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**Submission to the Queensland Parliament
Health and Environment Committee's
Inquiry into the Voluntary Assisted Dying
Bill 2021**

July 2021

About the Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Introduction

The RACP welcomes the opportunity to provide a submission to the Queensland Parliament Health and Environment Committee's Inquiry into the Voluntary Assisted Dying (VAD) Bill 2021 (the Bill).

In 2018, the RACP published a [Statement on Voluntary Assisted Dying](#). More recently, the RACP made a [submission to the Queensland Parliament inquiry into aged care, end-of-life and palliative care and VAD](#) in April 2019 and a [submission to the Queensland Law Reform Commission's legal framework for VAD](#) in November 2020. We also have a 2016 [position statement on Improving Care at the End of Life: Our Roles and Responsibilities](#). Our comments below are closely aligned with and build on these statements and submissions. We ask that the Inquiry refer to the above documents for the RACP's detailed position on VAD.

The RACP's Statement on VAD expresses concerns about the potential for legalised VAD to jeopardise traditionally underserved populations, be abused, expose health practitioners to professional risk, harm patients and families and erode trust in the medical profession. If any Parliament in Australia decides that laws should be changed to allow VAD, the development of laws, regulations and guidelines must be undertaken in consultation with medical and health experts, the RACP and other medical and health organisations.

We have chosen to focus on the key issues most relevant to our remit and expertise in relation to the Bill, in line with these concerns.

The RACP Statement

The RACP VAD Statement was developed following an extensive consultation and drafting process involving a wide range of our members and summarises our position:

The RACP respects and supports all its members and does not believe it is appropriate or possible to enforce a single view on a matter where individual conscience is important. The RACP recognises that legalisation of voluntary assisted dying is for governments to decide and that it must be informed by the will of the community, research, and the views of medical and health practitioners.

Legislative change related to VAD will affect individual medical practitioners in different ways. Different clinical settings require ethical and clinical considerations to be made carefully, deliberately and systematically. Our members are not unanimous in their support for or opposition to legislative change. The existence of divergent views constrains the RACP from developing a single position on the legalisation of voluntary assisted dying.

The RACP takes the following positions if and where voluntary assisted dying is legalised:

- Every patient should have access to timely, equitable, good quality end-of-life care, with access to specialist palliative care where appropriate. These services must not be devalued.
- On the specific issue of a competent adult in the last stages of incurable illness requesting voluntary assistance to die, the RACP supports a clinical approach of critical neutrality to encourage reflective dialogue.
- Although physicians should not be forced to act outside their values and beliefs, they also should not disengage from patients holding different values and beliefs without ensuring that arrangements for ongoing care are in place.
- Patients seeking voluntary assisted dying should be made aware of the benefits of palliative care. Referral to specialist palliative care should be strongly recommended but cannot be made mandatory. Voluntary assisted dying must not be seen as part of palliative care.
- Legitimate concerns exist around protection of traditionally under-serviced individuals or groups. Government, society and physicians must ensure that specific groups have equitable access to palliative and end-of-life care and that relationships of trust are not jeopardised. Specific regard must be given to cultural and Indigenous experience.
- All physicians must affirm the value of all patients' lives, exploring reasons for requests for voluntary assisted dying while remaining alert to any signs of coercion and reduced capacity.
- Assessments must not follow a 'tick box' approach. They must be underpinned by adequate physician-patient relationships, including appropriate training, skill and experience.
- Support, counselling and conflict mediation services must be available for individuals, families and health professionals involved.
- There must be rigorous documentation and data collection to enable review of any scheme and to assess changes in practice and the impacts on health professionals, patients and families.

This statement should not be taken as support for legislative change. The RACP will continue to highlight concerns about legislative proposals, drawing on both clinical experience and the ethical perspectives of our members. The RACP will continue to advocate for patient and physician well-being to support our members and contribute our expertise as medical specialists who care for dying patients.

For definitions, discussion and recommendations relating to the above statement, please see our full [Statement on VAD document](#).

Importance of end-of-life and palliative care

We note that the Bill's principles recognise the importance of end-of-life and palliative care and that its provisions would prohibit health care workers initiating a discussion on VAD without also discussing palliative care options. Further, information on palliative care options would need to be provided to anyone assessed as eligible under the proposed legislation.

While this recognition of end-of-life and palliative care is important within the Bill, it must be supported by the prioritisation of such care beyond the Bill. End-of-life and palliative care spans multiple sectors, including health, aged care, community care, disability care and mental health. To ensure that funding committed to end-of-life care leads to sustained improvement in patient outcomes, it is imperative that all state and territory governments,

including the Queensland Government, endorse palliative care and end-of-life care as a key priority for the National Cabinet. Appropriate palliative care services must be prioritised and funded across all age groups and settings, including an expanded presence in the community.

While the Bill recognises the importance of palliative care, it is important that provision of VAD is not conflated with palliative care. This may be difficult where VAD is provided within palliative care institutions and units; as such, we ask that the Bill should consider clarifying this within the Bill and in supporting guidelines.

Conscientious objection

The potential moral impact on clinicians from involvement in VAD may be felt deeply. Accordingly, comprehensive and clear provisions on conscientious objection are essential for VAD legislation. Such provisions would also avoid the practical uncertainties that would arise from unclear forms of conscientious objection. We note that conscientious objection for registered health practitioners and speech pathologists is covered in Part 6 of the Bill. Conscientious objection may also occur for other individuals within multidisciplinary teams or at an institutional level. Accordingly, we consider that the conscientious objection provisions within the Bill should be broadened.

We also note that under the Bill where a registered health practitioner conscientiously objects to participating in VAD, they must inform the person that they may be able to seek assistance from other health practitioners and provide them with information about a health practitioner or service provider who would be able to assist the person or with details of an official VAD care navigator service. We are concerned that this requirement may amount in some health practitioners' eyes to a requirement to refer. The RACP holds that physicians should not be forced to refer, but neither should they hinder patients from accessing such services.

Conscientious objection may present issues in certain settings, for example where it impacts inpatients of an objecting hospital or hospice, or those who are unable to go to another clinic wishing to access VAD, and where practitioners who would perform VAD are not accredited at a given site. We note that the Bill attempts to address some of these issues through its provisions relating to participation by entities.

As these provisions would require institutions to provide access to VAD on site through practitioners external to the institution, we note that institutions should still be able to formally conscientiously object under the Bill to make their positions clear. If the Bill were to become law as it stands, regulations and guidelines on access by external practitioners must be clear and outline liability in case of adverse outcomes. Further, we have concerns about the possibility of procedures being performed outside the governance and staffing arrangements of an institution that does not provide VAD.

Decision-making, consent and safeguards against coercion

Coercion of patients will be difficult to safeguard against completely; however, we note that the Bill attempts to address this key issue. We note that safeguarding vulnerable people from coercion and exploitation is outlined in the Bill's purpose and the principles and that, "approved training" may include "identifying and assessing risk factors for abuse or coercion".

Further, the proposed Voluntary Assisted Dying Review Board would oversee reporting and may be requested to provide reports and advice relating to safeguards. The Bill also

outlines that certain decisions could be reviewed by the Queensland Civil and Administrative Tribunal including on whether a person has decision-making capacity and is acting without coercion.

We wish to highlight the Bill's approach to allow medical practitioners to initiate a discussion of or suggest VAD to a person, provided other treatment options are also discussed. While we recognise that such a provision may support equitable access to information and patient choice, it also has the potential for coercion and misuse of power. Safeguards against coercion within the Bill must closely oversee and monitor those cases where a medical practitioner initiates a discussion of or suggests VAD.

In our Statement on VAD, we recommend that consideration is given to information exchange in accessible formats including the patient's preferred language and sign language. We commend the Bill allowing for a range of communication channels, including gestures, and for allowing persons to make requests for VAD using the assistance of an interpreter.

Expertise and training required of participating practitioners

Implementation of VAD legislation in Queensland would require the training of sufficient numbers of medical practitioners with appropriate expertise to provide the option of VAD to those seeking it. This will be a challenge given it is a relatively new area within Queensland and Australia and that it is crucial that practitioners involved in the VAD process are able to recognise coercion and assess capacity. Some medical practitioners with relevant skills and knowledge may not be willing to provide VAD and this must be factored into training enough VAD practitioners.

We note that the Bill sets out eligibility requirements for health practitioners in Part 5 and that this would include the completion of "approved training" as defined in the Bill, but that the details of the training would not be outlined in legislation. Regardless, we consider it important that the training is adequately funded and supports practitioners to undertake VAD assessments underpinned by a genuine and enduring relationship with the person. This is an important safeguard to avoid reliance on potentially simplistic assessments/reviews.

Reporting and evidence-based practice

We note that the Bill's proposed Voluntary Assisted Dying Review Board (the Board) would oversee mandatory reporting on VAD requests, monitor operation of the proposed Act, review individual VAD requests for compliance and record information regarding VAD requests.

We consider that the capture of information around the quality, performance and outcome of activities that result from the legalisation is important. It is imperative that robust and accurate records are kept both at the micro and macro levels and as part of the medical record.

We note that the Bill would prohibit the listing of VAD on a cause of death certificate. It is acknowledged there may be stigma felt by individuals in knowing that VAD may be listed as the cause of death. Even so, there is overriding public interest in having this information available in a de-identified manner. Enabling both the immediate and underlying causes of death to be listed and reported should be considered. Cause of death data must remain completely accurate for future planning of medical care. The cause of death must not only include the terminal illness that made the patient eligible, but also that a substance was taken to provide active assistance to the patient in dying.

Conflict and bereavement support

Adequate family counselling and conflict mediation services will be required in the event of this legalisation. We note that this may not be best addressed within the proposed legislation. However, the broader structures and institutions implementing any legislation must include support systems for individuals, families and health professionals who may be involved and who may suffer personal trauma or other harm because of this involvement, regardless of whether the patient ultimately proceeds with a medically assisted death.

Providers of conflict and bereavement support services must be part of any team implementing VAD legislation within institutions and these services should be separate to palliative care. It should also be noted that many families and healthcare professionals do not currently receive enough support to deal with the deaths they have witnessed.

Summary and recommendations

As outlined above, the existence of divergent views on VAD within the RACP means the College does not have a single position on VAD. However, we wish to emphasise the need for strong, appropriately implemented safeguards to protect potential participants in any such scheme, should it become operational in Queensland or any other Australian jurisdiction. Accordingly, the RACP would like to highlight the following points for the Queensland Parliament's Health and Environment Committee Inquiry into the VAD Bill 2021 to consider:

- Commitment to end-of-life and palliative care must be recognised within any VAD legislation and prioritised by the National Cabinet along with adequate funding.
- Any legislative provisions on conscientious objections to participating in VAD must ensure practitioners are not forced to refer and must extend beyond medical practitioners to multidisciplinary teams and institutions.
- Safeguards against coercion must be central to any VAD legislation and supported by appropriate policies and procedures.
- VAD training must be adequately funded and support practitioners to undertake VAD assessments underpinned by a genuine and enduring relationship with the person.
- Comprehensive monitoring and reporting must be part of VAD legislation to support evidence-based practice.
- Structures and institutions implementing any VAD legislation must provide conflict and bereavement support services for individuals, families and health professionals involved.

The RACP's [Statement on VAD document](#) contains further discussion on our positions relating to VAD and provides detailed guidance and recommendations, starting on page 23.