

**Committee Secretary**

Health and Environment Committee

Queensland Parliament

by email: hec@parliament.qld.gov.au

2 July 2021

Dear Committee Members

Re: Submission to the Inquiry into the Voluntary Assisted Dying Bill 2021**Executive Summary**

In this submission, I address select issues that the Committee may wish to consider during its Inquiry into the Voluntary Assisted Dying Bill 2021. Where appropriate, I make recommendations based on my research in the end-of-life field, which I have been pursuing over the last decade with colleagues at the Australian Centre for Health Law Research at Queensland University of Technology (QUT).

I note that the policy behind the Bill has received extensive consideration by the previous Parliamentary Committee. Additionally, the Bill itself has had extensive justification by the Queensland Law Reform Commission in its Report. This submission therefore focuses only on a few key issues regarding the Bill which relate to my research.

Overall, the Voluntary Assisted Dying Bill 2021 represents a measured approach to key challenges that have been identified in other Australian jurisdictions that have legalised voluntary assisted dying. This submission will focus on the following issues:

1. The critical importance of addressing key aspects in the Bill itself
2. Conscientious objection by individuals and the duty to refer
3. Objections by entities
4. Implications of the Commonwealth Carriage Service legislation

Background

I am a member of the Australian Centre for Health Law Research (ACHLR), a specialist research centre within QUT's Faculty of Law. ACHLR undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in health law, ethics, technology, governance and public policy.

Since 2012, I have pursued research into various aspects of end-of-life law, policy, and practice. My PhD research on law and policy regarding conflicts over life-sustaining treatment was funded by the QUT's National Health and Medical Research Council Centre of Research Excellence in End-of-Life Care and was awarded QUT's Outstanding Doctoral Thesis Award. I have collaborated with Professor Ben White and Professor Lindy Willmott (who were my PhD supervisors) on a number of research projects and publications in the end-of-life field. As part of this work, I contributed extensively to content development for the legislatively-mandated training for practitioners involved in voluntary assisted dying in both Victoria and Western Australia.

I am currently the Postdoctoral Research Fellow on the ARC Future Fellowship, *Enhancing End-of-Life Decision-Making: Optimal Regulation of Voluntary Assisted Dying*, led by Professor Ben White (see <https://research.qut.edu.au/voluntary-assisted-dying-regulation/>). This is a four-year funded project that aims to develop an optimal regulatory framework for VAD in Australia, examining the operation of laws, policies, professional standards, training, education and other regulatory mechanisms. As part of this project I am leading a case study of how voluntary assisted dying regulation operates in Canada, to serve as a comparator for Australia. I am also lead author on a comprehensive review of Victoria policy documents regarding voluntary assisted dying (this work is currently being finalised to submit for publication, and is co-authored by Professors White and Willmott).

This submission sets out some key areas to consider based on my research, and my experience in developing the voluntary assisted dying training in Victoria and Western Australia. Please note that this submission represents my views and does not necessarily reflect the views of other members of ACHLR or QUT. For this reason, I request that any mention of this submission is attributed to me in my capacity as an academic, and not to ACHLR, the Law Faculty or QUT as entities.

1. The critical importance of addressing key aspects in the Bill itself

A threshold point to emphasise is the importance of addressing key aspects of voluntary assisted dying in the legislation itself. This is preferable to relying on policy alone, which is the approach that has been adopted in Victoria for some issues (and, for example, in Canada in relation to conscientious objection). The argument that regulation via legislation is preferable to policy is made in [Ben White, Lindy Willmott, Eliana Close and Jocelyn Downie](#),

[‘Legislative Options to Address Institutional Objections To Voluntary Assisted Dying in Australia’ \(2021\) 3 UNSW Law Journal Forum 1](#) at pages 13-14.¹

The QLRC highlighted this aspect of our paper (above) in its discussion of non-participation by entities.² However, it is important to recognise this point extends to other aspects of the Bill beyond objections by entities (and indeed this was a repeated theme in the QLRC’s report). For example, it also applies to the duty to inform in response to a conscientious objection by individuals, and to the definition of suffering, for example (two aspects that the Victorian *Voluntary Assisted Dying Act 2017* is silent on).

Empirical evidence supports the importance of including detailed regulation in the legislation. Research across other international jurisdictions that have legalised VAD indicates that health practitioners perceive policies on VAD lack clarity and require interpretation by individual clinicians.³ A reason for this that policies are often framed as statements of principle, and can lack granular detail. Additionally, clinicians in practice are often subject to a variety of policy statements and ethical codes, which may have varying degrees of normative force and can conflict. Consequently, clinicians may be uncertain about how to interpret policy documents, or interpret individual criteria such as ‘intolerable suffering’ according to their subjective values.⁴

Defining and addressing key aspects in the legislation (supplemented with appropriate policies) is preferable to regulating these issues by policy alone. In contrast to policies, legislation is more authoritative, and can be relied on by parties to enforce their rights. This promotes more consistency in practice and will better protect individual patients. Therefore, as set out below, it is appropriate that the Bill addresses factors including the duty to provide information and objection by entities in the legislation itself.

2. Conscientious objection by individuals

I broadly support how conscientious objection for registered health practitioners is framed in clause 85 of the Bill (though prefer the referral model set out in the White and Willmott bill). Since the Bill has adopted a provision of information model, rather than one requiring referral, I suggest that the Committee may wish to consider additional protections for patients in the way this provision is framed.

It is appropriate that registered health practitioners are permitted to conscientiously object to participate in voluntary assisted dying, due to the deeply-held divergent views on the subject. However, given registered health practitioners’ special status in the healthcare system as key gatekeepers of access to medical care, it is important that this right to

¹ B White, L Willmott, E Close, J Downie, ‘Legislative Options to Address Institutional Objections To Voluntary Assisted Dying in Australia’ (2021) 3 *UNSW Law Journal Forum* 1.

² See, eg, Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying*, Report No 79, May 2021, p 493.

³ T Patel et al, ‘Clinician responses to legal requests for hastened death: a systematic review and meta-synthesis of qualitative research’ (2021) *BMJ Supportive and Palliative Care* doi: 10.1136/bmjspcare-2019-002018.

⁴ *Ibid.*

conscientiously object does not impede patients' access to lawful medical services.⁵ This gatekeeping function is particularly salient in rural and regional areas where individuals often do not have meaningful choices of healthcare providers.⁶ Patients rely on their health care providers (particularly GPs) to provide them with information and support to access services they seek. Some patients do not have the resources or may not be healthy or able enough to access services without the support or referral of a doctor.⁷

To ensure that patients are adequately supported they must at a very minimum: 1) be made aware of a health practitioner's objection; and 2) referred to a health practitioner or service that can help them. Referral here does not need to mean referral in the clinical sense, but can involve positive steps to connect a patient to an entity (such as the Care Navigators) or individual practitioner that can help them.⁸

In Victoria, the *Voluntary Assisted Dying Act 2017* (Vic) provides that a medical practitioner who refuses a first request must inform the patient about their conscientious objection. However, on the second point, the Act is silent on whether registered health practitioners who conscientiously object must provide information or refer a patient to another practitioner or service. While some professional guidelines, including the Victorian health practitioner guidelines for voluntary assisted dying and more general ethical codes of conduct (eg the MBA Code of Conduct and the AMA Statement on Conscientious Objection) suggest that objecting practitioners have a duty to inform the patient, it is not known the extent to which this happens in practice in relation to voluntary assisted dying. As noted in section 1, it is preferable to address these issues in the legislation itself.

The Bill has stopped short of requiring a referral in the clinical sense, and instead has preferred a model of information provision, which places a positive obligation on the patient to then make further inquiries. This position places only a minimal requirement on objecting practitioners. In the absence of a positive duty to refer, to further support the patient within this model, the Committee might consider recommending that it is also appropriate to include:

- A provision that states these steps must occur in a timely manner.⁹ This is critical in relation to voluntary assisted dying, because delays could lead to adverse outcomes for patients. These include a longer period of suffering, worsening medical condition,

⁵ This gatekeeping function is highlighted in a Canadian court case regarding the College of Physicians and Surgeons of Ontario's effective referral policy for medical assistance in dying, *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393. See College of Physicians and Surgeons of Ontario, *Medical Assistance in Dying* (June 2016, updated April 2021) College of Physicians and Surgeons of Ontario <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying>.

⁶ *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393, [42].

⁷ *Ibid* [43].

⁸ See, eg, College of Physicians and Surgeons of Ontario, *Advice to the Profession: Medical Assistance in Dying* (updated May 2021) <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying/Advice-to-the-Profession-Medical-Assistance-in-Dyi>.

⁹ This issue is emphasised in the College of Physicians and Surgeons of Ontario Policy, above n 5, and in its *Advice to the Profession*, *ibid*.

and compromised access due to the risk of a loss of decision-making capacity. This could be included in cl 85 (in addition to the requirements in cl 16 in relation to a first request) so it would also apply to those seeking information about voluntary assisted dying and not just those making a formal first request.

- A provision that states that a registered health practitioner must transfer medical records, upon request from another practitioner, for the purpose of facilitating voluntary assisted dying. This would accord with the Bill's aim to promote high quality care and treatment in clause 5(d).
- A provision that states the health practitioner must continue to provide all medical services to the patient that are unrelated to voluntary assisted dying, unless the patient requests otherwise or alternative arrangements are in place. This provision appears in the policy guidance in the Canadian province of Nova Scotia, for example.¹⁰

These provisions would help ensure that patients are supported to access voluntary assisted dying if they wish to do so, and are not abandoned for their choice. As noted, this is particularly important for patients in rural and regional areas, given their relative lack of choice over health care professionals and the problems posed by the Commonwealth Criminal Code in rural and remote areas.

3. Objection by entities

The provisions relating to objections by entities are one of the most significant parts of the Bill. For the reasons set out by the QLRC, I agree that it is critically important that the Bill address objections by entities, to balance the competing interests of patients and institutions who may seek not to participate.

The Committee may find it instructive to refer to our paper on this issue, which was cited extensively by the QLRC in Chapter 25 of its Report and is attached to this submission: [Ben White, Lindy Willmott, Eliana Close and Jocelyn Downie, 'Legislative Options to Address Institutional Objections To Voluntary Assisted Dying in Australia' \(2021\) 3 UNSW Law Journal Forum 1.](#)¹¹

This issue is complex and the Bill appropriately places emphasis on protecting patients in facilities where they are permanent residents (ie the facility is the person's home). The detailed treatment of objection by entities is appropriate, particularly the requirements to consider adverse effects on the patient when a transfer is proposed.

¹⁰ This obligation is included in the College of Physicians and Surgeons of Nova Scotia, *Professional Standard Regarding Medical Assistance in Dying*, (2018) https://cpsns.ns.ca/wp-content/uploads/2018/12/ProfessionalStandard_MedicalAssistanceInDying_Dec2018.pdf, s 4.3.4.

¹¹ B White, L Willmott, E Close, J Downie, 'Legislative Options to Address Institutional Objections To Voluntary Assisted Dying in Australia' (2021) 3 UNSW Law Journal Forum 1.

4. Limitations imposed by the *Commonwealth Criminal Code*

The challenges for voluntary assisted dying consultations presented by the *Commonwealth Criminal Code Act 1995* provisions relating to communicating about 'suicide' via a 'carriage service' are well known. These issues were canvassed extensively by the QLRC in Chapter 20 of its Report. The access problems for patients and families that have been reported in Victoria caused by the Commonwealth Code are likely to be exacerbated in Queensland, with its vast geography. It is regrettable that the Commonwealth government appears staunch in its refusal to remedy these problems.

The Committee may wish to refer to our paper on the carriage service issue, which was considered extensively by the QLRC and is attached to this submission: [Katrine del Villar, 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' \(2021\) Monash University Law Review \(In Press\).](#)

In our paper we provide a detailed legal analysis and argue that it is critical that the Commonwealth government clarify that voluntary assisted dying under State law is not 'suicide' under the Code. In the absence of doing so, the Commonwealth Attorney General should issue prosecutorial charging guidelines indicating that health practitioners acting lawfully under state laws will not be prosecuted.

The Committee may also wish to consider the Victoria and Western Australia's respective approaches to this issue in their guidelines. At the time of the QLRC's report, the Western Australian guidelines for practitioners were not yet public. The Victorian Government has recommended that all voluntary assisted dying consultations occur in person.¹² In contrast, Western Australia has adopted a more nuanced approach and has indicated that practitioners can discuss general information but should avoid discussing any information that relates to the act of administering a voluntary assisted dying substance over a carriage service.¹³ The Western Australian guidance aligns more closely to the areas of risk set out in our paper (above), but requires health practitioners to exercise a greater degree of judgment and therefore places a bigger burden on health practitioners to manage and assess risk themselves. This diversity in guidance emphasises the uncertainty created by the Code and emphasises the need for Commonwealth reform to ensure consistent practice.

Another issue that we raise in our paper (above), which the Committee may wish to consider, is that practitioner administration is highly unlikely to infringe the Commonwealth Criminal Code. This is because, unlike voluntary assisted dying by self-administration, practitioner administration does not satisfy the legal definition of suicide as 'self-killing'. This underscores the importance of allowing broader access to practitioner administration. We have argued in another paper that there are good reasons to allow patients to choose

¹² Department of Health and Human Services, Victorian Government, *Voluntary Assisted Dying: Guidance for Health Practitioners* (Policy Document, July 2019), p 74.

¹³ Department of Health, Western Australian Government, *Western Australian Voluntary Assisted Dying Guidelines* (Policy Document, June 2021), <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-guidelines.pdf>, p 26.

the method of administration of the voluntary assisted dying substance.¹⁴ The challenges presented by the Commonwealth Code are another reason to permit practitioner administration in broader circumstances.

Thank you for the opportunity to contribute to this Inquiry. I would welcome the opportunity to give evidence at a public hearing of the Inquiry, if called upon.

Yours sincerely

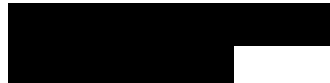


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¹⁴ B White, K Del Villar, E Close & L Willmott, 'Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417.