LUTHERAN CHURCH OF AUSTRALIA
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13 July 2021

The Secretary
Health and Environment Committee
Parliament House
George St
Brisbane Queensland 4000

Dear Secretary

The Lutheran Church of Australia Queensland District is grateful for the invitation to make a submission to the Health and Environment Committee on the *Voluntary Assisted Dying Bill 2021* and to appear to provide evidence at a hearing on 14 July 2021.

We request the Committee Chair seek leave to table this submission as evidence for the purposes of the Committee's consultation. We also attach the Lutheran Church of Australia's November 2020 submission to the Queensland Law Reform Commission consultation on a *Legal framework for voluntary assisted dying.* Our submission outlines our concerns and recommendations about any law that provides for Voluntary Assisted Dying (VAD) in Queensland.

The question of VAD is a deeply vexing issue. The Lutheran Church of Australia approaches the question of death not just from a philosophical perspective. We provide best practice palliative care to hundreds of Queenslanders each year as part of providing more than 550,000 days of residential aged care and retirement living annually. Our perspective is shared by other aged care providers who support over 40,000 older Queenslanders receiving more 10,000,000 days of seniors housing each year.

VAD is a serious departure from the long held medical and legal traditions of respecting life and supporting the whole person until death. We see life as a gift and as people progress towards death our role is to provide spiritual, physical, and emotional care where pain is managed in a loving and supportive way.

However, it is clear in Queensland that the majority seek access to some type of a VAD scheme and the Parliament is now considering a Bill. We are not insensitive to the pain and distress that many Queenslanders feel when they or their loved ones have a traumatic death, or dismissive of their desire that a scheme be established.

The role of these Committee hearings and indeed the Parliament as a whole, is to ensure any VAD legislation provides considerable safeguards, is balanced, implementable and crucially does not

have unintended consequences, or worse, contain wholly foreseeable perverse consequences as are included in the Bill in its current form.

In effect, the adoption of the Bill in its current form makes the rights of the individual to seek VAD central and overriding of the rights of others. Clearly, those who do not support the scheme, or, may support it for others but seek to conscientiously object, are broadly disregarded.

We will be pleased to provide further information if requested. This submission should be considered in combination with the verbal evidence provided by Mr. Nick Ryan, Chief Executive Officer of Lutheran Services, at the Committee's hearings.

Yours sincerely

+ Mark Vainikka
Bishop-Elect
Lutheran Church of Australia Queensland District

Attach.

Attachment One

LUTHERAN CHURCH OF AUSTRALIA | QUEENSLAND DISTRICT

About the Lutheran Church of Australia

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The people of the Lutheran Church in Queensland continue to serve within communities in Queensland in over sixty-five parishes with eleven aged care services, three Youth and Family Support Centres, five places for care for people with disabilities and two Youth Camp Sites.

The education of many thousands of young people in twenty-seven schools and fifty-eight centres for early childhood work is a crucial service of the District.

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Lutheran Services is a for-purpose agency of the Lutheran Church of Australia Queensland District, located in communities throughout southeast and central Queensland, with over 1500 qualified and dedicated staff, serving 920 aged care residents, 364 retirement living residents and over 300 home care clients. Our services to older Queenslanders include

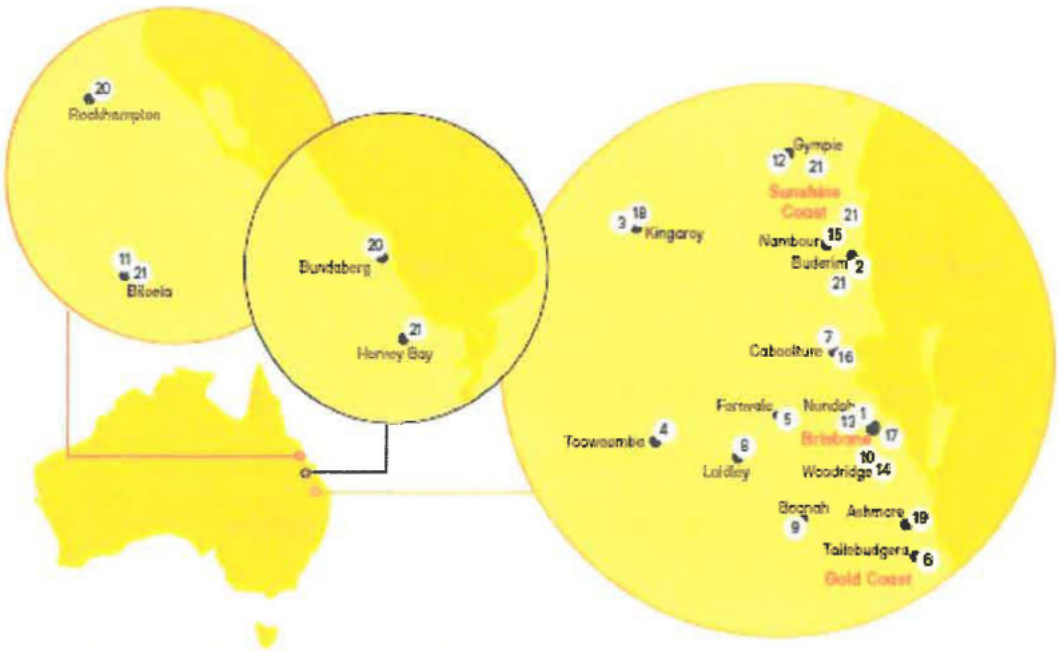
residential aged care, residential respite, independent retirement living, home care and allied health services.

Lutheran Services is dedicated to quality aged care for older Australians and continuously seek to improve the way we deliver this care. We cater for all needs and budgets, with a focus on each resident's health and wellbeing no matter what their diagnosis – including many of our residents living with dementia and Alzheimer's disease.

Lutheran Services provides palliative care for our residents, in a supportive and familiar environment. Our onsite and full time Lutheran chaplains offer all residents and their family members spiritual and emotional support to assist them to find a sense of meaning, security and hope including during end-of-life care. As such, we can attest to the effectiveness and compassion of palliation within a supportive community.

Lutheran Services also provides quality support and accommodation for young people and their families, people living with a disability or mental illness and people experiencing domestic violence and hardship.

As part of the Lutheran Church, Lutheran Services walks together with congregations, people and communities to tend to human need in the spirit of Christian love and service.



Our Service Reach

Residential Aged Care, Retirement Living & Home Care

1 Alondra Residences Nundah
2 Immanuel Gardens Buderim
3 Orana Kingaroy
4 Salem & Northridge Salem Toowoomba
5 Somerset Fernvale
6 St Andrews Tallebudgera
7 St Paul's Caboolture
8 Tabeel Laidley
9 Teviot Boonah
10 Trinder Park Woodridge
11 Wahroonga Biloela
12 Zion Gympie
13 Zion Nundah

Community Services

14 Bridges Reconnect Woodridge
15 Graceville Centre Nambour
16 Intercept Caboolture
14 Karawatha Community Woodridge
14 Keystone Centre Woodridge
17 Mary and Martha's Refuge Brisbane
18 Orana Kingaroy
5 Somerset Fernvale
19 Trinity Ashmore

Senior Wellbeing Programs

20 Wellbeing & Positive Ageing Program
21 Moving Moments

Service Stream key

- Youth & Family
- Disability
- Mental Health
- Retirement Living
- Home Care
- Moving Moments
- Aged Care & Respite Care
- Wellbeing & Positive Ageing Program

LUTHERAN CHURCH OF AUSTRALIA | QUEENSLAND DISTRICT

Attachment Two

Health and Environment Committee of the Queensland Parliament

Comments and Recommendations[1] concerning the

Voluntary Assisted Dying Bill 2021

Presented by the Lutheran Church of Australia

14 July 2021

1. **Eligibility to access VAD**
   - Section 10 currently provides for a period of 12 months before *expected death*.
   - Section 10 currently includes both physical and mental suffering as meeting the criteria for access to VAD.
   - A premise underlying the Bill is that a person has a *choice* between palliation and VAD. The Bill does not require that a person seeking VAD be assessed a palliative care specialist prior to seeking VAD. This is hardly an informed choice. Rather the person sees a doctor who may have little or no specialization in palliation.

     1. We recommend that eligibility for VAD be for those whose condition is likely to result in death within six months (not twelve months as per the current Bill).
     2. We recommend eligibility for VAD be for those experiencing physical pain (and not psychological pain).
     3. We recommend that a person seeking VAD first be assessed and advised by a recognized palliative care specialist so they can make an informed choice as to the real comparison between VAD and palliation.

[1] Unless otherwise specified, all references to sections of the Act refer to the *Voluntary Assisted Dying Bill 2021*.

2. **Conscientious Objection and entities**
   - The Bill in s.84 appropriately provides for the conscientious objection of *individual* health practitioners enabling them to opt out of the scheme.
   - Unlike provisions in other jurisdictions, there are insufficient protections for *entities* expressing a conscientious objection to VAD.
   - The Bill as it stands specifies obligations on entities to not hinder and many cases facilitate access to information, referrals, access to VAD practitioners, transfers for persons seeking assessment as per s.92 (3), or access to the administration of VAD, and, to host on their premises the administration of VAD medications resulting in death.
   - Other than expressing a conscientious objection the entity has no rights whatsoever other than to comply with the various decisions of a Practitioner whether they be consulting, coordinating and/or administering.

4. We recommend the State of Queensland, should it seek to establish a VAD scheme, be wholly responsible for the public communication surrounding the scheme and any and all practical actions to enable this to occur.
5. We recommend entities expressing a conscientious objection should be *wholly* exempt from any involvement in the scheme.
6. We recommend that entities have the equivalent protections in terms of conscientious objection and agree that such entities should be *obliged*, as per s.98 (2), to clearly publicise that it does not participate in VAD through websites, admissions processes, and other means so that those seeking VAD, or likely to seek VAD, are fully and properly informed and can seek other alternatives for care or accommodation.

3. **Inducing a person to revoke a request for voluntary assisted dying.**
   - The most objectionable provision in the current Bill is s.141 where a person who by 'coercion induces' (each of which may be interpreted widely) another to revoke their decision to access VAD is guilty of an indictable offence punishable by up to seven years imprisonment. The penalty is *identical* for inducing a person to access VAD.
   - This means that a person (an aged care chaplain, or a social worker, or member of the clergy or indeed a family member) who counsels a person who has applied for VAD that there are other options for them may be guilty of a serious indictable offence.
   - If the Bill is passed in its current form, the following serves as a comparison for other indictable offences.

Maximum sentence	Offence
2 years imprisonment	Going armed to cause fear, threatening violence, indecent acts, negligent acts causing harm.
3 years imprisonment	Riot (simpliciter), false declarations, observations, or recordings in breach of privacy, distributing intimate image or prohibited visual recordings, or threatening to do so, dangerous operation of a vehicle, common assault, deprivation of liberty, leaving a child under 12 unattended, possession of things used in connection with unlawful entry, forgery, uttering.
5 years imprisonment	Unlawful drink spiking, grooming children under 16, stalking, stealing, fraud, willful damage.
7 years imprisonment[2]	**Inducing a person revoke a request for VAD (if legislated),** Official corruption, attempting to pervert justice, procuring engagement in prostitution, · carrying on business of providing unlawful prostitution, serious animal cruelty, choking, suffocation or strangulation in a domestic setting, wounding, assaults occasioning bodily harm, serious assaults, kidnapping, abduction of child under 16, cruelty to children under 16, unlawful use or possession of motor vehicles, aircraft, or vessels, receiving tainted property.

- There is no justification or discussion *whatsoever* in the May 2021 Queensland Law Reform Commission Report (*A legal framework for voluntary assisted dying*) for this provision other than general discussions on 'voluntarily' or 'without coercion' on pp.145-146.

- In effect the adoption of the Bill in its current form ensures the right of the individual to seek VAD, and, alienates the rights and practices of aged care providers

[2] https://www.sentencingcouncil.qld.gov.au/about-sentencing/maximum-sentences/criminal-code. Neither the VAD offence nor the red circle are in the Sentencing Council's published list but are included here for comparative purposes.

and health care providers who do not support the scheme or may support it for others but seek to conscientiously object to participate.

- Unless amended it is reasonable to predict that Queenslanders will be convicted and punished under this provision up to and including periods of imprisonment.

> 7. We recommend the exclusion of 'revoke' from s.141 and retain the prohibition and subsequent penalty for inducing a person to request VAD.

4. Impacts on other residents or staff.

- Aged care regulation provides for choice and control for all residents. What if a resident objected to living in a facility where VAD is practiced, even if the entity had a strong conscientious objection? A medical practitioner has a right to object but another resident in the facility has no rights.

5. The establishment of a Voluntary Assisted Dying Review Board and Review of the Act.

- The Lutheran Church of Australia supports a full review of the Act and any VAD scheme within 3 years as per s.154.

- The Lutheran Church of Australia supports the establishment of a Review Board with statutory oversight of any VAD scheme.

- Ideally the Board would be located within a portfolio *other* than Health so there are reduced risks of VAD being seen, or practiced, as a 'normal health service.'

- The Lutheran Church of Australia likewise supports the requirement for strict timelines for annual ministerial reporting and subsequently tabling in the Parliament.

- Ideally the Board would be located within a portfolio other than Health so there are reduced risks of VAD being seen, or practiced, as a 'normal health service'.

> 8. We recommend the following professions be included in the eligibility criteria for the Board in. s.124; persons with expertise in *aged care, gerontology, disability services* and *holistic care*.

6. In the event VAD is unsuccessful

- The Bill is silent on what should occur if the VAD process (substance administration or efficacy) is unsuccessful.
- Should the person be revived?
- Should a medical practitioner take additional steps to the end the life of the person? What steps? How would this be reported?

9. We recommend the Bill be explicit about the steps to be taken in the event that the VAD process does not result in death.

7. Requirement for a witness to self-administration

- The Bill (esp. in s. 97) does not require there be a witness where a person self-administers VAD medications.
- The risks attached are significant. The person should have some access to assistance especially in in the event VAD is unsuccessful.

10. We recommend the Bill be amended to require that approval of the provision of VAD substances for self-administration be dependent on an undertaking by the person that they will at the time of self-administration have a witness fulfilling the requirements in s.38 or similar.

8. Subsequent amendments to other legislation.

- The Bill states the following will be amended as result; the *Coroners Act 2003*, the *Guardianship and Administration Act 2000*, the *Medicines and the Poisons Act 2019* and the *Powers of Attorney Act 1998)*
- It seems curious that the *Criminal Code Act 1899* is not included when Voluntary Assisted Dying is in direct breach of the *Code*;

> **s.311 Aiding Suicide**
> Any person who—
> (a) procures another to kill himself or herself; or
> (b) counsels another to kill himself or herself and thereby induces the other person to do so; or
> (c) aids another in killing himself or herself; is guilty of a crime, and is liable to imprisonment for life.

LUTHERAN CHURCH OF AUSTRALIA | QUEENSLAND DISTRICT

Health and Environment Committee of the Queensland Parliament

Voluntary Assisted Dying Bill 2021

Presented by the Lutheran Church of Australia

14 July 2021

List of Recommendations

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24 McDougall Street (PO Box 1535), Milton QLD 4064
07 3511 4023
www.qld.lca.org.au

27 November 2020

The Secretary
Queensland Law Reform Commission
PO Box 13312
George Street Post Shop Qld 4003

lawreform.commission@justice.qld.gov.au

Dear Secretary

We write to you on behalf of the Lutheran Church of Australia (LCA) and thank the Queensland Law Reform Commission (the Commission) for the invitation to make a submission to inform the Commission's preparation of a *Legal Framework for Voluntary Assisted Dying* (VAD) in Queensland.

A great number of faith communities[1], including the LCA, have already expressed opposition to the introduction of VAD and regard it as morally perilous and socially irresponsible. We are not oblivious to or unconcerned about the suffering of people with distressing diseases and conditions, nor do we wish to make light of their experience and those of their loved ones.

Society undermines respect for life when we establish laws that validate the concept of 'life-not-worth-living' and affirm the belief that it is reasonable and even compassionate to intentionally end a life. Indeed, laws not only reflect society, they in turn shape and inform society. Decriminalising or legitimising morally controversial acts helps to normalise them. Eventually they become so socially accepted many people no longer see them as 'moral issues.' In fact, because they are legal, many come to see them as 'rights' and as moral goods.

Given the task before the Commission and that Parliament will likely debate legislation in the coming twelve months, we make this submission. We argue for strong protections and safeguards in any scheme so that vulnerable people are protected, and, strong guarantees and protections are there for individuals, clinicians and organisations that choose not to participate in VAD.

It will be vital that any scheme has the highest level of transparency in terms of its performance with thorough regular public reviews. Experience in other jurisdictions where VAD laws have been introduced show that as time goes by, strict conditions are relaxed and/or violations are overlooked.

[1] : "A Good Death: Queensland Religious Leaders' Joint Statement on the Provision of High-Quality end-of-life Care" 2019.john

As a major provider of aged care in Queensland, and throughout Australia, we will be pleased to provide further details or assistance to the Commission in undertaking its task.

Bishop Paul Smith will welcome contact on 07 3511 4049 or Paul.Smith@lca.org.au.

Yours sincerely

+ John Henderson
Bishop
Lutheran Church of Australia and New Zealand

+ Paul Smith
Bishop
Lutheran Church of Australia Queensland District

LUTHERAN CHURCH OF AUSTRALIA
QUEENSLAND DISTRICT

SUBMISSION TO THE QUEENSLAND LAW REFORM COMMISSION CONSULTATION

ON

A LEGAL FRAMEWORK FOR

VOLUNTARY ASSISTED DYING

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Table of contents

QLRC VAD consultation questions

Principles

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

Q-2 Should the draft legislation include a statement of principles:

(a) that aids in the interpretation of the legislation?

(b) to which a person must have regard when exercising a power or performing a function under the legislation (as in Victoria and Western Australia)?

Q-3 If yes to Q-2(b), what would be the practical, and possibly unintended, consequences of requiring such persons to have regard to each of the principles?

Q-4 If yes to Q-2(a) or (b) or both, what should the principles be?

For example, should the statement of principles include some or all of the principles contained in:

(a) section 5(1) of the Voluntary Assisted Dying Act 2017 (Vic);

(b) section 4(1) of the Voluntary Assisted Dying Act 2019 (WA); or

(c) clause 5 of the W&W Model?

Broadly we are in agreement with the principles included in *QLRC A legal framework for voluntary assisted dying – Consultation Paper* (Consultation Paper):

- the importance of upholding and respecting human rights and the dignity and autonomy of individuals
- the need for safeguards to protect individuals who might be vulnerable to coercion or exploitation
- recognising that health practitioners are subject to a comprehensive legal, regulatory and ethical framework
- recognising, and not detracting from, the importance of high quality and accessible palliative care at the end of life
- respecting the diversity of individuals' and health practitioners' views, values and beliefs, and avoiding value judgments about others' lives and choices
- the need for the legislation to be clear and no more complex than it needs to be to achieve its purposes
- the need for the legislation to be well adapted to Queensland's geographic, cultural and health care environment.

(Consultation Paper pp. 25-26)

The one *exception* to the list quoted above is:

- the desirability of achieving reasonable consistency with the legislation in other Australian jurisdictions (more debate here).

We do not support commencing any VAD legislation for Queensland on the Victorian or Western Australian models and instead propose an alternative model as outlined later in this submission. We will however make recommendations that draw elements from other jurisdictions.

In addition to these, as a church that bases its teaching on the Christian Scriptures and as members of society, we recommend these additional principles as being in the shared interest of all Queenslanders.

1. **About the human person**
   1.1. Respect for human life as a divine gift and inherently valuable.
   1.2. Human dignity is not dependent on the acquisition and retention of certain capabilities.
   1.3. The principle of freedom of conscience and respect for conscience.
   1.4. That human autonomy must be responsibly balanced with the principle of the common good.

2. **About society**
   2.1. That society's responsibility is the protection of those who are most vulnerable.
   2.2. That society is measured by the way it cares for its most vulnerable.
   2.3. That the Queensland Government provides all Queenslanders with high quality, compassionate, dignity-preserving end of life care.
   2.4. The principle that the law not only reflects society, it also shapes and normalises/legitimises attitudes and behaviour.

3. **About any VAD legislation**
   3.1. Clear plain language legislation.
   3.2. Whilst legislation will respect the wishes of those who seek access to VAD, that there be equal respect for those who object to VAD and they not be penalised or involuntarily co-opted.
   3.3. That mainstream health practitioners not be presumed to agree to or administer VAD.
   3.4. That protections provided to individuals based on conscientious objections be extended to institutions.

Notwithstanding recent budget announcements, palliative care is chronically underfunded in Queensland. [1] We are concerned that the introduction of a voluntary euthanasia scheme, while many Queenslanders lack access to high quality, compassionate palliative care (which the state government says it regards as a 'fundamental right'), will move us little by little toward a moral culture that promotes VAD as a way of relieving ourselves of the duty and cost of caring for some of our most vulnerable citizens.

[1] https://www.brisbanetimes.com.au/national/queensland/queensland-s-end-of-life-funding-falls-short-by-millions-says-amaq-20201109-p56czq.html

Eligibility criteria for access to Voluntary Assisted Dying

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

(a) is incurable, advanced, progressive and will cause death (as in Victoria); or

(b) is advanced, progressive and will cause death (as in Western Australia)?

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

(a) have a disability; or

(b) are diagnosed with a mental illness?

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

Q-8 If yes to Q-7, what should the timeframe be? Should there be a specific timeframe that applies if a person is diagnosed with a disease, illness or medical condition that is neurodegenerative? For example, should the relevant timeframe be within six months, or within 12 months in the case of a disease, illness or medical condition that is neurodegenerative (as in Victoria and Western Australia)?

Q-9 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable (as in Victoria and Western Australia)?

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

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

(a) an Australian citizen or permanent resident; and

(b) ordinarily resident in Queensland?

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

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

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

If the introduction of VAD were to occur, we recommend the following eligibility criteria:

- Assessment by two independent medical practitioners who determine the applicant is
  1. An adult of 18 years or older.
  2. An Australian citizen.
  3. A Queensland resident of not less than three years (to avoid the risk of a person transferring to Queensland with the purpose of accessing VAD).[3]

[3] The film *Last Cab to Darwin* (2015) starring Michael Caton is based on this very premise.

4. A person with a terminal diagnosis where death is expected in a period not greater than four months so that the legislation is about avoiding excruciating deaths, not about giving people a 'right to die at the time of their choosing'.
5. That palliation has been assessed as an option and it is determined it not suitable for the person.
6. Has the capacity for decision-making and is likely to retain capacity throughout the process?
7. Intense and on-going physical pain (such as above 8 on the *Stanford Pain Scale*[4] or similar) that cannot be effectively managed with analgesia (say due to allergy).

Disability or mental illness, on their own or taken together, should not be criteria for eligibility. Whilst terminal conditions can be the cause of significant distress and/or depression these are treatable conditions.

As the Victorian and Western Australian Ministerial Advisory Panels advised, the **timeframe** is important to maintain the distinction between this being a choice about the manner and timing of a person's death rather than a choice between life and death.

Mental capacity until the point of death is essential as evidence shows that many persons having been approved for VAD either delay access or do not access it prior to death. Those without capacity are vulnerable to possible manipulation by family members or carers or those who may stand to receive a benefit. Our experience as an aged care provider is that often family members witnessing a loved one's decline, or final days or weeks, find it more intolerable than the resident themselves.

A key risk is that a person with a terminal condition may seek VAD to 'save' their loved ones from witnessing their suffering, or worse, imply **'a duty to die sooner'**.

The risk of implementing VAD that is limited to physical suffering is that it may be found to be **discriminatory** in cases of those claiming existential or emotional suffering.

The Victorian and Western Australian Ministerial Advisory Panels reveal that they consider it 'compassionate' to give access to VAD to people whose suffering is not unbearable or irremediable. They state that it is sufficient for the person to have a medical condition that cannot be alleviated in a manner acceptable to the person'. We consider such a low bar to be entirely unacceptable. The W&W model sets a higher bar, requiring that the suffering must be 'intolerable and enduring'.

[4]https://med.stanford.edu/news/all-news/2011/09/does-that-hurt-objective-way-to-measure-pain-being-developed-at-stanford.html

Voluntary and without coercion

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

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

For example:

(a) Should a person who loses their decision-making capacity become ineligible to access voluntary assisted dying?

(b) Should there be any provisions to deal with the circumstance where a person is at risk of losing their decision-making capacity, other than allowing for a reduction of any waiting periods? If so, what should they be?

(c) Should a person be able, at the time of their first request, to give an advance directive as to specific circumstances in which their request should be acted on by a practitioner administering a voluntary assisted dying substance, despite the person having lost capacity in the meantime?

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

We support the Commission in its view that explicit capacity for informed decision **without coercion should be present throughout the entire process**. Cases where a person is approved for VAD though does not undertake it (does not seek to fill the prescription, or, accesses but never take the drugs) it is evidence that people can and do change their mind.

Given the rising prevalence of dementia it will be essential that any VAD scheme be very specific on this point. Once **'implied capacity'** or **'earlier capacity'** is permissible, the door is open to the very abuse the Commission promises to exclude.

Any possible ambiguity in the *Powers of Attorney Act 1998* around substitute decision-making will need to be addressed to explicitly preclude VAD.

Initiating a discussion about Voluntary Assisted Dying

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

Q-16 If yes to Q-15, should there be an exception to the prohibition if, at the same time, the practitioner informs the person about the treatment options available to the person and the likely outcomes of that treatment, and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment (as in Western Australia)?

It must be the option of absolutely last resort.

We argue that if VAD were to be introduced it should be exceptional, be protected by significant safeguards, have a number of levels of oversight, have strict criteria and be explored only if and when all other health care options, including receiving best-practice palliation, have been exhausted.

Preventing doctors from raising VAD as an option would not impede 'the frank discussions between the practitioner and the patient that are needed for safe and high-quality end of life care.' It might ensure that other avenues are properly considered and trialled first.

For a medical practitioner to 'normalise' VAD as an option, or to first raise it, is and should remain an offence under the *Queensland Criminal Code* and no exemption allowed for VAD. If VAD is to be introduced, then s.311 must be preserved and explicitly referenced in any VAD bill.

AIDING SUICIDE

Any person who—

(a) procures another to kill himself or herself; or
(b) counsels another to kill himself or herself and thereby induces the other person to do so; or
(c) aids another in killing himself or herself;

is guilty of a crime, and is liable to imprisonment for life.

(Queensland Criminal Code Act 1899, s.311)

The Voluntary Assisted Dying process

Witnessing requirements for the written declaration

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

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

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

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

(a) are under 18 years (as in Victoria and Western Australia);

(b) know or believe that they:

(i) are a beneficiary under a will of the person making the declaration (as in Victoria and Western Australia);

(ii) may otherwise benefit financially or in any other material way from the death of the person making the declaration (as in Victoria and Western Australia);

(c) are an owner of, or are responsible for the day-to-day operation of, any health facility at which the person making the declaration is being treated or resides (as in Victoria);

(d) are directly involved in providing health services or professional care services to the person making the declaration (as in Victoria);

(e) are the coordinating practitioner or consulting practitioner for the person making the declaration (as in Western Australia);

(f) are a family member of the person making the declaration (as in Western Australia)?

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

Waiting periods

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

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

(a) the person is likely to die within that period; or

(b) the person is likely to lose decision-making capacity for voluntary assisted dying within that period?

Eligibility assessments

Requirement for the eligibility assessments to be independent

Q-22 Should the draft legislation provide that the coordinating practitioner and the consulting practitioner must each assess whether the person is eligible for access to voluntary assisted dying and that:

(a) the consulting assessment must be independent from the coordinating assessment (as in Victoria and Western Australia);

and

(b) the coordinating practitioner and the consulting practitioner who conduct the assessments must be independent of each other?

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

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

(a) is not able to determine if the person has decision-making capacity in relation to voluntary assisted dying—they must refer the person to a health practitioner with appropriate skills and training to make a determination in relation to the matter (as in Victoria and Western Australia);

(b) is not able to determine if the person has a disease, illness or medical condition that meets the eligibility criteria—they must refer the person to:

(i) a specialist medical practitioner with appropriate skills and training in that disease, illness or medical condition (as in Victoria); or

(ii) a health practitioner with appropriate skills and training (as in Western Australia);

(c) is not able to determine if the person is acting voluntarily and without coercion—they must refer the person to another person who has appropriate skills and training to make a determination in relation to the matter (as in Western Australia)?

Other requirements

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

(a) be a family member of the person; or

(b) know or believe that they are a beneficiary under a will of the person or may otherwise benefit financially or in any other material way from the person's death?

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

(a) is or is not ordinarily resident in the State (as in Victoria);

(b) at the time of making the first request, was or was not ordinarily resident in the State for a specified minimum period (as in Victoria and Western Australia);

(c) has or does not have decision-making capacity in relation to voluntary assisted dying (as in Victoria and Western Australia);

(d) is or is not acting voluntarily and without coercion (as in Western Australia)?

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

(a) the person who is the subject of the decision;

(b) an agent of the person who is the subject of the decision; or

(c) another person who the tribunal is satisfied has a special interest in the medical care and treatment of the person?

Reporting requirements for health practitioners

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

(a) after each eligibility assessment is completed (as in Victoria and Western Australia);

(b) after the person has made a written declaration (as in Western Australia);

(c) after the person has made their final request (as in Victoria and Western Australia);

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

Additional approval process

Q-28 Is it necessary or desirable for the draft legislation to require the coordinating practitioner to apply for a voluntary assisted dying permit before the voluntary assisted dying substance can be prescribed and administered (as in Victoria)?

The proposed process for seeking VAD – a Queensland Government administered function

If VAD were to be introduced in Queensland we propose a new model for its administration ensuring VAD is 'grave and exceptional' with significant checks and balances.

If the State wants to pass laws of this nature it should administer the function itself through a new stand-alone agency, not as part of the Health portfolio.

Ideally the agency would be within the **Premier's portfolio**. The Health Department, and its antecedents, were never involved in capital punishment in Queensland. Being separate to the Health Portfolio will ensure that VAD is not seen or administered as a 'health service' nor would the Health Minister and Queensland Health have to adjudicate between rivalling resource bids between VAD and palliative care within the bureaucracy.

1. The regular medical practitioner (assuming that he/she does not conscientiously object) of the person seeking VAD provides a reference to the state government VAD body stating that:
   1.1. The medical practitioner did not raise the option;
   1.2. The patient his/herself initiated the discussion of access to VAD;
   1.3. To the knowledge of the medical practitioner, no other person or entity is encouraging the person to seek VAD;
   1.4. The person seeking VAD meets all the prescribed criteria; and
   1.5. All other health care options including pain management and palliation have been specifically considered and excluded.

2. Following the referral, no earlier than twenty-one days later, two state-appointed independent medical practitioners would then assess the person against all criteria before approval is given. Given Queensland's geography, telehealth options may need to be used. The independent medical practitioners will:
   2.1. Have completed approved training;
   2.2. Have practised as medical specialists for at least five years;
   2.3. Have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed; and
   2.4. Have relevant expertise and experience in gerontology especially when considering applications from older persons.

3. In the event approval is given, two witnesses, one of whom is a Commissioner for Declarations, will be present when the applicant signs their VAD consent.

4. Witnesses must be over the age of eighteen, have no personal, financial or other conflicts of interest in the matter and should not be a healthcare practitioner.

5. Any interpreter who assists a person in requesting or accessing VAD must be accredited and independent.

6. Given that VAD would be the personal decision of a person competent to make this decision, the person who makes the decision should themselves self-administer the VAD medication.

7. Only where the person is incapable of self-administration should a medical practitioner administer the VAD medication.

8. These steps will all be administered by and be transparent to the independent oversight body, so questions of when reporting occurs are not relevant.

We agree that persons seeking VAD should be able to access to the Queensland Civil and Administrative Tribunal (QCAT) for review of a decisions pertaining to residency, timing, capacity and volition on an individual basis. Appeals and complaints about the broader administration of the VAD scheme are discussed later in the document.

Conscientious objection

Q-40 Should the draft legislation provide that a registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following:

(a) provide information about voluntary assisted dying;

(b) participate in the request and assessment process;

(c) if applicable, apply for a voluntary assisted dying permit;

(d) prescribe, supply, dispense or administer a voluntary assisted dying substance;

(e) be present at the time of the administration of a voluntary assisted dying substance; or

(f) some other thing (and, if so, what)?

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

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

(a) refer the person to another entity or a medical practitioner who may be expected to provide information and advice about voluntary assisted dying; and

(b) facilitate any subsequent transfer of care?

Conscientious objection

The majority of health care practitioners entered their respective professions on the basis of **assisting and preserving life**, not intervening to end life prior to its natural end.

Any VAD scheme should be premised on an **'opt-in'** basis whereby health practitioners and institutions are required to nominate to participate, rather than the assumption they will participate and having to explicitly 'opt-out' on conscientious grounds.

Many hospitals, aged care and disability care institutions have been established by Christians and are run according to Christian ethics, which explicitly reject VAD. It is reasonable for institutions that conscientiously object to VAD (ICOVs) to make their policy on VAD known for all current and prospective residents or patients and to be **wholly exempted from any VAD scheme** with no penalty or disadvantage.

We note the provision in the Victorian legislation for the conscientious objection of an individual. We propose that the **same protections and provisions should extend to entities and institutions** other than natural persons. This exemption is consistent with the Queensland *Human Rights Act 2019* and the *International Covenant on Civil and Political Rights.*[5]

Central to our submission are very strong concerns around any obligation, expectation or requirement for individuals with conscientious objections and ICOV entities to:

a. Provide information about VAD;
b. Participate in the request and assessment process;
c. Supply, prescribe, dispense or administer a substance reasonably suspected for use in VAD;
d. Be present at the time of the administration of a VAD substance;

[5] The AMA Queensland in its submission to the 2019 Parliamentary Inquiry stated *...an institution should inform the public of their conscientious objection and what services they will not provide so that potential patients seeking those services can obtain care elsewhere (for example, this information could be highlighted on the institution's website, patient brochures and on posters clearly visible at the front of the facility.*

e. To participate in the request and assessment process; and
f. To be present for or have the ICOV's property used for VAD.

We also strongly recommend that VAD legislation explicitly prohibit penalties, detriment or any comparative disadvantage whatsoever on the basis of conscientious objection for individuals and institutions.

Where an existing resident, client or patient requests access to VAD the ICOV should:

- Immediately inform the person of the organisation's objection to providing or facilitating VAD;
- While not facilitating, neither impede nor hinder the resident transferring to another environment;
- Transfer clinical records and other information for continuity of care, with a view of minimising suffering of the person seeking access to VAD.

The Queensland Government may need to negotiate with the Commonwealth to ensure that institutions that conscientiously object to VAD, resulting in transfers of existing residents, are not held to be in breach of their *Security of Tenure* obligations under the *Aged Care Act 1997*.

Oversight, reporting and compliance

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

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

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

or

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

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

(a) be dealt with by specific provisions in the draft legislation, as in Victoria, which provide for mandatory and voluntary notification in particular circumstances; or

(b) as in Western Australia, be governed by existing law under the Health Practitioner Regulation National Law (Queensland) which states when mandatory notification is required and voluntary notification is permitted?

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

Q-47 Should the draft legislation include protections for health practitioners and others who act in good faith and without negligence in accordance with the legislation, in similar terms to those in the *Voluntary Assisted Dying Act 2017* (Vic)?

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

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

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

An Independent state sector body to administer the VAD scheme

As stated previously in this submission, if the Queensland Parliament passes VAD legislation, it should create an **independent public sector body to administer any VAD scheme**. The body would have end-to-end responsibility around policy, oversight, activity, complaints, ethics, reporting and review. It would establish and monitor a panel of appropriate medical practitioners to review and process referrals.

The independent public sector body's **Board** should include representatives from diverse cultural, professional and religious groups, including those who object to the scheme.

The **Health Ombudsman** should be an ex-officio member of the Board given his/her statutory role in respect to medical practitioners. Board representation from the federal Australian Health Practitioner Regulation Agency (AHPRA) would add significant value.

Other protections

We support the inclusion in any VAD Bill of the requirement of notifications to the **Health Ombudsman and AHPRA** any allegations about health practitioners' professional conduct relating to VAD, especially around s.311 of the *Criminal Code*. We also recommend any VAD Bill to provide specific strong protections around conscientious objection for individuals and entities and that these be actively monitored.

Statutory oversight of a state VAD body - an *Inspector-General for Voluntary Assisted Dying*

In addition to the oversight roles of **QCAT** (to deal with individual participant matters), the Health Ombudsman and AHPRA (for health practitioner matters), we recommend an ***Inspector-General for Voluntary Assisted Dying*** office be secured in legislation to provide oversight that the state VAD body is acting within its statutory remit.

The *Inspector-General for Voluntary Assisted Dying* would provide a point of appeal and review of the conduct of the state administered VAD scheme. This would assist the **Parliament** in determining in an ongoing manner whether the new legislation has been properly implemented and that unforeseen consequences are detected and remedied early. It would also assist the Parliament in its responsibility to oversee one of the most far reaching laws it has ever passed.

We support a review of any proposed VAD legislation in Queensland within ***two years*** **from its commencement** to ensure the legislation had not embedded the very risks we have identified, and that essential changes can be made.

Recording and reporting VAD

We support that for the purposes of the *Births, Deaths and Marriages Registration Act 2003* and the *Coroners Act 2003* that the death is treated as 'an overdose of medicine' without reference to VAD. Given our proposal that a state agency administer the scheme, de-identified data will be recorded and reported.

Insurance

We appreciate that life insurance companies and others with financial exposure have specific interests in VAD deaths. Some insurance policies contain exclusion clauses regarding deaths from suicide. This is a matter for lawmakers, life insurance companies and their policy holders to resolve. Any VAD legislation must avoid granting any exemption to disclose a VAD death due to 'privacy'. An insurer must be certain that there was no perverse and unlawful encouragement or incentive provided by others, especially policy beneficiaries.

The role of the Coroner

Pursuant to the *Coroners Act 2003*, the Coroner should be attentive to referrals from the Queensland Police Service, the state VAD body, the *Inspector-General of Voluntary Assisted Dying* and the public around VAD cases, especially with regards to s.311 of the *Criminal Code* and where there may be a claim of coercion from those with a vested interest in the affairs of the person who accessed VAD.

Tabled: Mr Ryan.
Lutheran Service
Public hearing - Brisbane
14/7/21.