation in 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 practise medicine in their jurisdiction. However, in some jurisdictions, the legislation variously provides that the consulting practitioner who makes the second assessment must:<sup>33</sup>

- be competent in, or as to, the pathology concerned (Belgium and Luxembourg);<sup>34</sup> or

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30 Ibid 60.

31 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).

32 WA Ministerial Expert Panel Final Report (2019) 58.

33 Legislation in New Zealand requires the consulting practitioner to have held a practising certificate for at least the previous five years, or the equivalent 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 (as enacted, not commenced).

34 *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.

- be ‘qualified by specialty or experience’ to make a professional diagnosis and prognosis’ regarding an individual’s disease (state legislation in the United States of America).<sup>35</sup>

7.25 The federal legislation in Canada provides that medical assistance in dying ‘must be provided with reasonable knowledge, care and skill’.<sup>36</sup>

### Consultation questions

**Q-35** Should the draft legislation provide that only a medical practitioner can act as a coordinating practitioner or a consulting practitioner and assess the person’s eligibility for access to voluntary assisted dying?

**Q-36** Should the draft legislation 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?

**Q-37** If yes to Q-36, what should the minimum qualification and experience requirements be? For example, should it be a requirement that either the coordinating practitioner or the consulting practitioner must:

- (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 cause the death of the person being assessed (as in Victoria)?

### ROLE OF OTHER HEALTH PRACTITIONERS

7.26 The Parliamentary Committee considered that two (medical) practitioners should assess a person’s eligibility for voluntary assisted dying. It considered that ‘it is appropriate and prudent to require two practitioners to determine a patient’s eligibility for voluntary assisted dying’. However, it was also mindful that this requirement may create difficulties ‘in rural and remote areas where face-to-face

<sup>35</sup> 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 §§ 25-48-102(2), (3), (9), (11), 107; *District of Columbia Death with Dignity Act 2016*, DC Code §§ 7-661.2(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 §§ 26:16-3, 26:16-7; *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 practise in the State. Cf *Vermont Patient Choice at End of Life Act 2013*, 18 VT Stat Ann §§ 5281, 5283.

<sup>36</sup> *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(7).

access to two independent doctors, or even one medical doctor, may be problematic'. It therefore recommended that consideration should be given to:<sup>37</sup>

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.

7.27 The Western Australian Ministerial Expert Panel concluded 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'.<sup>38</sup> It considered that this will 'ensure that there is appropriate access to voluntary assisted dying across the geographically diverse state of Western Australia'.<sup>39</sup>

7.28 That approach was not implemented.<sup>40</sup> However, the legislation in Western Australia does permit suitably qualified nurse practitioners to administer the voluntary assisted dying substance.<sup>41</sup> It also permits another suitably qualified medical practitioner to administer the substance.<sup>42</sup>

7.29 The coordinating practitioner may transfer the role of administering practitioner to another medical practitioner or a nurse practitioner. The medical practitioner must be eligible to act as a coordinating practitioner for the person. The nurse practitioner must have practised as a nurse practitioner for at least two years and completed the training approved for these purposes. The nurse practitioner must

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37 Qld Parliamentary Committee Report No 34 (2020) 140, Rec 15.

38 A nurse practitioner is a registered nurse who has completed advanced nursing education and training and is endorsed by the Nursing and Midwifery Board of Australia: *Health Practitioner Regulation National Law Act 2009* (Qld) s 95; Australian Nursing & Midwifery Accreditation Council, *Nurse Practitioner: Accreditation Standards 2015* (July 2015). Nurse practitioners work independently and collaboratively to assess and manage patients. Their role includes the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations: see further Department of Health (WA), 'Become a nurse practitioner' (13 February 2020) <<https://ww2.health.wa.gov.au/Careers/Occupations/Nursing-and-midwifery/Become-a-nurse-or-midwife/Become-a-nurse-practitioner>>; Queensland Health, 'Nurse Practitioner' (3 July 2020) <<https://clinicalexcellence.qld.gov.au/resources/service-delivery-models/nurse-practitioner>>.

39 WA Ministerial Expert Panel Final Report (2019) 59–60, Rec 16.

40 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.

41 Legislation in New Zealand is similar to Western Australia. It requires two medical practitioners to assess a person's eligibility for access to voluntary assisted dying, but permits attending nurse practitioners to administer the voluntary assisted dying substance: *End of Life Choice Act 2019* (NZ) ss 4 (definitions of 'attending medical practitioner', 'attending nurse practitioner', 'independent medical practitioner', 'medical practitioner' and 'nurse practitioner'), 13–14, 19(3), 20 (as enacted, not commenced).

42 *Voluntary Assisted Dying Act 2019* (WA) s 54(1)(a).

also meet any requirements approved by the CEO of the Department of Health, which must be published on the Department's website.<sup>43</sup>

7.30 Most overseas jurisdictions require two medical practitioners to be involved in assessing a person's eligibility for voluntary assisted dying.<sup>44</sup> The exception is the federal legislation in Canada, which provides that a medical practitioner or a nurse practitioner can provide medical assistance in dying.<sup>45</sup> Nurse practitioners can assess whether the person meets all of the eligibility criteria.<sup>46</sup> They can also administer the voluntary assisted dying substance to the person.<sup>47</sup> In 2019, medical assistance in dying 'was provided primarily by physicians (94.1 %), while 5.9 % of medically assisted deaths were provided by nurse practitioners'.<sup>48</sup>

### Consultation question

**Q-38 Should the draft legislation provide that the voluntary assisted dying substance can be administered by:**

- (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)?**

<sup>43</sup> *Voluntary Assisted Dying Act 2019* (WA) ss 54(1)(a)(ii), (b), (2), 63, 160. As voluntary assisted dying is not yet implemented in Western Australia, it is not yet known what, if any, additional requirements may be approved in relation to nurse practitioners. However, it was noted during the parliamentary debates that the nurse practitioner would need to have 'the necessary clinical experience to fulfil the role of administering practitioner': Western Australia, *Parliamentary Debates*, Legislative Assembly, 17 September 2019, 6791 (RH Cook, Minister for Health).

<sup>44</sup> See [6.23] above.

<sup>45</sup> *Canada Criminal Code*, RSC 1985, c C-46, ss 241.2(1)–(2), 241.2(3)(a). 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.

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* (July 2020) [5.3] (note omitted).

<sup>46</sup> *Canada Criminal Code*, RSC 1985, c C-46, s 241.2(3)(a). This 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).

<sup>47</sup> *Canada Criminal Code*, RSC 1985, c C-46, s 241.1 (definition of 'medical assistance in dying').

<sup>48</sup> Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (July 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].

## MANDATORY ASSESSMENT TRAINING

7.31 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.<sup>49</sup>

7.32 In Victoria the training can be undertaken online and is reported to take an average of four hours to complete.<sup>50</sup>

7.33 The Department of Health is currently working on the implementation of voluntary assisted dying in Western Australia.<sup>51</sup> The government has indicated that the approved training will be available online and will take around six to eight hours to complete.<sup>52</sup>

7.34 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 Ministerial Advisory Panel and Western Australian Ministerial Expert Panel.<sup>53</sup>

7.35 The Victorian Ministerial Advisory 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.<sup>54</sup>

7.36 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 therapeutic relationship between the medical practitioner and patient to be

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<sup>49</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 17, 26, 114; *Voluntary Assisted Dying Act 2019* (WA) ss 25, 36, 160.

<sup>50</sup> 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>>.

<sup>51</sup> Department of Health (WA), 'Voluntary assisted dying' (3 April 2020) <<https://www2.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).

<sup>52</sup> Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6645–46 (JR Quigley, Attorney-General). The training will include information about the voluntary assisted dying legislative framework, the roles and responsibilities of coordinating practitioners, consulting practitioners and administering practitioners, the procedural requirements and safeguards, guidance about the eligibility assessments and each of the eligibility criteria, cultural competency training, training about how to have difficult conversations about end of life and choices at end of life, and medication management.

<sup>53</sup> 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.

<sup>54</sup> Vic Ministerial Advisory Panel Final Report (2017) 104–6.

maintained. For this reason, it also noted that the training should be readily accessible.<sup>55</sup>

7.37 The Western Australian Ministerial Expert Panel considered that the approved training should include more than information about the voluntary assisted dying legislative framework, the roles and responsibilities of coordinating practitioners and consulting practitioners, and each of the assessment criteria in relation to eligibility for access to voluntary assisted dying.<sup>56</sup> The matters raised in its consultation included that:<sup>57</sup>

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. ... [S]upport for the integration of competencies relating to working with people from culturally and linguistically diverse communities with the requisite clinical and procedural education was [also] raised.

7.38 The Parliamentary Committee recommended that any voluntary assisted dying scheme in Queensland should require that:<sup>58</sup>

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.

7.39 The W&W Model provides that the coordinating practitioner and the consulting practitioner must not commence their assessment for eligibility for access to voluntary assisted dying unless that practitioner has completed approved assessment training.<sup>59</sup>

7.40 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.<sup>60</sup>

### Consultation question

**Q-39 Should the draft legislation require health practitioners to complete approved training before they can assess a person's eligibility for access to voluntary assisted dying?**

<sup>55</sup> Ibid 105.

<sup>56</sup> WA Ministerial Expert Panel Final Report (2019) 63.

<sup>57</sup> Ibid 96.

<sup>58</sup> Qld Parliamentary Committee Report No 34 (2020) Rec 20.

<sup>59</sup> W&W Model cl 14.

<sup>60</sup> However, see, for example, n 34 above as to training of consulting practitioners in the Netherlands.

# Chapter 8

## Conscientious objection

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### INTRODUCTION

8.1 The terms of reference require the Commission to have regard to a number of specific matters, including ‘the legal and ethical obligations of treating health practitioners’ and ‘appropriate safeguards and protections, including for treating health practitioners’.<sup>1</sup>

8.2 This chapter considers a health practitioner’s conscientious objection to participating in voluntary assisted dying.

### CONSCIENTIOUS OBJECTION

8.3 Generally, a conscientious objection is constituted by a refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner’s personal beliefs, values or moral concerns.<sup>2</sup>

8.4 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’.<sup>3</sup> 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’.<sup>4</sup>

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1 Terms of reference paras 4, 5.

2 See, eg, AMA, *Position Statement: Conscientious Objection* (2019) [1.2]–[1.3].

3 *Human Rights Act 2019* (Qld) s 20(1)(b). See also, in relation to international human rights law, *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 18; *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 18. See also [3.4] and [3.37]–[3.40] above.

4 *Human Rights Act 2019* (Qld) s 13(1). See also s 13(2), in relation to factors that are relevant to deciding whether a limit on a human right is reasonable and justifiable. Similarly, the *International Covenant on Civil and Political Rights* provides that the freedom to manifest a religion or belief may be restricted only by limitations prescribed by law that are ‘necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others’: *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 18 (3). See also [3.8] above.

## Voluntary assisted dying and conscientious objection

8.5 In Victoria and Western Australia, a registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to:<sup>5</sup>

- 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 a voluntary assisted dying substance (Victoria, Western Australia);
- be present at the time of the administration of a voluntary assisted dying substance (Victoria, Western Australia);
- dispense a prescription for a voluntary assisted dying substance (Victoria).

8.6 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.<sup>6</sup> 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 because they have a conscientious objection to voluntary assisted dying. 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.<sup>7</sup>

<sup>5</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 7; *Voluntary Assisted Dying Act 2019* (WA) s 9(1). In Western Australia, the legislation provides that the list of circumstances in s 9(1) '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).

Generally, it has been explained that 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 or, for example, because they do not have the necessary skills or qualifications, are unavailable, or are 'unable or unwilling to perform the training and duties required'. A health practitioner can also make decisions about their level of involvement, for example, by choosing to only provide patients with general information about voluntary assisted dying. See, eg, 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' (3 April 2020) <<https://ww2.health.wa.gov.au/voluntaryassisteddying>>; 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>>; Vic Guidance for Health Practitioners (2019) 8.

<sup>6</sup> See further the discussion of the coordinating practitioner and consulting practitioner in Chapter 2 above.

<sup>7</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 13(1)(b)(i); *Voluntary Assisted Dying Act 2019* (WA) s 20(1), (2)(a), (4)–(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) regarding the acceptance or refusal of a referral for a consulting assessment. In Western Australia, the reasons for which a request can be refused include that the practitioner has a conscientious objection 'or is otherwise unwilling to perform the duties' of a coordinating practitioner or consulting practitioner: ss 20(2)(a), 31(2)(a).



8.7 In Queensland, the Parliamentary Committee recommended that health practitioners with a conscientious objection be able to choose not to participate in voluntary assisted dying.<sup>8</sup> The W&W Model includes a provision for conscientious objection in similar terms to Victoria and Western Australia, providing that a registered health practitioner who has a conscientious objection to voluntary assisted dying may refuse to do any of the matters listed in the provision. The practitioner must also disclose their objection to the person seeking access to voluntary assisted dying.<sup>9</sup>

### Referral or transfer of care

8.8 In Victoria, a medical practitioner who has a conscientious objection to voluntary assisted dying is not required to refer a person elsewhere or to transfer their care. The Victorian Ministerial Advisory Panel observed that termination of pregnancy legislation in that jurisdiction includes an obligation to refer a person to another health practitioner, but concluded that there are ‘key differences’ between termination of pregnancy and voluntary assisted dying which ‘make an obligation to refer unnecessary’ in the latter case.<sup>10</sup>

First, those who will be eligible for voluntary assisted dying under the proposed framework will already be engaged with a range of medical practitioners on a regular basis, whereas women seeking abortions may often have only a general practitioner who they see regularly. Second, although both the need for abortion and voluntary assisted dying are time sensitive, a matter of days may make a significant difference to the type and significance of the procedure required to perform an abortion. Conversely, while voluntary assisted dying should not be unduly delayed, the recommended process recognises there is not the same level of urgency.

8.9 Although there is no legislative obligation to refer, it has been explained that it is important that a health practitioner’s conscientious objection does not impede a person’s access to voluntary assisted dying.<sup>11</sup> The Victorian guidance for health practitioners explains that an objecting medical practitioner should (among other things) 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

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This clause reflects the position that a medical practitioner is professionally obligated not to unduly delay a patient’s access to voluntary assisted dying; they should make a decision and inform the patient as quickly as possible. It was considered 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 to the person, as they will refuse as a matter of course. However, other medical practitioners may require time to consider whether they are available to provide the service or, if they have not completed the required training, whether they wish to undergo such training, before giving their decision to the person: Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 8, 11.

<sup>8</sup> Qld Parliamentary Committee Report No 34 (2020) 144, Rec 17.

<sup>9</sup> W&W 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.

<sup>10</sup> Vic Ministerial Advisory Panel Final Report (2017) 110. See also Victoria, *Parliamentary Debates*, Legislative Council, 16 November 2017, 6082 (J Pulford, Minister for Agriculture and Minister for Regional Development).

<sup>11</sup> Vic Ministerial Advisory Panel Final Report (2017) 110; Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2947 (J Hennessey, Minister for Health). It was observed that there may be barriers to access in rural communities.

organisation's 'voluntary assisted dying contact' so that they can assist the person. Further, a medical practitioner may choose to refer a person to another medical practitioner or tell the person where they can get further information, such as a government website or a voluntary assisted dying care navigator.<sup>12</sup>

8.10 In Western Australia, a medical practitioner who refuses a request because of a conscientious objection is not required to refer the person elsewhere, but must give the person particular information.<sup>13</sup> It was explained that participation in the process by health practitioners is 'completely voluntary', but also that:<sup>14</sup>

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.

8.11 This requirement was recommended by the Western Australian Ministerial Expert Panel as an appropriate 'middle ground'. The Panel expressed concern about including a requirement to refer because of 'deeply held objections' by parts of the community and some health practitioners, but stated that 'it is not sufficient to simply not impede access' and that 'people should be provided with effective access to information'. It was explained that government involvement would be required to effectively implement this approach, for example by appointing 'navigators' and developing a 'central information hub'.<sup>15</sup>

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<sup>12</sup> Vic Guidance for Health Practitioners (2019) 8, 21. Health practitioners are also encouraged to inform their employer, so that health services 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'. See also Department of Health & Human Services (Vic), 'Health practitioner information' <<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* (2019) 2.

<sup>13</sup> *Voluntary Assisted Dying Act 2019* (WA) s 20(1)–(2)(a), (4)–(5). Specifically, this is described as 'the information approved by the CEO for the purposes of this section': s 20(4)(b). Because the legislation is not yet operational, the content of this information is currently unknown.

Similarly, legislation in New Zealand provides that, where a medical practitioner holds a conscientious objection, they must inform a person of their objection and of their right to request that the Support and Consultation for End of Life in New Zealand Group provide them with the name and contact details of a replacement medical practitioner: *End of Life Choice Act 2019* (NZ) ss 8(1)–(2), 9 (as enacted, not commenced).

<sup>14</sup> Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5137 (RH Cook, Minister for Health). It was further stated that 'standardised information' will be developed and available to all health practitioners, to provide to patients who require information or make a request about voluntary assisted dying. See also n 5, above.

<sup>15</sup> 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 require additional help to access and understand information in a way that enables them to make informed choices.

The Western Australian Joint Select Committee on End of Life Choices stated that a medical practitioner who has a conscientious objection should be required to offer to refer a person to another practitioner: WA Joint Select Committee on End of Life Choices Report (2018) [7.66] ff, [7.89], Rec 20. 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].

8.12 In Queensland, 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.<sup>16</sup> The W&W Model provides that a registered medical practitioner must disclose their objection and ‘offer’ to refer the person to ‘another practitioner or entity’. If requested, the practitioner must refer the person, or transfer their care, to:<sup>17</sup>

- (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 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.

8.13 It is explained that this approach ‘reflect[s] 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’. Additionally, the option of referral to an entity is intentionally broad, so that it could be satisfied by providing contact details of an entity that can give information to facilitate access to voluntary assisted dying, which some practitioners might consider ‘morally preferable’.<sup>18</sup>

8.14 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’.<sup>19</sup>

<sup>16</sup> Qld Parliamentary Committee Report No 34 (2020) 144, Rec 18.

<sup>17</sup> W&W Model cl 38(2)–(3).

In evidence given to the Parliamentary Committee, Professor Ben White, a co-author of the W&W Model, explained that the intention of this provision is that a registered medical practitioner is required to offer to refer the person elsewhere. Professor White 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 was considered that ‘it would be sufficient to provide information to enable someone to have access to that service’: Evidence to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, Brisbane, 5 July 2019, 12–13 (B White).

<sup>18</sup> W&W Model, Explanatory Notes 4. See also Evidence to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, Brisbane, 5 July 2019, 12–13 (B White). See also, as to the term ‘refer’ in the context of conscientious objection, n 21 below.

<sup>19</sup> 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, 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://bmcomedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5>>.

8.15 This approach is generally consistent with Queensland legislation relating to conscientious objection to termination of pregnancy.<sup>20</sup> In that context, it was considered that the requirement to refer a woman elsewhere or transfer her care would assist in facilitating access to services, including by reducing potential barriers for people living in rural, regional or remote areas or from a culturally or linguistically diverse background. Further, the requirement was consistent with relevant codes of conduct and guidelines applying to registered health practitioners.<sup>21</sup>

8.16 Codes of conduct and standards applying to registered health practitioners may also provide for referral or transfer of care. For example, the AMA explains that a medical practitioner who has a conscientious objection to a medical treatment or procedure should not impede a person's access to care, including by providing a patient with enough information that they can exercise their right to see an alternative practitioner.<sup>22</sup>

### Provisions applying to other entities

8.17 The W&W 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 to voluntary assisted dying and is residing or being cared for in a facility of an entity that refuses access, the entity must:<sup>23</sup>

- (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.

<sup>20</sup> *Termination of Pregnancy Act 2018* (Qld) s 8.

<sup>21</sup> Explanatory Memorandum, *Termination of Pregnancy Bill 2018* (2018) 10; QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) [4.140]–[4.142], [4.150] ff. The terms 'refer' and 'transfer of care' are not defined in the *Termination of Pregnancy Act 2018* (Qld). In developing draft legislation to implement its recommendations, 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].

<sup>22</sup> AMA, *Position Statement: Conscientious Objection* (2019) [1.4]–[1.5], [2.1]–[2.4].

<sup>23</sup> W&W Model cl 39.

In the United States of America, state 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 § 327L–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.

8.18 This clause is intended to apply broadly to ‘health service providers’ as well as 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 to voluntary assisted dying, with the aim of balancing the ‘significant potential implications’ for access to voluntary assisted dying with respect for institutional positions. It is suggested that ‘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’.<sup>24</sup>

8.19 In Queensland, the *Termination of Pregnancy Act 2018* does not include an equivalent provision. It was explained that the right to freedom of thought, conscience and religion ‘is a personal and individual right’ and does not apply to hospitals, institutions or services.<sup>25</sup>

8.20 In Victoria and Western Australia, legislation about voluntary assisted dying also does not include an equivalent provision. In Victoria, the Parliamentary Committee recognised the right of health services to conscientiously object,<sup>26</sup> but the Victorian Ministerial Advisory Panel recommended that this be limited to health practitioners:<sup>27</sup>

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.

8.21 Information about the Victorian legislation 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 in voluntary assisted dying is not obliged to refer a person elsewhere. However, the service should not inhibit a person’s access to treatment. It should

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24 Correspondence from Professors Ben White and Lindy Willmott, 31 August 2020.

25 Explanatory Memorandum, *Termination of Pregnancy Bill 2018 (Qld) 9, 20*; QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) [4.149]. The provision does apply to registered health practitioners who are employed in those settings.

To minimise barriers to access, the conscientious objection provision also does not apply to administrative, managerial or other tasks that are ancillary to the provision of termination of pregnancy services, or to administrative or managerial staff or others engaged in those ancillary tasks: Explanatory Memorandum, *Termination of Pregnancy Bill 2018 (Qld) 9, 20*; QLRC, *Review of termination of pregnancy laws*, Report No 76 (2018) [4.147].

26 Vic Parliamentary Committee Final Report (2016) [8.4.2].

27 Vic Ministerial Advisory Panel Final Report (2017) 110–11.

provide people who are seeking information about, or access to, voluntary assisted dying with information and support.<sup>28</sup>

8.22 In Western Australia, the Joint Select Committee on End of Life Choices stated that when a person is an inpatient at a health service that is unwilling to provide for voluntary assisted dying, the health service must facilitate the patient's transfer to a different service in a timely manner.<sup>29</sup> The Western Australian Ministerial Expert Panel recommended that a practitioner or service that has a conscientious objection to voluntary assisted dying should be required to provide information, but not to make a referral.<sup>30</sup>

8.23 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 conscientious objection, 'doctors should be allowed to refer patients seeking such a service to another doctor outside the facility'.<sup>31</sup>

## Consultation questions

**Q-40 Should the draft legislation 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:**

<sup>28</sup> 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>>; Victorian Government, *Health service participation in voluntary assisted dying* (2018) 1; Victorian Government, *Voluntary assisted dying model of care pathways for health services* (2019) 9, 13; Victorian Government, *Health service policy guidance for voluntary assisted dying* (2019). See also Victoria, *Parliamentary Debates*, Legislative Assembly, 19 October 2017, 3347, 3431 (J Hennessey, Minister for Health).

More specifically a health service that does not provide voluntary assisted dying should provide a person who requests information about, or access to, voluntary assisted dying with information, and support a person to seek further information or access to voluntary assisted dying. A medical practitioner at the service may refer a person to another practitioner or service that can provide assistance.

See generally McDougall and Pratt, above n 19.

<sup>29</sup> 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]. See further [8.11] and n 15 above.

<sup>30</sup> WA Ministerial Expert Panel Final Report (2019) 53. See further [8.11] and n 15 above. See generally, Western Australia, *Parliamentary Debates*, Legislative Council, 23 October 2019, 8165, 8178 (S Dawson, Minister for Environment).

<sup>31</sup> AMA, *Position Statement: Conscientious Objection* (2019) [3.1]–[3.2].

- (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)?**

**Q-41 Should a registered medical practitioner who has a conscientious objection to voluntary assisted dying be required to refer a person elsewhere or to transfer their care?**

**Q-42 Should the draft legislation make provision for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility? If so, should the entity be required to:**

- (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?**





# Chapter 9

## Oversight, reporting and compliance

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### INTRODUCTION

9.1 The terms of reference require the Commission to have regard to a number of specific matters, including ‘appropriate safeguards and protections, including for treating health practitioners’ and ‘ways in which compliance with the Act can be monitored’.<sup>1</sup>

9.2 This chapter considers the inclusion of oversight measures in the voluntary assisted dying legislative framework. Adequate oversight will be essential in supporting the safe, practical and transparent operation of the legislation.

### INDEPENDENT OVERSIGHT BODY

#### Other jurisdictions

9.3 A common feature of the voluntary assisted dying frameworks in other jurisdictions, including Victoria and Western Australia, is an oversight body.<sup>2</sup> The nature of the entity and the scope of its functions vary. Typically, the oversight body has responsibility for reviewing cases to monitor the application of the legislation.

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<sup>1</sup> Terms of reference paras 5, 6.

<sup>2</sup> See the *Voluntary Assisted Dying Act 2017* (Vic) pt 9; and the *Voluntary Assisted Dying Act 2019* (WA) pt 9. In overseas jurisdictions, see, eg, *End of Life Choice Act 2019* (NZ) s 26 (as enacted, not commenced); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* ch III ss 3-19; *Belgian Euthanasia Act 2002* ch V arts 6–13; *Luxembourg Law on Euthanasia and Assisted Suicide 2009* ch V arts 6–13; *Quebec Act respecting end-of-life care*, RSQ c S-32.001 ch 5 ss 38–47; *Oregon Death with Dignity Act 1997*, 127 Or Rev Stat, § 127.865.3.11.

9.4 The Victorian Ministerial Advisory Panel considered that an oversight body would ‘serve as the principal point of governance and administration for the new voluntary assisted dying framework’.<sup>3</sup>

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.

9.5 The Western Australian Ministerial Expert Panel considered that the creation of a statutory body to review and monitor voluntary assisted dying would be ‘a key safeguard’, as well as ‘a practical source of advice or recommendations to Government’.<sup>4</sup>

9.6 The approaches taken in Victoria and Western Australia are broadly similar. Their key features are outlined below.

## Queensland

9.7 The Parliamentary Committee found that voluntary assisted dying legislation in Queensland should include ‘a transparent review mechanism’ as one of several safeguards against coercion.<sup>5</sup> In particular, it recommended that a voluntary assisted dying framework in Queensland should provide for:<sup>6</sup>

the establishment of a review body similar to the Victorian Voluntary Assisted Dying Review Board to provide oversight of the scheme.

9.8 The W&W Model also supports the approach taken in the Victorian legislation. It does not include specific draft provisions—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.<sup>7</sup>

## Establishment

9.9 Part 9 of the *Voluntary Assisted Dying Act 2017* (Vic) establishes the Voluntary Assisted Dying Review Board as a statutory body.<sup>8</sup>

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<sup>3</sup> Vic Ministerial Advisory Panel Final Report (2017) 159.

<sup>4</sup> WA Ministerial Expert Panel Final Report (2019) 94.

<sup>5</sup> Qld Parliamentary Committee Report No 34 (2020) 132.

<sup>6</sup> Ibid 145, Rec 19.

<sup>7</sup> W&W Model pt 6.

<sup>8</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 92.

9.10 Members are appointed by the Minister for a term of up to three years. However, the initial Board is to be constituted by members appointed for a term of up to six years.<sup>9</sup>

9.11 Members must be persons the Minister is satisfied have ‘appropriate knowledge and skills’.<sup>10</sup> The intention is for membership to be extensive and multidisciplinary. The Victorian Ministerial Advisory Panel noted strong support in its consultation for the inclusion of a broad range of experts, including ethicists, nurses, pharmacists and psychologists, as well as community members.<sup>11</sup> It recommended a flexible approach that provides for appointments by the Minister, rather than listing specific requirements in the legislation.<sup>12</sup>

9.12 The present Board has 13 members and is chaired by a retired Supreme Court Justice.<sup>13</sup> 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. The Board is one of three independent consultative review councils in Victoria that monitor and report on specific areas of specialised healthcare.<sup>14</sup>

9.13 Part 9 of the *Voluntary Assisted Dying Act 2019 (WA)* similarly establishes the Voluntary Assisted Dying Board as a statutory body. The Western Australian Ministerial Expert 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’.<sup>15</sup>

Establishment of oversight board	Vic	WA
• Statutory body	s 92	s 116
• Agent of the Crown, subject to Ministerial direction (WA only)	—	s 117 s 123

<sup>9</sup> *Voluntary Assisted Dying Act 2017 (Vic)* ss 95(1), 96(1)–(2). Members may be reappointed for a further term.

<sup>10</sup> *Voluntary Assisted Dying Act 2017 (Vic)* s 95(2). The Board may also ‘co-opt’ a person with special knowledge or skill to assist it in particular matters, with the Minister’s approval: s 100.

<sup>11</sup> Vic Ministerial Advisory Panel Final Report (2017) 165–6.

<sup>12</sup> Ibid Rec 48.

<sup>13</sup> Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 18. See also Safer Care Victoria, *Voluntary Assisted Dying Review Board* (17 September 2020) <<https://www.bettersafecare.vic.gov.au/about-us/about-scv/councils/vad-review-board>>.

<sup>14</sup> See Safer Care Victoria, *Independent Review Councils* (2020) <<https://www.bettersafecare.vic.gov.au/about-us/about-scv/councils>>. The other two councils are the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, and the Victorian Perioperative Consultative Council.

<sup>15</sup> WA Ministerial Expert Panel Final Report (2019) 94, Rec 27. The Western Australian Board may also ‘co-opt’ a person with special knowledge or skill to assist it in particular matters, with the Minister’s approval: *Voluntary Assisted Dying Act 2019 (WA)* s 122.

<b>Establishment of oversight board</b>	<b>Vic</b>	<b>WA</b>
• Members appointed by the Minister	s 95(1)	s 125
• There are to be five members (WA only)	—	s 125
• Minister must be satisfied the person has the appropriate knowledge and skills (Vic only)	s 95(2)	—
• Members 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)	—

## Role

9.14 In broad terms, the primary role of the Board, in Victoria and Western Australia, is to review all voluntary assisted dying cases and report on the operation of the legislation. The focus is on reviewing each case to monitor compliance and identify systemic issues for improvement.<sup>16</sup>

9.15 Similarly, the W&W Model suggests that, in Queensland, the oversight body should:<sup>17</sup>

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.

9.16 The review of cases is facilitated by a system of mandatory reporting at key stages of the voluntary assisted dying process. There are differences in the process between Victoria and Western Australia, as noted in Chapter 6 above. In general terms, however, the medical practitioners involved are to report to the Board within a certain number of days in relation to eligibility assessments and final reviews.<sup>18</sup> Notification and reporting to the Board is also required in relation to the supply and return of the substance and of the person's death.<sup>19</sup> A system of 'thorough documentation and reporting at all stages of the voluntary assisted dying process' was also recommended by the Parliamentary Committee in Queensland.<sup>20</sup>

9.17 Receipt of those reports enables the Board to review each assessment and each case of voluntary assisted dying. These are reviewed to monitor whether the provisions of the legislation were complied with, refer potential breaches of the

<sup>16</sup> See, eg, Vic Ministerial Advisory Panel Final Report (2017) 161–4, Rec 47.

<sup>17</sup> W&W Model pt 6.

<sup>18</sup> Within seven days in Victoria; within two business days in Western Australia: see n 19 below.

<sup>19</sup> 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 Appendix B below.

<sup>20</sup> Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

legislation to appropriate agencies for investigation, and collect and analyse data about voluntary assisted dying.<sup>21</sup>

9.18 Cases are reviewed retrospectively.<sup>22</sup> The Victorian Ministerial Advisory Panel observed that contemporaneous review of the potential legality of particular cases ‘would be extremely traumatic for participants’. It noted that retrospective case review is the approach taken in other jurisdictions.<sup>23</sup> The W&W Model also suggests ‘post-hoc’ case review.<sup>24</sup>

## Functions and powers

9.19 In Victoria and Western Australia, the functions conferred on the Board relate to: monitoring, reporting on and providing advice about the operation of the legislation; the referral of issues to relevant agencies; and data collection, research and analysis.<sup>25</sup>

9.20 In Victoria, the Board has additional functions, not specifically conferred on the Board in Western Australia, relating to community engagement and the promotion of compliance and continuous improvement.

9.21 Each of those Boards has all the powers necessary to perform its functions. Additionally, each Board is empowered to request information to assist it in performing its functions.<sup>26</sup>

9.22 The W&W Model suggests that, in Queensland, the oversight body should have similar functions and powers relating to monitoring, reporting, referral and data collection. It suggests that the oversight body should be empowered to request information to assist it in its reviews of cases. It should also have power to:<sup>27</sup>

Undertake educational initiatives for registered health practitioners and the wider community to promote understanding of, and compliance with, the requirements of the Act.

9.23 The functions of the Boards in Victoria and Western Australia are as follows:

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21 Vic Ministerial Advisory Panel Final Report (2017) 161–4. See also WA Ministerial Expert Panel Final Report (2019) 94.

22 Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020) 4, 15.

23 Vic Ministerial Advisory Panel Final Report (2017) 162.

24 W&W Model pt 6.

25 See *Voluntary Assisted Dying Act 2017* (Vic) s 93(1); *Voluntary Assisted Dying Act 2019* (WA) s 118.

26 See *Voluntary Assisted Dying Act 2017* (Vic) ss 93(2), 103; *Voluntary Assisted Dying Act 2019* (WA) ss 119, 150.

27 W&W Model pt 6.

<b>Functions of oversight board</b>	<b>Vic</b>	<b>WA</b>
• to monitor matters related to voluntary assisted dying and review the exercise of any function or power under the Act (Vic) / to monitor the operation of the legislation (WA)	s 93(1)(a)–(b)	s 118(a)
• to provide reports to the Parliament (Vic) or to the Minister or the Department (WA) on the operation of the Act and any recommendations for the improvement of voluntary assisted dying	s 93(1)(c)	s 118(b)
• to provide reports (Vic and WA) or information (WA) to the Minister or the Department in respect of any matter relevant to the functions of the Board as requested (Vic) / matters relating to the operation of the Act on request or own initiative (WA)	s 93(1)(l)	s 118(b)
• to provide advice to the Minister or the Department in relation to the operation of the Act	s 93(1)(k)	s 118(b)
• to refer any issue identified by the Board in relation to voluntary assisted dying that is relevant to the functions of— <ul style="list-style-type: none"> <li>– the Commissioner of Police</li> <li>– the Registrar of Births, Deaths and Marriages</li> <li>– the Department</li> <li>– the State Coroner</li> <li>– the Australian Health Practitioner Regulation Agency ('AHPRA')</li> <li>– (in WA only, Corrective Services and the Health and Disability Services Complaints Office are also listed)</li> </ul>	s 93(1)(e)	s 118(c)
• to conduct analysis of, and research in relation to, information given to the Board under the Act	s 93(1)(g)	s 118(d)
• to collect, use and disclose information given to the Board under the legislation for the purpose of performing its functions	s 93(1)(i) also (h)	s 118(e)
• 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)	—
• any other function given to the Board under the Act	—	s 118(f)
<b>Powers of oversight board</b>		
• has all the powers that are necessary or convenient (Vic) or 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 its functions	s 103	s 150

### **Annual reports**

9.24 The Boards in Victoria and Western Australia have specific annual reporting obligations.

9.25 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.<sup>28</sup>

9.26 A report may include recommendations on ‘any systemic voluntary assisted dying matter identified by the Board during the reporting period’.<sup>29</sup> The legislation does not otherwise specify particular content. The Board’s most recent report for the six month period from 1 January to 30 June 2020 includes data about voluntary assisted dying 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.<sup>30</sup>

9.27 In Western Australia, annual reports on the operation of the legislation are to be given to the Minister, who must cause them to be tabled in Parliament. The legislation specifies a number of matters that are to be included in the report, such as:<sup>31</sup>

- the number of referrals made by the Board to other agencies; and
- information about the extent to which regional residents had access to voluntary assisted dying.

### **Statistical records**

9.28 The Boards in Victoria and Western Australia also have obligations to record and retain statistical information about voluntary assisted dying. Different information is specified in each jurisdiction.<sup>32</sup>

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<sup>28</sup> See *Voluntary Assisted Dying Act 2017* (Vic) ss 107–112.

<sup>29</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 107(2), 110(3).

<sup>30</sup> Voluntary Assisted Dying Review Board Report of Operations January–30 June 2020 (2020).

<sup>31</sup> *Voluntary Assisted Dying Act 2019* (WA) s 155.

<sup>32</sup> See *Voluntary Assisted Dying Act 2017* (Vic) s 117; *Voluntary Assisted Dying Act 2019* (WA) s 152.

**Statistical information to be kept about—**

**Vic:** s 117(1)–(2)

- 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 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

**WA:** s 152(1)

- 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

9.29 In Victoria, the Board is required to make the statistical information ‘publicly available in a de-identified form on an Internet site maintained by the Board’.<sup>33</sup>

9.30 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.<sup>34</sup> The legislation does not otherwise require the publication of statistical information collected by the Board.

### Consultation questions

**Q-43 Should the draft legislation provide for an independent oversight body with responsibility for monitoring compliance with the legislation?**

**Q-44 If yes to Q-43, should the oversight body have some or all of the functions and powers conferred on:**

- (a) the Voluntary Assisted Dying Review Board under the *Voluntary Assisted Dying Act 2017 (Vic)*; or
- (b) the Voluntary Assisted Dying Board under the *Voluntary Assisted Dying Act 2019 (WA)*?

<sup>33</sup> *Voluntary Assisted Dying Act 2017 (Vic)* s 117(3).

<sup>34</sup> *Voluntary Assisted Dying Act 2019 (WA)* s 152(2)–(3).



## COMPLIANCE

9.31 In Victoria and Western Australia, the consequences of non-compliance with the voluntary assisted dying legislation will depend on the nature of the breach and the circumstances. Not all breaches of the legislation will result in a penalty or sanction. The Acts include some specific criminal offences. Otherwise, non-compliance by a health practitioner with the procedural requirements of the legislation is to be dealt with under the national regulatory framework that applies to health practitioners.

### Referral to other agencies

9.32 The oversight bodies in Victoria and Western Australia do not investigate complaints or determine professional disciplinary matters.

9.33 Relevantly, the role of the oversight bodies in those jurisdictions is focused on compliance monitoring, reporting and referral. Responsibility for investigation and handling of complaints about non-compliance remains with other agencies, including the police and AHPRA. Accordingly, as noted at [9.23] above, in Victoria and Western Australia the Board is to refer instances of non-compliance to those agencies, as appropriate. A similar approach is taken in overseas jurisdictions.<sup>35</sup>

9.34 The Victorian Ministerial Advisory Panel explained that:<sup>36</sup>

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.

9.35 The Western Australian Ministerial Expert Panel observed that 'there are already pathways and processes that exist for people to raise concerns in relation to health and medical treatment or services', and noted support in its consultation for complaints about health practitioners' compliance with voluntary assisted dying laws to be handled through those existing mechanisms.<sup>37</sup>

### ***The National Health Practitioner Regulation Law***

9.36 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 the AHPRA together with the

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<sup>35</sup> See, eg, *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* ss 9(2), 10; *Belgian Euthanasia Act 2002* art 8; *Luxembourg Law on Euthanasia and Assisted Suicide 2009* art 8; *Quebec Act respecting end-of-life care*, RSQ c S-32.001 s 47.

<sup>36</sup> Vic Ministerial Advisory Panel Final Report (2017) 161, referring to Vic Parliamentary Committee Final Report (2016).

<sup>37</sup> WA Ministerial Expert Panel Final Report (2019) 93–4.

relevant professional boards such as the MBA.<sup>38</sup> In Queensland, aspects of the National Law are also administered by the Health Ombudsman.<sup>39</sup>

9.37 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. 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.<sup>40</sup>

9.38 A finding that a practitioner's conduct is unsatisfactory or unprofessional may result in disciplinary action such as cautioning or reprimanding the practitioner, or suspending, cancelling or imposing conditions on the practitioner's registration.<sup>41</sup>

9.39 The National Law provides a system of mandatory and voluntary 'notifications' of concerns about health practitioners' conduct. Other health practitioners and employers must notify concerns of a serious nature involving, for example, 'a significant departure from accepted professional standards'. Voluntary notifications may be made by any person if there is a concern, 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.<sup>42</sup>

9.40 In Queensland, notifications are made to the Health Ombudsman. In most of the other Australian states and territories, notifications are made to AHPRA.<sup>43</sup>

### **Notification provisions**

9.41 In Victoria, the voluntary assisted dying legislation includes specific provisions about mandatory and voluntary notification to AHPRA. They provide that

38 See generally AHPRA & National Boards, *What we do* (5 February 2020) <<https://www.ahpra.gov.au/About-AHPRA/What-We-Do.aspx>>.

39 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, *Making a notification to the Health Ombudsman* (2020) <<https://www.oho.qld.gov.au/health-service-providers/notifications/>>.

40 See generally AHPRA & National Boards, *Regulatory principles for the National Scheme* (4 April 2019) <<https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>>.

41 See Health Practitioner Regulation National Law (Queensland) s 5 (definitions of 'professional misconduct', 'unprofessional conduct' and 'unsatisfactory professional performance'), pt 8 divs 10-12; *Health Ombudsman Act 2013* (Qld) s 107.

42 See Health Practitioner Regulation National Law (Queensland) pt 8 divs 2, 3. See generally AHPRA & National Boards, *Concerns about practitioners* (29 March 2019) <<https://www.ahpra.gov.au/Notifications.aspx>>; and Office of the Health Ombudsman, *Registered Health Practitioner Notifications* (2020) <<https://www.oho.qld.gov.au/health-service-providers/notifications/registered-health-practitioner-notifications/>>.

43 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 42 above.

a 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:<sup>44</sup>

- (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.

9.42 The Victorian Ministerial Advisory 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’.<sup>45</sup>

9.43 The Western Australian legislation does not include any similar provisions. Neither does the W&W Model, which notes that:<sup>46</sup>

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.

## Criminal offences

9.44 The legislation in both Victoria and Western Australia includes specific criminal offences. The offences relate to conduct that would undermine key safeguards in the legislation. They include offences of failing to report as required to the oversight body or providing false or misleading information under the legislation. They also include offences relating to unauthorised administration of a voluntary assisted dying substance and inducing a person, by dishonesty, undue influence or coercion, to request voluntary assisted dying or to self-administer the substance.

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<sup>44</sup> *Voluntary Assisted Dying Act 2017* (Vic) ss 75(1), 76(1), 77. As to the definition of ‘health services’ and ‘professional care services’, in s 3(1) of the Act, see [5.3] n 3 above.

<sup>45</sup> Vic Ministerial Advisory Panel Final Report (2017) 178, Recs 55, 56.

<sup>46</sup> W&W Model, Explanatory Notes 7.

<b>Offences under the legislation</b>	<b>Vic</b>	<b>WA</b>
• 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 (or, in WA, for any other purpose under the legislation) 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 the substance when not authorised to do so. In Victoria, this includes administering a substance dispensed under a self-administration permit to another person.	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

9.45 The penalties for those offences vary. At the lower end, failure to give copies of the required forms to the Board as part of the mandatory reporting requirements is punishable by a fine of 60 penalty units (\$9913)<sup>47</sup> in Victoria or \$10 000 in Western Australia. At the highest end, unauthorised administration of a voluntary assisted dying substance is punishable by imprisonment for life or, in Victoria, for imprisonment for life or such other term fixed by the court. This is intended to reflect

<sup>47</sup> The value of a penalty unit in Victoria from 1 July 2020 to 30 June 2021 is \$165.22: Treasury and Finance, *Indexation of Fees and Penalties* (28 April 2020) <<https://www.dtf.vic.gov.au/financial-management-government/indexation-fees-and-penalties>>.

the seriousness of administering a voluntary assisted dying substance outside the process established by the legislation.<sup>48</sup>

9.46 The Victorian Ministerial Advisory Panel noted that existing criminal offences, such as murder and aiding and abetting suicide, would provide protection for people under the voluntary assisted dying framework.<sup>49</sup> It considered, however, that additional offences were warranted in light of the new instruments and new roles created by the legislation. It considered that 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’.<sup>50</sup>

9.47 The W&W Model includes similar offences for inducing a person to request access to voluntary assisted dying or to self-administer or ask a medical practitioner to administer a substance; making a false or misleading statement in, or in relation to, a request for voluntary assisted dying; and failing to report to the Board as required by the legislation.<sup>51</sup> It does not specify the penalties that would attach to such offences.

### Protections from liability for health practitioners and others

9.48 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’.<sup>52</sup>

9.49 The legislation in Victoria and Western Australia includes protections from liability for health practitioners and others who act in good faith in accordance with the legislation. This is consistent with the approach in overseas jurisdictions.<sup>53</sup>

9.50 By way of example, section 80 of the *Voluntary Assisted Dying Act 2017* (Vic) provides that:<sup>54</sup>

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

<sup>48</sup> See, eg, Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 5139 (RH Cook, Minister for Health).

<sup>49</sup> In Queensland, see Criminal Code (Qld) ss 300 (‘unlawful homicide’), 311 (‘aiding suicide’).

<sup>50</sup> Vic Ministerial Advisory Panel Final Report (July 2017) 179–80, Rec 57.

<sup>51</sup> W&W Model pt 8, cl 44, 45, 46, 47.

<sup>52</sup> Qld Parliamentary Committee Report No 34 (2020) 132, Rec 8.

<sup>53</sup> See, eg, *Oregon Death with Dignity Act 1997* Or Rev Stat, § 127.885.4.01(1); *California End of Life Option Act 2015*, Cal Health and Safety Code, § 443.14(a)–(c); *Colorado End-of-Life Options Act 2016*, 25 Colo Rev Stat, § 25-48-116(1)–(2); *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).

<sup>54</sup> See, to similar effect, *Voluntary Assisted Dying Act 2019* (WA) s 114.

- (c) liable in any civil proceeding; or
- (d) liable for contravention of any code of conduct.

9.51 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 legislation.<sup>55</sup>

9.52 Section 79 of the *Voluntary Assisted Dying Act 2017* (Vic) includes protection for other persons acting in good faith in accordance with the legislation:<sup>56</sup>

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.

9.53 The Western Australian provision also confers protection on a person who 'is present' when another person takes a voluntary assisted dying substance in accordance with the legislation.<sup>57</sup>

9.54 The Victorian Ministerial Advisory 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.<sup>58</sup>

9.55 The W&W Model includes provisions in substantially the same terms as Victoria.<sup>59</sup>

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<sup>55</sup> See, to similar effect, *Voluntary Assisted Dying Act 2019* (WA) s 115.

<sup>56</sup> See, to similar effect, *Voluntary Assisted Dying Act 2019* (WA) s 113(a).

<sup>57</sup> *Voluntary Assisted Dying Act 2019* (WA) s 113(b).

<sup>58</sup> Vic Ministerial Advisory Panel Final Report (2017) 176–7, Rec 54.

<sup>59</sup> W&W Model pt 7, cl 40, 41(1), 42.

## Consultation questions

- Q-45** Should notifications to the Health Ombudsman of concerns about health practitioners' professional conduct relating to voluntary assisted dying:
- (a)** be dealt with by specific provisions in the draft legislation, as in Victoria, which provide for mandatory and voluntary notification in particular circumstances; or
  - (b)** as in Western Australia, be governed by existing law under the Health Practitioner Regulation National Law (Queensland) which states when mandatory notification is required and voluntary notification is permitted?
- Q-46** Should the draft legislation include specific criminal offences related to non-compliance with the legislation, similar to those in the *Voluntary Assisted Dying Act 2017 (Vic)* or the *Voluntary Assisted Dying Act 2019 (WA)*?
- Q-47** Should the draft legislation 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 *Voluntary Assisted Dying Act 2017 (Vic)*?

## REVIEW OF THE LEGISLATION

9.56 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 its commencement 'to ensure the legislation is effective and working appropriately'.<sup>60</sup>

9.57 In Victoria, the Minister is to review and report on the operation of the legislation in its fifth year.<sup>61</sup> In Western Australia, the Minister is required to review and report on the operation and effectiveness of the legislation as soon as practicable after the first two years, and then at intervals of not more than five years.<sup>62</sup>

9.58 The W&W Model suggests a legislative requirement for the legislation to be reviewed after five years.<sup>63</sup>

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<sup>60</sup> Qld Parliamentary Committee Report No 34 (2020) 147, Rec 21.

<sup>61</sup> *Voluntary Assisted Dying Act 2017 (Vic)* s 116.

<sup>62</sup> *Voluntary Assisted Dying Act 2019 (WA)* s 164.

<sup>63</sup> W&W Model pt 9.

**Consultation question**

**Q-48 Should there be a statutory requirement for review of the operation and effectiveness of the legislation?**



# Chapter 10

## Other matters

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### DEATH CERTIFICATION

#### Notification and certification of death

10.1 One of the practical questions to arise in relation to voluntary assisted dying is whether, or to what extent, voluntary assisted dying should be listed as the cause of death of the person. It has been observed that:<sup>1</sup>

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.

10.2 The Victorian legislation has the effect that:<sup>2</sup>

- the person's cause of death is to be listed as the disease, illness or medical condition that was the grounds for the person accessing voluntary assisted dying; and
- the medical practitioner is 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.

10.3 This gives effect to the recommendations of the Victorian Ministerial Advisory Panel and is consistent with the approach in some overseas jurisdictions.<sup>3</sup>

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<sup>1</sup> WA Ministerial Expert Panel Final Report (2019) 85. See also Vic Ministerial Advisory Panel Final Report (2017) 149.

<sup>2</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 67; *Births, Deaths and Marriages Registration Act 1996* (Vic) ss 40(1A), 40A.

<sup>3</sup> Vic Ministerial Advisory Panel Final Report (2017) 150–2, Recs 41, 43, 44. See, 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).

10.4 Similarly, the legislation in Western Australia has the effect 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.<sup>4</sup>

10.5 The Western Australian Ministerial Expert Panel explained that, in this way, the relevant information is collected and recorded for statistical purposes, but the person's privacy is preserved.<sup>5</sup>

10.6 In Queensland, 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 death.<sup>6</sup>

### The role of coroners

10.7 A related issue is the role of a coroner. Under the *Coroners Act 2003*, coroners are responsible for investigating reportable deaths that occur in Queensland.<sup>7</sup> A 'reportable death' includes a death that was caused by accident, suicide, drug overdose or homicide rather than a disease's natural progression, was related to health care, or happened in suspicious circumstances.<sup>8</sup> 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.<sup>9</sup>

10.8 In Victoria and Western Australia, death by means of voluntary assisted dying in accordance with their voluntary assisted dying legislation is not considered a reportable death under their respective Coroners Acts.<sup>10</sup> In both jurisdictions, the oversight body under the legislation (the Voluntary Assisted Dying Review Board or the Voluntary Assisted Dying Board, respectively) can report concerns about deaths by voluntary assisted dying to their State Coroner.<sup>11</sup>

<sup>4</sup> *Voluntary Assisted Dying Act 2019* (WA) s 82.

<sup>5</sup> WA Ministerial Expert Panel Final Report (2019) 88–90, Rec 25.

<sup>6</sup> *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 authorises it: *Coroners Act 2003* (Qld) s 26(5).

<sup>7</sup> *Coroners Act 2003* (Qld) s 11.

<sup>8</sup> *Coroners Act 2003* (Qld) s 8(3). A person's death is a 'health care related death' if the person dies at any time after receiving health care that either caused or is likely to have caused the death, or contributed to or is likely to have contributed to the death, and immediately before receiving the health care, an independent person would not have reasonably expected that the health care would cause or contribute to the person's death: s 10AA(1). 'Health care' includes any health procedure: s 10AA(5)(a).

<sup>9</sup> See generally *Coroners Act 2003* (Qld) pt 3.

<sup>10</sup> *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.

<sup>11</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 93(1)(e)(iv); *Voluntary Assisted Dying Act 2019* (WA) s 118(c)(iii).

10.9 The Victorian Ministerial Advisory Panel considered that, while it is important that the coroner maintain the jurisdiction to investigate a suspicious death, ‘it would be unnecessary and burdensome as well as intrusive for grieving families [for] the Coroner to review each voluntary assisted death’.<sup>12</sup> The Western Australian Ministerial Expert Panel expressed a similar view.<sup>13</sup>

### Consultation question

**Q-49 How should the death of a person who has accessed voluntary assisted dying be treated for the purposes of the *Births, Deaths and Marriages Registration Act 2003* and the *Coroners Act 2003*?**

### IMPLEMENTATION

10.10 Effective implementation is essential to establishing a compassionate, safe and practical voluntary assisted dying framework.

10.11 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’.<sup>14</sup>

### Commencement of the legislation

10.12 The voluntary assisted dying legislation in Victoria<sup>15</sup> and Western Australia<sup>16</sup> provided for a period of up to 18 months between the passage of the legislation and its commencement.

10.13 The Victorian Ministerial Advisory Panel considered that this would allow adequate time to plan for and establish the voluntary assisted dying framework, including consulting with key stakeholders.<sup>17</sup>

10.14 The Western Australian Ministerial Expert Panel similarly observed that:<sup>18</sup>

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

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<sup>12</sup> Vic Ministerial Advisory Panel Final Report (2017) 155, Rec 45.

<sup>13</sup> WA Ministerial Expert Panel Final Report (2019) 89–90, Rec 26.

<sup>14</sup> Qld Parliamentary Committee Report No 34 (2020) 149.

<sup>15</sup> *Voluntary Assisted Dying Act 2017* (Vic) s 2(2); Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 1.

<sup>16</sup> *Voluntary Assisted Dying Act 2019* (WA) s 2(b); Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 1.

<sup>17</sup> Vic Ministerial Advisory Panel Final Report (2017) 200, Rec 66.

<sup>18</sup> WA Ministerial Expert Panel Final Report (2019) 102, Rec 30.

protocols to ensure that the legislation is translated safely, effectively and appropriately for Western Australia.

10.15 The W&W Model also suggests an 18 month delay in commencement ‘to permit time for implementation’.<sup>19</sup>

## Implementation of the framework

### Victoria

10.16 The Victorian Ministerial Advisory Panel considered that implementation of voluntary assisted dying should be considered in the context of existing end of life care options. This would support continuity of care and allow voluntary assisted dying to be reviewed as part of existing safety and quality review processes.<sup>20</sup>

10.17 A number of key agencies have roles in the voluntary assisted dying framework. The legislation is administered by the Victorian Department of Health and Human Services.<sup>21</sup> The Voluntary Assisted Dying Review Board, established as part of Safer Care Victoria, is responsible for ensuring safety and quality by monitoring compliance with the legislation.<sup>22</sup> The Voluntary Assisted Dying Care Navigator Service provides information and support to those wishing to access and navigate the voluntary assisted dying framework.<sup>23</sup>

10.18 Implementation of the voluntary assisted dying framework in Victoria has been led by a taskforce established and supported by the Victorian Department of Health and Human Services, as recommended by the Victorian Ministerial Advisory Panel.<sup>24</sup>

10.19 The Victorian Ministerial Advisory Panel made a number of other recommendations to support implementation of the framework, reflected in the terms of reference of the Implementation Taskforce.<sup>25</sup> These included the following:

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<sup>19</sup> W&W Model cl 2(2), Explanatory Notes 7.

<sup>20</sup> Vic Ministerial Advisory Panel Final Report (2017) 186, Rec 58.

<sup>21</sup> See generally Department of Health & Human Services (Vic) ‘Voluntary Assisted Dying’ (2020) <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying>>.

<sup>22</sup> See generally Safer Care Victoria, *Voluntary Assisted Dying Review Board* (17 September 2020) <<https://www.bettersafecare.vic.gov.au/about-us/about-scv/councils/vad-review-board>>. As to the functions of the Board, see Chapter 9 above.

<sup>23</sup> See Department of Health & Human Services (Vic), ‘Getting Support—Voluntary assisted dying care navigators’ (2020) <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/getting-support>>.

<sup>24</sup> Vic Ministerial Advisory Panel Final Report (July 2017) 189, Rec 60; 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>>.

<sup>25</sup> See Vic Ministerial Advisory Panel Final Report (July 2017) pt D, Recs 59, 61–65; 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>>.

- establishing the Voluntary Assisted Dying Review Board and supporting it to set up its processes and protocols;
- identifying clear roles for existing and new entities in providing policy direction and information about end of life care;
- developing resources to support health practitioners and the community—in consultation with clinical, consumer and professional bodies and service delivery organisations—including:
  - clinical guidelines;
  - consumer and community information;
  - service delivery models, for example, for hospitals; and
  - education and training programs;
- establishing a coordinated process for ongoing review of those support resources to ensure that they are up to date and reflect best practice; and
- engaging in research to identify best practice substances for use in voluntary assisted dying, including formulations, dosages, information and guidelines.

### **Western Australia**

10.20 In Western Australia, the Department of Health has similarly established an Implementation Leadership Team to coordinate and facilitate the work required to implement the voluntary assisted dying framework.<sup>26</sup> This will include:<sup>27</sup>

- [Development of the] training program for the doctors and nurse practitioners who take part in the process
- Setting up the Voluntary Assisted Dying Board
- Creating the IT system for processing and data collection
- Arranging services so that people can access the voluntary assisted dying substance once it has been prescribed
- Organising the Care Navigator Service who will assist people in finding out information on voluntary assisted dying and support people during the process if needed.

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<sup>26</sup> Department of Health (WA), 'Implementation Leadership Team', 'Voluntary Assisted Dying' (3 April 2020) <<https://ww2.health.wa.gov.au/voluntaryassisteddying>>.

<sup>27</sup> Ibid.

**Consultation question**

**Q-50** What key issues or considerations should be taken into account in the implementation of voluntary assisted dying legislation in Queensland?

# Appendix A

## 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-of-life 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 1 July 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-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.

**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 Attorney-General and Minister for Justice by 1 March 2021.

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

# Appendix B

## The voluntary assisted dying process in Victoria and Western Australia

B.1 The following diagrams give an overview of the voluntary assisted dying process under the Victorian<sup>1</sup> and Western Australian<sup>2</sup> legislation, respectively.

B.2 The first diagram is reproduced from the Vic Ministerial Advisory Panel Final Report (2017) 146 available at <<https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report>>.

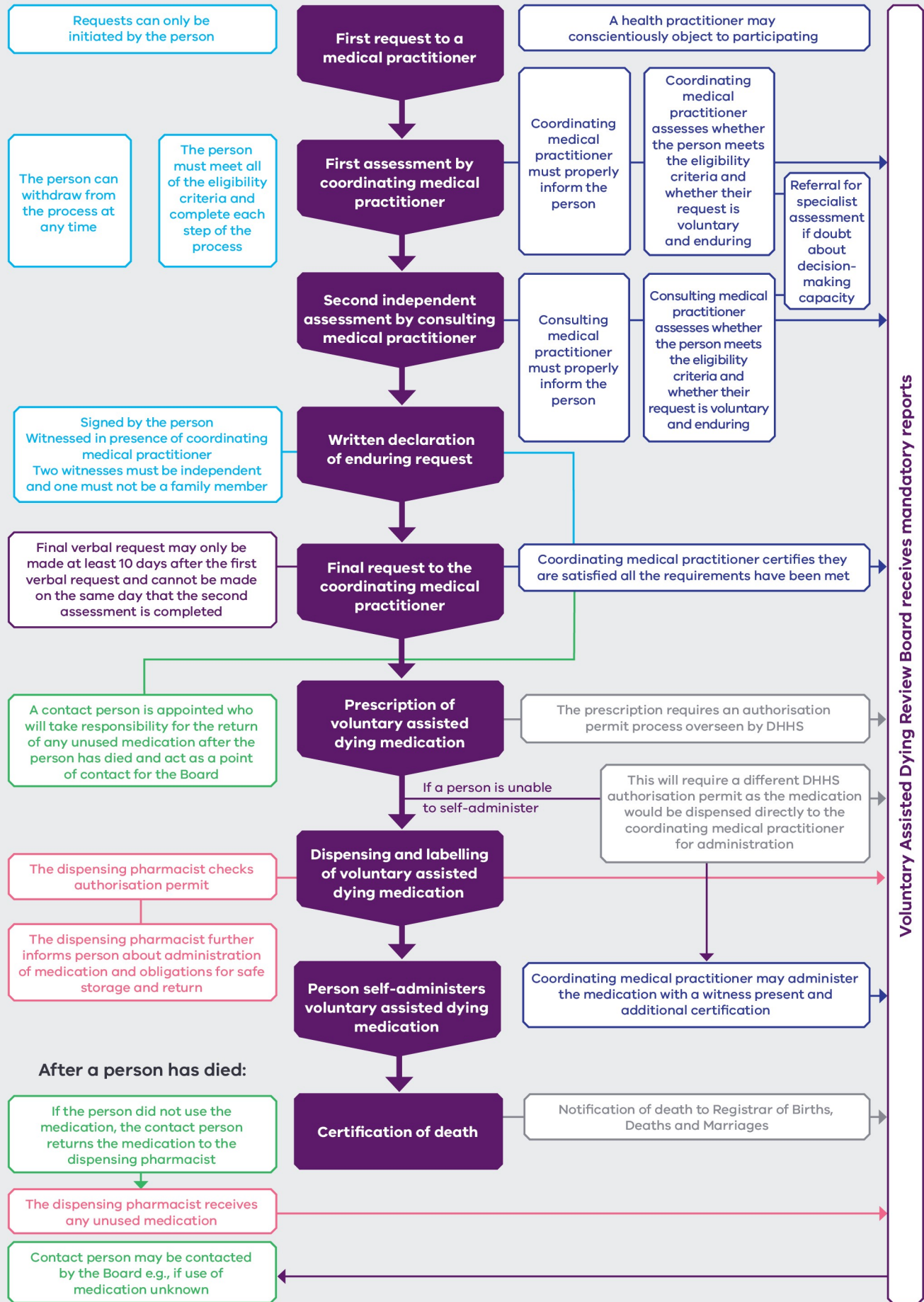
B.3 The second diagram is reproduced from Western Australia, Department of Health, 'Voluntary Assisted Dying' (3 April 2020) <<https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Voluntary-Assisted-Dying-Act-2019-process-summary.pdf>>.

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

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

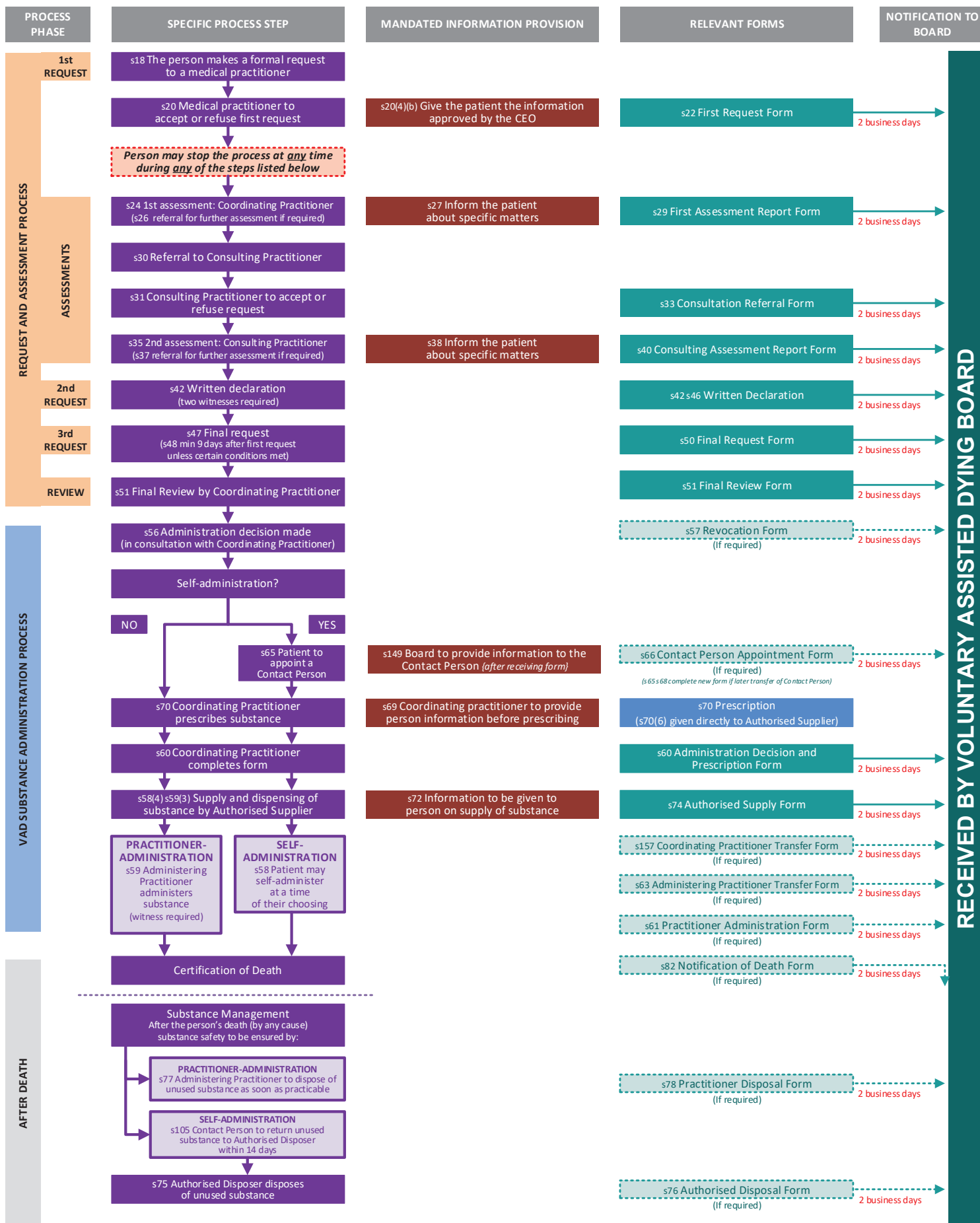
# The voluntary assisted dying process: an overview



The *Voluntary Assisted Dying Act 2019* provides for eligible Western Australian adults to access voluntary assisted dying in certain circumstances.

The flow chart below provides a representation of the process steps in the Act, however it does not include all of the steps and requirements – it is a guide to assist high-level awareness only.

For a detailed understanding it is essential to refer back to the *Voluntary Assisted Dying Act 2019*.



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# Appendix C

## Comparative guide to assisted dying legislation in selected jurisdictions

C.1 This table provides a brief comparison between the main provisions of legislation about voluntary assisted dying in Australian jurisdictions, and selected overseas jurisdictions. Specifically, the table refers to the following legislation:

- *Voluntary Assisted Dying Act 2017* (Vic);
- *Voluntary Assisted Dying Act 2019* (WA);
- *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;<sup>1</sup>
- *Oregon Death with Dignity Act 1997*, Or Rev Stat.<sup>2</sup>

C.2 This table should be read together with the discussion in the body of the Consultation Paper.

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<sup>1</sup> 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.

<sup>2</sup> 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.

	Victoria	Western Australia	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
Guiding principles in legislation	✓	✓				✓	
18 years or more	✓	✓				✓	✓
Resident in jurisdiction	✓ (12 m)	✓ (12 m)					✓
Person has decision-making capacity in relation to assisted dying	✓	✓	✓ <sup>1</sup>	✓	✓	✓	✓
Person is acting voluntarily and without coercion	✓	✓	✓	✓	✓	✓	✓
Decision is enduring	✓	✓	✓ <sup>1</sup>	✓	✓		
Diagnosed with an eligible disease, illness or medical condition (eg, advanced, incurable, progressive, will cause death)	✓	✓		✓	✓	✓	✓
Disease, illness or medical condition is expected to cause death within a specified timeframe	✓ (6 m, 12 m for a neuro-degenerative condition)	✓ (6 m, 12 m for a neuro-degenerative condition)					✓ (6 m)
Person is suffering	✓	✓	✓	✓	✓	✓	
Express provision that mental illness or disability alone is not an eligible disease, illness or medical condition	✓	✓					✓ (disability)
All criteria must be met	✓	✓	✓	✓	✓	✓	✓
Review by tribunal of some criteria (eg residency, decision-making capacity or voluntariness)	✓	✓					
Health practitioner must not initiate discussion about voluntary assisted dying	✓	✓					
Person themselves must make request	✓	✓	✓	✓	✓	✓	✓
Person can make a request in an advance directive			✓	✓	✓		
Person must make three requests	✓	✓					✓
One request must be in writing	✓	✓		✓	✓	✓	✓
Two witnesses to written request	✓	✓				✓	✓
Waiting period between first and final requests	✓ (unless likely to die)	✓ (unless likely to die or lose capacity)				✓	✓
Any interpreter must be independent and accredited	✓	✓					
Person may withdraw request at any time	✓	✓	✓	✓	✓	✓	✓

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In the Netherlands, voluntariness includes decisional competence. In addition, the person's request must be 'well-considered', which includes that the request must be consistent and not on impulse: Regional Euthanasia Review Committees (the Netherlands), *Euthanasia Code 2018: Review Procedures in Practice* (2018) [3.2].



		Victoria	Western Australia	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)	✓	✓					✓ (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	✓	✓					
	Complete mandatory training before assessing person	✓	✓					
	Conscientious objection	✓	✓	✓	✓	✓	✓	✓
	If conscientiously object, refer or provide information		✓ (give person information)		✓ (transfer file on request)	✓ (transfer file on request)		
	Mandated to report at points throughout the assisted dying process	✓	✓	✓	✓	✓	✓	✓
Administration of substance	Additional approval process — permit required to prescribe and supply, or possess and administer, voluntary assisted dying substance	✓						
	Self-administration is primary or default method	✓	✓					✓
	Practitioner administration permitted	✓ (if patient physically incapable of self-administration)	✓ (if self-administration is clinically inappropriate)	✓	✓	✓	✓	
	Requirement for administration to be witnessed	✓ (practitioner administration)	✓ (practitioner administration)					
	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)					

		Victoria	Western Australia	Netherlands	Belgium	Luxembourg	Canada (Federal)	Oregon (USA)
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 take make a false or misleading statement	✓	✓				✓	✓
	Offence to fail to report on assisted dying	✓	✓				✓	
	Offence to administer the substance when not authorised to do so	✓	✓					
	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	✓	✓				✓	✓
Oversight	Review by tribunal of some criteria for access (eg residency, decision-making capacity or voluntariness)	✓	✓					
	Oversight by an independent body	✓	✓	✓	✓	✓		
	Implementation period for legislation	✓	✓				✓	
	Review of legislation	✓	✓		✓	✓	✓	

