Submission into the Voluntary Assisted Dying Bill 2021

Submission No.:	1110
Submitted by:	NPAQ - Nurses' Professional Association of Queensland
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,Administration of the substance,Safeguards,Conscientious objection by either individuals or entities,Oversight and review,Other
Attachments:	See attachment
Submitter Comments:	

1 July 2021

The Nurses' Professional Association of Queensland's submission to the committee for the Parliamentary inquiry into Voluntary Assisted Dying Bill 2021.

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Part I

The Nurses' Professional Association of Queensland (NPAQ) is a non-partisan, industrial association of employees as recognised under section 12 of the Fair Work Act 2009 (Cth) that provides services to nurses, nursing assistants and personal carers. The NPAQ represents over 7,000 nurses, midwives and affiliates.

NPAQ strongly believes the *Voluntary Assisted Dying Bill* 2021 (the Bill) is fundamentally flawed and should not pass whatsoever. An Executive Summary of all points in this submission is provided below. Parts IA and IB provide a detailed explanation as to why VAD should not be legalised and why the Government should pursue increasing palliative care funding instead.

Parts II, III and IV discuss how the Bill should be amended to minimise harm and protect important interests in the event the arguments to oppose the Bill in its entirety are rejected.

An Appendix is provided at the end of the submission.

Executive Summary of Points Raised in this Submission

1. VAD fundamentally contradicts the right to life.

2. Legalisation of VAD will transform the very nature of the profession of nursing away from saving life and doing no harm to the intentional taking of life.
3. The legalisation of VAD is guaranteed to make nurses unsafe, subject to abuse and attacks, damage emotional wellbeing and undermine the health of the workplace. In particular, nurses will be vulnerable to abuse from families, general members of the public (due to a lack of privacy), hostile work environments, trauma and distress inherent in the process and additional workplace burdens. This is simply unacceptable.
4. The importance of VAD's impact on nurses has been totally neglected in the debate. Unfortunately, the QNMU has simply toed the Queensland government line and has failed to properly represent the interests of its own members. Sadly, neither the ALP nor the LNP have given any real consideration to the interests of nurses either.
5. VAD is being pushed as a cheap alternative to the woefully underfunded palliative care sector. The current VAD proposals will entrench a two-tier system where the wealthy will access palliative care and the average person will be left with no choice but to end their own lives.
6. The VAD Bill purports to give patients a choice to access palliative care through mandatory disclosure, but the Government has effectively destroyed that choice.
7. The Government has only guaranteed roughly 35% of needed money and that money is going to bureaucrats, not frontline care. Palliative Care needs to be given $375 million per year to meet needs estimated in conjunction with greater training, nurse led palliative care units and accessible homecare provision.
8. VAD is inherently ripe for abuse.
9. Even if the arguments against VAD are ultimately rejected by Parliament, eligibility requirements must be amended in order to minimise as much as possible the chances of abuse.
10. It is too easy to get away with putting to death those with marginal capacity or doing so through financial/economic coercion. This must be changed.
11. The Conscientious objection provisions for nurses are not good enough. Emotional, professional or liability concerns are not covered and nurses who are emotionally distraught may be forced to participate in VAD.

Nurses with conscientious objections will be compelled by law to still participate in VAD through mandatory referrals and will be strong manned into participation by colleagues or employers. The Bill needs to be changed to reflect these concerns.

- The Bill lacks an institutional conscientious objection provision which also leaves conscientiously objecting nurses vulnerable. The Bill needs to be changed to protect institutional conscientious objection.
- VAD leaves nurses exposed to being criminally prosecuted by the Commonwealth Government and no safeguards exist in the Bill to even notify nurses of this risk, let alone protect nurses. All assurances to the contrary that have been provided are wishy washy and lack substance.

Part IA - The Right to Life and the Role of/ Impact on Nursing

The right to life is a bedrock, fundamental right. The right to life is a moral entitlement that each and every human has irrespective of sex, gender, sexuality/sexual orientation, race, religion, ethnicity, nationality, disability, age or any other characteristic. The right to life is simply a right that springs from the inherent worth of every individual. The right to life is not a product of societal consensus, democratic whim or government fiat, and as such it cannot be morally taken away.

The right to life has been recognised in many different societies across geography and time periods. Article 1 of the UN Universal Declaration of Human Rights declares that all “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.” Article 3 then states “Everyone has **the right to life**, liberty and security of person.”

This understanding is currently contained in section 300 of the Queensland Criminal Code which criminalises unlawful killings of another person, regardless of whether the other person did or did not consent.

In respect to medical ethics, the importance of upholding the right to life through preservation has been a critical part of the medical profession since the Hippocratic Oath. The role of the nurse under the current system is to preserve life and to do no harm. Changing the law to allow for VAD would radically change this role for the worse.

The problem for VAD is the framing advocates use. VAD is framed as a purely private act undertaken by the person who wishes to die, that only concerns that person. This is simply untrue.

As the QLRC admits, attempting to commit suicide is not a criminal offence in Queensland. There are no legal restraints on individuals who currently wish to end their own lives by their own hands. The legal constraints that exist are directed at the participation of third parties in the process of the person ending their own life, either by killing that person (section 300) or aiding and counselling suicide (section 311).

As Australian legal philosopher John Finnis notes, VAD is not a private act. It is an act for seeking assistance from someone else, to share the intention to end the life of the person who wishes to end their own life. Moreover, the assessment of certain criteria before which this process can be undertaken really represents a value judgement on the value of life of the person at various stages of illness.

If a condition is deemed insufficiently serious such that a patient cannot access VAD, that person's life is deemed to be of sufficient value to not authorise VAD. Yet, if someone is suffering from a VAD eligible condition, this involves the law making an assessment that life at that stage is not worth as much.

Ultimately, this reasoning is inconsistent with the right to life, and it also puts nurses in the unenviable position of having to make an assessment (even implicitly) which they simply cannot make, namely the value of the life of the person wishing to end their own life.

In addition to these problems, there have been a host of challenges and burdens placed upon nurses that have been evident from legalisation in other jurisdictions. So far there has been insufficient emphasis placed on these burdens as the debate has mostly focused on the impact on patients. As important as that discussion is, the impact on healthcare professionals including nurses is equally as important.

In the Australian Health Review Rosalind McDougall and a number of other authors explored the implications of VAD for healthcare practitioners in Victoria. They found considerable burdens placed on healthcare staff of various kinds. These are summarised in dot point form below.

A. Abuse directed by family members of persons going through the VAD process against nurses and doctors administering the VAD process. This has resulted in nurses feeling physically threatened by the families of those who are undertaking VAD.

B. Disagreement between medical staff and the family of the person wishing to die in respect to the capacity of the individual to make their own decisions.
C. Capacity is a grey area and has proven difficult to assess.
D. The identity of nurses and doctors participating in VAD was not kept confidential leading to a threat to professional reputation and safety from various members of the public.
E. Decrease in public trust in the work of palliative care specialists.
F. Divisive work environments caused by VAD due to conscientious objectors and other staff judging the morality of each other's actions.
G. Conscientious objectors to VAD being maligned in the workplace and pressured to participate by various persons.
H. Increased conflict discussing VAD laws with patients who are ineligible for VAD.
I. A significant emotional burden placed on staff. Administering VAD is incredibly difficult emotionally.
J. A lack of emotional support for staff administering VAD.
K. Burdensome training requirements including significant time commitments needed to comply with the legal and professional/medical requirements and implications of VAD.
L. The burden of VAD often comes without sufficient increases in remuneration. Thus nurses and other health practitioners are working longer and taking increased administrative burdens with no or insufficient extra pay.

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The experience in other jurisdictions with VAD has not been good for the nursing profession. Many of the issues cited above are inherent problems in any VAD system. They will arise unavoidably as an incident of VAD and they cannot be legislated around if VAD is to exist. These burdens are substantial and extensive. It is unfair to impose these burdens on nurses and may only serve to discourage people entering the profession in the future.

NPAQ observes that the philosophical problems for nurses and the practical ramifications have been totally glossed over. The QNMU has toed the government line and has not stood up for the rights of its members. It has also been incredibly disappointing to observe that neither the ALP nor the LNP has decisively stood against the legislation.

VAD, philosophically and when put into practice damages the nursing profession and should not be legalised.

Part IB - Palliative Care

NPAQ is outraged that VAD is being pushed as the solution to problems so that costs can be cut.

Palliative care is a holistic approach to treating a patient's symptoms from diagnosis to end of life. To be clear, palliative care is not only applicable for end of life care. Palliative care encompasses ensuring health, social, emotional and cultural needs of the patient. Palliative care also involves providing proper grief counselling to families of those affected.

A properly funded palliative care system would resolve many of the issues surrounding end of life care. It would ensure a more equitable, egalitarian system.

The Queensland Government has allotted $171 million between 2021-22 and 2025-26 as an investment in palliative care in addition to $110 million per year. This roughly amounts to $138 million per annum in funding for palliative care in total. To contrast, the Australian Medical Association Queensland (AMAQ) and Palliative Care Queensland roughly estimate the cost of delivering comprehensive palliative care at $375 million per year. The current funding arrangement is barely over 35% of the funding to deliver needs, not even accounting for inflation.

Even worse, the current funding is directed to establishing a department of bureaucrats to formulate rules around palliative care. Not a single cent of the money will actually go to funding frontline nursing care needs.

As NPAQ President, Margaret Gilbert wrote in an op-ed for the Courier Mail, palliative care is underfunded and well overstretched. She noted the evidence suggested a significant unmet need for palliative care in Queensland, and that the treatment gap was widening. Annual referrals to palliative care were increasing by 20% but funding had only increased 5.6% between 2013 and 2019.

NPAQ's research suggested there are up to 71,000 Queenslanders over 65 who require specialist palliative care.

The Explanatory Notes erroneously argues that, "*for some Queenslanders suffering from a life-limiting condition, palliative care is unable to effectively manage their pain, symptoms or suffering*."

Inadequacies in the current palliative care scheme are not inherent defects that can only be remedied by VAD. These inadequacies are a product of specific failures in our current system.

First, a Harvard study found that adequately funded and well managed palliative care resulted in substantially less pain and that pain is well managed. Palliative care is successful at increasing the quality of life and it successfully treats the symptoms of the illness or condition.

Most importantly, the study found successful palliative care drastically reduced the need for admission of patients into emergency departments. Treatment in ICU beds can be incredibly traumatic. Around 2% of patients make it through this process. It is also incredibly costly. The status quo favours traumatic acute care treatment where if we had effective palliative care we would prevent this cost and suffering in the first place.

Second, often suffering in public hospitals is a by-product of a lack of rostered on experienced staff. Within a 24 hour week at a public hospital, 70% of the time is filled by junior doctors and staff. Specialist palliative consultants will often only be present 2 days per week, leaving junior doctors with the lion's share of the palliative work. Unfortunately, due to a lack of experience and expertise, patients cannot have their needs adequately met and often suffer. This is fixable through increased funding for experienced staff and training.

Third, the current system due to a lack of funding has baked in inequality. There is class inequality present. The wealthy can access palliative care. The poor, due to a lack of means, cannot access palliative care. We currently live in a two tiered system that exacerbates the pernicious effects of wealth inequality and poverty in our community.

Besides a poor vs wealthy divide, there is a serious city vs country divide. Many Queenslanders living in regional and rural communities simply cannot access palliative care because those services do not exist in rural areas. Queensland is a very decentralised state, increasing the magnitude of the problem. Under the status quo, many individuals simply commit suicide because of this lack of access. Again, this is not an inherent defect, it is a lack of resourcing.

Fourth, studies from Belgium demonstrate where patients are offered a legitimate choice between well funded palliative care and VAD, they overwhelmingly choose palliative care. Of eligible patients for VAD in Belgium, only 0.37% to 0.94% select VAD. That means between 99.06 and 99.63% select to be palliated. These statistics themselves overstate the prevalence of VAD because it is common for patients who have selected VAD to switch over to palliative care options. If palliative care was inadequate as the Explanatory Notes suggest, we should not expect to find such overwhelming usage.

Fifth, the text of the Bill itself recognises the choice to get palliative care is a fundamental one. Section 7(1) generally prohibits healthcare workers in the course of delivering a healthcare or personal service initiating discussion that is in substance about VAD or in substance, suggest VAD to a person. However, section 7(1) does not apply to a medical practitioner or nurse practitioner if among other things, they inform the person about palliative care options available.

Section 22 states that where a coordinating practitioner is satisfied a person is eligible for VAD, the coordinating practitioner **must** inter alia, inform the person of palliative care treatment options available to them and the likely outcomes of that care and treatment.

So, the legislation notionally recognises the critical importance of palliative care by making disclosure a mandatory requirement as well as excusing discussion of VAD if accompanied by palliative care as an alternative.

The problem is the importance is only notional. How can the legislation imply palliative care is a critical feature of the health system? How can it imply everyone considering VAD has a right to hear of it and access it based on personal deliberation and consideration in light of their specific situation, if in reality the present system cannot cope with the ramifications of the vast majority opting for palliative care?

Information mandates on paper aren't good enough. By themselves they cannot create a real choice which creates an inherent contradiction in the law. The lack of funding makes a mockery of these provisions. Without a good system the provisions are not worth the paper they are written on.

The solution for giving Queenslanders a workable palliative care solution is for the government to front up with the approximately $375 million needed to fund palliative care. But that is not all, NPAQ demands that the health system's resourcing changes. Queensland Health should create and fund nurse-led teams to ensure proper care in state run hospitals, the provision of grief counselling and palliative care delivered to the home.

On the other hand, VAD is a terrible fix that appears to be driven by the worst impulses in cost cutting. It is a cheap "fix" that does nothing to change either resourcing or healthcare system structure and delivery. VAD's legalisation will only encourage the perpetuation of a two tiered system that entrenches income and regional inequality. Those who are unlucky will increasingly opt to end their own lives. This is not the mark of a caring society, it is a tragedy.

NPAQ predicts that if VAD is legalised, it will become a political excuse to ignore the substantive issues with palliative. This will happen because it will be seen as the normal, legitimate option for end of life care. Therefore, there will be no political impetus or will to ever further reform the palliative care system. Not only is VAD not a fix, it will kill better, alternative efforts to address the same problem.

Part II - Eligibility Requirements

Summary of Part Recommendations:

- Amend section 10(1)(a)(ii) to change the time frame from 12 months to 6 months for all conditions except for neurodegenerative disorders which shall remain 12 months.
- Amend section 10(1)(a)(i) to include the word incurable.
- Insert a new section 10(1)(BA) to expressly repeal the presumption of capacity so that individuals seeking VAD will not be presumed to have capacity.
- The new section 10(1)(BA) should require capacity to be proven beyond a reasonable doubt.

Section 10 of the Bill provides for the eligibility criteria to obtain VAD. Section 10(1)(a)(i)-(iii) provides the person must have been diagnosed with a disease, illness or medical condition that is is advanced, progressive and will cause death and is expected to cause death within 12 months and is causing suffering that the person considers to be intolerable.

The Queensland proposal differs from other jurisdictions insofar as all states prescribe a period of time of 6 months for most diseases, illnesses or medical conditions. Tasmania, Victoria and Western Australia do allow for a 12 month timeframe, but only where it involves a neurodegenerative condition.

NPAQ takes the position that the eligibility requirements need to be stricter. While NPAQ believes abuse cannot be eliminated under any VAD system (hence why the legislation should not pass), if VAD was to become law, the law should be constructed to minimise abuse as much as possible.

NPAQ recommends in order to do this, the period of time expected death is going to occur must be within 6 months for all diseases, illnesses or medical conditions except for neurodegenerative conditions where the time limit should remain for 12 months.

NPAQ disagrees with the QLRC's assessment that the timespan should be a flat twelve months. There may be a change in the prognosis of a disease, medical condition or illness within a 12 month span of time. 6 months as a shorter timespan significantly reduces the chances of the prognosis changing and therefore provides a much stronger safeguard against abuse by preventing people who otherwise may have lived from taking or having their life taken.

Furthermore, distinctions based on type of illness are not arbitrary and without principle as the QLRC tries to argue. Neurodegenerative disorders are distinct because they are far more likely than other medical conditions to rob the suffering person of their capacity to make decisions. If there is a limit of 6 months on neurodegenerative disorders where VAD is legal, this may result in higher levels of malfeasance where patients with questionable capacity could be involuntarily killed.

The word incurable should be inserted into the Bill in addition to the phrase "advanced, progressive and will cause death." The phrase incurable is contained within the Victorian and Tasmanian legislation, although it was not included in Western Australian legislation.

The QLRC argues the phrase as it currently stands is clear, precise and reflects current terminology. In contrast, the QLRC argues a requirement for incurability does not materially add to the other eligibility criteria and could cause confusion as to the extent to which alternative treatments need to be exhausted in order to be eligible. They argue an incurability requirement is inconsistent with patient autonomy.

NPAQ notes the QLRC's argument is contradictory. How can the inclusion of the word incurable concurrently fail to materially affect the eligibility requirements while also providing an effective barrier to accessing VAD? The QLRC cannot have it both ways, and NPAQ observes the phrase does materially change the law, and that the QLRC's real concern is that the inclusion of the word incurable will restrict access.

Contrary to the QLRC's position, the inclusion of the word incurable is essential. The word incurable emphasizes access to VAD is a last resort. It emphasizes that all potential means should be exhausted prior to VAD. This is more (but not wholly) consistent with a view in which human life is recognised as inherently precious and valuable and in which every reasonable attempt is made at its preservation.

Under the terms of the legislation, conditions that can be cured are still sufficient to trigger the eligibility criteria. This creates the significant risk of abuse and coercion. Individuals whose lives could still be saved may be pressured by family or unscrupulous doctors, hospitals and insurance companies to end their own lives if costs are minimised. It is almost certain there will be cases in which VAD will be undertaken under this framework as a cost saving exercise. Moreover, governments may be less inclined to support subsidisation of new or relatively experimental treatments since VAD will be seen as a valid and less costly alternative. Directly or indirectly killing the most vulnerable individuals to cut costs is simply abhorrent and intolerable in a civilised, caring society. The mere prospect of even a single case of this arising should be sufficient to amend the legislation to preclude this as far as possible.

Thus far, NPAQ's submission has focused on the eligibility requirements in section 10(1)(a). Other eligibility criteria are contained in the rest of section 10(1). Sections 10(1)(b),(c) and (d) are attempts to curb abuse by requiring the person in order to be eligible to have decision making capacity, to be acting voluntarily and without coercion and to be over the age of 18.

Section 10(1)(b) in particular is nowhere near sufficient to even perform a safeguarding function. To understand why, the law of capacity must be understood.

The Guardianship and Administration Act 2000 (Qld) defines capacity in the schedule 4 dictionary as:

capacity, for a person for a matter, means the person is capable of—
(a) understanding the nature and effect of decisions about the matter; and
(b) freely and voluntarily making decisions about the matter; and
(c) communicating the decisions in some way.
Note—

Under section 146(3) in deciding whether an individual is capable of communicating decisions in some way the tribunal must investigate the use of all reasonable ways of facilitating communication, which may include symbol boards or signing.

The *Powers of Attorney Act 1998* (Qld) under its dictionary contained in schedule 3, defines capacity in an identical way, without the note.

Furthermore, at Queensland law, individuals are presumed to have capacity unless contrary evidence is provided to rebut the presumption. While the substantive tests for capacity in the Guardianship and Administrators Act and the Powers of Attorney Act are suitable, the presumption is totally inappropriate in the VAD context.

The policy underlying the general application of the presumption makes sense. The law values individual freedom and autonomy. If there is a borderline or grey area, the law favours a scenario which gives the benefit of the doubt to the individual so they can pursue their own interests. This is all well and good for things like contracts, wills, making certain medical decisions, etc. but it is simply inapplicable in the VAD context. VAD is a literal life or death decision. It is not remotely analogous to run of the mill decisions needed to be made in order to make life tolerable.

Applying a presumption of capacity in the VAD context will mean in borderline or marginal cases in which there is reasonable doubt as to the capacity of the person in question, the law will favour VAD. This is ripe for abuse. It is almost certain that in borderline cases in which individuals did not have capacity, those individuals will be put to death. As stated above, such scenarios are anathema to a caring, civilised society and cannot be countenanced.

In line with the other recommendations of this part, while we do not recommend passage of the Bill, if it is to pass it must minimise the risk of abuse as much as possible. To do this for capacity, a new section (1)(BA) should be inserted to abrogate the presumption of capacity insofar as it pertains to VAD as contained in this specific Bill. Section (1)(BA) should require that in order for capacity to be found to exist, the relevant assessing medical practitioner must be satisfied of capacity beyond a reasonable doubt.

Part III - Conscientious Objection Provisions

Summary of Part Recommendations :

- Amend section 84(1) to expand refusal rights beyond conscientious objection to include the words unwilling, unavailable and unable to expand the scope of the protection.
- Repeal section 84(2) and add to section 84(1) a right to refuse to refer.
- Insert a new section 84(1A) clarifying that health practitioners need not justify or explain their conscientious beliefs when denying participation in response to a request.
- Repeal sections 91-97 and insert a new section 91 which clarifies institutions have institutional conscientious objection protections and if a patient wants to access VAD, they need to be transferred from the outset. Outsiders should not be permitted into these facilities.

Section 84 of the Bill provides for protections for conscientious objectors to voluntary assisted dying (VAD). Section 84(1) confers on health practitioners, which includes nurses, the right to refuse to do any of the following -

(a) provide information to another person about voluntary assisted dying;
(b) participate in the request and assessment process
(c) participate in an administration decision
(d) prescribe, supply or administer a voluntary assisted dying substance
(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

While the NPAQ objects to VAD in general, if the Bill is to pass notwithstanding that objection, NPAQ strongly recommends significant changes to protect conscience and other valid reasons to not engage in VAD.

NPAQ strongly objects to the provisions relating to a right to refuse to participate in VAD being contained only to conscientious objection.

NPAQ notes elsewhere in the Bill protections for practitioners are more extensive. In section 16 of the Bill, medical practitioners have the right to refuse a request if they have a conscientious objection or are unwilling to to perform the duties of the coordinating practitioner or are unavailable or unable to perform the duties of a coordinating practitioner.

The Explanatory Notes for the Bill state the following:

The QLRC report notes that inclusion of the reference to 'unwilling' recognises that some practitioners may not want to participate for personal reasons other than a conscientious objection (paragraph 8.101). The provision also acknowledges that a practitioner may refuse to act as a coordinating practitioner due to other practical or professional reasons such as a lack of time, or for example, if the person's location is not easily accessible by the practitioner (paragraph 8.102).

Nurses may have personal reservations, they may find the procedure traumatic or distressing, they might be concerned with participating due to criminal or civil liability, they may be concerned with privacy concerns or abuse from distraught families or it could be for other professional reasons distinct from a clearly articulated conscientious objection. All these are valid reasons to refuse to participate and these should be respected by the law.

Therefore, section 84(1) should be amended to include the words unwilling, unavailable or unable so that the protections available to health practitioners mirror those to medical practitioners contained elsewhere in the Bill.

Additionally, the protections for conscientious objection that exist in the Bill are insufficient and are significantly undermined by section 84(2). Section 84(2) provides that where a health practitioner refuses to do anything in (1) due to a conscientious objection, the health practitioner must:

(a) inform the person that other health practitioners, health service providers or services may be able to assist the person; and
(b) give the person—

(i) information about a health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person; or

(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and inform the person seeking voluntary assisted dying not only of the fact other health practitioners or providers are capable of assisting the individual, but also the contact details) about a health practitioner, health service provider or service who may be able to assist the person.

The language of the provisions at issue here are similar to section 8 of the Termination of Pregnancy Act 2018. In relation to those provisions several faith groups cited concerns these provisions would make health practitioners of those faiths morally complicit in the behaviour to which they objected.

The Presbyterian Church of Queensland in its submission to that bill made the following points:

Such a requirement violates the rights of practitioners who both feel such a referral makes them complicit in act of the termination and is contrary to their duty of care for patients. A genuinely secular society which does not privilege the beliefs of one over another should not demand that a patient's freedom of conscience and choice should override a practitioner's. Indeed, it is beneficial for the integrity of health care provision that health care practitioners are able to act as self-consciously moral agents.

Many other faith groups made similar submissions along those lines including but not limited to the Australian Christian Lobby, the Catholic Medical Guild of St Luke, the Archbishop of Sydney for the Anglican Church. All considered the mandatory referral provisions would make affected practitioners complicit in the final act those practitioners were objecting to and thus these provisions totally undermined the purpose and effect of conscientious protection provisions in the other parts of the Act.

Analogous logic dictates that nurses of such faiths may hold similar moral objections to compelled referrals for VAD. Therefore, many nurses from those faiths will view themselves as morally complicit in VAD if they comply with the requirements in section 84(2).

NPAQ is not a religious organisation, and its objections to the conscientious objection provisions do not stem from any religious source. However, NPAQ is an organisation whose members come from a diverse range of faiths or lack of faith in the community, and the right of each individual member to practice their profession in accordance with their faith is a fundamental human right which is of paramount importance to NPAQ.

For this reason, NPAQ strongly opposes section 84(2) of the Bill and strongly recommends that even if the committee does not ultimately agree with NPAQ's argument against the Bill as a whole, it should nonetheless amend section 84(1) to include within its protections of conscience the right of the health practitioner to refuse referral to or provision about another provider.

Furthermore, on the webpage of the Queensland Government website on VAD, entitled '*Information for Practitioners*', it states that if a health practitioner receives a request and has a conscientious objection, the health practitioner must "immediately inform the person of their refusal and the reason for their refusal." The URL to the webpage is provided below to verify thus.
[redacted]

Nowhere in the text of the Bill or in the Explanatory Notes is this obligation provided. Nevertheless, NPAQ is very concerned about this idea because it could be used to publicly pressure those with conscientious objections into the difficult choice of publicly justifying their beliefs or losing the ability to exercise their right to their conscience. This could also involve entangling the State in questions of the metaphysical or philosophical validity of various religious, spiritual or non-religious moral beliefs. Therefore, for the avoidance of doubt, the Bill should provide expressly in a new section 84(1A) that there is no obligation to justify or explain the conscientious objection.

Finally, there are problems with the Institutional conscientious objection provisions in the Bill. NPAQ emphasizes that if VAD is to exist, institutions must also be conscientiously protected. Unfortunately, the provisions around institutional conscience totally undermine the professionals in those institutions.

Section 92 mandates that where a facility does not provide first request services, the facility must allow a medical practitioner whose presence is requested by the patient and where that medical practitioner is eligible to act as a coordinating practitioner or is a coordinating practitioner on a final request, reasonable access to the person at the facility. Similar provisions exist for second requests in section 93, first assessments under section 94, consulting assessments in section 95, administrative decisions under section 96 and most vitally, allow access to practitioners and witnesses to administer the fatal drug.

In other words, institutions which have conscientious objections will be compelled by law to allow access to patients within their care in order for those patients to participate in their own death up to and including the administration of their death.

From the perspective of nurses, it means nurses who choose to be employed at facilities which reflect their conscientious beliefs around VAD are still going to be subject to the reach of VAD. Compromising institutional conscience does not just compromise the conscience rights of the CEO or head of the facilities, it compromises the right to conscience of everyone working in that facility who take their duties to act in the best interests of their patient incredibly seriously.

It is simply untenable as a matter of law to allow for outsiders to facilities which conscientiously object to come in and out of those facilities, often unsupervised, and carry out VAD. It increases risks of abuse because the person's primary healthcare providers are not doing assessments and it creates potential liability issues for the nurses who owe a duty of care. The provisions, by allowing such broad interference by outsiders, are totally inconsistent with a holistic duty of care owed by the facility while the resident is still under its care.

NPAQ urges the committee that if the Bill is to pass, protections for institutional conscience must be far better. NPAQ recommends instead of the convoluted regulatory structure that allows for outsiders to traipse in and out of facilities, that the facilities transfer the patient out on an initial request to another facility from the outset, contained in a new section 91. Therefore, sections 91-97 in their present forms would be removed. This would not be a radical step given institutional conscience is already protected in South Australian legislation. There is no reason Queensland should be any different.

Part IV - Usage of Carriage Services for Suicide Related Material

Summary of Part Recommendations:

- The Bill should not pass because of the risk of liability, but if the Bill is to pass it needs amendment to address Commonwealth criminal liability. The current provisions are inadequate.

- Amend the Bill to include a new section providing a duty for employers to notify nurses of the presence of the Commonwealth provisions, the terms and scope of those provisions and warn nurses how liability could attach to actions they undertake using carriage services.
- Provide the new duty is enforceable by civil penalties.

The Commonwealth Criminal Code criminalises using a carriage service for suicide related material. Section 474.29A and Section 474.29B of the *Criminal Code Act* 1995 (Cth) provide various prohibitions. The text of the Act is quite long, so instead of excerpting the Act, tables summarising the relevant provisions are provided in the Appendix.

As can be seen, a wide variety of conduct relating to suicide involving carriage services is criminalised. These include counselling or assisting suicide, promoting suicide, giving instructions on suicide, possessing or supplying suicide related material intended to counsel or provide instruction on suicide.

Suicide is undefined in the Act. De Villar et al. discuss the various precedents surrounding suicide at common law and note under the traditional common law understanding of suicide, notwithstanding uncertainty, would include VAD. This is especially since the provisions became law in 2005 well before VAD became legal in some States.

The Explanatory Notes state that as a matter of Queensland law at the moment, as contained in the Criminal Code, aiding or counselling another person to commit suicide is unlawful under section 311. Due to section 311 and 300, it is unlawful to legally assist someone committing suicide. These provisions reflect a traditional understanding of suicide that included VAD, and therefore, the need to amend them in order to legalise VAD provides more evidence the understanding of suicide at the Commonwealth level includes VAD.

Therefore, performing the acts mentioned above using telephone, email or postal services is a criminal offence. The consequences for breach by an individual can be a fine of up to approximately $222,000.

The Explanatory Notes touch on these concerns and state the follow:

The Commonwealth Criminal Code (Criminal Code 1995 (Cth)) makes it an offence to use a carriage service (such as a telephone, videoconference, email or other *forms of electronic communication) to publish or distribute material that counsels or incites committing or attempting to commit suicide. The QLRC report states concerns have been raised about whether providing information and advice about voluntary assisted dying via a carriage service would contravene these Commonwealth offences (paragraph 20.4).*

The QLRC report notes that "uncertainty about the possible application of the Commonwealth 'carriage service' offences to conduct that is authorised by state voluntary assisted dying laws is unsatisfactory" (paragraph 20.74) and recommends that Queensland and other states with voluntary assisted dying laws raise the issue of legal uncertainty with the Commonwealth government (Recommendation 20-1).

As an interim measure, the QLRC also recommends the Commonwealth Director of Public Prosecutions be asked to consider issuing prosecutorial charging guidelines indicating that the Commonwealth Criminal Code offences will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state or territory voluntary assisted dying laws (Recommendation 20-2).

To say as the Explanatory Notes do, that the current legal position viz a viz the Commonwealth is unsatisfactory is an incredible understatement. Absolutely zero certainty is provided to nurses. Nurses who participate in VAD either for private facilities or for Queensland Health are going to be potentially exposed to criminal liability.

It is not good enough for the Queensland Government to request prosecutorial discretion from the Commonwealth DPP, this simply means nurses' futures are at the mercy of whichever administration happens to be in Canberra. What happens if the family of the deceased is upset with VAD and decides to press charges against the nurse for breach of Commonwealth law? There is no guarantee charges will not be pressed.

In addition, there is no real legislative fix to the problem. The legislation is validly enacted pursuant to Section 51(v) of the Constitution that gives the Commonwealth the power to legislate in respect to postal, telegraphic, telephonic, and other like services. Section 109 of the Constitution states that a validly enacted Commonwealth law prevails over a State law where there is inconsistency to the extent of the inconsistency. Even if the definition of suicide is amended at the State level, it cannot affect the interpretation of Commonwealth legislation.

The presence of sections 474.29A and 474.29B provide a further reason not to legislate VAD. They also provide good reason to further expand the right to refuse provisions mentioned above. NPAQ strongly urges that even if VAD goes ahead, the Bill must be amended to require that employers have a duty to warn nurses of the presence and terms of the Commonwealth law and describe how criminal liability may exist if they perform their duties using a carriage service. Failure to warn nurses should trigger civil penalties.

For further information, please contact the submitters on the details provided on page 1.

Yours sincerely,

Gilbert

Margaret Gilbert
President
Nurses' Professional Association of Queensland
[redacted]

Signed: 1 July 2021

Yours sincerely,

Aenghas Hopkinson-Pearson,
State Secretary

[redacted]

Signed: 1 July 2021

Appendix

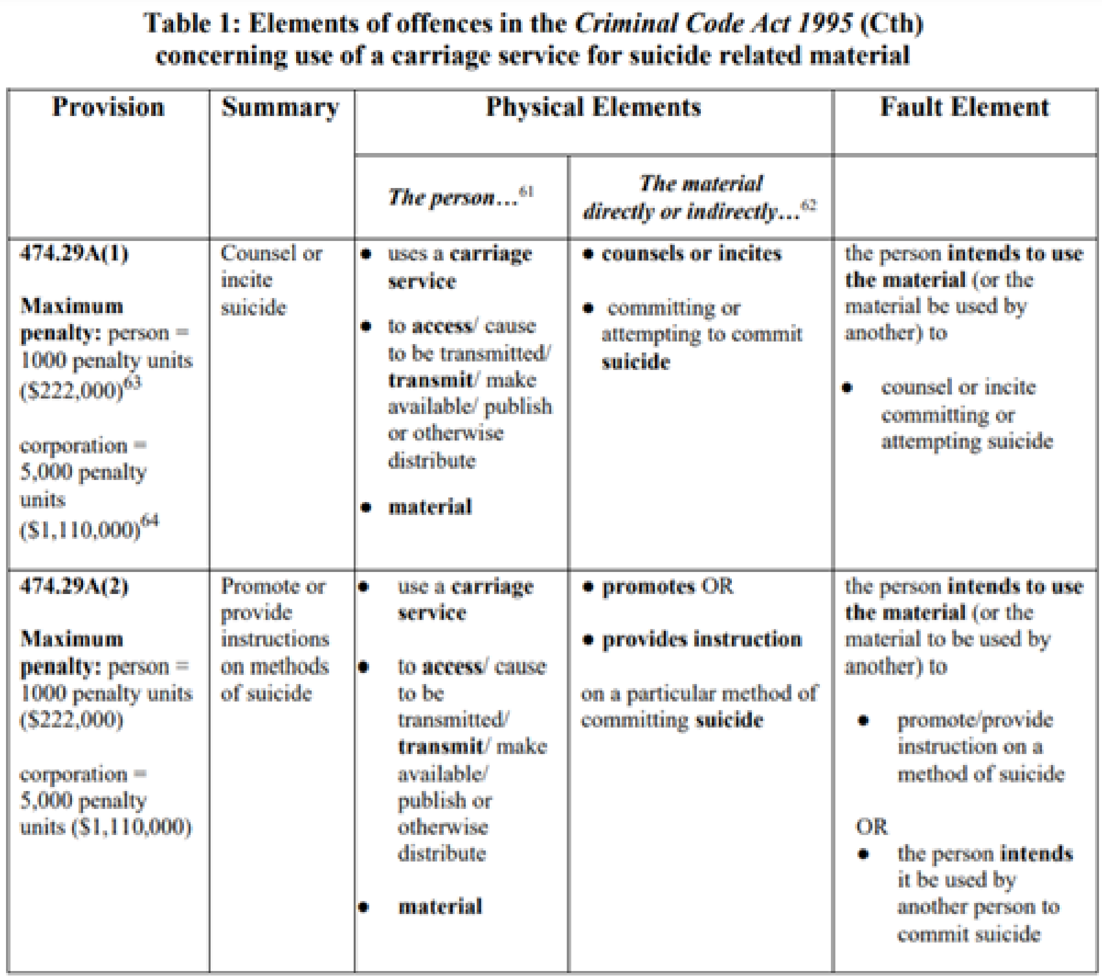

Table 1: Elements of offences in the *Criminal Code Act 1995* (Cth) concerning use of a carriage service for suicide related material

Provision	Summary	Physical Elements		Fault Element
		The person…[61]	***The material directly or indirectly…***[62]	
474.29A(1) **Maximum penalty:** person = 1000 penalty units ($222,000)[63] corporation = 5,000 penalty units ($1,110,000)[64]	Counsel or incite suicide	• uses a **carriage service** • to **access**/ cause to be transmitted/ **transmit**/ make available/ publish or otherwise distribute • **material**	• **counsels or incites** • committing or attempting to commit **suicide**	the person **intends to use the material** (or the material be used by another) to • counsel or incite committing or attempting suicide
474.29A(2) **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Promote or provide instructions on methods of suicide	• use a **carriage service** • to **access**/ cause to be transmitted/ **transmit**/ make available/ publish or otherwise distribute • **material**	• **promotes** OR • **provides instruction** on a particular method of committing **suicide**	the person **intends to use the material** (or the material to be used by another) to • promote/provide instruction on a method of suicide OR • the person **intends** it be used by another person to commit suicide

Table 1: Summarisation of Section 474.29(1) and (1A). Sourced from Del Villar, Katrine, Eliana Close, Rachel Hews, Lindy Willmott, and Ben White. "Voluntary assisted dying and the legality of using a telephone or internet service: The impact of Commonwealth 'Carriage Service' offences." *Monash University Law Review* 47 (2020).

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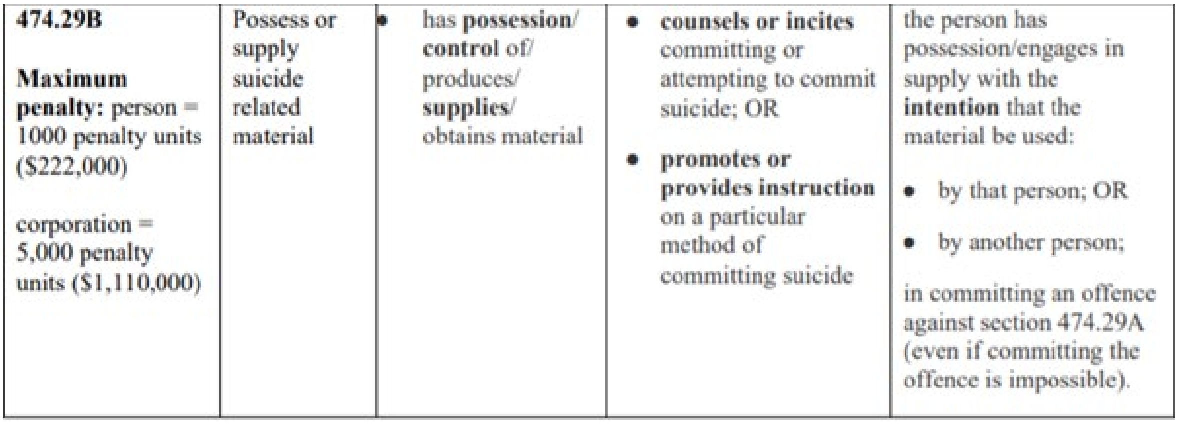

474.29B **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Possess or supply suicide related material	• has **possession/ control** of/ produces/ **supplies**/ obtains material	• **counsels or incites** committing or attempting to commit suicide; OR • **promotes or provides instruction** on a particular method of committing suicide	the person has possession/engages in supply with the **intention** that the material be used: • by that person; OR • by another person; in committing an offence against section 474.29A (even if committing the offence is impossible).

Table 2: Summarisation of Section 474.29B. Source: Ibid.