Submission into the Voluntary Assisted Dying Bill 2021

Submission No.:	1058
Submitted by:	Ben Lawson
Publication:	Making the submission and your name public
Position:	I/We do not support the Voluntary Assisted Dying Bill
Comments in relation to:	Eligibility criteria* ,The request and assessment process,Safeguards,Conscientious objection by either individuals or entities,Oversight and review
Attachments:	See attachment
Submitter Comments:	

Health and Environment Committee
Parliament House
Via Email to hec@parliament.qld.gov.au

1 July 2021

Dear Sir/Madam,

RE: SUBMISSION – VOLUNTARY ASSISTED DYING BILL 2021

I write in reference to the abovementioned bill, to make submission to the committee as they consider the Bill in preparation for its proposed introduction to parliament.

I wish to contribute the following points, referenced to the Bill by section:

S5(a)	The statement that "human life is of fundamental importance" has the effect of being contrary to the entire utility of the Bill which is to provide options to end the life which is stated to be of importance. If it is that important, then why have this Bill at all? This statement requires amendment or erasure to avoid its appearance for appearance sake only.
S5(h) And S16(4)a And S84	The right to a freedom of thought and conscience is contravened in s16(4) whereby the refusing health practitioner must refer the patient to others who they know will in all likelihood will allow the request. The conscience will not be clear if the practitioner knows that they must, under force of law, direct the patient towards the means for achieving the ends that they conscientiously object to. The wording of 16(4)b(i) "likely to be able to assist with" to any reasonable person means another who will grant the person's request.
S7(1)	There is no possible way that this can truly be policed unless the patient is aware of this section. It is impossible to warn patients of this safeguard without initiating a discussion on the subject of Voluntary Assisted Dying (VAD). Further, the only truly objective evidence of this section being breached would be to interview the patient. Who will do this?
S7(2)	This section is contrary to subsection (1), and hence raises the question about why subsection (1) is required at all. I would suggest the two subsections be combined in a 'may/must' series of statements, whereby a practitioner may suggest VAD but a) they must do so only after other exhaustive options have been suggested, and only as a last resort if the likely outcomes are death or significant and ongoing disablement from the activities of daily living (ADLs).
S7(2) and (4)	A nurse practitioner should not be able to facilitate this type of discussion. Differences in registration requirements, education and experience mean that advice regarding the "treatment options" could be less than comprehensive. A VAD discussion should only be able to be undertaken with a board-registered physician.

S8(b)	This is legislating falsity. If a patient is that determined to die at their own hand, then they should take responsibility for doing so, including having that on record. Whilst there is no denying (it is hoped) that the disease, illness or medical condition has been the primary *likely eventual cause* of death, a record of the patient accessing VAD needs to be made. To not do so practically allows a falsehood to be established at law.
S10(1)a(ii)	The Bill needs to be clear here about who makes the determination that death will be expected to occur within 12 months. This should be a minimum of two physicians not associated in any way with each other.
S10(1)a(iii) **Also S10(2)**	'Suffering' is subjective and hence is open to a wide degree of interpretation by different patients. The interpretation can also be affected by a patient's mental health and wellbeing and hence it is possible for a misinterpretation to occur by the patient. As such, there needs to be a degree of *objective* assessment here, which could include a physician interviewing close family members or friends regarding the daily experiences of the patient that they observe.
S10(1)f(i)	This section is subject to abuse, whereby a person may move to Queensland or otherwise have their domicile recorded as being in Queensland, for the purpose of accessing the bill. I suggest that the time period should be 2 years, and that there must be objective evidence, from other persons under oath, that the person has truly resided in Queensland for that time. The first example given in the 'substantial connection to Queensland' test in S11(2) would also be of assistance in making this determination.
S12(2)b	What is the purpose of this section? Isn't the entire Bill designed around 'compassionate grounds'? This section is subject to abuse, as the request regarding ending suffering is always likely to be allowed on 'compassionate grounds', consistent with human nature.
S14(3)	This subsection should require the request to be in writing unless the patient is unable to do so. If they are not able to do so, then the next option is dictation to another person who can write the request for them. Only failing those two options, should the request be allowed to be made 'verbally or with gestures'.
S16(6)b	2 Business days is too short a time. The time should be amended to 5 calendar days, to allow for appropriate time for consideration, and to take in to account the fact that any physician receiving a request on a Friday will have an additional 2 calendar days to consider the request.
S22(1)j	This should not be optional – other medical practitioners who are actively engaged in the treatment of the patient, including the patient's usual General Practitioner (as evidenced by treatment records) must be advised of the request, as an additional safeguard.
S23(1)b	This should be made clear, i.e. the patient must be able to demonstrate, verbally or in writing, to the satisfaction of the practitioner that they understand the points made in s22.

S25	This section needs to be strengthened, to prevent physicians within the same business group or other collaboration from utilising each other as Consulting Assessment physicians. A mechanism such as a register of Consulting Practitioners from which the initial coordinating physician may choose, or a randomly assigned physician from said list, assigned by the board, should be utilised, to prevent abuse of this section.
S26(3)	If the referral consulting physician is exempt from the requirement to provide information regarding another physician whom is 'likely to assist', why isn't the initial physician in S16 afforded the same liberty? The requirement of 16(4) should be removed to mirror this section.
S30(4)	This requirement should not be optional, and hence the word 'may' should be changed to 'must', in order to facilitate a truly informed assessment and decision.
S39	This section should afford witnesses the right (particularly given the certification requirement of (2)a(i) to assess for themselves, by asking the patient directly, whether the patient is signing "freely and voluntarily". The 'appeared to' reference in 1(a)ii weakens the protection that two witnesses are meant to provide in this section and process.
Part 3, Division 4	There should be a time frame dictated as to when the patient can make a second request, similar to the requirement in s43. I would suggest that this timeframe be 14 calendar days.
S42(3)	This and the requirement similar in S14 does not appear to have been replicated in Division 4. Division 4 requires the request to be made in 'the approved form', yet it is not made clear what this approved form is. All three section should be the same.
S43(3)	This period should be longer, to enable ample time for consideration by the patient. A minimum of 14 days, and possibly longer, would be more appropriate.
S52(4)c	This subsection should only make the supply available to the contact person if the patient/person is unable to accept the supply themselves. Affording the right to supply to an agent of the person is inappropriate given the nature of the supply.
S54	The Bill is silent on the requirement to have a witness to witness the *self-administration* of the substance and yet requires a witness for the practitioner administration. The Bill should require that the self-administration of the substance be witnessed by at least one other witness.
S56	This section appears to omit the consideration of what is to occur should the person referred to refuses the role of administering practitioner.

Part 4, Division 2	The appointment of a contact person should occur at a far earlier part of the process, to ensure a comprehensive support to the patient, particularly regarding their making of and considering the outcome of the requests and assessments. This supports the principle outlined in S5(f) regarding support in making informed decisions about end of life choices. I would suggest that this appointment be made immediately after making a first request, and the requirement for same be made clear to the patient by the coordinating practitioner.
S58	The eligibility requirements need to be strengthened in this section. The contact person requirements should be similar to the Statutory Health Attorney requirements in the Guardianship and Administration Act, in that the person should have known the patient well for a prescribed length of time (at least 2 years), unless there is absolutely no person of that description available. Lack of this additional requirement makes this section subject to abuse or inappropriate appointments.
S81(3)	Similar to S8(b), this is legislating the legality of a falsity, and is grossly inappropriate. If a patient is that determined to die at their own hand, then they should take responsibility for doing so, including having that on record. Whilst there is no denying (it is hoped) that the disease, illness or medical condition has been the primary *likely eventual cause* of death, a record of the patient accessing VAD needs to be made. To not do so practically allows a falsehood to be established at law. The death certificate requirement should be that the primary cause of death was the disease or illness, and that the secondary cause was the administration of the VAD substance.
S165	This section should specify a minimum duration of training either in hours, days or weeks. A minimum of 3 days training of at least 75% face-to-face interactive course delivery should be mandated.

I tender this submission and wish the committee well as they consider this significant Bill.

Yours sincerely,

Ben Lawson