HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP
Dr MA Robinson MP

Visiting Member:
Mr MC Berkman MP

Staff present:
Dr J Dewar—Committee Secretary
Ms A Groth—Assistant Committee Secretary
Mr J Gilchrist—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE VOLUNTARY ASSISTED DYING BILL 2021

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 15 JULY 2021

Brisbane

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The committee met at 9.01 am.

CHAIR: Good morning. I now declare this public hearing of the Health and Environment Committee open. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all now share.

I would like to introduce the members of the committee. I am Aaron Harper, member for Thuringowa and chair of the committee. The deputy chair is Mr Rob Molhoek, the member for Southport. The other members with us today are Mr Stephen Andrew, the member for Mirani; Ms Ali King, the member for Pumicestone, who will join us at a point in time; Ms Joan Pease, the member for Lytton; and Dr Mark Robinson, the member for Oodgeroo. Also joining us is the member for Maiwar, Mr Michael Berkman.

The purpose of today's hearing is to assist the committee with its inquiry into the Voluntary Assisted Dying Bill 2021. The committee would like to thank submitters who provided submissions to the inquiry. The submissions will assist the committee with its consideration of the bill. This hearing today is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. I remind people to turn off phones and other devices or switch them to silent. Hansard will record the proceedings and you will be provided with a copy of the transcript.

WHITE, Professor Ben, Professor of End-of-Life Law and Regulation, Australian Centre for Health Law Research, Faculty of Business and Law, Queensland University of Technology

WILLMOTT, Professor Lindy, Professor of Law, Australian Centre for Health Law Research, Faculty of Business and Law, Queensland University of Technology

CHAIR: Welcome. You are well known to the committee for your previous engagement and considered advice, including the draft legislation in the former inquiry. We are now at a point in time when the Queensland Law Reform Commission has drafted its recommendations. We certainly would like you to make an opening statement before we go to questions from the committee.

Prof. Willmott: Thank you for the invitation to be a witness before the committee today. I acknowledge the traditional owners of the land on which we meet. My name is Lindy Willmott, and I am a professor of law at QUT and a member of the Australian Centre for Health Law Research. For the past 20 years, my colleague Ben White and I have researched almost exclusively in the law, policy and practice of end-of-life decision-making, including in relation to voluntary assisted dying. In the two years since we last addressed this committee, we have also undertaken empirical research into how the Victorian VAD system has been operating, and this research informs our position.

At the outset I note that in the report tabled by this committee in March 2020 recommendation 1 was that the Queensland parliament use as a legislative framework the model VAD bill that was drafted by Ben and me and submitted to this committee. For the record, Ben and I still endorse the policy approach that underpinned our draft bill but accept that the reform process has moved on. The QLRC has since undertaken a comprehensive review and now recommended the VAD Bill, which was tabled in Queensland parliament in May and which is now being considered by this committee.

In our view, the bill recommended by the QLRC should be enacted. While we suggest some minor amendments to the bill in our written submission, we believe it is a sensible and measured bill that will provide choice for terminally ill patients while operating safely, including protecting the vulnerable in our community. In these opening remarks I would like to respectfully urge the committee to adopt the approach to reform taken by the QLRC. That is, while the Queensland bill broadly reflects the Victorian model, we should not use Victoria as the default starting point for Queensland legislation. Instead, we should be enacting the best legal framework for Queensland and should not be constrained by other laws in Australia. A departure from the Victorian model does not mean that a Queensland bill will be inferior or not as safe. The fact that the Victorian act is the first act in any Australian state does not make it the best possible act.

There are two very sensible reasons that we would in fact expect a Queensland bill to be different from legislation in Victoria or, indeed, any of the other Australian states. The first is that the Victorian legislation has been in operation for two years and there are important lessons to be learned from their experience. We could address the committee about the results of our research into the Victorian experience if that would be useful. The second is that any Queensland bill should take into account Queensland's unique circumstances, including its diverse geography. It is critical for this committee and the Queensland parliament to exercise its own judgement to ensure that any law that is passed is one that is best for Queensland and to resist the suggestion that any departure from the Victorian, Western Australian, Tasmanian or South Australian model is risky or unsafe. Thank you. That concludes my opening remarks.

Prof. White: I, too, acknowledge the traditional owners of the land on which we meet. I agree that the Queensland bill is a sensible and measured VAD law. I believe it should be enacted by the Queensland parliament, with some minor amendments as outlined in our submission.

Lindy explained why it is appropriate for Queensland to have some differences from other states. I want to mention two improvements in the Queensland bill that address known problems in Victoria. The first is the expected time until death. The usual Australian position has been that a person must be expected to die within six months to be eligible for VAD except for neurodegenerative conditions, in which case it is 12 months. The Queensland bill's eligibility is different. Instead, it is 12 months for all.

First, this is a more coherent approach to designing VAD laws. It is hard to justify having different time limits for different illnesses. Second, a longer eligibility period allows a person more time to apply for VAD. The Victorian experience shows that the process is very demanding for terminally ill and sick patients and takes some time. Indeed, some are dying during this process. A 12-month period may allow patients to start this process a little earlier and reduce the likelihood that they may die or lose capacity first. This does not mean necessarily that people will take the VAD medication earlier, just that they have more time to work through this rigorous approval process.

The second improvement is that the Queensland bill deals with objections by institutions to VAD. This is important because there is evidence in Victoria that some institutions are blocking access to VAD for patients who would otherwise be eligible. This is a complex part of the bill—and that reflects the complex balancing of interests that is required—but the Queensland Law Reform Commission has proposed what we think is a sensible middle path or a compromise approach. The bill respects an institution's desire not to be involved in VAD but makes sure that patients are not deprived of the choice to access VAD just because of where they happen to live at the end of their lives.

I conclude my opening remarks by making two brief points about lawmaking. The first is to repeat our call for evidence based lawmaking. Decisions about the best VAD law for Queensland should be based on the large body of reliable and high-quality evidence that is now available about how VAD systems operate, including the emerging evidence about how the Victorian system works. This committee took an evidence based approach in its previous inquiry, as did the Queensland Law Reform Commission in its report. We anticipate and support a respectful, evidence based discussion in parliament.

The second is for Queensland to avoid making its law inconsistent and perhaps even incoherent in places by the ad hoc addition of safeguards. The Queensland bill is a safe and measured law that has been written in a logical, structured and coherent way by experts following a series of comprehensive reviews and consultations over an extended period. We urge the Queensland parliament to avoid the situation that other states have had where safeguards are later and awkwardly added in an ad hoc way to an already sound law. This has led to inconsistent and sometimes incoherent VAD law that does not actually improve patient safety or community safety.

CHAIR: Thank you both very much for your opening remarks. Before we move to questions, Lindy, can we go with your suggested research into the Victorian model? Do you want to table that and/or send it to the committee? It might be helpful. It depends on how long you wanted to use to go through that.

Prof. Willmott: I think we have already sent through a copy, but I can check. If we have not sent through a copy of the two papers, we will send them through. I can briefly refer to some of the findings just in an abridged form if that would help.

CHAIR: Yes.

Prof. Willmott: I will start off with a paper that I led which was published in the *Medical Journal of Australia* fairly recently. We undertook a project which interviewed 32 doctors who had been involved in voluntary assisted dying in the first year of operation in Victoria. Our goal of the research was to find out their experience with the legislation in supporting patients to access voluntary assisted dying.

The goal of the legislation in Victoria, of course, as it is here, is to balance safety of the community so that only patients who are eligible can access voluntary assisted dying but, at the same time, facilitate access to patients who are eligible. The findings of this research were that the doctors did not perceive there were issues around safety. They were not concerned that non-eligible people were able to access voluntary assisted dying. Rather, they had concerns about the ability of eligible patients to access VAD and to get through the process.

The issues that we identified in the *Medical Journal of Australia* were threefold. The first was the section 8 prohibition in the Victorian legislation against health professionals being able to initiate a conversation about voluntary assisted dying. The doctors felt this inhibited the ability of patients to make an informed choice about end-of-life options. It disadvantaged people whose first language was not English and people potentially with low health literacy. There were concerns around that. I do note that in the Queensland bill the provision is different and that they do not have a blanket prohibition, but in our submission we also have some concerns about there being any restrictions in raising voluntary assisted dying for the reasons that we outlined in the submission. I am happy to go back to that later.

The second concern raised by doctors was the requirement for all interactions to be done in face-to-face mode. That resulted from the Commonwealth Criminal Code and the provision there which puts at risk—we can talk more about this later—doctors communicating in relation to suicide, which is the term used in the Commonwealth legislation.

The third problem identified by the doctors that we spoke about in this paper were problems regarding implementation. I will be very brief about this, because the other paper Ben will talk about goes into this in a bit more detail. There was complexity of process in terms of the many forms—what they described sometimes as pedantic checking—which led to frustration in terms of doctors' ability to navigate the system; for example, required documentation especially in relation to permanent residency, Australian citizenship and demonstrating that a person had been in Victoria for 12 months prior to making the first request. I think there are some improvements in relation to that in the proposed Queensland bill which might avoid some of those evidence issues. Thirdly, even after the secretary of the department issued a permit they were concerned about delays in getting medication to patients who had been assessed as eligible. I will hand over to Ben to talk about the other paper.

Prof. White: The second paper is one which is published in *BMJ Supportive & Palliative Care*. It is the same cohort of 32 doctors that we interviewed, but we specifically focused on a unique feature of the Victorian system; that is, to require a government permit prior to being able to access voluntary assisted dying. This is not required in the Queensland bill nor in the Western Australian model that is now in operation. We support that. The findings of this research support why it would be a problem and why the Queensland model is better in this regard.

What the doctors reported, essentially, was that this process of applying for a permit to go to the board, submitting forms which bounce back and forth, and then finally having to seek permission from the government prior to assisted dying being permitted led to delays which meant eligible patients missed out on voluntary assisted dying.

There were a number of themes that emerged from that. One of those themes was that the system in Victoria is not well designed for the patients it is supposed to try and help. Part of that is: when the law is passed, it is absolutely critical to get the balance right between safety and access. We must have a system that is safe and protects patients, protects the vulnerable and protects the community, but we must also have a system that is usable. These laws are designed to allow terminally-ill people who are already dying access to voluntary assisted dying. The concern is that the balance between access and safety under the Victorian system is so heavily weighted to safety and so heavily weighted to process that the patients it is designed to help are dying through that process.

The only other point to mention relates a little bit to the idea I mentioned before: the suggestion about not adding on safeguards, not adding on 'here's a new thing we could do', and instead seeing how the system operates as a whole. When you look at the Victorian system as a whole, all of its safeguards, all of its processes, are so stringent that this additional requirement of a permit was seen to impede access for otherwise eligible patients.

CHAIR: Thank you very much, Ben. Lindy, you touched on the telecommunications issue, which has been raised significantly in submissions. Can you speak to that and Queensland's unique geography? What solution can you suggest to overcome this? Andrew Denton yesterday talked about a political response from the Commonwealth government, but clearly having access face to face in Queensland might be a significant challenge. If doctors reported through your research that it was frustrating to go through the process in Victoria, I can only imagine how frustrating it is for patients. What is the solution for Queensland?

Prof. Willmott: Chair, I wish I could say there was a solution for Queensland that could be undertaken by the Queensland parliament. I do not think that is the case. Unfortunately, this must be addressed at the Commonwealth level. We do not believe it is enough simply to state that voluntary assisted dying, if carried out pursuant to the Queensland act, does not constitute suicide.

In a paper that was led by one of our colleagues, Dr Katrine Del Villar, we set out the reasons this is still potentially regarded as suicide, even though there is a provision in the Queensland legislation saying that it is not suicide. I am not sure much more can be done. We also had a suggestion that we urge the Commonwealth to develop prosecutorial guidelines saying that if voluntary assisted dying occurs pursuant to and in conformity with state legislation then prosecutions will not be brought. That is a less-than-optimal situation as well, because that relies on the exercise of the discretion.

It would be an extremely easy fix for the Commonwealth simply to amend the Commonwealth Criminal Code to carve out an exception for lawful behaviour under state legislation. I note there has recently been a letter from our Premier to the Commonwealth Attorney-General and they have rejected that. They have indicated that they do not intend to amend the Commonwealth Criminal Code. They suggested that the Queensland parliament needs to pass legislation that is consistent with the Commonwealth legislation which, to be honest, I think is unhelpful and misses the point of voluntary assisted dying legislation, which is within the constitutional power of the states. That was a longwinded way of saying that I am not sure this is able to be corrected legally or addressed legally from a Queensland parliament perspective.

Mr MOLHOEK: Has the paper that you referred to been tabled as part of your submission?

Prof. Willmott: Yes, that has been tabled as part of our submission. It is in the documents that we forwarded, as were the two papers we referred to earlier.

Mr MOLHOEK: I am sorry, what was the name of the paper again or the source?

Prof. Willmott: It is the last one we sent through. It is the last one on the list. It is called *Voluntary assisted dying and the legality of using a telephone or internet service: the impact of Commonwealth carriage service offences*. It is reported in the *Monash University Law Review*.

Mr MOLHOEK: Professor White, it would be helpful to understand the carriage laws more broadly. Why do we have that legislation federally, and what other things does it cover? I cannot imagine there is a whole act that just talks about not using the phone to talk about suicide.

Prof. White: This was initially prompted by concerns about suicide promotion groups. The activities of Phillip Nitschke were also a trigger for the Commonwealth to include this in there. There are a range of other provisions dealt with as well. As far as voluntary assisted dying is concerned, that was the original impetus for it. That was passed at a time when voluntary assisted dying was unlawful throughout the country. That was the context in which it occurred.

Mr MOLHOEK: How long ago was that?

Prof. Willmott: The Criminal Code Act itself was enacted in 1995 and it is very big legislation. This amendment was made subsequent to the enactment. As Ben said, it was to target pro-suicide websites, internet chat rooms and online cyberbullying that may incite vulnerable people to suicide. It has been some time since I looked at that legislation, but when I did I noticed that these particular provisions, sections 474.29A and 474.29B, which were passed in 2005, are nestled in between other provisions. My recollection is that one relates to child pornography, so it clearly was not designed to make actions under a voluntary assisted dying regime unlawful.

Dr ROBINSON: Thank you for appearing before the committee and for your work. Can I pick up on a comment that Professor White made about the Victorian legislation. I just want to clarify that I understood you correctly. You were talking about the balance between safety and access and that in your opinion it may well be that the legislation, in being stronger or tighter around safety, may have limited access to some degree. Is that roughly what you were saying?

Prof. White: Yes. I will just qualify that by saying it is a balance between access and safety, but I think there is probably also a point to be made about whether or not additional safeguards actually add any practical safety at all. For example, some of the doctors who reported on the operation of the legislation said that forms were being returned where a person had a full name and a shortened name. Part of the safeguard process that the board secretariat undertook was to return a form and say, 'We cannot process this form because it says "Michael" here and "Mike" here.' I am using hypothetical examples. In my view, if 'Michael' is used four or five times throughout the forms and 'Mike' is used once, that does not actually materially improve the safety of the community or the safety of the patient, but it does come at a cost to access. There is a 24-hour processing time frame: it goes to the board, it sits with them and it comes back. I think there is an important balance to be struck between access and safety, but I think it is also important to note that some safeguards may not add any safety at all.

Dr ROBINSON: I guess it is no surprise that members of parliament are very cautious about new legislation, especially legislation in the medical and health arena that in the end deals with life-and-death matters, so do excuse us if from time to time we err on the side of safety, but I appreciate your qualified answer. I am not a fan of the bill; I will just be up-front about it. You have not convinced me. I think there are a whole stack of problems before we roll something like this out.

In various countries around the world there have been a substantial number of claims of wrongful death once this type of legislation is introduced; for example, in Belgium, the Netherlands, Canada and Oregon. There have been claims that people did not have capacity to make the decision and there are numbers of examples where family members—as has been mentioned in the hearing so far—and others have been involved in coercing somebody into being euthanised. I have a deep concern that, because that is happening in Western countries, it is going to happen in Queensland. I do not see how, once we lift the lid on this, you will be able to prevent it, because nobody else has. Can you comment on that?

Prof. White: I can probably say a few things. In evaluating the claims you have mentioned, the starting point would be to take an evidence based lawmaking approach. The starting point would be to evaluate where it sits on the pyramid of reliability. In one of the papers that we submitted we proposed a pyramid of reliability, adapted from a colleague's work overseas, that allows a chance to interrogate the reliability or otherwise of the claim. At the top of the pyramid are population-level studies—for example, the work that is being done in Belgium and the Netherlands—looking at whether vulnerable populations are more likely to use voluntary assisted dying than other groups. The answer to that is no. That is the conclusion of all of the high-quality, peer reviewed evidence published in *The Lancet* and all of the best medical journals in the world that have been subject to peer review.

At the other end of the reliability pyramid are anecdotes, ad hoc claims and those sorts of things. I do not know the information that you are talking about, but my advice and response would be: when those claims come in, have a look at where they sit in that reliability pyramid. Is this population-level data? Has it been externally peer reviewed? Has it been reviewed and scrutinised by a committee like this so we can have confidence in its findings? For example, there was some work done in New Zealand and there were published claims that allowing voluntary assisted dying would lead to—this wording is not exactly verbatim—family discord and other societal problems. When you actually looked at it, it was one interview done with one person from a different country.

Dr ROBINSON: There is a veracity issue. I accept that things need to be tested and verified.

Prof. White: Absolutely.

Dr ROBINSON: Can you give an undertaking to this committee that if this legislation is introduced or supported there will not be wrongful deaths in Queensland?

Prof. White: I think I would probably come back to my evidence point. In answering that question, I am probably not in a position to give an undertaking. I would love to be the boss of the world.

Dr ROBINSON: I would love to have an undertaking that people in Queensland are not going to have their lives taken from them.

Prof. White: I would respond to that by saying that I would look at the evidence. The evidence in Australia now includes the Victorian model, which the Queensland law is very similar to. The Voluntary Assisted Dying Review Board Chair, Betty King, has been looking for coercion, has been looking for concerns about capacity, and she has not found that. Indeed, sometimes the discussions that are had involve coercion the other way. Family members are saying, 'Mum, Dad, we do not want you to do this.' That is probably how I would respond to that. As an academic, that is probably all I can say.

Dr ROBINSON: I would be surprised if coercion only worked one way.

Prof. Willmott: I make the point that today, currently, end-of-life decisions are being made by doctors and patients in a whole lot of different contexts, including withholding and withdrawing life-sustaining treatment, provision of palliative medication which can hasten death and decisions about palliative sedation. These decisions are being made. We trust our doctors to be able to recognise (a) does a person have decision-making capacity around these decisions and (b) are they being coerced? Currently we trust doctors with those decisions.

I realise that this a different kind of medical decision. I would point to the very heavy regulation and the safeguards in the legislation which surround this kind of practice and are not there for other end-of-life decisions. I think we can take some comfort in the very regulated nature of voluntary assisted dying. I would also add that there is mandatory training under this legislation which specifically flags issues around capacity assessment and flags for coercion.

I would like to finish up with a comment. I heard a speech by a geriatrician, a very considered man, who was involved in voluntary assisted dying in Victoria. His take-home comment was that a person had to be extremely determined to be able to get through the voluntary assisted dying process because it is so difficult, so prolonged and so onerous. He did not see any chance of a person being able to be coerced down that particular path.

Mr ANDREW: I asked yesterday about the regulation of 1992 and whether that regulation can impact this bill at any stage without the Legislative Assembly's input. Could you elaborate on that? Is that a possibility or not?

Prof. Willmott: I am not familiar with the regulation of 1992.

Mr ANDREW: The regulation act 1992. I would not mind understanding that.

Prof. Willmott: I am happy to have a look at that and take that question on notice.

Mr ANDREW: Could you please, because I am trying to understand it?

Prof. Willmott: We will take that on notice.

Ms KING: I have followed your writings on this topic for many years now and always appreciated your input very much. I was interested to hear your comments about the Victorian model. When that legislation was introduced I read the bill with some degree of interest and reflected that if I were a person at end of life I may not have the energy to pursue that model. We know that the Queensland Law Reform Commission has as the central goals for this legislation that it be safe, compassionate and accessible.

The committee has heard from a number of submitters that they are pursuing a range of amendments. I will note a couple of them. They want a six-month limitation for the end-of-life period. They want a minimum 14-day period between the first request and accessing the substance. Some want to minimise the number of cases a doctor can assess. They want to add additional witness requirements. They want specialist assessment of capacity and specialist assessments of the person's illness. There are many amendments that are being sought by a range of groups. In your view, would this legislation continue to be safe, compassionate and accessible if those amendments were enacted by the parliament?

Prof. White: I might begin because I think it speaks to that point I made earlier. The bill before us has been the subject of extensive examination and extensive consultation and consideration. It is a structured, logical, coherent bill, largely based on the Victorian legislation. When we say that it is different from Victoria's, we are talking around the edges. The Victorian model was talked about as the safest and most conservative model in the world. It really is what we have in Queensland with a few variations.

The point I concluded with in my opening remarks was trying to avoid exactly this. One of the challenges is: when you have a sound and safe law and bits are added on, things happen and all these other things come in later in an ad hoc way, you can end up with law that is not usable, not functional and does not really materially improve safety. I think a good example of this is what happened in Victoria. The bill that was recommended by the ministerial expert panel and went to the lower house and was indeed passed by the lower house had a 12-month time limit. It then went to the upper house and not for reasons of principle, not because it is safer and not because it is better—it was just a political compromise because two MPs wanted different things—the compromise was reached to have six months except for a particular cohort of cases. That sort of model has been adopted and picked up throughout Australia without really critically thinking about what it looks like.

Queensland has addressed that in the way that was originally recommended in Victoria and originally recommended in Western Australia. I think that is an example of where some of these additions will (a) distort what is already a sound and logical bill and (b) not necessarily materially improve safety. For example, the difference between nine and 14 days. If someone has already gone through what is an extraordinarily rigorous process and they have finally got to the stage where that waiting period begins, I am not sure what difference an extra five days will make other than that folks who are already close to death may die, may lose capacity or may otherwise give up during the process. Those are some observations.

As we mentioned, this bill is based on the Victoria model with some tweaks. It is sensible and measured. We would urge the parliament to resist tinkering with it because you end up with a mishmash of legislation which has caused problems elsewhere.

Prof. Willmott: Specifically you mentioned medical experience and the qualifications of the doctors and the requirement to have a specialist to assess capacity in relation to illness. I think the QLRC bill has improved the Victorian model. Clause 82 sets out the experience and qualifications needed. I have heard concerns expressed that there should be specialists required. However, I am very comfortable about the ability of Queensland doctors to carry out the duties which are requested of them in this legislation.

I would make a couple of points in relation to that. We do not currently require specialists to undertake those assessments with other end-of-life decisions of the kind I mentioned earlier. Secondly, clause 82 does require experience. A junior doctor will not be able to undertake eligibility assessments. They will have experience for some years. The third point I would like to make is that doctors must do training before they will be able to do eligibility assessments. They will know precisely what is expected of them under the legislation, including in relation to eligibility assessments. The bill also requires them to refer to a specialist if they believe they are not certain as to whether a person satisfies the eligibility requirements.

I think there is sufficient safety. Although we have moved away from the Victorian model, I think it is an improvement. It is very safe. It has the added benefit that it will increase the pool of doctors who will be available to do eligibility assessment, which I think is critical particularly given Queensland's diverse geography.

Ms PEASE: You said earlier that we all currently rely heavily on the expertise of our doctors to make decisions about our treatment and care and no more so than at end of life. You mentioned that introducing legislation around this would make it more regulated and give more protections for people. What currently takes place is that, as you say, the terminal medication, the terminal sedation, the end-of-life pain relief decisions are being made by the consulting physician in discussion with family members or the person involved. Do you imagine that this is going to give more choice, better options and more protections for those at the end of life?

Prof. Willmott: Yes, I absolutely agree with that. Although it is highly regulated and it raises challenges for access, I think it is needed for legislation of this kind. The advantage of that is that things are so much more transparent. It is not just a matter of a patient or the families going along with anything recommended by the doctor; there must be an active request and the request must occur over a period of time. There is an assessment of capacity over a period of time. For the reasons I articulated earlier, I think this much more highly regulated regime puts in so many more protections to ensure this is absolutely the request of the person who is seeking voluntary assisted dying. Naturally, it does provide another choice at the end of life.

Ms PEASE: Further to that, it does not take away from the great work that our end-of-life and palliative doctors are currently doing to assist the patient and their families. This is voluntary. It is a decision of the person; they make that choice.

Prof. Willmott: Absolutely. I will make a comment in relation to palliative care. I was on the Palliative Care Australia Board for seven years. I am a passionate believer in palliative care. Every person with a life-limiting illness should have access to palliative care. I am concerned that there is not sufficient palliative care around Australia. I do not see this as a trade-off between palliative care and voluntary assisted dying.

Some years ago Palliative Care Australia commissioned a report from Aspex Consulting which looked at correlations between palliative care funding and countries which had introduced voluntary assisted dying. There was a correlation of certainly as good palliative care funding or increases in palliative care funding in equivalent, for example, European jurisdictions which did not have euthanasia. Palliative care seems to go hand in hand with voluntary assisted dying. It should not be a competition.

Mr MOLHOEK: Yesterday we heard from some of the church organisations. The Lutheran Church raised concerns about the provision in the bill that refers to inducing a person to revoke a request for voluntary assisted dying and the proposed penalties for being found guilty of having done that. I would be interested in your response or reflection on that. There are many people who provide advice to people. There are counsellors, pastors, spiritual mentors and family members. In the context of perhaps the last year, where we have seen up to a 200 per cent increase in demand for counselling and support services around the nation, are you concerned that this requirement is perhaps a bit too broad?

Dr van Gend made the comment in his presentation that suffering is a part of life and people will typically seek all sorts of sources of advice and guidance in times of crisis. He went on to talk about how the brain chemistry significantly alters when people are under incredible stress. Are we at risk of introducing a law where we could see chaplains and pastors and qualified counsellors ending up in jail because perhaps they have been called on to support a family through a time of crisis and then they find they are actually being caught up by this provision?

Prof. White: Thank you for raising that. I think you are talking about clause 141 of the bill.

Mr MOLHOEK: Correct.

Prof. White: That provision requires, for criminal liability to arise, dishonesty or coercion. I cannot imagine chaplains engaging in dishonest or coercive behaviour to induce someone to not go down the path of voluntary assisted dying. That is the only instance in which that provision would apply.

CHAIR: We are over time. We have some other professors on standby. I apologise. We can always write to you if there are other questions.

Ms KING: Would it be possible to ask the professors to provide a response on notice to that question? I am interested in hearing more.

Mr MOLHOEK: That would be great.

Prof. White: I am happy to assist further.

Dr ROBINSON: The member for Mirani wondered about the justification for the penalty, the seven years. The member for Mirani was wondering about the reasoning behind that. I am sure there is reasoning.

Mr MOLHOEK: If you could perhaps address that as well.

Dr ROBINSON: Is that okay to be included, if that is in your domain?

CHAIR: We have three questions on notice. Thank you for your time this morning and for your time since we have started this inquiry. Can we have the responses by Thursday, 22 July, please? Thank you both very much. We appreciate your time and advice.

BONYTHON, Associate Professor Wendy, Faculty of Law, Bond University

CARTWRIGHT, Emeritus Professor Colleen, Chair of the Human Research and Ethics Committee, Southern Cross University (via videoconference)

CHAIR: Would you like to give an opening statement before we go to questions?

Prof. Cartwright: Thank you very much for the opportunity to be a witness here today. I want to congratulate the drafters for producing what is, in my opinion, an excellent bill. If it goes through parliament without significant amendment it will be the best VAD legislation so far in Australia, in my humble opinion.

As noted in my submission, there are four areas that I consider to be better than in the other states. One is the option to have the doctor administer the medications—that not being dependent on the physical incapacity of the patient but the doctor being able to assess that it is inappropriate for the patient to do it themselves.

The residency exemptions I also think are very, very good because that will not only benefit the patient and those close to them but also the health system. When you have people who are terminally ill and they have some support systems in place, that can be a major benefit to everyone.

The conscientious objection provisions, insofar as people cannot be denied access: I think the provisions within there are very good. The eligibility and time to expected death provision: some of the other states and territories have six months unless it is a neurological condition. This bill says a blanket 12 months. Now, I do have one point related to that just at the end which I will add, but as far as this bill is concerned I think that is also very good.

I do think we require an amendment that the healthcare worker cannot initiate the VAD discussion. I believe that is unethical and contrary to the duty of care of health providers to advise patients of all of the options that are available to them. There are certain categories that can introduce the subject, provided they introduce other subjects too, but I think if someone is with their GP then the GP should be able to tell them all of the options available to them. I was a bit unsure why speech pathologists were singled out for the conscientious objection section. In the other categories for health professionals, social workers clearly have a major role to play in relation to VAD and there does not seem to be any recognition of that.

My major concern, not with just this bill but with all of the legislation throughout Australia, is that it discriminates against people with dementia. If you are 12 months out from death with dementia, there is no way known to man that you are going to be in a state where you can request assistance. In my submission I have made a couple of recommendations about how that issue could be addressed, but I do think it is certainly a major barrier and discrimination against people with dementia. That is my opening statement.

Prof. Bonython: Good morning. My name is Wendy Bonython. I am an associate professor in the Faculty of Law at Bond University. I am a cross-disciplinary law, medicine and health technology researcher. I would also like to acknowledge the traditional owners of the land on which we meet. I commend the Queensland government for its thoroughness in researching and consulting in preparation of this bill. After nearly 50 unsuccessful attempts to pass VAD laws in Australia since the Commonwealth overturned the Northern Territory's Rights of the Terminally Ill Act in the late 1990s, several states have now passed legislation that seeks to respect the needs and wishes of many Australians whilst also seeking to protect the most vulnerable through implementation of sophisticated and nuanced systems of safeguards.

The current generation of bills reflects a commitment on the part of legislators to reflect on the hesitancy those early bills attracted and to learn from the experiences of those jurisdictions that have considered this complex and confronting issue. That willingness to learn and consult must not end with the passage or defeat of this bill. As we are seeing demonstrated by empirical research coming out of the Victorian experience, no bill is guaranteed to get all of the components of striking a balance between safeguards and access right at the outset. It may be the case that the bill, or act as it may be, undergoes amendments in future to calibrate that balance. This should not be seen as a failure but rather as a highlight of a dynamic and evolving legislative environment.

Queenslanders deserve to debate this issue. As a scholar of health law and regulation I have previously worked in a jurisdiction where citizens are denied the right to even debate VAD laws due to Commonwealth prohibitions applied exclusively to the territories. My following comments are necessarily influenced by my experiences within that context and particularly concerned for people located outside of metropolitan areas.

A key feature of the Law Reform Commission consultation was the overall patient centred focus of the proposal. In places this bill sacrifices that focus in order to facilitate better access for patients in remote and regional areas. That access appears predicated on the belief that the Commonwealth will amend existing legal provisions to enable health practitioners to provide VAD assistance without committing an offence under the Commonwealth laws. Based on my observations of the Commonwealth's previous engagement with VAD in the context of attempts to repeal the Andrews bill, that reliance may be optimistic. If the Commonwealth proves reluctant to make the necessary amendments, building that reliance into the bill may result in the exact inequitable access problems dividing metropolitan and remote and regional Queenslanders that it seeks to avoid. To that end, the drafter should proactively plan for an alternative means of ensuring equitable access for remote and regional Queenslanders that is not dependent on telehealth, including reinstating those aspects of patient centred care that have currently been subjugated for that purpose. Examples include the approach to transferring care between practitioners which diminishes the role of the patient as an active stakeholder and diminution of the patient's presumptive right to have the health practitioner present during self-administration, which we outlined in our submission to the QLRC.

I also note that the conscientious objection provisions are broadly consistent with those in other health contexts. In some forthcoming research, colleagues and I critique the adequacy of existing conscientious objection provisions, finding that they are generally unsophisticated, expose patients to implicit, perceived or actual judgement of what are otherwise lawful and legitimate moral choices, and disproportionately compromise the human rights of practitioners. The bill in its current form permits practitioners to opt in by virtue of mandatory training. We contend that, provided employers cannot force practitioners to undertake the training, employee health practitioners should be able to self-select out of providing VAD services simply through abstaining from the requisite training.

Additionally, they should not be forced to disclose their conscientious objections, particularly to patients, but should instead simply be able to state that they are not accredited and refer patients to practitioners who are. Such an approach is consistent with practitioner human rights, including rights to privacy regarding thought and belief, and minimises patient exposure to unsolicited moral judgement through disclosure of CO status which may be distressing, patronising or harmful, is inconsistent with ethical and legal approaches to patient autonomy and serves no legitimate purpose.

Dr ROBINSON: You make the point, Professor Bonython, about conscientious objection. We have heard, through witnesses from numbers of religious organisations—those involved in aged care, in health, hospitals and hospices—deep concerns in this area of conscientious objection, whether as individuals or as institutions, about the right to have values and at an individual level the right to, as a doctor, not be involved in the referral process. For some that is quite an offensive thing to them and they have expressed that clearly. The Human Rights Commission picked up on this and I asked the question, 'Does the bill restrict those individuals' rights and potentially freedom of religion for the institution?' to which they said, 'Yes, there are some limitations.' I think 'limitations' was the term used, given the view that there were some restrictions. My interpretation of that is that it is potentially discriminatory against people of faith, whether Muslim, Christian or otherwise. If this bill opens that up and is discriminating against them, why should that be allowed? Why do they have any less rights than anybody else?

Prof. Bonython: Firstly, I would start by saying that the idea of institutional human rights is a bit of a fiction. Human rights are available to humans and institutions do not meet that criteria.

Dr ROBINSON: I think I clarified that already. It was a difference. Freedom of religion was the issue with institutions.

Prof. Bonython: Even so, I think it is problematic to talk about an institutional right to freedom of religion grounded in human rights theory.

Dr ROBINSON: We will differ on that, but go ahead.

Prof. Bonython: An institution is typically an incorporation so it is a legal person in terms of the way it can enter legal relationships, but it does not have all of the attributes that we would normally attach to a human being.

Dr ROBINSON: Can I say that they also mentioned that it was a community of people. It is not just an institution; it represents a faith community of people.

CHAIR: Member for Oodgeroo, you have asked a question. I am very interested in the response. Let's not argue with the witnesses.

Prof. Bonython: That brings me to my next point that obviously those organisations are staffed by individual people who do have human rights, including rights to freedom of religion. To be honest, most of the conscientious objection provisions we see recognise this but they do so in a pretty clunky way: 'Yes, you can have your religious belief system, but we are going to force you to disclose it to anybody who needs to know about it in terms of being a patient.' You can tell your employer about your conscientious objection if you do not want to provide that service. We argue that, for some of those groups that you mentioned—Muslim practitioners in particular, or Catholic practitioners—being forced to publicly wear those conscientious beliefs on their sleeves may expose them to discrimination. In extreme cases it may expose them to violence, and it is actually a violation of their right to having a degree of privacy of thought and belief.

The fact that the model includes a requirement for mandatory training means that people can opt in or choose not to. That is a better way of managing that gateway into provision of the service or not, both from the perspective of patients and from the perspective of practitioners. It is also worth noting that not all conscientious objections are grounded in religious belief. There are plenty of practitioners who are uncomfortable with voluntary assisted dying who are agnostic or even atheistic but nonetheless have strong systems of ethical and moral beliefs that do not necessarily derive their foundation from religious teachings.

CHAIR: Colleen, do you have any views on that?

Prof. Cartwright: I totally support what Wendy is saying there in terms of the option of not taking the training. My only concern is that if I was a terminally ill patient I would not want to find out that I was barred from something that other members of the society have access to after I am already in an institution. If this is going to happen, it must be made very clear to anyone entering that facility—both staff and patients or residents, depending on whether it is an aged-care facility, a hospital or whatever it might be.

The way I read the draft bill is that it is possible for institutions, organisations or entities to hold the objection but not to bar someone coming in—for example, a VAD navigator. A person who is in that institution could ask a friend, a colleague or a healthcare provider if they can get them some information, and that may mean the VAD navigator or someone coming to visit them. Unless it is made very clear to anyone entering that institution ahead of time that this will never be an option, then I do not think it should be allowed.

Dr ROBINSON: The Christian leaders and others who commented along those lines felt that being able to be up-front, with an opt-out facility or opportunity, was important to them. They felt that could go a long way to resolving some of those issues. I do like your training comment, potentially. However, at the end of the day, religious leaders have said to the committee that they have concerns—that freedom of religion and conscientious objection of individual doctors or nurses should be something that is more than taken into account. I will probably leave my comments there for now to let other members have a chance.

CHAIR: Member for Mirani, do you have a question?

Mr ANDREW: Not at this stage.

CHAIR: My observation around this institutional objection and listening to people over the last few days is that it appears there is a hierarchical institutional objection over a human right. Following on from what the member for Oodgeroo was saying, the Human Rights Commission said yesterday that they felt that it was justified to allow the person's right. Should an institutional right override the human right? That is probably the question.

Prof. Cartwright: Not from my perspective—not when there is a simple solution, not when the person's human right would not be overruled if they were to go somewhere other than that institution. If they know that up-front and they can make the choice then they are not being overruled, are they?

CHAIR: Correct.

Prof. Bonython: The only thing I would add to that, though, is that we know from experience with aged care that there are issues in people being able to choose the venue where they do their ageing in place. There are logistical reasons people may end up ageing in place and indeed engaging in palliative care in the place they have chosen to reside in. As much as anything, there is a logistical question there about how available those alternative venues are to people in a realistic sense, which Colleen has just mentioned.

Mr ANDREW: Yes, especially in rural and regional settings.

Prof. Bonython: To draw back on my previous experience, the only palliative care provider was associated with one of the church groups. I would imagine that similar stories operate in a number of rural areas in Queensland as well.

Prof. Cartwright: Wendy, you are absolutely right. You may not have the option of another facility. However, just quickly, I note that Palliative Care Australia have said that they are neutral on this topic. I would be presuming that they would allow at least some information to be given to the person. That is an assumption.

Ms PEASE: Thank you both for appearing today. I really appreciate your submissions and your wise words. We have discussed and we are aware of the issue around the carriage service. Professor Bonython, you have talked about your experiences in the territories not even being able to discuss such matters. Can you offer some suggestions around any other potential ways we might be able to overcome this?

Prof. Bonython: I think this is the intractable problem that arises, particularly in the context of Queensland. To me, the practical solution is to view VAD as part of a spectrum of end-of-life care. I note that accompanying this bill there is an announcement for increased funding to support palliative care services. To my mind, VAD should be one of those—not the favoured, not the only, not an alternative. It should be part of a broader suite of end-of-life care provided to practitioners.

I note that historically there have been issues with people accessing palliative care in remote and regional areas in Queensland that are in fact a model of the sorts of access issues that are envisaged with this bill. I think the telecommunications issue may prove to be insurmountable, based on observations with the attempts to revoke the Andrews bill previously. I suspect perhaps what needs to happen is planning for a whole of end-of-life outreach program to operate in those areas. One advantage of this bill is that it does open up that opportunity outwards to 12 months, which at least means you have a little bit more time for things like outreach programs to travel to some of those remote and rural areas. It will not solve all of the problems, but at least it gives something to provide some degree of access to Queenslanders who are not located in inner metropolitan areas in the time that it is likely to take to get the necessary Commonwealth amendments through.

Ms PEASE: Professor Cartwright, do you have anything to say to that?

Prof. Cartwright: Yes. Wendy's comments reminded me of when I was researching in the Netherlands and speaking with some of the medical practitioners there who said that they saw what was then called euthanasia as the last step in a long relationship—as one said, 'I promised my patient I would walk as far as possible with him'—rather than being something added on or way out there in left field. When everything else had been offered and tried and the person had decided they did not want to go through it anymore and it was time for them to go, one doctor said to me, 'It's not an easy thing to do but I will walk with my patient to the very end of that road as far as I can.' I support Wendy's point about it being part of a spectrum, not something sitting out by itself.

Ms PEASE: May I concur that that is exactly how my local GPs who I have spoken to felt. They have watched the families go through their own journey—of having children, the children growing up and having children and then their passing away. It is a real privilege for those doctors to participate in that.

Prof. Cartwright: Absolutely.

Mr ANDREW: Do you see any inadequacies? Is there anything else that could be supplementary or could improve the bill in your mind?

Prof. Bonython: I would like to see a few tweaks that shift the emphasis back on to patients in the wording of the legislation. In particular, I was a bit concerned about the provisions dealing with transfer of care from one doctor to another. It reads almost as though this is something that is being done to the patient, and I am not entirely comfortable with that. I think the patient and the patient's needs need to be more front and centre, even in the wording of that legislation, because the legislation really is setting the temperature and the tone for the entire program. To pick up on Colleen's recent point about walking a journey with someone, I would like to see within the framework for the self-administration a presumptive option for patients to choose to have their healthcare practitioner, the nurse practitioner or whoever it is who is managing that final stage, to be there with them.

Prof. Cartwright: Yes.

Prof. Bonython: I know that the Quebec model actually requires the practitioner to be there. I think it needs to be assumed that they will be, unless the patient chooses not to, but I think that choice should be the patient's. I do not think it should be assumed that, 'You've chosen the self-administration option. You're on your own.' I think it very much needs to be a choice made by the patient.

Prof. Cartwright: I support that. For someone who is terminally ill and perhaps trying to hold some container or something and they could spill it over themselves—there needs to be someone in place. Also, I come back to the 12 months that Wendy mentioned. I think the best option is for someone who has been diagnosed with a terminal illness and suffering unbearably in their situation to not actually have a time frame at all. There is no question that 12 months is better than six, but this is where we could talk at another time about the issue for people with dementia and the option of requesting in an advance directive under very, very special circumstances and very clearly 'when I reach this stage'.

In all of the research in the big population based studies I have done in Queensland, New South Wales and the Northern Territory, when we say to people, 'If you were terminally ill, what do you think would cause you the most distress?' the loss of mental faculties comes in first every time—every time—above pain, above death, above anything else. This is a fear in the community that we could help to allay if we made some access available. Right now we say, 'No, you can't have it. You've got dementia.'

CHAIR: That was certainly something we heard in our inquiry leading to the development of this bill. Time and time again there were concerns around that and there could be further work, as the QLRC has flagged, in that section perhaps with advance healthcare directives and so on. Professor Bonython, do you have another point to make?

Prof. Bonython: I do. I think there is a little bit of drafting uncertainty around sections 16(2)(a) and 26(3)(a). It talks there about somebody who has a conscientious objection or is otherwise unwilling, but a couple of clauses later it splits the time line for a response by the relevant practitioner along different lines. There is just a bit of murkiness about what grounds for being otherwise unwilling might be, given that there is already a catch-all mechanism about somebody who is unable to provide that particular support service. That is more of a drafting clarity issue around those two sections which I think adds a little bit of murkiness that probably is not helpful given the complexity of the bill.

Ms KING: Thank you both for being before us today. I have heard your feedback about the bill and thank you for providing it. On balance, do you take the view that the legislation that is before us is safe, accessible and compassionate and would you like to see it implemented?

Prof. Bonython: I think it is the best of the now 50-plus models of voluntary assisted dying and euthanasia bills that have been presented to legislatures around the country. I think it strikes a good balance. I would be very keen to see an in-built review mechanism after perhaps the first two years—what has happened so far and what are the things that maybe need some tweaking or amendment?—but that needs to be done on an evidence basis. I would be concerned about seeing a kind of a Christmas tree bill effect where everybody attaches an amendment to build in a few more safeguards which ultimately leads to a bill that is just unworkable and inaccessible. I think that is a little bit the experience of the Victorian act today.

Ms KING: Professors White and Willmott certainly provided that precise feedback as well.

Prof. Bonython: I think it is as good a foundational bill as I have seen but, as with all things, it is probably going to come down to seeing how it rolls out within that first 12 months to two years.

Ms KING: Thank you.

CHAIR: Do you have any concluding comments in the time remaining?

Prof. Cartwright: Just that I also think it is the best bill I have seen in Australia, certainly. It would depend on what happens to it when it is actually on the floor of parliament, and I note Wendy's point about amendment after amendment making it unworkable. Sometimes that can be a deliberate thing. We have seen from Victoria some of the difficulties. You mentioned that Lindy and Ben were here earlier so you have all of that, I am sure. Thank you for this opportunity.

CHAIR: Thank you both for joining us today and for your considered approach towards the draft bill.

Proceedings suspended from 10.15 am to 10.37 am.

ANDERSON, Ms Rebecca, Chair, Elder Law Committee, Queensland Law Society

HERRALD, Ms Chris, Chair, Society of Trust and Estate Practitioners Queensland

SHEARER, Ms Elizabeth, President, Queensland Law Society (via videoconference)

SHEEAN, Ms Jennifer, Deputy Chair, Society of Trust and Estate Practitioners Queensland

CHAIR: Welcome. Would you like to start by making on opening statement before we move to questions?

Ms Shearer: Thank you for this opportunity to speak to the committee. In opening, I would like to acknowledge the traditional owners of the lands on which this meeting is taking place and pay respects to their elders past, present and emerging. As the committee is aware from our submission on the bill, the Queensland Law Society considers that, on the whole, the bill strikes a reasonable balance between important and fundamental human rights. We have in our submission made a number of recommendations about amendments which we consider would allow the legislation to operate effectively and practically and in a way that recognises and protects human rights and that will ensure it interacts appropriately with existing laws.

The only other aspect I would like to present in opening is our view that a person exercising a power or performing a function under the legislation should be required to have regard to the principles in section 5 of the act. We acknowledge that the Queensland Law Reform Commission considered this issue and came to a different conclusion, but our view is that such a requirement would enhance the protection of the important human rights that the bill engages. As you have noted, I am joined by Rebecca Anderson, chair of our Elder Law Committee, and we welcome questions that the committee may have.

CHAIR: We will come back to that and get you to unpack that particular amendment and talk to that in a moment. We will now ask either Chris or Jennifer for an opening statement as well, please.

Ms Herrald: I would firstly like to acknowledge the First Nations people as the original inhabitants and traditional owners of the land we are on today and pay our deep respects to elders past, present and emerging. Thank you, Chair, and members of the committee for allowing STEP Queensland to assist with this inquiry and be consulted about this bill. I am the current chair of STEP Queensland, and Ms Sheean is the current deputy chair. While we are both practising, we are only speaking on behalf of STEP Queensland today. Ms Sheean was also the chair of the STEP Queensland subcommittee that undertook the review of the voluntary assisted dying law proposals.

STEP stands for the Society of Trust and Estate Practitioners and represents professionals such as lawyers, accountants and financial advisers that specialise in trust and estate law matters and support the need of families. The overarching objective of STEP is to advance the interests of families across generations.

STEP Queensland recognises that, as a member organisation, we have differing divergent views and personal convictions about the introduction of voluntary assisted dying laws within our organisation. As such, we are not here today to comment on whether the bill should or should not be passed but we are here to make sure it is good law if it is passed.

In our view, sections 5, 21, 32 and 84(1) might require some amendment to ensure the bill achieves the purposes set out in section 3, in particular to establish sufficient safeguards to protect vulnerable persons. Briefly, we support the Queensland Law Society's proposal that section 5 mandate that any person exercising a power or performing a function under the bill have regard to the principles set out therein. Consistency in approach of drafting legislation, especially that which deals with vulnerable people, is desirable, and that approach would be consistent with the current provisions of the Guardianship and Administration Act and the Powers of Attorney Act.

Sections 21 and 32 of the bill provide an opportunity for a coordinating practitioner or consulting practitioner to, in effect, get a second opinion on whether a person has capacity for a voluntary assisted dying decision and also whether a person is acting voluntarily and without coercion.

The first matter is one that can be referred to another registered health practitioner, while the second matter can be referred to another person who has appropriate skills and training to determine the matter. However, there does not appear to be any guidance in the bill about who such a person might be. STEP Queensland respectfully suggests that both matters should be referred to a lawyer from a panel with extensive experience in determining whether a person has capacity. Ideally, that is something that could be referred to QCAT, but at this stage we believe that it is unlikely the tribunal could be able to deal with those matters as quickly as may be required.

Finally, section 84(1) deals with conscientious objection. The way it is currently drafted, it could mean that a person who might be eligible for VAD might be unaware that it is an option available to them. In effect, it makes registered health practitioners who conscientiously object gatekeepers for whether a patient is aware that VAD might be an option. Such an approach takes away from the autonomy of a person who might fulfil eligibility requirements but would otherwise be unaware that VAD could be an option or that they might fulfil eligibility requirements.

CHAIR: Elizabeth, you flagged a section you wanted to propose an amendment around or had an issue with. Can you go back to that and inform the committee, please?

Ms Shearer: Our submission proposes a number of amendments, but the one that I wanted to flag, and Chris has also mentioned this, is section 5. It sets out some very important principles that guide the operation of the act. We have two proposed amendments. One is that a further principle be included that specifically references the Queensland Human Rights Act. The second more important issue is that people exercising a function under the act should be required to do that guided by those principles. At the moment, the principles are there but there is no legal requirement that a person must act in accordance with those principles. We are just saying that, as a matter of strengthening the human rights protections, you might include a provision that a person who exercises a function under the act must act in accordance with those principles. Otherwise, private actors will not have any obligation. The way our human rights framework operates in Queensland is that the Human Rights Act binds only public entities. With a private entity exercising a function under this act, or a private person, the Human Rights Act, which provides protections about the state exercising power, does not apply to private individuals or private entities.

CHAIR: Do you have any views on that, Chris?

Ms Herrald: No. We support the Queensland Law Society's view about that.

Mr MOLHOEK: I am a bit confused on what you are actually saying in regard to section 5. Are you concerned that there are no safeguards in place for the individuals who would seek VAD from family members wanting to get their hands on their estate? I got a bit lost. Can you dumb it down a little for me?

Ms Shearer: The issue is not about the person exercising the function; it is not so much family members as doctors or healthcare providers or the people who are charged with taking certain steps under the act, that they must do that having regard to all of those principles set out in section 5. You might think the principles are there and, therefore, anybody who is exercising a function under the act will have to act in accordance with those principles, but there just is not that link in the legislation.

Mr MOLHOEK: If it were more strongly linked, and I think I heard you say earlier like in the Victorian legislation, what does that mean practically? Does it mean that they could be prosecuted or they could be made liable? Does it make them more or less accountable? I am struggling to understand why that link is so important.

Ms Shearer: I think just because it provides clarity and transparency. I do not know if you want to add anything, Rebecca?

Ms Anderson: I do not have the relevant section in front of me, but the concern is that health practitioners or other interested parties who are involved in this situation and choose to not participate may not do so as fulsomely in their referral process. It is putting in a safeguard that they must take into account the person's rights. It has this clear obligation for them that they just take it into account and that they act appropriately. It is not to say that if they have an objection and they do not want to participate they have to, but they have to do this legislation as fully as possible with recognising someone's human rights.

The other reason for the clarity is that the Australian Medical Board provides the code of conduct for doctors. Within their code they say that they always give way to legislation. Their code of conduct gives them guidance but it does not give them certainty. If it was clear in the legislation that they must take into account the person's human rights, it provides the practitioners that certainty.

Mr MOLHOEK: Prior to morning tea we heard from Wendy Bonython from the Faculty of Law at Bond University. She presented an alternative view that said that you should not have to state that you are a conscientious objector or that you do not agree with this; rather, there should be facility within the legislation to simply say, 'Look, I'm not qualified to deal with this,' or 'I'm not approved to deal with this.' She was concerned that people could be discriminated against because they said they were a conscientious objector or that they did not want to deal with it. You are going the other way.

Ms Anderson: I do not think so. I think I am probably not explaining myself very well. Having this clarity is not going against anything that she is suggesting at all. It is giving certainty to the practitioners. It is not compelling them to participate in the scheme at all. It is just giving them certainty that they have to be clear with what they are doing. That is not to say that they have to explain themselves for not participating further than the legislation is already asking them to. It is just so that they know that they have to take into account the human rights. The Human Rights Act only binds public entities, as we have already talked about. That leaves some practitioners who may work in the private system with some uncertainty around this space. This is giving them some clarity to take into account the person's human rights.

Ms Shearer: I think it is also important to recognise that section 5 includes that protection of freedom of thought, conscience, religion and belief. That is one of the rights that is being balanced here and that is referenced specifically in section 5. It is really just because that is a right that is not recognised in Queensland except that public entities have to take account of it. Having this link means that anyone, whether they are a public entity or not, has to have regard to all of the principles. It is not really undermining conscientious objection; rather, it is making clear that that is a valid choice for people to make under this legislation.

Ms Sheean: I might add to that. There were two suggestions from the QLS. One was the inclusion of a section that says that people must have regard to the Human Rights Act but also that section 5 itself, giving regard to all of the principles in there, should be mandated. Going back to your question, Mr Molhoek, that would be in line with what is in sections 11B and 11C of the Guardianship and Administration Act as well as the Powers of Attorney Act in sections 6C and 6D where it sets out principles that must be followed when acting under that act. It would bring it into line with those two acts. In terms of what it might mean for protections, if there is a review of any decision by QCAT then QCAT would ensure that those principles had been acted upon. It is really that sort of safeguard.

Mr ANDREW: Yesterday we heard testimony from some witnesses about what happens if the medication did not work sufficiently or if there was an issue with the medication when it was administered. Should there be a way that, if the medication taken by the person who is participating in the VAD does not work, that could be captured in law? What are the processes if it does not work? There have been cases where it has not worked. Could you comment on that, please?

Ms Sheean: My knowledge of what the medications would be is absolutely nil, so I do not know anything about what may be required to make sure the dose is correct for the person. In my view, if it did not work there may be some action in negligence against the practitioner who prescribed it in any event. I do not know whether this law itself would need to encapsulate it or whether it is already sufficient. Having said that, that is a question without notice. That is my immediate response.

Mr ANDREW: I asked earlier about the Statutory Instruments Act 1992. It is a question on notice to another witness, but you may be able to clear that up. Can this bill be affected by that act?

Mr MOLHOEK: More poignantly, are there areas within this legislation that can be changed or altered by regulation down the track without going to the parliament? That is really the question, perhaps to Elizabeth.

Ms Shearer: Yes, it may be something that we can take on notice. That is not my reading of the act. There are very limited provisions in the act where there is power to make regulations—I think. With legislation, if an act authorises the making of regulations then those regulations can be made. We can review the act if you think that—

Mr MOLHOEK: Can we put that as a question on notice and ask you to see if there are any potential flaws or a risk in that regard?

Ms Shearer: Yes. It is not something that I identified but I am happy to take that on notice.

Dr ROBINSON: I have a couple of questions that are all one line of thought. In terms of estate law and dealing with wills, how difficult is it to be certain that a person both has the necessary decision-making capacity to make a valid will and is not subject to any coercion or undue influence by an interested party who is hoping to benefit? If a will is found to be invalid after a person's death, what is the remedy?

CHAIR: How is that relevant to the bill?

Dr ROBINSON: I will get there. Please be patient, Chair. I have a follow-up question to that.

Ms Herrald: There is already really robust law in place in terms of testamentary capacity and capacity to make a will or not. The court has inherent jurisdiction to deal with those issues as well as the jurisdiction given to it by the existing legislation. As to the intersection between testamentary capacity and capacity to access the VAD regime, they are two very distinct legal questions. I am not sure what—

Dr ROBINSON: I will come to the final part of my question in a second. What remedies are there if, afterwards, it is found that there was coercion or something inappropriate in terms of influence on the person when making their will about their estate? What remedies are there afterwards?

Ms Herrald: Currently there is a very strong body under the forfeiture rule. I would have thought that if somebody had been found to have coerced somebody into accessing the VAD regime the forfeiture rule and the principles under that rule would step in to operate there.

Dr ROBINSON: You are coming to where I am going. In the case of this legislation, what would be the remedy if the person's request was found to have been invalid after they are dead? How do you remedy that if it turns out that they were coerced?

Ms Herrald: That is a separate question to the operation of succession law. I think your question: what remedy does a family have against a—

Dr ROBINSON: What I am saying is: what remedy to the situation is there? In terms of the court and challenging a will, that can happen. However, once a person has passed away and it is found that there was coercion involved in that process, you have a wrongful death. How do you right that whole circumstance, which this legislation potentially opens up?

Ms Herrald: I do not think the legislation potentially opens up differing causes of action in terms of the operation of the forfeiture rule when you are talking about somebody's estate. That is why STEP Queensland's position has been that there are safeguards in the act that enable the assessment of capacity—the referral to practitioners to get second opinions. Because capacity is ultimately a legal test, no matter what the capacity is for—whether it is for the ability to do a will or the ability to make an enduring power of attorney or the ability to access the VAD regime—they are all distinct legal tests. Some people would call them medico-legal tests, but ultimately it would always be a court of competent jurisdiction that would be making a determination on whether or not somebody had capacity to do that. That is why STEP Queensland is saying that there should be at some point in the process the ability for a question to be referred to a lawyer for determination on the capacity issue.

Dr ROBINSON: My point is how difficult it is in that process to determine whether there has been coercion or whether there has been some inappropriate level of influence. That is already technically difficult in law to establish, yet we are going to do that when it comes to a person's life in terms of whether it is their choice, whether they are suffering from dementia. We are making those determinations that are very difficult to make but without specialists. I have some concerns around that.

CHAIR: We are running out of time. We have one question very quickly and you can write to us if you want to add more.

Ms KING: Thank you so much for coming in and for all of your very thoughtful contributions on this bill. I really appreciate the feedback that you have provided. If the laws were passed as they are, do you consider on the whole that they would present a safe regime for voluntary assisted dying in terms of having appropriate safeguards?

Ms Sheean: I would have to say mostly. There are those issues that we have identified, and Queensland Law Society has also identified, that really would need to be looked at before passing it. As we have said, we do not support one way or the other whether it does get passed or not, but it is important that in our view section 5 is mandated. It is important for people who have concerns about whether it may be easy to influence somebody to actually take the step and, as has been said, there is no remedy. People do not come back.

Can I just make a point on that particular question—and I am sorry, Ms King, for co-opting your question to go back to an earlier question? Dr Robinson, as I understand this regime, the determination of capacity is done while that person is still alive, which is a much easier thing to do than after someone dies. In a challenge to a will on the basis of coercion, after someone has died it is nigh on impossible to actually have evidence, because one person is dead and one person is self-interested. In this case, the determination is happening more than once while someone is alive and it is ensuring that is a sufficiently strong process to make sure we hopefully do not, but at least as little as possible, have problems with being coerced into something they do not want to do.

CHAIR: We are right out of time. You have taken one question on notice. Would you take another one on notice? Ask the question, please, Deputy Chair.

Mr MOLHOEK: I apologise if the terminology is not right, but my question is: are there any amendments required to existing estate laws or trust laws in respect of coercion or wrongful death as a result of VAD? If there was a contested will and it could be proved that a family member had wrongfully coerced someone into death, is that covered under the current legislation and laws?

CHAIR: It is probably best to take that one on notice because we are completely out of time. We are eating into other people's time.

Mr MOLHOEK: I probably have not explained it very well, but I think you understand.

CHAIR: Are you happy take that on notice?

Ms Shearer: Yes, I think I understand the question and we can certainly answer that.

CHAIR: Can we have the responses to questions taken on notice by Thursday, 22 July, please? Thank you very much, each of you, for attending today.

COPE, Mr Michael, President, Queensland Council for Civil Liberties

VALLANCE, Ms Sarah, State Committee Member, Australian Lawyers Alliance

CHAIR: Mr Cope or Ms Vallance, would you like to give an opening statement?

Ms Vallance: Thank you for inviting the ALA to attend the public hearing. I did want to begin by acknowledging the Turrbal and Jagera people, traditional custodians of the land on which we gather today, and pay my respects to elders past, present and emerging. The ALA has reviewed the Voluntary Assisted Dying Bill and we have provided our submissions.

Especially given the time frames, I am not going to go into detail, but I just wanted to make a few points. One was with respect to practitioners initiating discussions with patients about voluntary assisted dying. We note that the bill does not support the Victorian model, and we strongly agree with that approach for a number of reasons. We think the Victorian model is problematic. It does not allow practitioners to have open and fulsome discussions with patients about all of their options, which is something that they do in every other aspect of health care. We think having a provision that prevents those discussions is inconsistent with the current legal principles that we have in Queensland and it is also inconsistent with the ethical principles that we have.

With respect to a contravention, unlike Western Australia, there is no statement that a practitioner who has a discussion in contravention of that part of the bill would be unprofessional conduct. It is our position that there should be consideration that it is unprofessional conduct. I note that concerns have been expressed that if a breach of that provision is automatically considered unprofessional conduct that could have serious implications to practitioners, so I guess it needs to be determined whether there is a specific provision, whether there are enough safeguards elsewhere in the act. Perhaps one other option is that there is a presumption in favour of unprofessional conduct but then giving a practitioner the opportunity to rebut that presumption, particularly if it is a minor breach of that provision.

With respect to time frame to death as one of the eligibility provisions, our position is that there should not be a specific time frame. We feel that a voluntary assisted dying scheme is not just about a person choosing the time and place and manner in which they die; it is also about their level of suffering—the fact that they have decided that the level of suffering they are going through cannot be ameliorated. I guess our concern is: if a person has the same level of suffering as another person, why should they be prevented from accessing voluntary assisted dying simply because they are expected to live longer and therefore suffer longer? If a specific time frame does remain in any legislative scheme, we feel there should be no differentiation between neurodegenerative conditions and other medical conditions.

One of the other major concerns that we have is just how persons living in rural and remote areas of Queensland are going to access the scheme. We have made a number of submissions about the role of nurse practitioners. That may not be a straight solution because, again, you need to have nurse practitioners in those areas who are also willing to be involved in this kind of scheme, but we think careful consideration needs to be given as to how persons who have terminal illnesses or serious medical conditions that will cause death are going to access this scheme. Are they going to be expected to travel? It may not be practical for them to travel. Especially with the interaction with those Commonwealth laws, we feel there should be careful consideration as to who can participate in the scheme to ensure there is equitable access for all Queenslanders.

CHAIR: Thank you very much. Mr Cope, would you like to make a statement?

Mr Cope: Good morning, committee members. On behalf of the council, I thank you for the opportunity to appear this morning. This sort of reform is something that has been on the agenda of the council for many years, and in broad terms we welcome the legislation. We think the Law Reform Commission has done an excellent job and produced a bill which meets the two competing interests: that people who are suffering from unbearable pain are entitled to ask that they be relieved of that pain but that everybody else is entitled to ask that vulnerable people be protected from the abuse of that right. We note in our submission that the legislation does not go as far in relation to eligibility criteria as we would like, but we think this is an important piece of legislation and it should pass without pressing that issue.

Having said that, in a slightly contradictory way, I do want to talk about the issue of the use of advance health directives. This is an issue which, quite frankly, is a very big interest to some senior members of the council who, like many people in the community, are afraid of what is going to happen if they develop dementia or some other condition of that nature. This is, no doubt, a difficult issue, as the commission notes and as the excellent paper by the Canadian Council of Academics that they refer to also deals with. We want to make two points about that.

Firstly, the commission, at paragraphs 7.294 to 7.296 of its report, makes reference to a recent amendment in the Canadian legislation which basically deals with the situation of a person who has gone through the process, has clearly said that they want to die and in between loses their capacity. The amendment seems to simply allow that to proceed on the basis that they have completed everything and they have lost consciousness or whatever it might be. That seems to us to be a reasonable amendment which could be dealt with now, but we would be suggesting to the committee that what it should do is amend section 154 to make it specific that when this legislation is reviewed that issue is dealt with in a comprehensive fashion. It may be that it is already covered by section 154, which talks about eligibility, but to the extent that somebody might want to suggest that it is not quite in that category we would suggest that there is obviously more work to be done in this area. The existing regimes in the Netherlands and Belgium and Luxembourg—some of them are relatively new, but we think it is an important issue for many people in the community and it should be addressed again in a comprehensive fashion.

Mr MOLHOEK: Thank you very much, Mr Cope and Ms Vallance. Thank you for coming today. Can you tell me about the Council for Civil Liberties organisation in Queensland. Is it membership based? How many members do you have?

Mr Cope: The Council for Civil Liberties is an organisation of volunteers. We do not accept funding for our day-to-day operations from government or private organisations with whom we do not agree or are likely to disagree. We have approximately a couple of hundred members. We have been around since 1967. Our basic charter is to seek the implementation in Queensland of the Universal Declaration of Human Rights. That is where it starts. It is just an organisation of volunteers. We subsist on membership and donations, largely.

Mr MOLHOEK: The Australian Lawyers Alliance: what is the composition of your organisation?

Ms Vallance: It is a national association of lawyers and academics. We are involved in a number of areas of law, but at the core of that is protecting and promoting justice, freedom and individual rights.

Mr MOLHOEK: I am not sure I have read this correctly, Mr Cope, but one of the statements in your submission says that a person who wishes to take advantage of statutory immunity should be required to report their actions to the voluntary assisted dying board. I am assuming that is referring to people who are conscientious objectors or not wanting to be a service provider or provide that advice. Was that the intent of that statement?

Mr Cope: No.

Mr MOLHOEK: I have read that wrong?

Mr Cope: That is a reflection of the Dutch system, which, as I understand it, says that, if you are a health practitioner and you are involved in this process, in order to have the criminal immunity you have to report the whole thing.

Mr MOLHOEK: You are actually asking for a tighter provision?

Mr Cope: Yes. Broadly, our various submissions on this topic have basically adopted the Dutch system. It seems to me that that system requires that, if you are the medical practitioners going through this process, if you want to have the immunity then you should be required to report the whole process. That will assist people with reviewing the thing and making sure it is being done properly. As I read the legislation, it is not a requirement of getting the immunity that you actually go through the whole process and you report the whole thing to the board or whatever it is called. It is not directed at conscientious objectors or those sorts of people at all.

Mr MOLHOEK: Are you suggesting that the legislation does not factor in any accountability?

Mr Cope: No, it does. Obviously, you can commit an offence; there are various offence provisions. What I am saying tightens up the offence provisions by saying, 'If you want the immunity in the legislation, in addition to doing all the other things that are in there you should report everything that you do to the board.' As I say, it is just taken from the Dutch model.

Mr MOLHOEK: Sarah, you mentioned that you think there should be no time frame. You are not happy with 12 months or six months? Do you have some sort of time frame in mind?

Ms Vallance: No, to have no time frame. That is on the basis that in the current model it is that the condition will cause death. Our position is that there should be no time frame. In those kinds of models you then tend to focus more on the level of suffering. You are looking for a higher level of suffering that that person feels cannot be ameliorated.

Mr MOLHOEK: Yesterday we heard a number of presenters, one being Dr David van Gend. He raised the concern: how do you protect vulnerable patients from their own depression? He went on to say that when people are facing a very adverse health issue or crisis it can alter their brain chemistry significantly when they are under distress. They would argue that there should be a shorter time frame because we need safeguards in place to protect people from perhaps making rash decisions. One of the stories we heard involved a gentleman who had actually got the family involved in making and doing collage on a coffin, getting them all ready for the fact he was going to die, but he went on to live for another 10 years. You are not concerned that by removing that safeguard or limit we could be opening it up?

Ms Vallance: I do not think so. I will try and step through in a logical way. The Victorian data and data from other countries shows that, in the majority of cases, people are choosing to end their life through voluntary assisted dying right towards the end of their illness. Not a huge number of people are looking to end their lives at a much earlier time, but that is not to say that they should not have that option if that particular person has that level of suffering.

You want a process in place that is long enough so it is preventing those rash decisions but not so long and burdensome that it prevents people from accessing the scheme. You are trying to find that balance. The qualifications and the training that will be provided to practitioners involved in that scheme will be paramount, because people have to make difficult decisions all of the time, including withholding or withdrawing medical treatment. If they are being provided with good support, you hope that those situations will be very limited where someone makes a rash decision.

With the first parliamentary inquiry, some of the submissions were about people ending their own lives in other violent ways and the resultant impact. They have lost their life, but what of the impact that has on family members and first responders? There is always this tension between the importance that we place on the sanctity of life and that conflict with an individual's autonomy. If the other parts of the scheme are robust, the level of suffering is high and it is going to take a longer time for them to die, why should they be prevented from accessing the scheme just because they in fact have longer to suffer?

Mr MOLHOEK: It sounds like you are almost trying to create a circumstance where—say someone was diagnosed with a terminal illness but it might take some time. In a sense, it is almost providing a health directive, giving them the option to have something in place if things deteriorate.

Ms Vallance: Having the option of an advance health directive would be quite different, in my opinion.

Mr MOLHOEK: It is almost like that. If you have approval three years out and you do not exercise it until later in the piece, it is kind of like you have set it up, haven't you?

Ms Vallance: It does not mean that you will then choose to go through with it, and you have to have capacity at all the relevant times. The ALA did not make submissions about the advance healthcare directives, but our position is that a person has to have capacity at all the relevant times, including at the time of taking the substance or having it administered.

The laws in general in Queensland relating to advance health directives are incredibly problematic in general. They do not work. There is an issue about whether common law advance health directives have any effect. Even with withdrawing and withholding life-sustaining treatment, there are a number of criteria and it has to then be in accordance with good medical practice. If we were ever to go down the path that someone has the ability to make an advance healthcare directive, that whole scheme needs to be closely examined.

Mr MOLHOEK: That is the problem with law, isn't it? It is a fairly blunt instrument.

Ms KING: Thank you both and your organisations for taking the time to prepare such careful and thoughtful submissions on the matter. Mr Cope, I was interested in your organisation's comments or views about the idea that conversations about voluntary assisted dying should not be initiated by practitioners. This is contrary to the view of the bill, which provides a certain set of circumstances in which they can be, where all the patient's treatment options and prognosis issues are examined by that practitioner. The views of your organisation that those conversations should not be initiated I understand are raised by you out of concern about power imbalances, but other submitters have raised concerns that that leaves patients with low health literacy and perhaps from non-English-speaking backgrounds at a particular disadvantage when it comes to knowing their full range of treatment options. What are your responses to that?

Mr Cope: My first question is: is this a treatment option? I think this also comes out of the Dutch situation. I think this is where this comes from; I am not sure about that. I do not think it is a treatment option.

Ms KING: Shall we say 'care option', then? 'Options at end of life' perhaps?

Mr Cope: Our view is that there is a power imbalance and the initiation of this process should clearly come from the person. There should be no doubt that it has come from the person. We see that as a very fundamental point at the starting point of the process, that it clearly comes from the person and is not coming out of something else. Obviously in any circumstance there are going to be discussions in families and things, but medical practitioners have clearly a recognised power imbalance. People will feel pressure that it is some sort of a treatment option. I understand what you are saying, but I think it is important that the process is clearly initiated by the person and not someone in that relationship with them.

Ms KING: On balance, is it the view of your organisation that, if enacted in its current form, this legislation presents a good—

Mr Cope: We have identified some issues with it but, yes, on balance, we think it is a pretty good bill.

CHAIR: I think the QLRC in its consideration made comment around 'medical procedure', if you like.

Mr Cope: I accept that we are disagreeing with the commission, but I just think it is important that it starts clearly with the person and not coming out of a relationship like that.

CHAIR: Ms Vallance, you raised the issues of telecommunications, equity and access. Who is best placed to resolve this issue?

Ms Vallance: I think the federal government needs to address the issue about telecommunications and practitioners being able to provide advice about end-of-life care options, including voluntary assisted dying via telehealth services.

CHAIR: I think that is an articulate answer. Thank you very much. We thank you both very much for your attendance today and your contributions. We certainly appreciate it.

CORNELL, Dr Kristin, Private capacity (via videoconference)

PARENTE, Dr Phillip, Private capacity (via videoconference)

CHAIR: Dr Parente, would you like to make an opening statement before we move to questions?

Dr Parente: Thank you for the opportunity to speak. I will give a bit of a background to myself. I am a medical oncologist in Melbourne, Victoria. I am a director at a public tertiary institution but also work in the private sector. I have been an oncologist for approximately 20 years. What is relevant is that I am of Italian ethnicity with a strict Catholic upbringing. I was taught by the Catholic educational system. When voluntary assisted dying was initially debated within Victoria, my initial feelings were that of objection, that I would be a conscientious objector. Really, I think that was influenced by my Catholic beliefs and Catholic upbringing. I never really thought of the implications about patient care. It will always stand in recorded history—it is on the internet—that my name is on the letter to parliament of about 100 doctors opposing voluntary assisted dying, but when my first patient came to me when the legislation was enacted in Victoria I felt I was letting the patient down. It did not feel quite right to me. This was a long-term patient who at the time was dying and had requested voluntary assisted dying. As his treating oncologist I said, ‘No, I am a conscientious objector.’ That led to my really rethinking my stance, going off and doing a sabbatical in health and medical law, and changing my views from being a staunch opponent to being an avid supporter. Really, the pillars of patient autonomy and choice override other aspects, in my opinion. As I said, I have become a major advocate.

Our institution has the best access for patients. Patients have really acknowledged this, both within our institution and within the community. The best part of voluntary assisted dying is that it is really a choice issue. I want to ensure people understand that just because you access the VAD legislation, it does not mean that the medication is taken. It is a choice and it is up to the patient if they are going to take it or not in their disease journey.

I cannot speak about other diseases, but as an oncologist, cancer is very disempowering and patients lose independence. In the terminal phases of their disease, this enables a bit of patient control and autonomy over the disease.

CHAIR: We will come back to questions. It is an interesting transition: someone who was opposed and, because of their patient interaction, now supports choice. We also have online Dr Kris Cornell. We will take an opening statement from you and then move to questions for both of you.

Dr Cornell: Primarily I am a daughter and an advocate for voluntary assisted dying. I was not given a great deal of information on what you would like from me today, so I will assume you want a summary of my story and how my involvement has occurred over the years with the legislation.

My father had a delayed diagnosis of motor neurone disease. This all occurred throughout the year of 2019. That in itself was a very difficult journey, but once we got to the end of it and he finally received a diagnosis, his deterioration was very, very fast. There are lots of different types of motor neurone disease, varying in aggressiveness, and certainly his was aggressive. He was diagnosed in November that year. Around February the following year he raised voluntary assisted dying with me. It had really only been in Victoria for six months at that stage. Being in the medical system for some time, I was very keen to get the ball rolling for him pretty quickly because I could see the progression and how fast things had been going. It is always different seeing something through a doctor’s eyes and sometimes you wish you did not.

We approached his GP who had not yet done the training but had planned to. There was a bit of a delay in that sense because Dad was very faithful to his GP. This happens a lot. I have done the training myself now. GPs often wait to be asked by a patient until they do the training. We have been trying to advocate, through my involvement in Western Australia, for GPs to train before they are asked because that phase of the program can take weeks. It is not simple training. I have been involved with some roadshows conducted in Victoria. I think they are fantastic and that is how I did my training; it was all done in the one day. You need to make things really easy for doctors because they are busy and a little bit lazy as well at the same time. That is why we wait for things to come to us. That is a really great thing I have been talking to Western Australia about as well in trying to get people accredited.

We had a lot of delays. The main issue was getting a neurologist. I am not sure how aware you are of all the Victorian legislation, but if you do not have cancer and you have a different sort of disease—sorry, if you have anything, you need a specialist opinion as the second opinion. If you have a biological condition where you are expected to potentially live longer than six months but less than 12, you need another specialist opinion to confirm that diagnosis. This all has to be done in a face-to-face environment.

Obviously you have a very busy day, so I want to try to be as succinct as I can. That is why I am advocating really strongly at the moment, through politicians and anyone I can, for the release of these bounds on us with telehealth and being unable to use them. I think that it is important, particularly in that first consultation. There are no neurologists outside of Melbourne. The whole of regional Victoria have to travel to see a neurologist for that second opinion and for the third one as well.

Unfortunately, due to some timing issues, something lapsed for Dad and he had to go back to the first neurologist again, so three in total that we had to see over the course of about three months during which he went from being upright to barely being able to get out of a chair and lift his neck up and keep upright. By the third consultation, everyone agreed that he was not even going to make six months anyway, ironically.

That just made things very hard for us and for Dad. My dad was a really staunch man and father—a big, burly bloke who talked quite a bit about how important voluntary assisted dying was to him. When he told me about the whole thing, he talked about how he had thought about going out and gassing himself in a car or driving himself into a tree because he just did not want us to deal with what his end days would be. It was very confronting to hear Dad talk like that. In some of the interviews I have done, you can hear some of the audio when he talks about it. It allowed him to live for longer, to be a better man, he said, to his family, because he was not going to be doing something horrendous like that because of the fear of the unknown of the end of what we all know is a really horrible disease.

Jumping forward, after it was all finished and everything was signed off and the multitude of signatures were approved, everything like that, and we finally got the tick, Dad was in his last couple of weeks of life. He had a really bad night on the Sunday before the medications were coming down from the pharmacist on the Wednesday. They had a terrible night. Mum could not get Dad out of bed. He was incontinent. He had had enough. If it had have been there already in his cupboard, that was his day. Everyone has a line in the sand and that was my Dad's. He had to live two or three days beyond that with palliative care, which was amazing, but he suffered in those days and he lived longer than he wanted to in a state that he did not want people to see.

There are so many things I think we can improve to lessen the hoops for people. For us, in the end he did get the medication. For you in Queensland—I am probably making assumptions and suggesting how to go about it rather than whether to go about it. I believe he would have gone on for days because his body was well; it was just that his muscles could not help him breathe anymore and he could not swallow. He got to do it and it ended for him finally. I truly believe he would have been in that state for much more time yet.

We are so grateful. It was not perfect and it was not ideal, but we are so grateful, and he was grateful. He was so grateful he lived in Victoria when that diagnosis came through and it came hammering home.

I think there are so many ways we can do it better, but we are just so lucky that it exists at all. Having that power of it sitting in the cupboard, as people talk about it, and to have that choice. As the previous speakers noted around that choice, they do not have to, but if they hit their line in the sand like Dad did, it is there.

CHAIR: Thank you so much, Kristin, for sharing that. That is deeply personal. Coming from a clinical background, it is always hard as well because you are watching a loved one go through one of the worst neurodegenerative conditions. A fellow with NMD came before us in Rockhampton and it is pretty advanced. I think 'the line in the sand' is a good analogy to use when they have just had enough.

To both of you, you have probably seen the Queensland Law Reform Commission's draft bill. It is to make it as less complex as possible. There has been argument about the need for specialists. I think you have just articulated how difficult it is to go to a specialist. My question to both of you is: do you think that relationship with a GP and using—it may well be a nurse practitioner in a remote area to assist—to make it less complex, is that the way to go in terms of dragging the process out and attending these specialists appointments?

Dr Parente: Definitely. For any health right, the most important path is access. I have seen issues with access. I am fortunate that I live in metropolitan Melbourne and my patients live in metropolitan Melbourne, but my rural patients do not have that same access. Enabling GPs and nurse practitioners who will always liaise with treating specialists because there is always correspondence which documents the patient's disease journey which enables that to happen. In Melbourne, doctors are willing to do home visits, but when you have 50 kilometres or 100 kilometres to travel, that is not technically feasible. It has been shown that having just a small core of people who are VAD assessors is not going to work. They would also get what is called work stress and become overburdened. Really, to expand on the number of core people who are able to be VAD assessors, whether they be general practitioners, nurse practitioners or consultant specialists, will actually help on both fronts, for the patient and also for the workforce.

Dr Cornell: I think that is such a strong point. We have people who are burning out in Victoria really quickly because the burden of who can do this training as a specialist is huge, and we do not want to lose people because they are overburdened with this care. I live three hours south-west of Melbourne. My dad was a bit closer to town than that. I know personally of people in my community who have just given up. They just have not got there; they could not do those journeys. A lot of the time, a lot of the information can be done over telehealth and then you have your accessory things like investigations, chest X-rays, lung function test, liver function test—all the things that are used to get prognosis often do not always need a face-to-face meeting. We have all seen through COVID how possible all of this is. It has very quickly become second nature to all of us of as specialists.

I also feel that a second opinion is often needed, and that is fine. Doctors are sensible and they are not going to sign someone off if they do not feel confident about their prognosis; they will get that second opinion. But if that has to be through a face-to-face meeting with a neurologist who is accredited, I can tell you that there are only about five or six in Victoria and we are a highly populated place, probably what it would be like in Queensland, how many neurologists are you going to be able to get accredited for something like this? It is a major bottleneck in the process. It is really disenchanting for patients who just do not see it coming. They think, 'Yes, we have done this, this, this and this and, bang, now we just need this last bit of the process but it will take us another three months.' Sensibility is so important. Overcoming the federal law is really our main challenge because everyone will have little hopscotch rules around this legislation that varies from state to state so that we are avoiding the word 'suicide' in the documentation, but that is just going to have to come with time.

The only other thing I would make a point of is that delivery of the medication is not by the pharmacist. They are amazing, but I think what Western Australia is doing in releasing it to specific pharmacies across the state is a fantastic initiative as well, rather than it being a handed-over procedure face-to-face by the only pharmacist in Melbourne.

Mr MOLHOEK: Kristin, thank you so much for coming online and sharing your experience with us. I wanted to ask some questions about the actual training. You said it is basically a one-day course. Can you tell us a little bit about what that training covers and how you participate in that training?

Dr Cornell: We all thrashed it out in an hour. I did one of the mobile roadshows that they started. I am not sure whether they have been able to do any more with COVID-19 up and down in the last few months. There were about 15 of us. We did the first three modules at home and then we all met up. We would do a module at a time, with the VAD coordinators floating around the room and doing brief talks at the beginning and end. Then we could all discuss any little questions we had around things. There was a lot of ethics covered. There were a lot of specifics around persuasion; exactly who qualifies and the criteria around that; how to recognise when people might be being pressured by family; and who needs second opinions and who does not. Doing it with colleagues was fantastic because we could turn to each other and say, 'What about this specific instance?' As we had the VAD coordinators with us in the room and also one of the leaders from Geelong hospital who was involved in the legislation, it was a great network. We had speakers come in. We had pharmacists come in for a talk on this from their perspective. We had the guys from VAD who do the final sign-off come in and talk to us around little problems they have on the website—things like, 'This is the most common thing that people stuff up or do not put in or it bounces back. If you do this, it does not.' It was a fantastic day. I say day, but I do not know whether you could do it in less than five or six hours. There is a quiz at the end. I thought it was a great way to do it. There was a lot of support in and around the day and how it is done.

Mr MOLHOEK: I guess it probably deserves a day. It is a fairly big topic to cover.

Ms PEASE: Dr Parente, thank you very much for your comments. During our inquiry in 2018-19 we heard from lots of medical practitioners. One in particular was from overseas who spoke about when voluntary assisted dying was first being discussed and introduced in his country and the fact that he was a conscientious objector. His journey was not too dissimilar to yours. He is now a conscientious supporter of voluntary assisted dying. You spoke about being a faith based practitioner. How have you been able to reconcile voluntary assisted dying with your faith?

Dr Parente: That is an excellent question. Maybe I might be excommunicated. Who knows? I also did my training on Christmas Day, which is probably even worse. It was the only time that I had a day off to do it. In the portal you have the dates of your training, so each time you do a new case it comes up. It comes up each time just to remind me what a great Catholic I am!

For me, medicine is about compassion. No matter what religion you are talking about—Christianity, being a Catholic, Islam, Judaism, Hinduism, Buddhism—the basis of every religion is compassion and love. I cannot see anything more compassionate than supporting a patient. They do not just think about doing voluntary assisted dying. They struggle with it for weeks and weeks and months. They have to struggle with it within themselves and they know the decision will hurt their loved ones. You can see the struggle for them. They see that their partners, their children, their grandparents will support them, but they know what it ultimately means. It is a big decision. For me to support that means I am being the most compassionate doctor I can be. Saying no is not me being a religious person. Denying someone the biggest and hardest request they have probably made in their life is not compassion. That is how I reconcile it.

Ms PEASE: One of the presenters before us yesterday was a general practitioner and he spoke about the fact that with life comes suffering and that everyone has to suffer at some time in life. Would you be able to put some context around that?

Dr Parente: I would not agree with that. None of us likes suffering. All of us have suffered in life—a financial burden, a relationship burden, death, birth. All life is like that, but there are some things that we can control. If we can control that then why put people through that suffering? I do not agree with that. Death does not need to be a suffering process. Each voluntary assisted dying case I have seen has been done with humility and compassion. I have been honoured and humbled on every occasion. I would not agree with that.

Ms PEASE: Kris, would you like to comment on that?

Dr Cornell: I think the background to that comment is a religious one. With what I have learned from Andrew Denton when we talk about these origins and some of the palliative care theories around suffering and death, I think it does have Christian origins around the fact that if you take away that last part of death—the suffering—then you are robbing the patient of their passage into eternal life or heaven or whatever. I think that is where that comes from. I must admit that it has taken me a long time to understand it or to work out what it is exactly that the core of palliative care has against voluntary assisted dying. Andrew said it to me like that. I get it now. It makes sense.

I do not think they are really wanting to see people suffer. Overwhelmingly, if you speak to any family or friend of anyone who has died or any person who is dying, what they want the least is to suffer or for their family member to be in pain or to suffer. I think that is where it comes from. It does not exist on the ground. On the ground you have palliative care workers who know all about VAD, who know the people who are doing VAD, who are helpful, kind, generous and angels. At the top of palliative care is the idea that we do not mesh and consult with colleagues. I do not think it has trickled down the chain. I think that is where those thought patterns come from. If you have some GPs who have specialised in palliative care—you are able to do that as a GP like you are with anaesthetics and obstetrics—that is where I feel that mentality is coming from. It is a long-engrained, perhaps Christian approach towards death. I think it is paternalistic, outdated and sad.

Dr ROBINSON: Dr Cornell, your story of your father's passing and loss is very sad. I had a similar story with my father and empathise with you. My question goes to the area of freedom of conscience and religion. In terms of suffering, Dr van Gend's view is that, from a Christian perspective, we should relieve suffering. That is what a lot of Christian thought and Christian practice has been for a long time. It is not to prolong suffering. I am just clarifying that if that is what the reference was to. It was that we should relieve suffering wherever we can and to do it through palliative care.

My question is particularly sparked by Dr Parente's comments. My story is one of having been non-religious and an atheist and coming to faith. I am a pastor today so I put that out there for openness. I go back to your earlier view—and this is not being judgemental in any way; please do not see it that way. You would understand that some people with strong religious views or values—some doctors and some leaders of Christian institutions involved in hospital care and aged care—feel very strongly about being able to opt out of the process. They may have a very strong conscientious or religious objection. This bill means that doctors will have to refer people on. Some people and organisations that have presented to this committee or put in submissions have objected to that strongly and believe that they should be allowed to opt out. Some have said things like institutions should declare up-front that they do not provide VAD services. That might be one way to do it. Doctors have said that up-front it could be made clear they do not do it. Do you have a view on that, considering you will know colleagues who will be in the position you used to be in and for whom rights need to be retained?

Dr Parente: We had a similar situation with abortion in Victoria. As you know, it is a mandatory legal requirement for us to refer even if we do not agree with the process. I see this as analogous with that.

Dr ROBINSON: Good point.

Dr Parente: The way I see it is that a referral does not mean you are agreeing to it. A referral is enabling access. That does not actually mean that you subscribe to the legislation. Just because you refer does not mean you agree to what is going on. It is enabling access. We live in a country that is non-secular. Patients should expect the right to access health care. That is what the mandatory referral process does. When I refer people to have an abortion—I do not agree with that and I will say that—it does not mean that I am subscribing to it. I am enabling the patient to see a doctor to make a choice.

I really would say to my colleagues and institutions that referral does not actually mean that they are participating in voluntary assisted dying. It is enabling a patient to see another health professional to enable access. A lot of referrals relate to medicine that we may not necessarily agree to, but it enables them to see another doctor—like a second opinion and so forth. We do this in medicine all the time. I hope that answers the question. Abortion is an analogy. We have been doing that for about five or six years in Victoria already.

Dr ROBINSON: I think that is a good analogy. I respect that you have come to that understanding and that that does not offend your conscience. Some doctors have said that it does offend their conscience. I am not challenging your view. Some believe that being part of the referral process—whether it is abortion or euthanasia or VAD—draws them into the process that they did not have to be in before and that is a serious offence to their conscience. What do you say in that case? If you cannot convince them to your way of thinking and it is their thinking that they are being discriminated against, what is your view about that? Should they be left alone to do that and to opt out or should they be forced into it?

Dr Cornell: At the end of the day, they are doctors and they have a duty of care. We need to bring it back a little bit to the patient and their rights. If it is a legislated law and something that they can access, they deserve to be able to access it. Sorry if I jumped in there, but it is not just about us the doctors. We can be a bit precious. If it becomes a law then the patient has rights.

In the situation where the patient is declined a referral, it really leaves them feeling very disempowered. Dad was actually declined a review in the second part of his neurology assessment by a conscientious objector who did not actually need to be part of the VAD process; he just needed to agree with the prognosis. He did not even have to be accredited. It was not going anywhere on it. It was just that he agree with the prognosis and he declined. Even that was a huge blow to us. We know that actually it is okay—and when you separate it out from all the emotion it is okay—but you cannot help but feel that you are doing something that is wrong or that someone does not agree with. Do you know what I mean?

If you actually bring it back to how that feels when a patient experiences that, we need to be quite careful that they do not then think, ‘I’m doing the wrong thing. Maybe this is a bad idea.’ We just need to turn it around, away from how the doctors are feeling all the time. If they have the opportunity, they can refer on and it becomes someone else’s problem. To me, that is very easy. There is no explanation required: ‘I don’t have to deal with this. I feel uncomfortable.’ If they are still feeling that offended by that small part, I think that is probably the doctor’s issue and not ours or the patient’s or the legislation.

Dr Parente: To echo Kris’s comments, that is a very paternalistic view and it is antiquated. It is not patient centred care. Health care is patient centred care. The patients need to be the primary focus. If the doctors cannot handle what has really now become a standard of care, maybe they need to look at their role in medicine. The doctor has the issue, not the patient. The patient should not be denied access to health care, and that is what I feel nonreferral does. There are other jurisdictions around the world that make referral mandatory. Australia is not unique in this aspect.

CHAIR: Thank you both very much. We are out of time. We really appreciate your contributions today. Kris, thanks again for sharing that very personal story of your dad. Certainly it hits the mark for us. One final word from both of you: is our bill as drafted sound, practical and compassionate?

Dr Parente: I am jealous of it.

Dr Cornell: We have to wait three more years to even potentially have something that looks like that. Thanks very much, from my perspective, for the opportunity. I am trying to beat the drum down here so that people do not make some things quite as challenging as they are down here. Your patients will have a much better experience. Good luck. Thanks for the opportunity to speak today.

Dr Parente: To make one more comment, I understand about confidentiality. The other doctor had a similar journey to mine overseas. Are you able to give me his name or not really?

Ms PEASE: I will have to review the documentation and talk to the chair.

Dr Parente: There are not many of us. Thank you, I appreciate it—and well done.

BOON, Dr Kym, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists

GOOD, Professor Phillip, Palliative Medicine Specialist, Australian and New Zealand Society of Palliative Medicine

PULLE, Dr Chrys, Council Member, Australian & New Zealand Society for Geriatric Medicine

WILLIAM, Professor Leeroy, President, Australian and New Zealand Society of Palliative Medicine (via videoconference)

CHAIR: I will leave it in your hands as to who would like to go first with opening statements before we move to questions.

Prof. Good: Firstly, I acknowledge the traditional owners and elders past, present and future. The Australian and New Zealand Society of Palliative Medicine is a specialty medical society that promotes the discipline and practice of palliative medicine to improve the quality of care delivered to patients and families living with a life-limiting illness. Our members are medical practitioners who either practise or have an interest in palliative medicine.

I start by saying that dying is an intensely individual, personal and emotional experience both for the person who is dying and for those who love and care for that person. ANZSPM does not see VAD as part of palliative care practice and thinks it should be funded separately and independently of palliative care. We also acknowledge that obviously there is a divergence of views about VAD in society and within medicine, and even within our own specialist society.

One of the challenges of legislation around VAD is summed up by a recent journal article I read. It said that it is one of the main hallmarks of an open democratic society to allow for the peaceful coexistence of divergent points of view, particularly concerning ethical issues. It falls to the parliament to create the legislative framework in which space is given for divergent ethical attitudes and their implementation in real life.

I want to touch on a few aspects of the legislation. I think all aspects of implementation of the legislation need to be voluntary. This includes the person free of any undue influence, the medical practitioner free to choose to participate or not and the institution free to choose to participate or not. That would make the legislation truly voluntary.

Allowing any medical practitioner to go into a hospital room and perform a procedure on a patient without any governance or oversight by the hospital, as in the current legislation proposed, is far below standard healthcare practice and is not acceptable in any other part of medicine. Any new procedures or new clinicians need to undergo a credentialing process at that hospital. That process is not there to impede access to clinicians or procedures but to make sure patients have access to interventions that are performed in a safe and responsible manner. That responsibility includes the ongoing care of a patient after a procedure and also being responsible for managing any adverse outcomes. Given that VAD has an adverse outcome in up to five per cent of patients, this proposed aspect of the legislation would reflect what currently would be considered unsafe practice and far below current healthcare standards.

Prognosis, which again is mentioned in the legislation, is always uncertain, but I do think that people who are experienced in diagnosing and managing an illness are the best people to give a reasonable estimate. That would seem very important when time estimates are given in this legislation. Transparency and openness around death and dying are important both from a medical point of view and a societal point of view, and also from a governance and safety point of view.

Currently in the legislation I think one of the downfalls would be that we think VAD should be documented on the patient's death certificate just like any other medical procedure that may contribute to death currently. Every Queenslander who has a life-limiting illness and who will have an expected death should have access to high-quality palliative care. No person should choose VAD because of inadequate access. Many people in the dying process will choose to access palliative care. A small number of people will choose to access VAD, with or without palliative care. Adequate funding for palliative care is essential for people to have the best end-of-life care possible.

Dr Pulle: I acknowledge the traditional owners of the land and pay respect to elders past, present and emerging. The Australian & New Zealand Society for Geriatric Medicine represents specialist geriatricians and medical professionals who strive to provide the best possible health care for older people. The society supports an older patient's right to refuse or discontinue burdensome or futile treatment and it supports an older person's right to adequate symptom control and optimal access to expert palliative care, characterised by dignity.

ANZSGM's view is that policymakers and funders of health care can best help patients nearing the end of their life by ensuring adequate provision and funding of high-quality community care, palliative care and geriatric medicine services. The society acknowledges the wideranging perspectives and ethical views held in the community on voluntary assisted dying, likewise with ANZSGM members, but they do hold some concerns with this proposed legislation. There are three most important concerns.

The first is that frail older people should not be put in a position where they consider VAD because they feel they are a burden on others. Such feelings are often due to underlying depression, financial concerns, lack of available community services or family dynamics. Psychological abuse comprised 76 per cent of the 1,534 notifications recorded by the Queensland Elder Abuse Prevention Unit in 2019-20 alone. An older person requesting VAD has the right to have a comprehensive assessment that addresses medical, psychological and social aspects of health.

Dementia and other cognitive disorders become more common with age. Therefore, there will be older people who lack the capacity to make decisions on VAD. It is important that a process to adequately assess capacity is in place. We do not support a substitute decision-maker having the ability to make decisions about VAD on behalf of a person who does not have the capacity to do so. With the increasing number of frail older people, it is important that the development of VAD does not detract from the increased resources that are needed to look after older persons at the end of their life, for instance, palliative care, geriatric medicine and community services.

On specific views on the proposed legal framework, as Phillip mentioned before, in best practice palliative care the number of people experiencing unrelievable pain is small. Losing autonomy and a decreasing ability to participate in activities far outrank reasons for accessing VAD. The priority should be for all Queenslanders, no matter where they live, to have timely access to controlled pain relief to alleviate their suffering—not VAD. A person with intolerable suffering that cannot be relieved in the manner that the person considers tolerable should have a referral to a palliative care consultation prior to accessing VAD and have access to specialist assessment in the field of terminal illness. This will allow improvements in things such as prognosis, new available treatments or other palliative options. The specialist should be a consulting medical practitioner for VAD, as legislated in Victoria. This is to ensure that all patients are given all potential management options at the end of life or no treatment.

There need to be safeguards to ensure that the scheme will always be voluntary. If medical practitioners are able to suggest VAD, it opens the door to subtle coercion by well-meaning practitioners not fully aware of palliative care options. When VAD is initiated by a patient, their medical practitioner should inform the patient of other treatments and palliative care options.

Turning briefly to capacity, ANZSGM agrees persons accessing VAD should have a capacity assessment prior to accessing the scheme, as per the Guardianship and Administration Act 2000. Capacity should be assessed by a specialist medical practitioner who has expertise in capacity assessment not, as mentioned earlier, by a simple MMSE, as one of the witnesses said yesterday. One of the difficulties is that they meet people who have capacity to be eligible for the VAD scheme but then subsequently have diminished capacity closer to the time of the actual VAD act.

Finally, if the proposed VAD scheme is to be legislated in Queensland, the most important prerequisites that legislators must consider are that persons accessing the scheme must have capacity at the time of application, be fully informed of all treatment and palliative options, and have the capability of changing their decision prior to the final act. A coordinating and/or consulting medical practitioner must have specialist experience in the care of older people with terminal illness, and medical practitioners and health professionals who conscientiously object must have a right not to participate in any part of the process.

CHAIR: Thank you, Dr Pulle. We will come back to you. You were here when the two previous doctors talked about the significant barriers of accessing specialist assessments and Dr Cornell spoke about her father who had motor neurone disease. I would be interested to get your views on that in a moment, but I do not want to disrupt the hearing too much. Dr Boon, from a psychiatrist's point of view, would you like to make a statement?

Dr Boon: I also acknowledge the traditional owners of the land and leaders past, present and emerging. The Royal Australian and New Zealand College of Psychiatrists acknowledges that the public want the option of VAD if there is intolerable suffering in a terminal illness at the end of life.

There are divergent views within the College of Psychiatrists, but broadly we think the bill is not unreasonable. We think VAD, though, should not be the only option at the end of life. There should be much more comprehensive care of the suffering at the end of life. We also have some concerns about the practice. There can be difficulties in practice and things can go wrong, as my colleagues have also mentioned.

The first point I want to address is concerns about capacity and the voluntariness of the assessment process. Capacity is a critical consideration in the application for VAD. It is not just thought content and processes but also the effects of emotional factors on capacity. Assessing capacity to consent, make treatment decisions, withdraw from treatment and voluntariness is not always easy. Sometimes it is very difficult.

Psychiatrists find it challenging and it is often our bread and butter. I work in the field of liaison psychiatry in the medical and surgical settings. Old age psychiatrists also often do these assessments. We are often asked to provide second opinions when the treating specialist teams struggle to really know. The flowchart with capacity criteria in the 30-minute online training modules for the VAD process and the consent rituals do not adequately predict understanding. Medicine not a tick-the-box process. The best learning is years of experience, which is what we and old age psychiatrists have in these kinds of assessments. Assessing capacity for these VAD decisions can be a lot more nuanced than is able to be applied in a tick-the-box 30-minute online assessment.

With respect to voluntariness, none of us make decisions that are free from influence. It can be very hard to know where influence ends and undue influence starts. People who are very ill are prone to undue influence. The negative effect of profoundly devalued lives, an ageist and ableist society, consumerism, the risk of unconscious economic motives, and children who want to inherit now can cause undue influence. Our view of the individual now is so individualised and so focused on the notion of autonomy, but our decisions about ourselves are made in the context of relationships. We have become autonomous in the context of friends, family, culture and society. There is some anecdotal evidence from Victoria that there is coercion from family for people who are asking for VAD. Voluntariness is not a tick-the-box exercise. Choice may appear voluntary but it may be made on the basis of coercion. There are a variety of ways, implicitly and explicitly, that coercion can impact on a patient's request.

We think that the assessment of capacity is too restrictive and too short. I have just completed an ethics masters and I assess patients who are requesting treatment for severe psychiatric illness, pain and specialist pain issues. The hurdles for people to request treatment for things like deep brain stimulation, spinal cord stimulation and ECT for severe psychiatric illness are far more rigorous than the capacity process for someone who is requesting death. I think there are more hurdles for people who are requesting treatment than ending someone's life.

My second point is also consistent with my colleagues'. There is inadequate, underfunded and inequitable palliative care. I work in the biggest hospital in Queensland and we do not have dedicated palliative care beds. There is inadequate, underfunded older aged care, especially for dementia, mental illness in older persons, resourcing to support the elderly at home, staffing and aged care. We only have 10 to 12 beds in the biggest hospital in Queensland for elderly psychiatric patients. There cannot be a genuine choice until mental health and older aged care is equitably funded. Mental health needs to be a core factor in end of life. There is late, inadequate access to palliative care, older aged care and psychiatric care. It is much more challenging then to deal with psychological, spiritual distress and suffering.

My third point is that somewhere in the legislation there should be a role for psychiatrists or an acknowledgment of the role of psychiatrists—not mandated—but it should be recognised that mental health is a core factor in end-of-life care and a request for voluntary assisted dying. Mental health should be funded in health services for this practice. The motivation to access VAD reflects multidimensional distress. There are many pathways to unbearable suffering, including: depression, demoralisation, communication problems within treating teams, within families, families are stressed, loneliness and the dire meanings of symptoms that patients do not understand. Patients may want to re-establish a sense of control and request VAD for symptoms that may mean something dire to them but may not mean end of life, which means there is a risk that people request VAD in error.

Depression and demoralisation are underdiagnosed, particularly in the older age and palliative care communities. There are established links between depression and euthanasia. There are established links between depression and suicidality. Depression and demoralisation affect people's competency and the relative weighting patients give to positive and negative aspects of their situation, so that can drive someone's request for voluntary assisted dying when they have a treatable condition. For depressed patients, the request for death may be part of their illness, the correct response being treatment rather than assistance in dying. Psychiatrists have a unique ability to explore the reason for the VAD request and possibly do something about it such that the VAD request goes away and the patient does not really want it.

CHAIR: Dr Boon, we have conducted a lot of public hearings throughout Queensland. People say they do not want to leave their communities. They want to be treated in their communities, not shipped away to a medical institution somewhere to die within four walls when they are diagnosed with a terminal illness. This goes to a point raised by the two previous doctors. I do not know whether you heard them, but they talked about the difficulty in accessing specialists. How many practising psychiatrists are there in Queensland?

Dr Boon: I cannot give you a number, I am sorry.

CHAIR: You can take that question on notice. What I am trying to articulate is that it is problematic. We just heard from Dr Cornell, whose father suffered from motor neuron disease, and how difficult it is to find a specialist or psychiatrist in rural and remote regional Queensland. Do you have any commentary around that?

Dr Boon: I think it is very difficult. Mental health care is underfunded. Psychiatry trained physicians are underfunded. We do not have enough psychiatrists in Queensland, and that is a funding problem.

CHAIR: If you are diagnosed with a terminal illness, are you suggesting that you get a psychiatric assessment before—

Dr Boon: I am not suggesting it is mandated, no.

CHAIR: I just wanted to clarify that.

Dr Boon: It should not be mandated.

CHAIR: Dr Pulle, can I just get some understanding of your views?

Dr Pulle: I think regional Queenslanders deserve the same degree of specialist care that metropolitan Queenslanders do. First of all, they would have had to have a diagnosis of a terminal illness. Presumably, that is done by a specialist such as in an oncological diagnosis or a neurological diagnosis, so there is capacity for that. Are we living in two Queenslands? Should we not try and improve the specialist assessment for regional Queenslanders first so that everyone has the same access to treatment before we consider VAD?

CHAIR: Can I ask all of you this: if palliative care was sufficient, would that mean that you would support VAD as drafted in the bill? Let’s say in a Utopian world we have excellent palliative care no matter where you live. Would it change your views on the draft bill and what is before us at the moment if palliative care specialists were everywhere and people had access? What are your views?

Dr Boon: I think it is clear that even the best palliative care cannot control all symptoms.

CHAIR: We heard that from Dr Will Cairns in Townsville, yes.

Dr Boon: In situations like that VAD is not an unreasonable request, but it has to be made in the setting of people having the full option of all treatment. It is not a treatment in itself.

CHAIR: Are there any other views?

Prof. William: Yes. I would like to acknowledge the traditional owners of the lands upon which we are meeting and pay my respects to elders past, present and emerging and the ancestors who have brought us here together to this meeting.

I think that, when we talk about suffering, there is a slant here that it is the responsibility of doctors and the medical profession and health care to relieve all suffering. No-one has ever made the claim that we can relieve all suffering. In fact, suffering is inherent to life. There are many people who do not have anything wrong with them in terms of a health illness who are still suffering. There are many people who are marginalised in our society. There is a role here for society to relieve suffering wherever we see that suffering, irrespective of whether health is a problem related to it or not.

Even if we have a Utopian world where everyone had the best palliative care, there will always be a proportion of people who want to do what they want to do because of the way they perceive their lives to turn out. That happens in any society, wherever we are. There are many people in society who have an autonomous view about how they want to live their lives. We do not allow them to do that if it is going to affect other people or if we think that from a societal perspective that is not what we believe is the right way to run a society. No-one has ever said that we can relieve all suffering. I think it is a false narrative to say that, even if we had the best palliative care, perhaps that is the reason we should have voluntary assisted dying.

What we do know is that our healthcare system is not focused on holistic care throughout the journey that someone has in the healthcare system. Ideally, every clinician should know about palliative care for someone whom they might see who is dying. They should be able to refer to specialist advocates to access support as needed. There is a gap here in terms of educational supports to get people to the right level, and there is also a gap in terms of access to specialist types of care when needed.

If we take the idea of cardiology, not every cardiologist sees everyone with a heart. They see the people with the most complex problems and everyone else does the generalist cardiology. It is the same with palliative care. We do not need to see everyone who is dying, but we certainly need to see the ones who are most complex. It does mean that the rest of the clinical community needs to support people with generous palliative care needs and also that there is an educational basis where training in palliative care in the undergraduate space is more than an average of one week in five or six years, whereas cardiologists would not get that training in the budgeted curriculum.

I just want to make those points about the idea that, if we had the best palliative care involvement for everyone, it would negate the need for voluntary assisted dying. It would not then negate the suffering that people have; it would also not negate the need of people who are suffering and may want to do this because of other societal factors that exist.

CHAIR: I will open it up to questions.

Dr ROBINSON: I thank each one of you for appearing before the committee. I have a lot of questions, but I will try to keep it tight to let others have an opportunity. In terms of the potential risk of inequitable access, we are looking at shortfalls in palliative care and VAD coming in. Since the VAD laws came in in Victoria, the data shows that 38 per cent of requests for VAD came from regional and remote areas of Victoria. Palliative Care Victoria and palliative care doctors particularly have held the view that these areas have had little access to palliative care, despite what we have seen in terms of increased funding in Victoria. The increased funding has not necessarily changed the dynamic of the potential for inequitable access. It would appear to me that potentially, in the early stages of what we may be seeing in Victoria, are we already seeing inequitable access? People are not able to access palliative care in Victoria, and we have a bigger decentralised state here in Queensland. Palliative Care Victoria said that something like approximately 10,000 deaths per annum are happening with little to no palliative care. Do we have a problem in that the bill may make it so easy to access VAD that people are then less likely to get palliative care with the scant resources we already have?

Prof. Good: Leeroy works in palliative care in Victoria, so maybe he can give a quick summary of that experience.

Prof. William: If we take someone in rural and remote Victoria as an example, we need to be clear what we are talking about when we say ‘access to palliative care’. Often when we say that, we are talking about specialist palliative care services. As I stated in my last response, there are people in the community who should be able to provide general palliative care and refer to specialists when they need to.

The main practitioners involved in the care of rural and regional communities are general practitioners and specialists. The first question is: what do we know about general practitioners and their involvement with palliative care services and engagement with end-of-life care? Are their skills adequate? Can they manage those cases from a generalist perspective? The same questions apply to the relevant clinicians who are involved in care. People can phone to access support and advice and then for transfers to occur. We completely understand that people want to be cared for in their own communities and to be supported by community and hospital services. We have community palliative care services that are trying to support people, but they are underfunded from a specialist perspective. There is an educational gap, as I mentioned previously.

Anywhere there are rural and remote problems—and that could be in any state in Australia but also in New Zealand, in Canada—there are many areas that do not have the same access to services. That is something that the Royal Australasian College of Physicians has been trying to address over many years and in many different specialities. Yes, we do need to improve access for people. During COVID, we have seen that metro areas have had the same experience as rural and remote areas, because they have not been able to access the usual services they would have. We have seen people experience issues of psychological wellbeing when they have been more isolated and not able to access services. During that period of time, there was no diminished access to voluntary assisted dying. When you pull resources away from people, they are more isolated and, psychologically, they feel more stressed. There was no cessation in the work of voluntary assisted dying, whereas in other countries that did happen during COVID.

Getting back to the point of rural and remote services, yes, there is a problem with access. We should maintain access to palliative care services, both generalist and specialist. Due to the educational gap and the ability for people to manage end of life well, there is a problem in rural and remote areas particularly. Those clinicians may not have the necessary generalist knowledge to manage those patients. They are doubly affected by lack of access.

CHAIR: Do we need to increase the workforce in palliative care, from nursing through to practitioners? Wouldn't that be fundamental in establishing—

Prof. Good: Of course, yes.

Prof. William: If we think about the needs in the community, there is a base of needs that are generalist. People come into the hospital and they get a mixture of generalist and specialist. Obviously from a specialist palliative care perspective, we have a workforce that is small and trying to manage our own specialist group as well as a generalist deficit. Yes, there is a need for extra workforce and there is also a need for extra education within the generalist workforce.

CHAIR: The department that came before us talked about increasing the workforce with the money that was announced. There are issues around retaining people in regional Queensland. Coming from regional Queensland, I know it is incredibly difficult.

I know that people are setting the scene, but I ask members to shorten their preambles and get to the point. We have limited time, so I ask members to get to their questions quickly.

Mr BERKMAN: Dr Boon, you said in your introductory statement that you think there should be a role for psychiatrists in the bill but not a mandatory requirement. Can you give the committee a clearer sense of what that role is? What do you think the bill should require in respect of the role of psychiatrists?

Dr Boon: I think there should be an acknowledgement that some people might request VAD when they have psychiatric illness and that needs adequate assessment and treatment and, then, that person's suffering may settle. I do not know where you should put it in the bill, but I do not think it should be mandated. Clearly, there is going to be a workforce problem with mandating psychiatric assessment. It will not always be necessary, but there will be some patients who may request VAD for whom there are very complex psychosocial situations, psychological distress, demoralisation and suffering. If that was addressed by a psychiatrist, then that would be an alternate pathway to addressing suffering.

Mr BERKMAN: When you say that there would be a 'workforce issue with any mandatory requirements around psychiatry', as I understand it, you are indicating that would present a real barrier to access to a VAD scheme if there was a requirement to consult a psychiatrist.

Dr Boon: It could be a barrier. It depends on whether people are regional or remote, because we have a lack of psychiatrists in the regional and remote setting. The college of psychiatrists have in our submission said that we would favour telehealth services being more available and they may be appropriate in this setting. Having said that, I do telehealth for both pain medicine and psychiatry and it is not easy. It is not easy establishing that rapport and understanding what a patient is suffering and what their lives are like over a telephone or videoconference.

Ms KING: Dr Boon, you stated in your submission that, across the spectrum of patient experience, at the end of life for some patients a request for voluntary assisted dying will not be the result of a psychiatric issue; it will be a reasonable request or a reasonable 'wish to have'. Firstly, did you consider that the legislation that is before us on the whole, if enacted, would be a reasonable response to that expectation of patients?

Dr Boon: Yes, the college of psychiatrists does accept that, broadly speaking, the bill is not unreasonable.

Mr MOLHOEK: Dr Boon, one of the concerns raised by a previous group was in respect to the proposed penalties for people who counsel or advise someone to revoke their request for voluntary assisted dying. I imagine psychiatrists play a role in counselling and providing advice to people. Is your organisation concerned that someone who was seen to be convincing someone to change their mind could be facing seven years in jail?

Dr Boon: I do not think that psychiatrists would view their role as 'convincing people to change their minds'. Our role is to explore an understanding of a patient's request for voluntary assisted dying, not to change their mind necessarily. If there is a treatable psychiatric illness, we would make recommendations that treatment be offered.

Mr MOLHOEK: Earlier, you commented that there is a fine line between influence and undue influence. Are you worried that you or your colleagues are constrained in that space?

Ms KING: I am just going to provide clarification that the member is referring to section 141, which involves inducing a person to revoke their request for voluntary assisted dying using dishonesty and coercion. Do you have concerns that your members might stray into using dishonesty or coercion and that that should not be an offence?

Dr Boon: I think it would be very unlikely that psychiatrists would use dishonesty and coercion to persuade people to make a different decision.

Mr MOLHOEK: Have you had the opportunity to look at that particular area of the legislation?

Dr Boon: I cannot recall it at the moment.

Mr MOLHOEK: As a question on notice, can I ask that you provide a response as to whether there could be concerns around where you could stray in those areas?

Dr Boon: Yes.

Dr ROBINSON: Dr Pulle, as geriatricians have stated, it can sometimes be difficult to identify whether there is coercion or abuse occurring in patients. Is there a risk in the bill that, if a specialist is not involved in the process, we could end up with wrongful deaths, as has happened in other parts of the world where VAD legislation has been introduced?

Dr Pulle: Potentially. We need to look at it holistically. If the practitioner knows the patient and the family or the carers and there has been a long line of giving medical care then that might help, especially when patients are entering early stages of dementia and they still have capacity. I understand this bill only allows for patients with capacity to suggest VAD. There needs to be a holistic approach. Certainly, in the aged-care sector, as a result of the royal commission findings, we have lots of patients who are scared witless by the prospect of entering residential care—and understandably so. With potential influences from family members, they are at risk, with early dementia and potential frailty, of requesting VAD without looking at their full options.

Dr ROBINSON: In the legislation—as you are probably aware—the doctor does not have to know the patient.

Dr Pulle: That is a concern, especially if they are referred to practitioners of VAD who do not know the patient but who potentially take histories from their carers or their EPOAs.

CHAIR: If there are no further questions, we are on time. There are two questions on notice for Dr Boon. Can we have that reply back by 22 July? A bit of ambo humour as we go to our break: stick around as I might need a psych assessment after carrying this for the last 2½ years! Thank you all very much for joining us today and thank you, Leeroy, for being online. We will now adjourn until 1.30. Thank you.

Proceedings suspended from 12.43 pm to 1.31 pm.

MONOHARAN, Dr Bav, Vice President, Australian Medical Association, Queensland

PERRY, Dr Chris, President, Australian Medical Association, Queensland

SANDFORD, Professor Alan, President, Royal Australasian College of Medical Administrators

CHAIR: Welcome back to the hearing on the Voluntary Assisted Dying Bill 2021. I understand that Professor Alan Sandford, whom we met in Rockhampton, is under some time pressure. If it is okay with the AMAQ, we will hear his statement. I understand that he needs to go after that. We will hand over to you, go to opening statements and then go to questions.

Prof. Sandford: Thank you, Mr Chairman and committee members. It is good to see you again. I have a brief statement on behalf of the Royal Australasian College of Medical Administrators which is the specialist medical leadership group. The Royal Australasian College of Medical Administrators notes the task: the Queensland government is proposing voluntary assisted dying legislation be drafted that is compassionate, safe and practical. RACMA does not approve nor deny the framework as outlined in the proposal but would like to make the following comments. Initial member consultation discussed with our college, conducted late last year with the policy and advocacy committee and the Queensland jurisdictional committee, provided the following member feedback. It is critical that no clinician can be forced to take someone's life by any legislation. The doctor can participate normally in the process but withdraw from any single request. The option to end a life must be absolutely voluntary on every occasion, with no penalties for doctors who decline any request. There should be immunity from prosecution or defamation for those who choose to withdraw. There should be a right to live legislation for intensive care patients and their families. There was no perspective of a medical specialist administrator with any of the clinical aspects of the decision-making. They are the statements that have been received from our collective membership, representing both the Queensland jurisdictional committee and, more broadly, the college. I hope they may be helpful for the committee in its ongoing deliberations and collection of information.

CHAIR: Thank you very much, Professor Sandford. Thank you again for appearing the other day in Rockhampton. It was valuable to hear from you for an extended period of time. We will take that as the statement. It is entirely up to you if you want to stay for the rest of this hearing.

Prof. Sandford: Thank you, committee. I congratulate and applaud you on the hard work you are doing. I shall now leave my colleagues to speak to you.

CHAIR: Thank you, Professor Sandford. Dr Perry, would you care to give an opening statement?

Dr Perry: Mr Chairman, ladies and gentlemen of the committee, thank you very much for inviting AMA Queensland to present the views of the membership of our organisation on the Voluntary Assisted Dying Bill 2021. Today's comments are based on our most recent submission to this committee of 21 June this year and our previous submission to the Queensland Law Reform Commission dated 1 December last year. AMA Queensland believes laws are a matter for society and government and not the AMA, of course. What is critical from our perspective is that doctors and patients have their rights and beliefs protected and that the options provided through legislation are equitable throughout the state.

Overall, AMA Queensland is pleased that the draft Voluntary Assisted Dying Bill 2021 reflects the majority of AMA Queensland's answers in our submission back to the Law Reform Commission in December last year. The answers in our submission were based on the results of a survey on VAD sent to all AMAQ members which resulted in the largest response to any survey AMA Queensland has ever sent out in its history. It is an indication of the importance of this topic to doctors in Queensland. However, there are some parts of the draft Voluntary Assisted Dying Bill which we recommend the Health and Environment Committee consider in its deliberations on the draft bill.

First, eligibility: AMA Queensland wishes to raise a concern regarding eligibility. We believe the current eligibility criteria for patients wishing to access VAD schemes should be phrased 'the person must have been diagnosed with a disease, illness or medical condition that is incurable, advanced, progressive and will cause death'. As outlined in our first submission to the Law Reform Commission, AMA Queensland believes that the word 'incurable' must be included, otherwise legislation could include curable conditions. It is not currently there. Restricting VAD to incurable conditions would be in line with other Australian state models.

Organisational conscientious objection: the issue of organisational conscientious objection was addressed in both of our submissions. AMA Queensland is pleased to see the inclusion of conscientious objection for doctors in the draft bill. However, we recommend that this also be sent on or include organisational conscientious objection issues. Institutions, after all, are organisations of people in a workplace. They are not just a series of buildings. Hospitals and aged-care facilities have staff—doctors, nurses, cooks, cleaners and administrators—who also need rights to conscientious objection status. A person's own choice if they are involved in helping someone to die should be respected. Choice and respect are a two-way street. We will hear others propose that an individual patient's choice must take precedence over the choices of their carers'. I propose that Queensland parliament has the wit to respect both groups' rights.

It is on average 31 minutes between drinking a Victorian VAD cocktail and death. We acknowledge that most people accessing VAD wish to die in their own home or the home of close family members. Surely, transport out of an objecting institution's premises to another site, a home, a beach or a respectful quiet room in a public hospital is a better choice than pursuing religious and other organisations out of the hospital and aged-care space. We believe that some healthcare facilities may have a distinctive mission or ethos that should allow it to refuse to provide particular services due to an institutional conscientious objection. In that situation, institutions should inform the public that they object so that patients can find care elsewhere and, preferably, much beforehand. It should be able to be said, 'No, we do not want voluntary assisted dying in our institution.'

We would like to see a Queensland VAD website to explain in plain English how to access VAD so that nobody can say the information was not available to them. Everybody should be able to go to a simple website, if not their very close relatives could.

Telehealth: COVID-19 has shown us how important telehealth is to link those in need of a doctor. AMA Queensland agrees with the Queensland Premier's request that the Commonwealth Criminal Code should allow doctors to use telehealth to provide care options for patients with terminal conditions. This may be especially helpful for those living in rural and remote Queensland wanting to access VAD. Self-administration should not be the default option. Queensland AMA does not believe that self-administration should be the default option. We believe that decision on the mode of administration should be with the patient. They may want a loved one to help steady them and to hold the cup.

Enduring request: enduring requests act as a fundamental safeguard for those accessing the VAD scheme. We believe that the request should be enduring unless the patient rescinds it. This will help ensure the decision was well considered and not a short-term reaction to their condition. Advance health directives: Queensland AMA was disappointed to see that the advance health directives which name VAD will not be followed. AMA Queensland is a strong advocate of advance health directives as this ensures the patient's wishes are fulfilled. Some 77 per cent of our doctors support this in our VAD survey. A VAD associated advance health directive should be followed. Advance health directives are there for the very time when patients may lose capacity, such as during a VAD process.

Referral to a psychiatrist for mental health and/or capacity assessment: AMA Queensland believes the decision to refer the patient to a psychiatrist, mental health and/or capacity assessment should be made by the coordinating medical practitioner if they are unable to assess the patient's capacity. However, the requirement to refer a patient to a psychiatrist for a mental health and/or capacity assessment should not be mandatory. Hopefully, the coordinating doctor knows the patient, their wishes and their mental state very well. There is not a lot of spare capacity in Australia's psychiatric services. Already, the aged-care royal commission wants psychiatrists to see and medicate terminally ill patients who may harm themselves if they move very widely. Where do these psychiatrists come from?

Lastly, we also wish to point out to the committee the disparity between the prognosis time periods for the dying person to access palliative care, which is three months, compared to the proposed VAD scheme in Queensland, which is 12 months. We also deplore the low-funding level for palliative care in Queensland. Palliative care is the choice of passing of more than 98 per cent of Victorians, Canadians and citizens of Oregon in the United States. It obviously needs to be adequately funded, but currently it is not. If people are keen for choice, the choice for the patient should be between a well funded, palliative caring model and, ultimately, a quicker and cheaper VAD model. VAD should not be thrust on these vulnerable people because they have no other way out of pain and unbearable suffering. I thank the committee for inviting us to speak today on this extremely sensitive and important health issue.

CHAIR: Thank you very much, Dr Perry and the AMAQ, for being here today. I have a couple of observations on your survey. Was it something like 12,500 respondents?

Dr Perry: No. Unfortunately that is a multiplication of 10; it was 1,250.

CHAIR: How many?

Dr Perry: Twelve hundred and fifty.

CHAIR: That is good. If we refer to the draft bill as proposed by the QLRC, is the AMAQ's position for or against?

Dr Perry: The AMA's position is quite nuanced, as you know, Mr Chair. The world Council of Medical Speciality Societies does not support voluntary assisted dying. However, if people, through their elected representatives, elect to go down the pathway of voluntary assisted dying, we would like it to be equitable for people who are incurable and dying. We want to respect the conscientious objection status of doctors, but there are many other people in the health services outside of doctors whose conscientious objection status we would like to see respected as well.

CHAIR: How many doctors do you represent in Queensland?

Dr Perry: That is an interesting question. Probably four to six times the number of union members in most areas in Queensland.

CHAIR: What percentage of Queensland doctors does the AMAQ represent? You can take it on notice if you need to.

Dr Perry: I think it is about one-third, which is much higher than the union membership.

CHAIR: Some 74 per cent of your surveyed respondents said that they would support referring a patient to a VAD practitioner if they conscientiously object, is that correct?

Dr Perry: Yes.

CHAIR: Does that change the AMA's position?

Dr Perry: No. The AMA's position is quite nuanced, because there is the blank question of, 'Do you support voluntary assisted dying?' It is probably a bad thing, but if a young person within prison who is depressed asks the doctor to help them die, I do not think anybody in Queensland would be in favour of that. It is the nuance about it. It is how you pose the question. What is the voluntary assisted dying procedure, the technique of it, which is being proposed? We went out of our way not to ask that. From talking to doctors around the state—which I have done a lot of—it is probably fifty-fifty. So 50 per cent are in support of what is happening and 50 per cent are not and we have to respect the views of everybody.

CHAIR: I want to keep these as short as possible to allow for questions. It states that 97 per cent of those surveyed—and I say this from being a regional MP—say that regional and remote communities should have access to VAD as well. That was the response of the survey.

Dr Perry: Yes, very much so.

CHAIR: That is quite a few per cent.

Dr Perry: Yes. We want equity.

CHAIR: Who is best placed to fix the Commonwealth telehealth laws?

Dr Perry: I think it is the Commonwealth but every state is lining up against the Commonwealth on this.

CHAIR: I am going to give you a copy of a letter received by the Department of the Prime Minister and Cabinet from a constituent from regional Queensland. They wrote to the Prime Minister regarding equity and asked them to address the carriage service issue so people had access and equity. The response we got back from the Department of the Prime Minister and Cabinet was very clear. They thanked the person for the email and said, 'Looking at the issues you raise, the Queensland state government would be best placed to respond to you.' How do you find that as a response to addressing the Commonwealth carriage law? Is it not the responsibility of the Commonwealth to—

Dr Perry: It appears to be. Every state recognises the Commonwealth law.

CHAIR: I just thought I would share that and that is now published on our website because it has come up time and time again. When we travelled extensively during the former inquiry that led to the draft bill, people said they wanted access to care in their communities. I just wanted to clarify that with the AMAQ. Maybe you could address that from your organisation but you have clearly stated it is the Commonwealth's remit to address that.

Dr Perry: That is our understanding. We are not lawyers but, yes, that is what every state in Australia, every jurisdiction, says. It is Commonwealth.

CHAIR: Thank you. We will move to questions.

Mr ANDREW: I spoke earlier about the opportunity for the medication that was being administered to not be effective. What is the position of the AMA on that?

Dr Perry: Victoria are quite enclosed in terms of the information of the three drugs which are in their remit to give. The time from ingestion to death is on average 31 minutes. It is quite sudden. You have to be quite desperate to do this really and most people are not that desperate. There have been people who have been alive, somehow breathing, up to three days after they have ingested. Whether they are conscious or not, I do not know.

Dr Manoharan: It would be very difficult to answer that question without knowing the exact medications that will be used in Queensland and how they differ from the Victorian medications.

Mr ANDREW: Should we do anything with the bill to ensure that that is taken care of—that there is a component in there to make sure we know how to act legally from a doctor's perspective?

Dr Perry: I understand the main drug is Pentobarb and I believe there is an oral form of a muscle relaxant which is also used.

Dr Manoharan: I do not know if the legislation is the appropriate place for that. However, in the implementation, there would be a review of which medications are most effective and I imagine that would be informed by the experts.

CHAIR: That would be best placed in the clinical governance.

Dr Manoharan: Absolutely.

Dr ROBINSON: I have several questions but I will try to keep it to two. Dr Perry, you mentioned briefly a world council body but I did not quite pick up the name.

Dr Perry: It is the world medical society body. I do not know the name.

Dr ROBINSON: It is some international—

Dr Perry: It is an international body that medical societies subscribe to and are associated with.

Dr ROBINSON: I thought you said something like they did not support VAD.

Dr Perry: Yes. They do not support VAD.

Dr ROBINSON: Can you help us understand why there is that concern about VAD amongst this world body?

Dr Perry: I think everybody in this room knows the issues. How do you protect people? How do you make sure that the vulnerable people and conscientious objection is not ignored?

Dr Manoharan: Certainly speaking from an Australian perspective, the Australian Medical Association broadly does not support any treatment where the primary intention is to end life, which is what we are talking about in VAD legislation. What it does recognise is that it is a decision for society, and through their elected representatives in front of us today and parliament more broadly, to decide whether VAD legislation becomes a reality. If that is what society wants, then doctors really need to be involved in determining how we implement it. We might not as a profession see treatment which ends life as something that holds to the medical ethos but it is a societal decision.

Dr ROBINSON: You gentlemen are saying that there is this leading world body saying it is up to societies and parliaments to decide respectfully. However, what are you saying yourselves as part of that world community—in particular, the Western world and broader and in OECD countries where there are higher standards of health? Are you saying that this is a positive development or, in your view, is it not a positive development for patient care?

Dr Manoharan: We specifically did not ask the question whether our members were for or against voluntary assisted dying in the survey.

Dr ROBINSON: I did hear that. What about yourselves perhaps?

Dr Manoharan: Part of the rationale for that is that there is such a diversity of views even in the profession. It is beyond the political spectrum, but it also goes to values and how people's cultural upbringings have affected them. We are a nation of a number of cultures and we know that everyone will have different opinions on this depending on their own personal experiences as well. We have not put out a position for the profession because I think that would be inappropriate.

Dr ROBINSON: I move to my other area of questioning. Dr Perry, you identified a couple of key concerns in the legislation as it currently stands. You talked about the term 'incurable' being included in the legislation, and you also identified conscientious objection as being important. I may be value-adding and I will try to be tight. Certainly, others from a religious point of view—whether religious leaders or some religious doctors with some faith—have said they feel that the legislation does offend their views and values if they are forced to participate. Even in referral, some have said—

CHAIR: Can we move to a question?

Dr ROBINSON: I am. In terms of institutions, if they were not able to opt out, it would be a problem. If that interpretation is correct about the current bill, if it is not amended do you feel that you personally can support it?

Dr Perry: I really feel for the institutions—UnitingCare Health, the Catholic Church, the Church of England and the Muslim community—that they find elements of this difficult to digest. We do not want to get them out of the space of health care and aged care. They are the honest brokers. They have 30 per cent of the beds. It was a bad thing when Medibank Private privatised because it got the honest broker out of the health insurance industry. We do not want to get them out of health and aged care either. We must have the wit to work out how we can satisfy everybody's conscientious objection status and still offer this option to people.

Doctors have been helping people to die without pain for thousands of years with a tincture of opium and laudanum on battlefields. My mother and my aunty as a nun died with morphine in their systems and it was quite okay. I started out without liking this idea at all but I have seen some people die of motor neurone disease. Some people might say that they are not in pain; well, they are suffering. If you cannot swallow, it is a pretty tough way to end your life and that might be a long time. That is my personal view. That is not the AMA view.

CHAIR: Let us get to a couple of other questions.

Ms KING: Thank you for being here. We appreciate your contributions today. Across the course of this inquiry and also I think during the previous committee, a number of submitters made their own recommendations around the role of specialists. You represent the full spectrum of medical practitioners. You represent GPs through to—

Dr Perry: Medical students, yes.

Ms KING: And specialists. We have had a number of submitters who have sought amendments to this bill to say that GPs should not be trusted to make capacity assessments of a person's capacity to access voluntary assisted dying and that they should not be entrusted with the assessments of a person's medical condition in terms of their terminal prognosis or their time to death. Do you back your GP members to make those decisions that they make every single day in their work? It is not really a yes or no answer that I am after. I am interested in your comments.

Dr Manoharan: I think it is a yes or no answer. We absolutely do back our GPs in this space. For the most part, GPs have a really good understanding of their patients and their psychosocial needs as well, on top of their medical and biological needs. It is disappointing to think that we would consider a GP unable to make capacity assessments when capacity assessments are made every day by junior doctors who are interns onwards about their consumers and patients that they look after. There will be instances where capacity assessments are more difficult. In those rare instances, it would be behest on that practitioner to seek advice. It could be due to mental health conditions. In that case, there might be an avenue for a psychiatrist to be involved. However, that would be very unusual and rare. For the most part, GPs would be well placed to make those decisions.

Ms KING: And that is normal medical practice, is it not, to seek more specialised advice when you yourself are not able to reach a determination?

Dr Perry: Yes. In fact in country towns the GPs are very good palliative care physicians. They have known the patients for some decades and they can easily make a choice. They know the interaction in the families so they are very well placed and probably better than a fly-in fly-out psychiatrist.

Ms KING: In terms of skills, even if a GP does not know a particular patient, they are very familiar and practised in these skill sets, are they not?

Dr Perry: Yes.

Ms PEASE: Thank you for all of the great work you do in the community. I want to tease out the matter around institutional conscientious objection. You raised a moment ago the issue of access and equity for regional and remote places in Queensland. Often people do not have a choice in those places apart from entering into a faith based organisation and that particular organisation may decide to conscientiously object to giving access to a local GP who is supportive of voluntary assisted dying in their long-term doctor, or it could even be someone in Brisbane down here in Wynnum in my neck of the woods. Can you explain how that might work to give equity to people in regional Queensland, given that we heard from the Uniting Church that their organisation would potentially be able to work with dealing with that situation if they were confronted with it?

Dr Perry: The simple answer to that question is I fail to know of any significant country town in Queensland without a health facility which is usually Queensland Health owned.

Ms PEASE: If they are in a nursing home, for example.

Dr Perry: They can get an ambulance or with their relatives go down to the hospital some days before it.

Ms PEASE: Do you imagine a GP who has been treating them—who was not allowed to go in and visit them in that centre to be able to give them care—would be able to bundle up a very ill, fragile and frail person onto a bed to transport them? Is that not removing the best level of care that you are meant to be giving to them?

Dr Perry: You also have to be careful that you do not bring litigation against the people who own those institutions so they have to sell the institution and the town has not got one.

CHAIR: It is interesting the AMAQ has come up with a position on institutional conscientious objection when you represent doctors and practitioners.

Dr Perry: We just do not want to see 30 per cent potentially of private hospitals and aged-care facilities being sold onto people whose bottom line is the shareholders, the share prices and the CEO's wages.

Ms KING: But this has not happened in other states, has it?

Dr Perry: We will see what happens. The other states are largely protected. Queensland is the first one to go out of its way not to offer institutional conscientious objection, whereas South Australia has gone out of its way to do it.

CHAIR: On balance, do you think the human rights—

Dr Perry: There are human rights on both sides of the argument.

CHAIR: Conscientious institutional objection—

Dr Perry: Yes.

CHAIR: I think it was declared that they do not have a conscience.

Dr Perry: That is unfortunate. Hopefully it is just a blip.

CHAIR: I will let you debate that with the Human Rights Commissioner. He appeared before us yesterday.

Dr Perry: They are people.

Dr Manoharan: I think there should be a balance struck between the public health and the public good, and also individual conscientious objection. If we are talking about equity of access to health care, we have to consider that equity of access to aged-care services is also an important factor and that is not just provided by Queensland Health; that is provided by private providers. We need to find that balance.

Mr MOLHOEK: Dr Perry, I would assume that most of the directors of the organisations that you are referring to would be volunteer directors and not paid?

Dr Perry: I am not sure.

Mr MOLHOEK: Therefore, they would be very nervous about their liability?

Dr Perry: They would be quite liable. People are saying that if an institution does not do it they will go to the court and get a court order that they have to do it. If they have to do it against their conscience, they may well feel that they need to get out of that space and we certainly do not want that. That is a bigger disaster than the occasional person—we are only looking at about 100 or 200 people a year in Queensland accessing this. How many people are going to want to do this in a church run facility when they have no way that they can go somewhere else to have this done? A quiet room in a public hospital—we have those all over the place. We have prayer rooms with a green arrow pointing towards Mecca. Those places do exist. You do not have to force it on institutions that find it morally a serious problem.

CHAIR: We have come to the end of the session with the AMAQ. We now call representatives from Palliative Care Queensland.

ADAMS, Ms Margaret, President, Palliative Care Queensland

MILLS, Ms Shyla, Chief Executive Officer, Palliative Care Queensland

CHAIR: Good afternoon. It is great to have Palliative Care Queensland back in front of us. You have been informing us for a long time through our work in the previous inquiry. Welcome and thank you. We will start with an opening statement before we move to questions.

Ms Mills: I will make an opening statement on behalf of Palliative Care Queensland and then Marg Adams, our wonderful president, and I will be available for any questions. Firstly, thank you to the committee for keeping the public conversation going about the end stage of life. We know that this rarely gets airtime and we thank you that it is still going. On behalf of the palliative care peak body for Queensland, we appreciate that.

I think it is important to acknowledge the elephant in the room. As BJ Miller, a palliative care physician in the US who lost both of his limbs and a hand in an electrical accident, said, there is necessary suffering and there is unnecessary suffering in life. We all age, we all get sick at some point, most of us break an arm or a leg at some point in life, we all fall over, many of us lose or change jobs, our relationships break down, our loved ones move overseas or far away and people die. Those are some of what BJ was referring to when he talked about the necessary sufferings of life. A VAD bill will not stop all the suffering, just as palliative care, ICU, social funding of all systems and human rights laws will not stop all of life’s suffering. What we are really talking about is reducing suffering, particularly unnecessary suffering.

Suffering due to the end stage of life will not be solved simply by a VAD bill. It takes a whole of system and societal response, just as the answer to the suffering of the COVID pandemic was not simply a new treatment option or more ventilators. It has been a whole-of-system and societal response, including a strategy for prevention, public education, health professional education, compassionate corporate responses, government funding to support staff who cannot work, a targeted focus on the underserved populations and those who keep falling through the gaps, a kindness pandemic response, a care army of volunteers and so much more. A whole of system and societal response, including palliative care, is what is needed for the end stage of life.

Unfortunately, the current funding of palliative care just is not enough. It is between $100 million to $155 million per year—it is really difficult for us to get an accurate figure on the current spend of funding and our palliative care physicians across the state are not aware of the current palliative care spending—plus the additional new funding of approximately $28.5 million per year over six years. It is just not enough to ensure the whole-of-system and societal response that has been identified out of your wonderful Queensland inquiry into aged care, palliative care, end-of-life care and VAD—the whole of system.

Palliative Care Queensland is neutral on VAD. It is up to society and politicians to create laws. We firmly believe that VAD is not part of palliative care practice, but, just as we coexist with curative treatments, we can coexist with VAD.

Our submission to the inquiry stated six recommendations, and those are summarised as follows. Recommendation 1 and 2: to ensure equal access to specialist palliative care and VAD. We request that specialist palliative care is funded to be made available, for at least a minimum, at the same level as the proposed VAD laws in clause 10, which is 12 months. Ideally it is actually from diagnosis but at least for 12 months. We request that there is an increase in palliative care funding based on the PCQ-AMA Queensland palliative care director’s pre-budget submission for $275 million per year. With the new funding for the sector there remains a shortfall of $247 million per year.

Recommendation 3: bereavement care is critical in this space. We request that clause 5 be amended to include the words ‘every person and their family should have access to bereavement care from diagnosis of a life-limiting illness to a minimum of 12 months after death’. Recommendation 4: social workers play a critical role in this space. We request that section 85 should be amended to include social workers.

Recommendation 5: transparent public reporting about palliative care is needed for a whole-of-system and societal response. This is similar to the South Australian bill. We request that greater statutory reporting requirements of the Attorney-General or the health minister require them to report to parliament on the amount the Queensland government spends on palliative care during the financial year and the aggregated amount spent by Queensland on palliative care during the preceding five financial years. Recommendation 6: transparent public reporting about VAD. We request that the voluntary assisted dying board be required by law to report to the parliament every six months as well as produce an annual report and that this be an ongoing reporting requirement.

To close, I remind you of the bigger picture of why we are here today. In palliative care we often talk about the bookends of life. The first breath of a child is a key moment at that first stage of someone's life, yet from the moment someone is pregnant they need support to know about pregnancy, birth and after-birth care and all the options of care. In the first nine months before the first breath, it takes a wide circle of care and support around that baby, mainly provided by their primary caregiver—their mother—but also by the family, the health professionals—both specialists and generalists—and their community. In the last days before the birth and at that first breath, there is increased care support during the labour period, often provided after hours in a variety of settings.

We know there is necessary suffering that is involved in labour—I have had two children myself—however, people are educated and they plan for this well in advance. People are aware that things do not always go according to your birth plan, but because they are educated and they have had time to think about it often it happens a lot easier. Whether it is a natural birth or a caesarean birth, everyone works together to try to reduce that suffering until the baby takes their first birth. After the first breath of that baby, there needs to be ongoing support for everyone involved to help them move forward into the next stage of life because their life has just changed. It is exactly the same at the end phase of life.

While today is about the VAD Bill—and so many people have told you about their immense suffering; we have incredible compassion for those people, and I know that you all do too—we urge you not to forget the elephant in the room. Do not forget that this VAD Bill is such a small part of a much, much bigger system of end-of-life care in which palliative care plays a crucial role. We say: please do not forget palliative care in the bigger picture.

CHAIR: Thank you very much, Shyla. I am mindful of time. Margaret, it is up to you if you would like to make a statement but we would like to get to questions.

Ms Adams: We are united as a duo representing the state and our members.

CHAIR: Thank you very much for the work that Palliative Care Queensland has done. You have been great in informing us, particularly in our former inquiry that led to a number of recommendations and increased funding. I know that you always say that more is needed. We certainly have heard that. Shyla, you said that VAD is not part of palliative care practice. There is an Oregon report that some 70 per cent of people on the palliative care pathway chose to access VAD. We have heard that from palliative care practitioners, some supporting and some not supporting. There are divergent views. I want to tease that out a little, because a lot of people are being cared for by compassionate and wonderful palliative care specialists and nurses but at a point in time they might choose this. I know you have come to a neutral position. Out of interest, do you have some views on that?

Ms Mills: I think it is probably not relevant so much to the bill; it is probably more about the clinical practice part of this and the next stage. I think how it is going to work or operate within the system needs to be nutted out at that point. From a palliative care point, we do not hasten death. That is one of the practices of palliative care. However, like we said, we can coexist with curative treatments, which we do every day. If earlier discussion happens, that makes it much easier for us. We can coexist with VAD. Palliative care would not be the ones to introduce VAD—it would be a different team—but, just as we coexist in the health system, it is exactly the same.

Mr MOLHOEK: I add my thanks and acknowledgement for the great work that Palliative Care Queensland does and the important role that you play in helping people. Thanks for coming today. I refer to two of your recommendations, recommendation 5 and recommendation 6. The first one specifically refers to tracking ongoing spending and also providing some detail on the historic spending in previous years. Recommendation 6 talks about an ongoing requirement to report every six months, I am assuming to the parliament or through estimates or something. I would be interested to understand why you see those as particularly important recommendations. I certainly would endorse them, but I would be interested to hear your comments as to why you feel it is so important to have that included, in your submission.

Ms Mills: As a peak body for the state, we find it very difficult to understand the current spending on palliative care, like I mentioned and as has been debated constantly. I have a couple of examples of that from what we have looked at in *Hansard* or from different discussions in government. In 2015 it was announced that funding was $100 million for palliative care. In 2018 it was announced that there was $95 million for palliative care. Obviously I have evidence of this if you need it. In 2018-19 it was $123 million. We asked our medical directors what was being spent at the time we made our pre-budget submission. At that time they were informed of $110 million and then just recently—I think it was a few weeks ago—it was $150 million or $149 million. It is just around getting some accurate figures.

We have spoken with the department around how these figures come about, and that is the complexity. Are we looking at actual figures or predicted figures? Are they looking at hospital and health services or Queensland Health? The funding allocation for palliative care is very challenging in that space—like most of health, to be honest—so we want to have an accurate amount of what is being spent at a specialist level and at a generalist level, and then a transparent and accountable way of reporting that. We thought it would be a good opportunity as aligned with this to demonstrate that.

Mr MOLHOEK: Are you suggesting there needs to be a way of collecting the broad data, not just the direct money that goes into specific palliative care beds or palliative care organisations, but some way to track? I remember the Grattan Institute writing some data on this probably 10 years ago, and their estimates were something in order of 20 or 30 per cent of the entire health budget was spent looking after people through the last two weeks of their lives. I think it would be worthwhile, but a very challenging data set to try to unearth. Would you be happy to table those figures that you quoted at some point?

Ms Mills: I can provide that. We are working with Queensland Health as part of the new strategy as it is a strategy for palliative care and end-of-life care, and we are hoping that that will be included around accurate and transparent spending for the states. As part of that strategy for the next whatever years it will be, we are hoping that some clear data sets are included in that one around funding and also the outcomes. There is not much point focusing just on funding; it is what that money achieves, which is what we are talking about for people's lives which is most important.

Mr MOLHOEK: I suspect that the ultimate goal is not only to track it so that there is some real evidence there but also to make sure that the government is held to account into the future.

Ms Adams: I think also that data is power. When you think of the geography of Queensland and in terms of looking at access and equity, the spending and variability of the spending between metropolitan and the rural and remote areas is going to be so different. Also looking at costs around transport—we have done some work with the coal community and looking at First Nations people being able to stay on country—the costs associated with travel that are not linked necessarily to a clinical issue, and this is what we are meaning when we talk about the broader systems that are required to keep a person feeling whole and connected to what is important to them and then their illness might come into play. For these people, when you are thinking about distance, the cost of transport—flying and whatnot—is something that needs to be connected to those dollars. It helps you to realise, 'Well, we probably need to be providing a little bit more for the north than other areas.'

CHAIR: May I ask a question directly linked to the deputy chair's? You will find that we have publicised the department's response to the breakdown and I have given a few pages of detail.

Mr MOLHOEK: We only got that this morning, by the way.

CHAIR: It will become available. They note that palliative care is delivered in a range of settings including public and private hospitals, hospices, resi, aged-care facilities and home-based care in private residences. You might have to take this question on notice. During our big inquiry into aged care, we heard of people literally dying waiting for a level 4 home care package, so when they were palliating at home and they needed to receive care. Is there funding from the federal space in that aged-care arena that directly assists in delivering palliative care at home and in private residences?

Ms Mills: We will take that part on notice. I will just mention that given the results from the last inquiry, which had several recommendations around aged-care specific, that are specific for federal, we have asked Queensland Health to provide us a response as to what the Commonwealth has provided to them in response to those, because we are worried that they are going to be stuck in the ether between state and federal. We are concerned that we will not get anywhere on those inquiry results.

CHAIR: Good luck with that. We asked the Commonwealth Department of Health and we did not get a response.

Ms Mills: We are trying. We are actively working with other NGOs to try to get a response there because we know aged care keeps falling through the gaps. To be honest, one of our biggest challenges in palliative care, as you all know, is the fact that we cover the whole health spectrum from in utero to geriatrics, across all disease spectrums. We cover federal and state, and we are looking at hospital and health services. Because of that, there is a lot of shifting of blame in the space and often the patients fall through the gaps in the end. We know it is no-one's specific fault, but we really appreciate using this time while people are discussing end of life that palliative care does not get off the agenda because it still needs to be there.

Mr MOLHOEK: Margaret, I really appreciate your comment about the unforeseen costs in dealing with people. I recently travelled to far western Queensland and met an Indigenous family who came to see me. One of their family members had pancreatic cancer and had travelled between Mount Isa, their town in far west Queensland, and Toowoomba, regularly over a period of time. There were RFDS flights involved, there were buses, Angel Flight—to try to capture some of those costs and understand how to really deliver that.

Ms Adams: I am a registered nurse and nurse practitioner. I have been working as a nurse since I was 17 and I am now in my 50s. When you think about the cost and you think about the cultural connection to family—and this is not isolated to First Nations people—when you see that there is such a desire to be around familial, and when we have met with people in Coen and the stories of being disconnected and not being able to visit, that is happening all the time and you cannot put a dollar value on that.

Mr MOLHOEK: Sometimes not having decent internet access either to have a Zoom call or—

Ms Adams: Correct. There are a lot of things. It is challenging, but we are optimists without being in denial.

Mr ANDREW: It must be jaded water. You cannot see the federal funds as they come through to the state?

Ms Mills: We cannot, obviously.

Mr ANDREW: You cannot request that. Could you just go into more detail about reporting for VAD? You said you wanted it every six months and you wanted an annual report. Was there any other part to that? I have heard other people saying they want it on death certificates and all sorts of things.

Ms Mills: We would like in the next stage to look at what is needed. As any system changes, you need to be flexible to respond to that change. It is around understanding what is happening at the end of life. Like we said with palliative care, we do not have a specific data set. We are saying at the moment that we would like to look at what is needed to tell the story. As things change over time, we would like to be able to amend that to the latest best evidence to collect the data based on that. That would be the process we would recommend.

Ms KING: I have two questions. Nice to see you, Shyla. I never see anything about Ambulance Wish without thinking about the work we did together on that. We have heard from a number of people, but in particular today we heard from Dr Kris Cornell who talked about her experience as a health practitioner, but also about her father accessing voluntary assisted dying in Victoria, and her words were very moving. One phrase she used has stuck with me. She talked about 'the comfort of knowing that the medicine was in the cupboard' for her father. I think it may have been Dr Will Cairns who talked about the palliative value of a patient knowing they have access to voluntary assisted dying in that sense of giving the patient greater autonomy and control. I wonder if you could briefly reflect on that. As part of patient-centred care, do you think that voluntary assisted dying, if offered well, has in itself a palliative, spiritual perhaps or emotional value to patients?

Ms Mills: I would say we would be neutral on that, as a response. We talk to people about suffering. For us, the big part is to look at intolerable suffering, as you have talked about in the legislation, and how well our health professionals are trained, both generalists and specialists, to talk about intolerable suffering.

Ms Adams: I think being able to recognise suffering is very challenging, and to be present with it as well, but what you are talking about is whether people have a choice. Knowing that you have someone you can call on is helpful.

Ms KING: Almost. What I am talking about is whether, in your view, the comfort of knowing that that option is there, for those who want it, whether that in itself provides comfort emotionally or spiritually at the end of life.

Ms Mills: We would not be able to talk about what the view of our patients would be in that space; we have not experienced that. But we do know that palliative care, if provided well from specialists and training is provided to generalists, which currently is a big gap across the state—if that is provided, the comfort to actually have a conversation and openly talk about the elephant in the room to people which is often not done until very late—the option of palliative care, so that you do not always have to have a curative treatment, you have an option of palliative care from a time of a diagnosis. Most people are not offered that currently, and that is the bigger picture—to enable that conversation to happen. If we are talking about choices, we really need to talk about true choice. Palliative care is not a true choice for a lot of people because people do not know about it as an option, and they do not see it as an option.

The conversation is often about, 'Oh, there is nothing more we can do. Palliative care might be able to do something.' We are a profession in our own right and we believe that we do a good job with what we do, but we just do not have the capacity to provide that to the level that we would like to. Really, that is what we are talking about. It is understanding where people are feeling with intolerable suffering, how they can get a community of support around them to deal with that, and how the health professionals, their community and their workplaces can come together to support them, and so that people do not have to go on carer's leave or use leave or funding for their own jobs, so that they can support each other during this time. That is really what it is about. It is not just the last breath; it is the last phase of life. That is what a great society looks like. I referred to birthing. It is exactly the same; we do it there. We should look at the bookends and really support people for their whole journey. That would be an amazing society to live in.

Ms Adams: I wanted to add that we talk about palliative care being everybody's business. Look at the corridor conversations that we have just as human beings; so even when you take your hat off as a clinician or palliative care specialist and when you are a human being in community. I had a conversation just before I came here with a colleague who has a family member going through a very difficult time. Just being able to have a talk about matters and listening—the community education side of things, being able to support conversations about what is important to you and what matters most. In answer to your question, having a choice one way or another, whether it is VAD or palliative care, is going to be something that is that individual's possibility. However, when we are coming from the palliative care lens, I think we have a lot of work we could do to support community to be able to feel okay about supporting their neighbours with awareness of help because people feel helpless.

Ms PEASE: Thank you very much for the great work you do. I recognise you are professionals and do an outstanding job in the community. Particularly, I have experienced the great assistance from palliative care nursing within my own family journey. I know you are probably not in a position to comment on the matter around institutional conscientious objection, but one of the areas that they are claiming would be appropriate is potentially moving a palliative patient at end of life to another facility to be able to access voluntary assisted dying if that is the journey they wanted to take. What would be the impact on a patient who is at or near the end of life having to be bundled up and relocated when they are very near the end of their journey?

Ms Mills: We can take that on notice about the response from a palliative care angle, but I guess have a look at what happened during COVID.

Ms PEASE: Tell us about that.

Ms Adams: When you are looking at displacement of a person from their familiar surroundings and if you are talking about an example of an institution being a person living in a residential—

Ms PEASE: Exactly.

Ms Adams: We would class that as a person's home rather than—

Ms PEASE: That is what I meant.

Ms Adams: I think when you are looking at being displaced and you are very frail, you are sick, I would imagine that would be very distressing. It would be not only distressing for the individual but also distressing for the people around them and the people who are supporting them.

Ms PEASE: And no doubt the palliative care team that is taking care of them as well.

Ms Adams: You may not have a palliative care team. You may have the generalists who are coping with support, doing very nicely. I would suggest that, from a practical point of view, we could all imagine it would be very distressing for an individual who is suffering.

Dr ROBINSON: Just to get your view as Palliative Care Queensland and as experts in palliative care, a number of palliative care doctors and others have said to the committee that they saw a clear distinction between palliative care treatment and VAD treatment. Just to be brief, the general view is that palliative care treatment is to treat the symptoms, treat the pain and things like that while the person is dying but not to contribute and the intention is not that they pass away as a result of it.

Ms Adams: To not hasten death.

Dr ROBINSON: As opposed to that, the specific intention of VAD is to take the person's life or to end the person's life. Do you have a comment? What are your views as Palliative Care Queensland on that?

Ms Mills: I think, as you have said, the word 'intent' is the critical part of that. It is about the intention of what you do. Palliative care should be available from diagnosis through to bereavement, and that needs to be considered in this. We are talking very much smaller than that, as in this discussion. There is a distinct differentiation between the two.

CHAIR: I am so sorry, we have gone over time. I want to thank you. I draw your attention to our former inquiry, in particular recommendation 56. Have a look at that. That called on the Australian government to increase funding in all of those areas. We never got a response from the federal Department of Health. Good luck to you. Maybe you could tackle that as well. We need the answer to that question on notice back by Thursday, 22 July. I will end with Ambulance Wish Queensland, because I know that you are keen to establish it in North Queensland, in my hometown of Townsville, and I look forward to those ongoing discussions. Thank you so much for the excellent work that Palliative Care Queensland does. Thanks for your time today.

BROWN, Dr Jenny, Queensland State Convenor Group, Doctors for Assisted Dying Choice

FINNIGAN, Dr Sid, Queensland State Convenor, Doctors for Assisted Dying Choice

PARKER, Professor Malcolm, Queensland State Convenor Group, Doctors for Assisted Dying Choice

Prof. Parker: Thank you for the opportunity to support our written submission to the inquiry from Doctors for Assisted Dying Choice. We are a national organisation of Australian doctors committed to attaining the legal choice for rational adults with intolerable suffering for which there is no realistic cure or relief to end their lives at a time of their choosing and in the presence of those whom they choose.

My name is Malcolm Parker; I am a retired GP and Professor Emeritus of Medical Ethics at the University of Queensland. My colleagues are: Dr Sid Finnigan, a retired ophthalmologist with a subspeciality in ocular malignancy and Queensland convenor of our organisation; and Dr Jenny Brown, a consultant physician in general medicine with extensive experience in managing and palliating patients at the end of life. Jenny is also responsible for setting up a palliative care service in a major Brisbane teaching hospital.

Our organisation endorses the Voluntary Assisted Dying Bill 2021 in its entirety, and we strongly urge the committee to recommend that the bill be enacted. The development of the draft bill and the enactment of the legislation will be one of the clearest demonstrations of democracy transparently at work at the state level. It will also constitute the best VAD legislation enacted to date in Australia in terms of its clarity, its consistency with modern medical practice and its fair balancing of civic freedoms and the safeguards required. In particular, we strongly endorse these medically focused sections of the bill, and we are happy to enlarge on these as the committee desires.

I will just run through the dot points: the 12-month interval to death for voluntary assisted dying requests; the eligibility provisions for participating doctors and nurses, including overseas trained doctors; the ability of doctors (and nurses where appropriate) to raise the issue of VAD with patients; the distinction that the bill makes between voluntary assisted dying and suicide; the detailed provisions pertaining to conscientious objection by individual practitioners and institutions; and the provision of flexibility in the administration of medications and the time between first and final requests. These important, progressive provisions are based on evidence from jurisdictions with lawful VAD while providing robust safeguards for Queensland.

The existence of the bill indicates that the fundamental arguments for and against VAD have now been thoroughly explored. We now have a practical bill produced through detailed and expert testimony and evidence, transparent processes of inquiry, and an exemplary democratic political process that have maximised the contributions of those whom the bill's enactment will affect. We urge the panel to recommend that the current version of the draft bill be that which the parliament considers and votes on.

CHAIR: Thank you very much, Professor. I will open it up to questions.

Mr MOLHOEK: Your submission talks about supporting the provisions that address 'disease, illness or conditions expected to cause death within 12 months'. One of the AMA's recommendations was that it should be broadened to include other incurable diseases. I would appreciate your comment on that.

CHAIR: They wanted to amend it to include incurable diseases.

Prof. Parker: Do you mean by that other than terminal illness? Is that the gist?

Ms KING: They wanted an additional criteria added. It was not just that the condition be advanced, progressive and cause death but that it would also be incurable.

Dr Finnigan: My thoughts would be that if it was an 'or' scenario that is perfectly common sense, but based on the premise that this whole exercise is trying to give autonomy to the patient themselves there would be predictable circumstances. For instance, a terminally ill person may be offered an operation that was totally unacceptable for them to go along with, so that would potentially exclude that person from it even though they are exercising the ethical right they have to have autonomy and decide with their medical professionals what treatments to take. I would be personally—this is just very quick—cautious about putting that word in as an obligatory eligibility requirement just for that reason.

Ms KING: They were seeking it as a requirement, yes—not as an alternative but as an additional prerequisite.

Dr Finnigan: Knowing the AMA, I would think they are just being careful. I think, off the top of my head, that may present a potential legal step which may exclude someone if it could potentially be argued that they are choosing, with their own right to autonomy, to not have a particular part of a procedure which someone may argue could cure their problem. I do not think that is the intent of the AMAQ president in saying that. We are doctors, not lawyers and constitutional people, but just as a thought I would be very careful about that.

Dr Brown: I do not know that adding 'incurable' really adds anything very much to it. If we are saying the person is terminal, progressive and in the last 12 months of life, I do not see how that adds a lot. I am not a lawyer either, but I think it is pretty tight as it is, I would have to say.

CHAIR: You have a letter in front of you from the Department of Prime Minister and Cabinet in response to a constituent from regional Queensland who asked them to address the telehealth issue. Who is best placed to resolve the issue of providing advice for rural and remote regional Queenslanders who may want to access VAD should this be passed?

Dr Brown: My understanding is that the carriage act is Commonwealth legislation and that federal Commonwealth legislation supersedes state legislation, but that legislation was put in place before voluntary assisted dying legislation was enacted in any state in Australia. I think that took place in relation to the Northern Territory and Nitschke saga. I think there is going to have to be a real biff-up between the states and the Commonwealth, perhaps meetings with the health ministers, to thrash this out. It really is a big issue, because it is going to be very difficult to get doctors to do this in the country. If they feel they are going to be the test case for this legislation with a potential 10-year sentence, it is just not going to happen. It means that people in the country are just not going to get an equitable access to the service. It is madness, especially in this climate of COVID. We are consulting online now for everything, never mind this stuff. I think there needs to be a real push from all the states on the Commonwealth. I think it needs to be made very public to the people of Australia if the Commonwealth is not playing ball on this and make it an issue at the federal election.

CHAIR: The response says, 'Looking at the issues you raised in the letter,' which was about that carriage service, 'the Queensland state government would be best placed to respond to you.' Do you think that is adequate?

Dr Brown: It is hopeless. It is hopeless like the vaccination program is hopeless.

CHAIR: We will not get into that.

Dr Finnigan: I can add something to that. I have personally been asked in roundtable discussions whether, if I were in that scenario, I would use telehealth measures to meet a terminally ill patient in a VAD scenario. I must admit that, bravado or not, I definitely said yes, because it is quite clear I would not be inciting suicide, which is the intent of the federal law. However, until such time as that very commonsense, very straightforward amendment is put into the federal law to exclude VAD, as long as it is performed under the auspices of the state legislation—until that is excluded, I would personally be much happier if we had a statement from the federal prosecutor saying quite clearly that it is not in the public interest to pursue a doctor who was participating in—as long as he was meeting the right eligibility requirements—what would be a legal medical option which very soon hopefully will be in every state in Australia—and, with a bit of luck for the terminally ill in the territories, also for Australians in the Northern Territory and the ACT. Until that time comes and the amendment is made, I think we should just be asking for that statement from the federal prosecutor.

CHAIR: Do you have any views, Professor?

Prof. Parker: I agree with my colleagues. That is an unequivocal cop-out by the Commonwealth, the contents of that letter, because, as Jenny said, it is a Commonwealth law so clearly no state or territory can do anything about it directly. As the remaining jurisdictions adopt VAD, which in my view there is no doubt will happen—it is becoming a more rapid process—I think the Commonwealth will be forced to act, if for no other reason than political reasons.

Mr MOLHOEK: There has been a lot of discussion over the last few days around safeguards. One of the doctors who was with us yesterday made the statement about how do we protect patients from themselves, brain chemistry alters significantly under duress. My question is: is there a need for other health professionals to be involved in the consultative process? Should psychiatric care or assessment be mandatory? Are the two medical appointments enough, notwithstanding the challenges of telehealth and all of that?

Dr Brown: We make many decisions in medicine in terms of treatment and treatment withdrawal without psychiatric input. I think if we are in doubt about a patient’s competence then we have to declare that. People will say that they want to have chemotherapy or they do not want to have chemotherapy or they want to be taken off a ventilator or they do not. We have to accept that people have a right to tell us what their truth is and I believe we have to respect that truth. I do not think this is any different really from these other areas of medicine. It is different in some respects, but it is not different in the sense that the patient is deciding autonomously what they want.

Jeff Kennett from Beyond Blue says that suicide and this are not in any way really related. This is someone who is dying and what they are doing is deciding in that process of dying that enough is enough. I personally want to have that choice. I cannot imagine anybody in this room who would actually feel that if they had a strangling tumour of their nasopharynx or if they had motor neurone disease or if they had advanced multiple sclerosis that they would not want to at least have the right to choose, not necessarily to choose, but the right to choose, that it would be legal for them to have that right.

In answer to the question about whether or not it makes a difference as to whether or not people have the capacity to do that, it makes a huge difference because in Oregon where there has been a lot of work done for 20 years now on this, a third of people never take it. They have the drugs prescribed, they have them in the cupboard. They have the confidence to know that if it all gets too much they are able to get off the bus. I got MS when I was 30 and I knew that I had the access and the knowledge to leave this world if it all got too much for me. But 40 years later I am hanging in and fine so it was not a choice I ever had to make but I think if I have the knowledge and I have the choice then other people should have the right to that knowledge and choice and I think it is wrong for people not to have it.

Prof. Parker: I think it is also important to recognise that things are a bit out of date because general practitioners—and you are talking about general practitioners essentially being the two doctors involved and the question over that about specialist knowledge and skills—are now recognised as specialists officially by Ahpra and by the Medical Board of Australia so there is that sort of terminological lack of currency. I think also that general practitioners are the ones, by and large, who do look after patients at the end stages of life in their homes or nursing homes and particularly if they do have an elderly population they are more than capable, with support from specialist care, and there is no doubt that they will need it. To use an example that Jenny said, if it is multiple sclerosis or motor neurone disease, obviously a general practitioner will be working in cahoots with specialist support with the patient, but they are the ones on the ground and they are the ones who know not just about the physical aspects of the illness but the emotional and psychological and spiritual ones better than the consulting specialist in most, if not all, cases.

Dr Finnigan: The really short summary of that, directly to your question I think, is that referral for alternate specialist assessment, consultation, is entirely at the discretion of the participating practitioner in the first place. That is just entirely normal medical practice for a whole range of serious conditions like VAD and coronary disease and infarct so it is not anything out of the normal. On top of that, it would be an incredible workforce issue problem if our Queensland legislation required mandatory referral. Not only is it a workforce thing it is just not normal practice.

Mr MOLHOEK: You mentioned that the terminology or the reference to medical professionals is a bit out of date. I think that is a valid comment. Equally so, the days of having a family doctor are long passed as well. I would suspect that a large proportion of Queenslanders do not have continuity of care with a regular GP. Do you see any concerns around the connection to patient and whether there is that real understanding of a person’s mental, emotional and spiritual ideology or state?

Prof. Parker: I see the point you are making. I have no references to say, well, it is still hunky-dory in the land of looking after elderly people and so on. I think you are right. I think there is much more movement between doctors on the part of patients. It is much more mobile. It is a different society than when I started in general practice. Things change, but I do not think that means that people are forsaken by their general practitioners. General practitioners still do house calls. Again, I am not sure the extent to which they do.

Dr Finnigan: Can I add to that? The old days where there was the one doctor who delivered your younger brother and did dad’s gall bladder operation and everything are gone because of the exponential increase in technology and knowledge. We really went super specialisation. However, while I have no reference for this, I do have colleagues and friends in both RACGP and the Australian College of Rural and Remote Medicine, both of which will be heavily involved in the workforce for this, for palliative care and for voluntary assisted dying. I can directly paraphrase conversations with both of them that there is a great return to educating the graduating members from those colleges to be the prime controller of all of these super specialists because in simple terms, a super specialist looking after my bit of the brain here does not have the time or understanding of what is happening in my kidney. There is a return to that, fortunately. This is a general comment which is correct to your very appropriate question. It will not be the old GP who does it all like in the previous era, but there is a return to a central person organising it all and that person is the family physician.

Ms KING: Thank you all for being here with us today and for your contributions to this matter. I am interested in this matter of institutional conscientious objection. We have had a number of submissions arguing for changes to the bill to create the ability for institutions to effectively have what is termed a conscience. In Andrew Denton and Go Gentle's submission, there is reference to a man called Colin M, a 79-year-old Melbourne man who was dying of metastatic bowel cancer. He was assessed by two doctors and found eligible to access voluntary assisted dying in 2020. He was resident in a Catholic aged-care institution and that aged-care institution, exercising their institutional conscientious objection, refused to allow the pharmacist dispensing the voluntary assisted dying medication access to him. Not only did they do that, but they refused to even tell him of that decision for nine days and so he was left in distress and pain and anxiety for that period of time. I wanted to seek your reflections on this idea of an institutional conscientious objection. Firstly, are you comfortable with what is proposed in the bill before us? Do you think it strikes a good balance? Secondly, if the bill was changed to allow entities to withhold access to information or outside medical practitioners, how would that impact people at end of life in your view? I am sorry, they are hard questions, I know.

Dr Brown: I do not think that would be appropriate at all. I think hospitals are one thing, but I think nursing homes and places where people live are quite another. The reality is in acute-care facilities when elderly people come in and cannot go back to their own homes because they are too frail and need care, they go to the first nursing home that is available. They are just shot out the door in an ambulance and they really get very little choice about where they are going to end up. They may end up in a religious institution or they may end up in something different. I think if that is the system it cannot be okay then to say that these people, because they are put somewhere—and they need to be put somewhere because the hospital system obviously cannot keep them forever—then in that circumstance their choices in relation to voluntary assisted dying should be limited.

I also think it is entirely inappropriate to be moving people around who are terminally ill and at end of life. I had a person myself just last week who had end-stage Parkinson's disease with a PEG and could not swallow and there was discussion about going back to another hospital. We spoke to the family and with him and he said he wanted to stay where he was and he died quietly there. It is really important that these things are managed in a low-key, but comfortable way for people. Ambulances and trolleys and then, worst of all, people dying in the ambulance is just hopeless really.

Ms PEASE: Can I comment there? We had the president of the AMAQ, Dr Chris Perry, make a comment after I asked a similar question. He felt that conscientious objection for entities is fine and that it would be suitable for residents of a residential aged-care facility to be transported to the nearest hospital to potentially a prayer room or some other area outside of what essentially is that person's home. We have also heard from Palliative Care Queensland who said, like yourself, that the distress and trauma associated with moving someone at end of life is terrible. That just reiterates what you have said, I suppose. Would you have anything else to say to that?

Dr Brown: I understand that it is going to be a problem for the religious entities, but I think they will have to look into their own hearts really and to say, if they are truly loving and caring for the people who are there, it is really about their best interests. If people are legally entitled to this, they are not of a faith that disposes them not to wish it, then really if they are taking that person without that person having any choice about going anywhere else then I think it is incumbent upon them to participate in legislation that is wanted by the vast majority of Queenslanders and which the parliament hopefully will pass.

CHAIR: We heard during our inquiry the term euthanasia light from palliative care nurses, practitioners—people who supported the idea of giving people choice. I have tried to tease this out a number of times in the clinical aspect—if you give enough people incremental opioids, fentanyl, midazolam, or a combination of then—and the term terminal sedation is what people wanted to avoid. We heard from loving relatives where people would be unconscious for days and become dehydrated and their organs would shut down—all of the suffering we heard about. This puts regulation around voluntary assisted dying. I just wanted to get your views on that topic around, as we heard, euthanasia light, which happens now in some respects but people do not talk about it.

Dr Brown: It happens in every hospital every day. It is extremely common because it is the comfort care that is given to people at the end of life and it is not regulated, as you know. Basically, there is discussion with family. If you are lucky you have a discussion with the person themselves and say do you want comfort care, this is what it will involve, this is what we will do, this is what it looks like and they will say yes or no to that or their family will say yes or no on their behalf. When I first went to work at the Mater, the sisters were very happy—I probably should not say this—as long as people were comfortable. A lot of this is about the words. It is about changing what is happening into something that is bad, but giving the control back to the person themselves. The great thing about this sort of legislation is it is the person themselves who gets the chance to decide. When people are really sick and they are moving towards the end of their life they have very little control over anything. For them to have control because they choose it, to decide on this, is really important because it means that they have a sense of autonomy and they have capacity themselves. Terminal sedation is legal because of—

CHAIR: The intent not to do harm.

Dr Brown: The intent not to do harm and Lord whatever-his-name was—

Prof. Parker: The double effect doctrine.

Dr Brown: Yes, the law of double effect. That is used as a way of doing this. It is much better than having nothing, but it is not as good as people being able to choose.

Dr Finnigan: Can I raise another aspect to do with that? I think it is often forgotten that the voluntary assisted dying process we are talking about now is tightly regulated. It is not terminal sedation, it is a little bit before that scenario where the patient—I will not go through it for you. Not everyone will choose that. Some people will be extraordinarily happy to go through terminal sedation. That is a give-me. My point being that the evidence shows that in jurisdictions where VAD law has come into effect other end-of-life services, for instance, our palliative care services, actually get better. There is more talk about it, more money into it and more awareness. My own personal feeling is that the clandestine nature that does surround terminal sedation now, which is not always asked for by the patient, even terminal sedation, will get better in that it will be talked about more, people will understand it more, the practice will get more uniform, there will not be some doctors who do it perfectly, there will not be some other doctors who underdo it. The whole process, not just voluntary assisted dying legislation by the strict eligibility criteria we are talking about, these other aspects of end of life, will also improve, according to the evidence.

Mr MOLHOEK: Dr Brown, I think you heard you correctly. Did you say you had actually had a personal experience with this where you had been diagnosed with a terminal condition?

Dr Brown: No, not terminal. I was diagnosed with transverse myelitis, so I had multiple sclerosis when I was 30. When you have an illness like that it brings into focus for you what your thoughts are on how you want your life to be and what you would be prepared to tolerate and what you would not. I was comfortable because I was a medical person that I had both access and knowledge in terms of deciding what I would do if things got too bad.

Mr MOLHOEK: That was 40 years ago?

Dr Brown: That is right. It never was an issue that I had to finally address, but I would have had I needed to.

Mr MOLHOEK: Which leads me back to the question I asked you earlier about mental health or the ability for people who are under extreme duress or pain to actually make that decision. Is it possible that someone could be approved for VAD, have the medication at home in a lock box and could have lived for another 10 years, but they went sooner because in a moment of trauma they just rushed things?

Dr Brown: I would not have actually fulfilled any of the criteria that you need to fulfil.

Mr MOLHOEK: I understand that.

Dr Finnigan: Absolutely all the evidence is that that does not happen. It is absolutely clear cut that the VAD eligible terminally ill patient is not suicidal, to put it in one sentence. The evidence from 21 years in Oregon and Canada now and Victoria coming is that the person, once granted the permission, and they still have to do their third request yet, will hold on for as long as possible. The late member for Stretton announced to you guys emotionally that people do not want to die. We heard the gentleman with advanced motor neurone disease in Rockhampton say he fought that, he feared dying, he kept going, but you do get to a stage where you fear living more and it is only then that they will take it. Quite clearly, as was mentioned earlier, the Oregon figures show one in three people granted eligibility end up not taking it. The direct answer to your question is the evidence is that, no, that is not the concern.

Mr MOLHOEK: I am just wondering about the two in three that did.

Dr Finnigan: I appreciate that.

Mr MOLHOEK: I accept what you say.

Dr Brown: It did give me the opportunity to look deeply into what I thought about the matter and it certainly taught me about what fear and suffering is like. In that sense it was very educational for me as an individual. Can I say one thing very quickly: 60 per cent of people die in hospitals, 20 per cent die in nursing homes and 20 per cent die at home. The vast majority of palliative care that is provided or end-of-life care is provided in acute hospitals and nursing home facilities. I think palliative care is super important and, as I said earlier on, I was involved in setting up a service, but I think it is very important this education of staff in the big organisations, because I think that is the cost-effective way of delivering palliative care. Palliation is about relief of suffering and all doctors should be involved in relief of suffering and all doctors should be involved in holistic care and if we are not doing that we are not educating our doctors appropriately.

CHAIR: That is a good way to finish. We will break now.

Proceedings suspended from 3.06 pm to 3.19 pm.

SMITH, Ms Catherine, Board Member, Australian College of Nurse Practitioners

WARD, Adjunct Professor Kylie FACN, Chief Executive Officer, Australian College of Nursing (via videoconference)

YATES, Distinguished Professor Patsy AM, Chair of End of Life Policy Chapter, Australian College of Nursing

CHAIR: Good afternoon. I invite you to start with an opening statement.

Prof. Ward: The Australian College of Nursing would like to thank the Health and Environment Committee for the opportunity to provide feedback on the Queensland Voluntary Assisted Dying Bill 2021. As the peak professional body and leader of the nursing profession, the Australian College of Nursing is committed to supporting nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct and professionalism. Attending today and providing information are myself, Adjunct Professor Kylie Ward, chief executive officer of the Australian College of Nursing, a fellow and a registered nurse; and Distinguished Professor Patsy Yates AM, a fellow as well and chair of the Australian College of Nursing's end-of-life policy chapter. Distinguished Professor Patsy Yates is a registered nurse with extensive experience and a leader in education and research as well as palliative and end-of-life care. She is also the executive dean of the faculty of health. Prior to her appointment in 2020, Patsy became a professor and fellow at the Queensland University's School of Nursing.

The Australian College of Nursing, ACN, is a member based organisation with a corporate and individual membership reach of over 150,000 nurses in all states and territories. About 24 per cent of that representation is in Queensland. Our membership consists of clinical nurse experts, organisational leaders, academics, educators and researchers as well as early- and mid-career nurses looking to move into leadership roles within the profession. We are also an accredited higher education provider and registered training organisation, graduating 100,000 nurses in the past 15 years with postgraduate qualifications, including those relevant to this area. ACN has provided hundreds of thousands of clinicians with clinical professional development training in all settings and is proud to have provided over 15,700 immunisation qualifications for our health workforce in the last decade-plus.

As a registered and regulated profession, nurses have an obligation to fulfil all legislative requirements as well as demonstrate sound judgement and a person centred approach to care. We support a person's choice and right to receive person centred end-of-life care where the person has freedom, autonomy and self-determination in making decisions that meet their values, needs and preferences.

We support this inquiry and the open and evidence based discussion around voluntary assisted dying; however, ACN suggests some key changes to strengthen the Queensland VAD Bill. Without discussing and addressing our concerns, we fear there may be unintended consequences. We believe that nurses, including nurse practitioners, are uniquely placed to provide trusted, compassionate and professionally competent care to patients making end-of-life decisions, noting that we are bound by the Nursing and Midwifery Board of Australia's professional standards, code of ethics and code of conduct. We strongly advocate for nurse practitioners, advanced practice registered nurses and clinical nurse consultants to act as a coordinating or consulting practitioner and assess eligibility requirements. Effectively and economically utilising these valuable members of our nursing and health workforce is important to CAN, as detailed in our white paper *A new horizon for health services: optimising advanced practice nursing*. This utilisation of this workforce is especially beneficial in rural and remote areas, which often have a shortfall in health practitioners. It is the nurse who is almost always readily accessible and available to the patient and who almost always knows their patient best of all, having spent the most time with them.

The eligibility requirements and conditions as set out in the Queensland bill to access the VAD program are appropriate. Our concerns include that the role of nurse practitioners, advanced practice nurses and clinical nurse consultants in administering or assisting in the voluntary assisted dying process is largely overlooked. This bill would put barriers in place for those under nurse practitioner led palliative care, and issues regarding inequities across VAD in rural and remote areas of Queensland would occur. The bill inhibits both the therapeutic and the medical role a nurse provides to a patient and, as a consequence, a patient may not receive all the necessary knowledge and options in order to consider the right of choice for them.

Other issues I raise are that we do not believe this bill adequately considers the cultural needs and safety of people in diverse and marginalised communities, including those of culturally and linguistically diverse backgrounds, such as provisions for independent or appropriately qualified interpreters; and the bill and associated documents do not appear to be based on meaningful consultation or engagement with Aboriginal and Torres Strait Islander peoples, communities or organisations. There may be valuable lessons, perspectives and cultural knowledge that may assist First Nations patients seeking voluntary assisted dying in a culturally appropriate manner, including as an example the presence and assistance of an Aboriginal health worker. We also would support the legislation, subject to issues raised being addressed and changes made to the existing legislation. Thank you to the committee for your time. Patsy and I look forward to your questions.

Ms Smith: Thank you very much for including the ACNP in this committee and its inquiry and including nurse practitioners in the process. We acknowledge the past, present and future elders of this land. The ACNP is a membership group which is founded to represent the professional development and ongoing advocacy of nurse practitioners and advanced practice nurses. Presently we have over 1,200 members in Australia of which the majority are nurse practitioners. I am a board member and practising nurse practitioner, have worked in aged care and have been involved in end-of-life services with patients. I do not consider myself a specialist in this area, but I am definitely a specialist as a nurse practitioner, working in the private sector for the whole of my eight years as a nurse practitioner.

The Australian College of Nurse Practitioners considers two key focus areas when looking at healthcare decision-making and what is happening: that there is access to all and that all should have a choice of who their health provider is. In terms of our statistics, which are collected from our membership, as of 30 June this year nurse practitioners in Queensland provide numbers of services which could be linked to this legislation. That is, 12 per cent of our currently practising Queensland nurse practitioners work in aged care and palliative care; 24 per cent work in primary health care; and 20 per cent work in areas of chronic disease management. This means that 56 per cent of the 536 currently practising endorsed nurse practitioners in Queensland could be providing services that are linked to patients' end-of-life choices.

The ACNP would like to make the following recommendations. This legislation should not be considered as a replacement for or possible reduction to any access to palliative care services, which all need to be increased. Clause 14(1) should include nurse practitioners as well as medical practitioners. Clause 16 should include that nurse practitioners are a possible referrer to the first accessing medical practitioner. The present wording is not inclusive. In clause 16, nurse practitioners should be considered as a possible consulting practitioner. The process would include a first practitioner, which is a medical practitioner and of consultant level, and a nurse practitioner with the training completed as per the medical practitioners as the consultant or secondary accessing medical practitioner.

Although this would be a step ahead of many other states, it would not be the first time that Queensland went first in areas of nurse practitioner practice. The changes that we have instigated in Queensland in the past have been found to be nation leading and other states have followed us. These changes have also led to Queensland being the state with the most nurse practitioners practising in the state as well as outside of the state health system and in primary practice, aged care and such.

Why should nurse practitioners be considered for this? They should because of possible inequality in access to care, which is a key consideration in all health legislation. Several populations of patients will be quite challenged without nurse practitioner inclusion. These include but are not limited to the homeless population, rural and remote areas, aged-care facilities and patients who do not have a regular GP as their primary healthcare practitioner. Without nurse practitioners involved, some of these groups of patients will be very reliant on state healthcare services.

When I worked at a residential aged-care facility, at one time or another there were 40 residents in a 170-resident home care facility who did not have a general practitioner as their sole primary healthcare provider. This service was provided by a nurse practitioner or the state system. Homelessness services are regularly provided by nurse practitioners and these people do not have regular GPs. Rural and remote services, as we know, are presently provided by many nurse practitioners in many communities across the Queensland. The inclusion of nurse practitioners in rural and remote areas is especially important due to the inability of us to use telehealth services for this particular service.

Some Queenslanders also choose to use nurse practitioners as their primary healthcare provider. These patients will not have the relationship with a GP that would be required to have this first requesting conversation. All Queenslanders should be considered in this process, not only those accessing primary health care provided by a GP.

The ACNP supports all palliative care and chronic disease nurses in their care in the palliative care community and their role in the education and communication of these patients ensuring that service provision and palliative care is the patient's choice. This legislation should support these services more. In addition, nurse practitioners, in the signing of advance health directives as part of the COVID-19 emergency legislation, have supported more Queenslanders' ability to make end-of-life choices by improving communication and education.

Ensuring patients' choices for end of life is not a quick process, but it is supported by both nurse practitioners' long appointments and the time palliative care nurses spend with patients. Communication and patient education are skills and services provided by nurse practitioners and nurses. Additionally, nurse practitioner involvement in this process has not had a negative impact on safety and quality of care but has improved access and patient satisfaction. In summary, inclusion of nurse practitioners in more of this legislation will ensure more Queenslanders have access to choice for their end of life.

CHAIR: Thank you very much, Catherine. We got to meet a nurse practitioner in Rockhampton. She was wonderful. She had 27 years of experience.

Mr MOLHOEK: Faye Tomlin.

CHAIR: She is just amazing.

Ms Smith: One of our members as well.

CHAIR: We are limited in terms of time for questions. You referred to telehealth and said that it would not be able to be utilised.

Ms Smith: I understand that the federal legislation would prevent conversations related to potential end-of-life care or patients choosing to terminate their life. There are some grey areas around that. We would need that defined well before we would do it.

I do a lot of telehealth in what I do. To do something that is emotional and challenging on a telehealth platform I think is probably a bit cold. What do you think, Patsy? You do not need to be touching the patient, but you need to be present with the person. Particularly for those early conversations and that sort of thing, adding telehealth to the process when we are still learning how to use that platform is probably not a good solution. I think a better solution is to include all of the fantastic rural and remote nurse practitioners who live in those communities and have relationships with those people.

CHAIR: It is about increasing the workforce for delivery. Coming from regional Queensland, I know that it is hard to get people to live in some of the smaller communities. That work continues.

Ms Smith: More positions and more scholarships would achieve that. We have people wanting to train; it is just that they need to know there is a job. We need to know that that is happening. The interest level for training at the university that Patsy is engaged with is that they are getting 240 applications and we are only able to take 60. If you want more of us, there are barriers that need to be removed. Those are there. All of the positions advertised in Metro North went to nurse practitioners and they trained palliative care ones. That has been a fantastic program that is doing really good work in that area and making a difference. Again, we cannot be trained overnight.

Mr MOLHOEK: We better get Alan Sandford from Rocky back in here and get him to get CQ fired up to train up more of you in Rockhampton!

Ms Smith: They are having challenges at CQ at the moment. There are a lot trying to train but they are having challenges getting training positions and spaces—

Mr MOLHOEK: As in placements?

Ms Smith: Placements and things like that. There are some areas there that we know we need to be working with better. Maybe we need to be engaging more with not just the health services but also more regional areas. We are looking at how we can get involved in that. They have too many wanting to train in that space at the moment. It is not a bad problem, but it is still a problem that we need to sort out. We are looking at how we sort it out. Hopefully we will have some meetings with Queensland Health before too long to try to look at that.

CHAIR: We have not heard from Patsy. We have only about five minutes to go and then we will see if there are any brief questions.

Prof. Yates: I think my colleagues have said it all, really. I would highlight the points that have been made around the fact that these sorts of conversations are not really conversations that you can stage at a point in time—that is, a medical practitioner comes in. Oftentimes, the way patients raise issues about their end-of-life care means that it is often the nurse who is with them who provides that support. We need to understand and appreciate the complexity around this. There needs to be education for nurses around how they have those conversations, about points of referral and understanding the law.

We have done some research on this. I know that you have heard a lot from Ben White and Lindy Willmott. I collaborate with them on research in this area. When we have done research on nurses, we have found they have great fears around their lack of knowledge and understanding of the law. These are complex areas to appreciate. I think there is work that needs to be done there.

I refer to the points that have been made about the workforce. The big part of the workforce delivering care and delivering these services is nurses. We have to have legislation implemented in a way that supports the realities of day-to-day practice.

CHAIR: Division 4, section 7 of the bill refers to initiating discussions about voluntary assisted dying. It mentions that a nurse practitioner may do a number of things, including discuss the palliative and treatment options available to the person and the likely outcomes of that. Nothing in that section prevents a healthcare worker, which you would be defined as, from providing information about voluntary assisted dying to a person at the person's request. There are some foundational things in the bill about nurse practitioners in that space, but we certainly hear what you are saying about continued further involvement. We have that on the record.

Prof. Yates: And nurses' understanding of what that means so that they are not fearful of engaging in conversations which might be supportive for patients.

Prof. Ward: It is so important and I am very impressed to see nurse practitioners, but that is a separate authorisation to a registered nurse. Clinical nurse consultants—expert clinical nurses—also need to be considered, because otherwise we will inhibit the people accessing this care from actually getting the care. We particularly cannot underestimate the therapeutic relationship expert nurses and nurse practitioners have with our medical colleagues as either GPs or specialists. Sometimes there are communities where those two are the two who work together as a consequence of having a large number of workers of our own kind. As long as the bill makes sure that high-end expert registered nurses as well as nurse practitioners are able to have those conversations, we would be comfortable.

CHAIR: At section 83, 'Eligibility to act as administering practitioner', at (a)(ii) and (iii) it talks about a nurse practitioner who meets the approved nurse practitioner requirements or a nurse who has practised in the nursing profession for at least five years and meets the approved nurse requirements and training.

Ms Smith: That is the administering. We are actually talking about the starting of the process.

CHAIR: Yes, but I go back to the fact that nothing in the bill prevents you from actually discussing that.

Ms Smith: As a nurse practitioner it is probably okay, but as a palliative care nurse it is not respected and seen. If you take the worst case scenario—a particular person wants this choice but their family does not—is that nurse left in the position where they could face challenging questions from a family member because the legislation does not back them up? That is where we need to be. We have regularly found that anytime you leave a hole someone puts their foot in it and makes it harder for us and adds a barrier to our life.

If you do not believe that, just look at the insurance issues with COVID-19 leaving nurse practitioners out of the immunisation program. Our professional insurers decided we were not good enough to give it and that we were not safe. Obviously, that is not an intended consequence and not something that the government even thought of, but these are the issues that we see repeatedly when there are loopholes. We end up with something that we have to work around to achieve an outcome. We know that nurses are the experts at workarounds. We would prefer to limit the number we do a day, if possible.

Mr MOLHOEK: On that point, are you saying, Catherine, that you are concerned about the potential penalties that the legislation provides for people who have induced a person to revoke a request and other areas around that or are you just talking more broadly?

Ms Smith: Probably more broadly. What was said to me by some members is that it is a bit murky. If we were considered to be the instigator of a conversation, does that actually make us more at risk and things along those lines—not necessarily in terms of the client but their family? We always have to consider that. The client will most likely not be still present, but the family could be there and they could have reservations about the whole process and have a different agenda. We need to know that all nurses in that process are considered. Everything I do is informed consent. If it is not informed consent, it is not coercion. It never has been coercion, but it could be seen as that by the way this is written. I did not see clear wording that allowed informed consent to be okay.

Mr MOLHOEK: It is more at the other end, where the onus is on the patient to ask for the advice and whether it could be perceived that you have encouraged them to seek that advice.

Ms Smith: There is a definite grey area between informed consent and coercion. The clearing of that to ensure there are no repercussions for nurses is good. The patient will not be left in the situation. They will be gone, but the family will be there. Will there be some issues? There possibly could be. Do we need those to go through our courts? I do not think so.

Prof. Yates: And even if it does not get to court, it is the distress that it might create.

Ms Smith: Ahpra issues or whatever.

Mr MOLHOEK: This is a question on notice to Kylie. You mentioned concern about unintended consequences but I could not see anything in your submission about that. You also referred to a white paper on the future or something. I am wondering if we could have those.

Prof. Ward: Absolutely. I am happy to do that.

CHAIR: Any questions on notice need to be back by Thursday 22 July.

Prof. Ward: I just said to my colleague, Catherine, the comments that we have put forward are actually because of the work that we have done with Patsy's leadership in Victoria and WA and other areas. Some of these unintended consequences we have been able to take from the learnings of discussions with doctors, nurses and nurse practitioners in areas where they are being inhibited from providing the care that they wish to. We will capture those. Apologies that they were not—

CHAIR: No, that is fine. We are over time by a couple of minutes. We thank you all for your time and for coming before the committee. It is very much appreciated. I call representatives from the Queensland Nurses and Midwives' Union, the Queensland Council of Unions and the United Workers Union.

HARTLEY, Mr Robert ESM, Member, United Workers Union

KING, Ms Jacqueline, Assistant General Secretary, Queensland Council of Unions (via videoconference)

PRENTICE, Mr Dan, Professional Research Officer, Queensland Nurses and Midwives' Union

SHEPHERD, Mr Jamie, Professional Officer—Team Leader, Queensland Nurses and Midwives' Union

CHAIR: Jacqueline, would you like to make some opening remarks, then we will go to the table and then move to questions.

Ms King: The Queensland Council of Unions has outlined in our short submission that we have an interest in this both in terms of our affiliates who are professionals in this space—health unions and two of those unions are there today—and also from a social justice perspective. Our unions fight for human rights on a daily basis. We have simply sought to highlight a couple of key issues in terms of the bill. The first that I will mention is the concern about equal access of all Queenslanders to voluntary assisted dying, particularly in rural and regional areas. We understand that this is not a state matter and that there are Commonwealth laws with respect to carriage service offences. We want to raise that as a particular issue for the committee to consider and understand that that is a matter for the state government to take up with the Commonwealth. We flag that as a potential issue.

The second issue that we would like to flag is that we support the provisions in the bill with respect to the eligibility factors and the presumption of capacity and we do support the Queensland Law Reform Commission and the previous parliamentary committee's recommendations to do further work in the area where people have entered into advance health directives and then subsequently lose capacity through dementia. Again, that is not a matter for this bill but something for this committee that we think should be reviewed at a point in time.

In finishing, we made a specific reference to clause 124 of the bill stating that we think that there is some benefit in explicitly stating that there should be a community representative or an advocate type role to be on the actual review board. We note a lot of the professions are there and we also acknowledge that there is capacity for the minister to make an appointment subject to the person's experience. We think that there is some benefit in saying quite explicitly that there should be a role for a community advocate to address those viewpoints.

Finally, the last issue is in relation to the complaints process. We would see again that there would be some value in investigating an ombudsman style independent complaints process, particularly if we do face issues in implementation in terms of a lack of access by rural and regional Queenslanders, in particular, to health practitioners or service providers in the regions or in cases where service providers are not conscientiously objecting but are not referring matters on to other service providers. Those are our opening statements. We would leave it at that, thank you, Chair.

CHAIR: Thanks, Jacqueline. I will come back to you in relation to the ombudsman question. The committee has oversight of the Health Ombudsman and I wonder if that would suffice. I will let you think about that and maybe respond later. Dan and Jamie, it is good to see you. One of you may like to make an opening statement and then Robert Hartley from the United Workers Union can make an opening statement.

Mr Prentice: The Queensland Nurses and Midwives' Union would like to thank the Health and Environment Committee for the opportunity to appear at this hearing into the Voluntary Assisted Dying Bill 2021. Voluntary assisted dying as proposed in the legislation has many sensitivities and we welcome the opportunity to participate in this discussion on behalf our members, those they care for and the wider community.

The QNMU has over 67,000 members working across public, private, diverse, aged-care and disability sectors and we acknowledge that our membership comes from varied cultural, religious and ethnic backgrounds with a whole range of beliefs and attitudes about voluntary assisted dying. In Australia, as a society we do not like to talk about death and dying as the inevitable ultimate consequence of living. Much of the end-of-life and dying process has been medicalised and we tend to hide behind euphemisms when it comes to those often very difficult conversations with our loved ones, those we care for in a professional capacity and more generally at a societal level.

The QNMU supports legislative reform to enable persons who have an incurable physical illness that creates unrelieved, unbearable and profound suffering to have the right to choose to die with dignity in a manner acceptable to them. They should not be compelled to suffer beyond their wishes. A survey of QNMU members in February 2021 indicated that 80 per cent of respondents supported VAD legislation in principle. The QNMU is comfortable that the QNMU's survey and poll results align with community sentiment. We have recently resurveyed our members for further information on the main elements of the legislation and have incorporated those findings into our latest submission to the committee.

The QNMU acknowledges the sensitivity and delicacy of this issue and that nurses and midwives have the right to hold their own opinion about these matters and for that opinion to be respected. The QNMU supports those health practitioners who do not wish to participate in a voluntary assisted dying scheme and conscientiously object to involvement.

In terms of the bill, the QNMU has made three recommendations to the committee, including to remove clause 10(1)(a)(ii) of the bill, 'is expected to cause death within 12 months'. Our view is consistent with one of the recommendation of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's report where the committee recommended that any voluntary assisted dying scheme should not include a precise time frame for a person's anticipated death. We would like nurse practitioners included in the role of consulting practitioner and, as a general comment, review the bill to ensure that it is culturally inclusive.

If passed, there must also be a considered and effective implementation strategy to ensure that the objectives of the legislation are met, which must include education and training for health practitioners. This education must also have input from nurses, be comprehensive, evidence based and ongoing and be available to all who wish to undertake it. Further, the QNMU is supportive of an education campaign for the public.

In any discussion about voluntary assisted dying, it is important to also acknowledge palliative care. The QNMU makes the distinction that voluntary assisted dying is not an alternative to palliative care and the QNMU will continue to lobby for adequate resourcing of palliative care, including suitably qualified and adequate numbers of nurses for those requesting and/or requiring palliation. Part of a state palliative care strategy must be the commitment to ensuring high-quality palliative care services are delivered in a range of settings and that there is better and more equitable access to high-quality palliative care not only in the south-east corner of Queensland but also extending to regional, rural and remote areas.

The QNMU would also like to acknowledge our members who are employed in palliative and end-of-life care. For some of our members working in palliative care, voluntary assisted dying goes against the very work that they are providing in good palliative care. We respectfully acknowledge their voice on this issue and support their right to conscientiously object. Thank you for the opportunity.

CHAIR: Thanks very much, Mr Prentice. Mr Hartley, welcome.

Mr Hartley: I would like to acknowledge the traditional custodians of the land on which we meet, the Jagera and Turrbal people, and pay my respects to the elders past, present and emerging. I dedicate this time to a long-term partner of mine, Catherina van Rhijn, who died in circumstances in which this legislation is looking to allow people to have a choice in their destiny and to end their lives with dignity. I am a longstanding member of the Emergency Services committee of over 30 years. Through that time, as an ambulance member of the United Workers Union and a union delegate, I stand as a union member who will fight for the choice and decency that this legislation will afford.

I speak today specifically in relation to the significant amount of end-of-life circumstances I found myself supporting people in over three decades. I have seen many of my friends and colleagues transition into death, many of whom died in the most undesirable ways. I do commend the proposed legislation as it does have clear processes for those who wish to take this pathway that affords the choice to act or not.

Cat was terminal with an expectation of up to 24 months if the palliative chemotherapy and radiation therapy worked well. She lasted only 13 weeks. Death was a subject that we discussed at length from her original diagnosis 4 ½ years ago. She was clear on what the numbers meant. She knew what was likely to be her survival time frame and while we hoped for the best the pragmatist in her wanted to have the opportunity of ending her suffering should that be her choice. Her stage 4 metastasises made it entirely likely that the spread of her cancer would involve the brain. Her observations of others in the same situation supported her thought that this was a path that she did not want to follow. At that time the legislation was going to be way too far into the future to be considered an option.

Cat was single-minded in controlling her destiny. Her primary concern was that she was not to die alone. Above all, she wanted some dignity at the end of her life. She was not frightened of death or the cessation of her suffering. Rather, she was concerned that she would make a mess of any attempt to end her life and increase her and her loved ones' suffering. For Cat her final days progressed quickly and, as she predicted, brain involvement of the tumours created an almost unmanageable situation of pain, discomfort, distress and—I use the term deliberately—suffering. She had capacity to make decisions up to 48 hours before her death.

I must acknowledge the care, love and support offered to Cat and us by the palliative care team at the Royal Brisbane and Women's Hospital. Given a choice, Cat would not have been there. She would not have had to endure the pain that she experienced in her final weeks. She would have felt empowered to make decisions and have some control of her destiny, to slide into the inevitable in the loving presence of her family and loved ones.

This legislation offers terminal patients an option without a risk of incomplete suicide attempts in the company of loved ones without putting them at risk of prosecution and ultimately offering those loved ones a memory not tainted by the shocking realities of those sorts of deaths that can be afforded to observers. While I commend this legislation to you, I think the constraints are too tight, in particular for those who have degenerative diseases that may advance over many years. I do, however, recognise that we must start somewhere. I thank the committee for your work in this sphere. I look forward to the day when humanity and love can be a part of the end-of-life journey whichever pathway we choose for us. Thank you. I am sorry; it has been only three months.

CHAIR: Thank you for sharing that story of Cat. We are at a point in time now where we have the bill before us. I will open it up to questions.

Mr MOLHOEK: My condolences, Rob; thank you for sharing.

Mr Hartley: I will pass it on to her family.

Mr MOLHOEK: I have refrained from sharing some of my stories because I think I would end up like you are today, which is fine. My question is to Mr Prentice. We heard from nurse practitioners and other nursing groups as well as the Royal Australian and New Zealand College of Psychiatrists that there is concern around the protection of their members. I would assume it would be the same for your members, being nurses. They spoke about the fine line between influencing and coercing someone to make decisions about end of life. Are your members concerned about any of the definitions or the protections that are afforded to them in that it could be construed they have encouraged someone to consider voluntary assisted dying, which would be in contravention of the guidelines or the proposed legislation?

Mr Prentice: Certainly those issues always arise in discussions. We surveyed our members. I think the survey results were an attachment to our submission.

Mr MOLHOEK: They are in there. I have not had a good look at them.

Mr Prentice: Obviously, as both a professional and industrial organisation, the protection of our members is a high priority.

Mr MOLHOEK: That is why I am asking.

Mr Prentice: Making sure that any legislation maximises those protections is really important. It is not one of the major issues. Irrespective of the issue, as healthcare professionals there is always that underlying concern that one practises within guidelines with professional standards, that sort of thing. As for it being a highlighted issue, I do not believe so.

Mr MOLHOEK: Would you like to take it as a question on notice? That will give you some time to have a look at the particular clauses and how they may relate and if there is a concern from your members.

Mr Prentice: In our latest survey around whether healthcare workers can initiate a discussion there was significant agreement across the board that that is the case, but I would be happy to put something together based on our information.

Mr MOLHOEK: I imagine there would be many discussions with nurses and patients quite informally about all sorts of things.

Mr Prentice: Absolutely.

Mr MOLHOEK: There are potentially some areas of risk or some grey areas there.

Mr Prentice: This is very new legislation. It has been introduced into other jurisdictions in a similar form, but I think the fact that there is a three-year review period is essential, because it is those kinds of issues that will be teased out over time. When that review takes place, I think that is when a lot of those issues will be identified—if there are issues.

Mr Shepherd: Once the legislation is presented and becomes proclaimed, we will certainly be putting out comprehensive advice to our members about what they can and cannot do with regard to discussions around voluntary assisted dying. We will certainly give them as much information and education as we can around their role and their scope and where the scope starts and where it finishes.

Mr MOLHOEK: I understand that. It is just that some of the earlier groups spoke of a fine line, and sometimes it is hard to determine.

Mr Prentice: Those conversations with patients are often almost what you would regard as quite intimate in a lot of ways in terms of the kind of discussions that are had, yes.

CHAIR: I have a quick question to the QNMU and the suggested removal of clause 10 in relation to the 12-month time frame. I am looking back at our previous work. In fact, I think it was you, Mr Prentice, who appeared before us. You said it could be difficult to estimate how long someone will live. At page 119 of our previous report Ms Stacey Thorpe, director of services, Motor Neurone Disease Association of Queensland, said—

> … the predictability or the unpredictability of the disease means that, with 12 months, it is difficult to understand what somebody's condition will progress into in that time. It could appear to be a slowly progressing condition that changes rapidly. From today, you might think that 12 months seems a reasonable survival period and then next week that might change quite considerably ...

We just heard from Rob as to how quickly someone can deteriorate. I want to talk a little bit about further reasoning. I know that you went to our formal work. Do you have any other commentary around the 12 months?

Mr Prentice: In a general sense, the main issue here is that arbitrary deadlines occasionally have perverse consequences or at least unanticipated consequences. It may be that it only affects a small number of people, but the proposal in our submission is that potentially there would be a body that might be able to assist in those kinds of decisions so that, rather than it being arbitrary, there are more guided decisions around what might be possible. Our position is that, as with all things human, there is always the need to discuss and look at what flexibility may be possible rather than saying, 'I'm sorry, we can't help you,' simply because there is this legislative restriction on us doing that.

CHAIR: Thank you, Mr Prentice. Ms King, I did have a question for you in relation to your opening statement, but I cannot quite remember it. I hope you took notice.

Ms King: I think it was in relation to the Health Ombudsman. I have just had a quick look at section 7(1) of the Queensland Health Ombudsman Act. It can deal with complaints in relation to a health service for 'maintaining, improving, restoring or managing people's health and wellbeing.' I think that could probably have a little bit more clarity to do with a situation where possibly managing people's health and wellbeing could be related to a voluntary assisted dying situation, but it may also not. I do believe there is provision there, however, for a health service to be prescribed under regulation, and I think in the interests of clarity that is one avenue that could be adopted.

CHAIR: The OHO is appearing before us on Friday morning so we can talk a little bit more about that, but that is a good point.

Dr ROBINSON: Thank you all for appearing today. Mr Prentice and others, you mentioned conscientious objection and cultural inclusion. Those issues have come up in various contexts here in terms of institutions wanting to be able to opt out. Some doctors are concerned about referral. Some believe that referring on is fine if they have a conscientious objection themselves; others say they do not believe that is fine. They are just a few of the examples where the bill is seen as potentially limiting or restricting people's freedom of religion, freedom of thought, whatever. What feedback are you getting from your members in the areas that you have raised, and what does conscientious objection mean in your context? Could you tease out your comments a bit more?

Mr Prentice: As an organisation we represent carers in aged care, for example, registered nurses and midwives. Conscientious objection has always been an element of our policy decisions. I will give you an example. Currently, as you would imagine, mandatory COVID vaccination is quite a topical issue. Our policy on vaccination does support conscientious objection in that sense. Conscientious objection has always been something that we acknowledge simply because society is a broad church. We, as an organisation that is probably quite representative of society in many ways, are also a broad church. There will be a range of views. I think we need to accommodate those within our approach. Within the legislative framework that has been proposed, I think conscientious objection is dealt with as well as any legislation could do. This is the first time that Queensland has gone down this track. It will be reviewed in three years time. As it stands, the way that conscientious objection is dealt with is certainly something that we would be comfortable with at the moment.

Dr ROBINSON: Are there examples of the types of potential conflicts that nurses and nursing practitioners may be part of where they may want to opt out of something or not do something that you feel could be some areas of concern?

Mr Prentice: Based on my experience as a nurse for about 40 years, and having had those conversations many times in years gone by, that can be anything from religious perspectives to cultural perspectives. If I recall correctly, some of the evidence would suggest that certain groups within healthcare professionals, perhaps people who work in the palliative care space, may well have a higher level of conscientious objection than other groups within healthcare professionals. It is probably very difficult to pin down, but it very much comes back to the individual and their view of the world. We need to be respectful of that view and as much as possible accommodate that view while at the same time make sure that the person, for example, who is asking to go down the voluntary assisted dying pathway is still able to avail themselves by making sure they are referred on and that they do not drop through the net, so to speak, simply because they may have spoken initially to someone who is not supportive of voluntary assisted dying. I think that is probably pretty important.

Mr Shepherd: That principle flows through the codes and guidelines of the Nursing and Midwifery Board of Australia through to the standards for practice. If someone is unable or unwilling to provide a health service, it is really incumbent on them to refer them on to someone. You cannot just leave them sitting there and walk away. It is unprofessional.

Ms KING: I really do appreciate the extensive work that went into the QNMU's submission. In particular, the survey results that you have provided are very helpful in understanding how your members see these matters. I understand that a very high percentage of your membership responded to the survey; is that correct?

Mr Prentice: I believe so.

Mr Shepherd: About 3,500.

Mr Prentice: Yes, about 3,500 I believe, yes.

Ms KING: Is that quite a large number of responses?

Mr Prentice: Yes. Generally when we have surveyed our members I think that was good buy-in.

Ms KING: I am interested in the issue of institutional conscientious objection. I can see that a total of over 90 per cent of your members either agreed or strongly agreed that if a practitioner is asked to provide voluntary assisted dying services and they have an objection then they should refer. I believe that you called that a matter of good professional practice. Is that what you said?

Mr Shepherd: Professional conduct.

Ms KING: I also noted the next response about institutional conscientious objection. As I understand it, in your survey you put an explanation of the clause in the bill to your members, 'An entity may refuse to provide a voluntary assisted dying service on the basis of what is sometimes known as institutional conscientious objection.' Can you describe the responses of your membership to that concept?

Mr Prentice: Yes, that is an interesting result. I think that is potentially something we could explore a little further. As you can see, it was very evenly divided across the five, everything from strongly agree to strongly disagree. I think my initial view would be that that simply does reflect the broad range of attitudes within our organisation, and potentially the rest of Queensland as well, about whether or not organisation or institutional conscientious objection should be in that legislation. I note that other jurisdictions—Victoria and I think Western Australia—are silent on that. We have indicated in our submission that, in terms of legislation, we would much prefer that was regulated in the legislation itself rather than being left to a policy. I found a really good article which was done this year by the *University of New South Wales Law Journal* called 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' and that was actually a very interesting read.

Ms KING: Was that Professors White and Willmott?

Mr Prentice: That was White, Willmott, Close and Downie. I thought that was a very good analysis, I guess, of the pros and cons of taking any of those approaches. It would seem that, consistent with the article itself, this legislation is taking a middle ground. As I said, I do not wish to keep harking back to that legislated review period, but I think that will be a very good time, after three years, to identify whether or not that particular aspect of the legislation is working and what impact it has. It is very difficult, I think, for some of these things because we can anticipate a range of potential outcomes but really, in reality, we often have to wait and see what that actual outcome would be. I think that is probably where I could be at the moment.

Mr Shepherd: We all know that any legislation that is open to interpretation will be interpreted not necessarily for the better.

Ms KING: Mr Hartley, I want to start by thanking you very much for your contribution today. Thank you for sharing your story with us. It means a lot to us to have those stories and see what this legislation really means for people in practice if it becomes enacted. I wanted to speak to your role as a delegate representing members in the ambulance sector. Recently when I engaged with some ambulance officers—paramedics—in my local area to talk to them about our first responders legislation, it was not the conversation I was seeking to have at all but they kept raising with me the PTSD impacts they had experienced from attending the suicides of terminally ill people. One in particular, Amy, talked about attending the death of a very elderly lady who had jumped from a height when she received a terminal diagnosis. Do you think this legislation will make a difference for your members when it comes to their day-to-day work in that respect?

Mr Hartley: One of my roles within the Ambulance Service is that of a peer support officer. I have been fulfilling that role now for 13 or 14 years. With some care to not identify particular people or circumstances, it is really clear to me when I listen to people talking about their stories that the incomplete or really messy suicides are things that live with you. My role in the last 26 years has been in the operations centres. I am now the quality manager of ambulance and I listen to hundreds of calls. From a union perspective our membership are really clear on the fact that the impacts upon people who have to suffer unnecessarily are hard to forget—impacts upon post-traumatic stress injury. Exposure to trauma helps inoculate you for the future, but who knows what that one thing is that is going to be the point where it just says, 'I've had enough. I need to shut down for a while'? Fortunately, we have a lot of treatment, we have great support mechanisms through our Priority One system, and as a union we support that wholeheartedly. Your conversation with Amy is one that I hear regularly as either a delegate or a peer supporter and I also hear it on the phone. It is a regular occurrence. Where you feel you have no control is probably where it hurts the most, because you cannot unhear it and you cannot unsee it.

CHAIR: That takes me back to the Hervey Bay public hearing, where we had a paramedic who graphically spoke about the person attending, and we had others write to us about stepping over a weapon where someone had taken their lives, and that clearly impacted him.

Mr Hartley: From a personal point of view, when you cannot get there and you are sitting remote on a phone, sometimes hundreds of kilometres away, the impact upon our emergency medical dispatchers and what they have to hear—you often visualise things far worse than they really are. If we can just reduce that by a bit, that would be helpful.

CHAIR: Good point, Bob. Jacqueline, I raise this issue of telehealth and providing care to rural, remote and regional Queensland. There are provisions within the draft bill. The QLRC went into some discussion in regard to the carriage service and the Commonwealth law. A regional member wrote to the federal government about the carriage law and the response was that the Queensland government would be best to deal with this. Does that seem adequate? Where is this best dealt with, given it is a Commonwealth carriage law? The response from the federal government was, 'Looking at the issues you raise in your letter, the Queensland state government would be best placed to respond to you.' Who, in your opinion, is best placed to deal with this carriage service law?

Ms King: There is a pretty basic provision in the Australian Constitution in section 109 which says that where there is a Commonwealth law that conflicts with a state law the Commonwealth law will prevail. If there is a Commonwealth law around carriage services, it will override, potentially, issues here in this space about telehealth. I also understand from reading that this was a particular issue in Victoria, where there have been matters.

I have lived in both Victoria and Queensland and, as most people in Queensland would be aware, we are a much more vast state with more remote, rural and regional areas perhaps than any other state. In that context this is, from our perspective, about being consistent with human rights and ensuring that every single person in Queensland who wishes to and meets the eligibility criteria should be able to access voluntary assisted dying if they choose to. It is a choice. The Commonwealth simply responding and saying that it is a matter for the Queensland government is in conflict with the Constitution. That would be how I would answer it.

CHAIR: I will get the others at the table to speak on it. I am talking about division 4, clause 8 of the bill, 'Voluntary assisted dying not suicide'. It states—

> For the purposes of the law of the State, and for the purposes of a contract, deed or other instrument entered into in the State or governed by the law of the State, a person who dies as the result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act—
>
> (a) does not die by suicide …

I ask that because the carriage service directly relates to providing information around assisting someone to take their own lives, whereas the draft bill clearly states that it is not. Is there any other commentary around this issue?

Mr Hartley: On behalf of our members who work in the operations centres, we know that we are governed by the federal telecommunications acts in relation to carriage services. Our policy and procedure are based on that. The concern that immediately comes to me would be: should legislation change in order to block what is happening here in Queensland or other states from a federal entity that decides they want to do that, it could be quite harmful to the process.

CHAIR: There is one question on notice for Dan Prentice about initiating discussion of VAD. Could we please have the response by close of business on Thursday, 22 July? We thank the QNMU, QCU and the United Workers Union. Bob. I have known you for many years. That was pretty tough, but thank you so much for sharing that.

GEARON, Ms Nicola, Adult/Aged Care Project Officer, Speech Pathology Australia

MURRAY, Dr Alexandra, Senior Policy Adviser, Australian Psychological Society—Queensland State Committee

CHAIR: Welcome to you both. I ask you to make your opening statement.

Ms Gearon: I am representing Speech Pathology Australia, the national peak body for the speech pathology profession. As a rural speech pathologist, I also work closely with the demographic who may wish to access voluntary assisted dying, including those with neurodegenerative disease and those with cancer on the palliative care program.

Speech pathologists are university trained allied health professionals with expertise in communication and swallowing, both of which are very often compromised toward the end of life. For example, the majority of people with motor neurone disease will experience a communication impairment and a swallowing disorder. As such, speech pathologists are essential and will be essential for many people who wish to access voluntary assisted dying, to assist them to communicate their wishes accurately and effectively in making that informed choice. The speech pathologist may assist the medical practitioner to help the individual with communication strategies. This may be during the determination of decision-making capacity and also during the necessary VAD conversations. The speech pathologist may also assess swallowing to determine if the person is able to ingest the medication orally for self-administration.

There may be some barriers to access, particularly for those with multiple disabilities and complex communication needs. If I can provide an example, a person who uses eye gaze and assistive technology to communicate actually requires the speech pathologist to program that vocabulary that they may need for any conversation. The person then selects the words or the pictures that they wish to use to express themselves with eye movement. Under the bill, that programming of vocabulary on the topic of voluntary assisted dying would not be possible, because it may be perceived as initiation by a speech pathologist or even coercion, so there may be some individuals who may have capacity who are unable to express themselves and access voluntary assisted dying.

As already mentioned today, there are likely to be issues in rural and remote areas to general access to speech pathology services, which may be limited. I must also provide accuracy as a final point regarding the regulation of speech pathologists. This is relevant throughout the bill but requires amendment in the clause regarding speech pathologists with conscientious objection.

CHAIR: Clause 85.

Ms Gearon: Thank you. Speech Pathology Australia provides the only professional self-regulation of speech pathologists nationally to assure safety and quality in the provision of services. A Speech Pathology Australia member, or a non-member, who provides evidence of recency of practice and continued professional development may meet the requirements. This would be worded as ‘a speech pathologist is a person who holds the credential Certified Practising Speech Pathologist, CPSP, under the professional self-regulation framework of the Speech Pathology Association of Australia’. I would be happy to provide further details regarding those requirements if you wish.

Dr Murray: Good afternoon, members of the committee and everyone else in attendance today. I begin on behalf of the Australian Psychological Society by acknowledging the traditional owners of the land on which we meet, both here and other locations virtually, and pay my respects to elders past, present and emerging. I also thank the Health and Environment Committee for the invitation to be part of this hearing, marking an important issue facing Queenslanders today.

As a professional society representing 27,000 members nationally and over 5,000 in Queensland, the Australian Psychological Society has immense expertise and experience in working with palliative care patients and in settings with patients at the end of their life. It is important to acknowledge that the Australian Psychological Society neither opposes nor supports voluntary assisted dying but advocates a best practice approach to end-of-life care. Of course, that includes the alternative, which is high-quality palliative care.

The APS emphasises the importance of a process that is characterised by care, compassion and considered decision-making over time. Decisions about assisted dying are often made in the context of serious social inequities. I know there have been many discussions of that. It is vital to ensure equity of access and that that is carefully considered in the implementation. This is in particular for people living in the rural and remote areas and for Queenslanders who have cultural, linguistic and ability-diverse backgrounds.

There are four other elements to which I draw the committee's attention. The first is the importance of the assessment of acting voluntarily and without coercion. This should include strategies to minimise the risk of coercion and patients being fully informed of all options available to them. This will of course involve the understanding of the ramifications of any decisions they make. Second, psychologists are in a unique position to conduct capacity assessments due to a core skill set that uses a combination of evidence based assessments of cognition and behaviour and the ability to differentiate between certain conditions such as mental illness, dementia and delirium on decision-making.

The third point is the importance of having a capable and skilled workforce. That is absolutely essential to meet the needs of people approaching their end of life and of course their caregivers. Finally, the APS welcomes a connected and patient centred statewide care navigator service to assist patients, families and friends as well as health practitioners throughout the whole journey, including—and I must emphasise this—the decision-making process. Increased access to psychological services as part of this service will be critical, particularly for the decision-making capacity assessment. There should be therapeutic support for patients, their families and other affected people and clinical supervision for the practitioners and other personnel involved in delivering assisted dying services. This is important both to reduce the psychological burden on practitioners and to ensure best practice is maintained. The APS welcomes the opportunity to co-design any psychological support component of this service.

CHAIR: I note that you also submitted to the royal commission into aged care around this issue of decision-making capacity. It is a complex area. We have heard from some witnesses in regard to assessment, particularly GPs, who say that a psychological assessment is not needed because—with respect, I know you all do great work—every day a GP makes an assessment when someone walks into their clinic based on provisional diagnosis or a working diagnosis as to whether they have to go to a specialist for oncology or whatever. I want a counterargument from APS as to why you have put that particular amendment to us.

Dr Murray: On behalf of the APS—it would be remiss of me to comment on another profession's ability—I can comment upon the nature of very complex cases, where there may be comorbidities of anxiety, depression, other mental health conditions or other neurological illnesses that may be also presenting symptoms and may complicate any of those assessments. Again, I reiterate that I do not want to say that another profession is not capable of making those assessments but, in a case where a GP or another medical practitioner may not feel that they have sufficient expertise to make that assessment, a psychologist may be the appropriate alternative.

CHAIR: That becomes more pertinent, as we heard, with people living in regional, rural and remote areas. I said to another psychologist appearing today: how do we actually get that to those small communities? In our former work, people said to us that they did not want to leave communities but wanted to be surrounded by loved ones. It becomes a challenge. That particular witness took a question on notice about how many psychologists we have out there. No doubt it is a challenging area, but it actually goes to Nicola's point about motor neurone disease, where people cannot communicate. This draft bill has provision that the person has capacity all the way through. In Rockhampton we met Peter, who has advanced motor neurone disease and who obviously wanted to come and talk about accessing it. It must be incredibly difficult for your members, dealing with people who are at end of life with motor neurone disease. It has given me a whole new appreciation for speech pathologists. I want to say thank you for the work that your organisation does. It has to be tough.

Mr ANDREW: Is there anything in the bill that should be bolstered? Is there anything that perhaps we have missed or that perhaps we should add?

Ms Gearon: In terms of changes, my only point is to make that amendment regarding the regulation of speech pathologists to ensure that wording is accurate and that 'certified practising speech pathologist' is the requirement. As it is worded, it states that a speech pathologist needs to be eligible for membership with Speech Pathology Australia. That is completely inadequate. Membership is not the point and it is not the regulation. A person could be a member of Speech Pathology Australia and not meet CPSP status. Also, a person could be not actually a member of Speech Pathology Australia but provide evidence to Speech Pathology Australia, under the professional self-regulation framework, that they meet the requirements of completion of an appropriate accredited university course, specified recency of practice and a minimum standard of continued professional development. That then awards them the post-nominals and the credential of certified practising speech pathologist. We see that change as essential.

CHAIR: We need further information as there was no submission from Speech Pathology Australia. Can we get that information?

Ms Gearon: There was a letter. I have it here.

CHAIR: I do not have it in front of me. I am happy to be corrected. I must have missed it.

Dr Dewar: It was not a submission; it was just a letter that was not dated. Could we have that in writing?

Ms Gearon: Sure. We can send that through.

Ms PEASE: Thank you both very much for coming in and for the great work that you do in the community. Nicola, I would like to talk about the eye gaze, the software and the data that goes into the equipment so that people can make those requests. It is a quite interesting point that you raise. One thing of interest to me is access for people who live with conditions like that. Some people would think they would not have capacity.

Ms Gearon: And these are the people we are talking about.

Ms PEASE: Many of them, whilst they might not have the ability to speak, still have capacity to make decisions. Alexandra, can you comment on that, too? We need to make sure there is access for them.

Ms Gearon: Certainly. What we need is awareness and acknowledgement from the medical team that that person requires speech pathology support. Hopefully that is already in place and they have a system to communicate. Certainly as speech pathologists, our primary objective is equal access to communication for a person, so giving them a voice, whether that be literally a voice to speak or some other means of expressing themselves, as to their needs and exercising their autonomy. That might be the assistive technology I described. Some people have communication boards where there are pictures on a board and they point. That sort of communication support is quite common for people with neurodegenerative disease and towards the end of life, so we definitely need acknowledgement of that.

Speech Pathology Australia would welcome the opportunity to contribute to any training for health professionals and guidelines about communication difficulties and how to support people. It is really about having that speech pathologist who is familiar with the person and who has conducted an assessment, made a diagnosis and supported them in how best they can get their point across to be involved, which can be a challenge if there are access issues.

Ms PEASE: That is correct, but just because there is a communication inability does not necessarily mean they do not have capacity.

Ms Gearon: Absolutely, yes. Many people do, yes.

Mr ANDREW: It more goes towards reducing the suffering because you are understanding the person in a more in-depth way.

Ms Gearon: Yes, definitely. Everyone has a right to communication, particularly at this point in life, and, 100 per cent, a lot of people maintain their capacity and their cognition but lose their ability to speak clearly. Yes, that is quite common in types of motor neurone disease.

Ms KING: Thank you to you both for the work that you do. Ms Gearon, I want you to briefly unpack what you were saying about speech pathologists needing the ability to initiate conversations. It was about ensuring the person has access to the technology and vocabulary so they can effectively initiate the conversation? Is that where you were going?

Ms Gearon: Yes.

Ms KING: Could you expand slightly on that?

Ms Gearon: I am not necessarily saying that we need to be able to initiate the conversation.

Ms KING: That might be an example of—

Ms Gearon: I am saying that it could be perceived that way if we were to make available that vocabulary for a person. A speech pathologist never speaks for a person; however, that is the concern that it would be perceived as coercion or as initiation. A speech pathologist purely gives the person the opportunity to communicate. As you said, it would be providing the range of vocabulary they may need. It may be about voluntary assisted dying. It may be about the palliative care options and the treatment options holistically and the language they may need to navigate that. For many people, hopefully they will be able to express themselves with whatever system of communication they have and have hopefully been supported in developing; however, there may be some individuals who really cannot find that specific vocabulary within their system with their profound disability, if that makes sense.

Ms KING: It does. Thank you for expanding on that for us. I want to ask both of you about the particular issues you have raised that you have given us feedback about. The QLRC had as their goals the provision of a voluntary assisted dying scheme that was compassionate, safe and practical. Assuming these issues that you have raised are met, do you consider that the legislative scheme we have before us for consideration meets those goals of being compassionate, safe and practical, on the whole?

Dr Murray: On behalf of the Australian Psychological Society, I would say yes and I would commend its conception and the way it has been thought through.

Ms Gearon: I would agree. We are very pleased to see that people have the option to communicate with varied methods. We are really pleased to see that. There is the mention of verbal communication, gesture or other means available to the person. As I mentioned, there may be some barriers for some individuals, but on the whole we are pleased to see that noted.

Ms KING: Thank you so much for your contribution.

Ms PEASE: I want to go a little bit further. In the bill there is talk of opportunities for conscientious objection. I note that is put down for speech pathologists, and I understand the background around that. I am interested to hear your thoughts around entities and their capacity to undertake conscientious objection given that you would both, no doubt, have clients or have seen clients who reside in a residential aged-care facility, a Youngcare type of home or something like that for young people who may have some sort of neurological disease. How do you feel with respect to the capacity of entities to conscientiously object and the impact that will have on the residents?

Dr Murray: That is a difficult question to answer. I can foresee a situation where a resident may, for example, request to access voluntary assisted dying but they may be in a care institution that is affiliated with some organisation that would object to them accessing that type of service. In this situation, the Australian Psychological Society would say that there is a diversity of opinion and a diversity of belief, and the bill as it stands supports that and encourages that diversity. However, the overriding guideline ethically is that, if for whatever reason there is an objection and that particular service is not able to be provided, there is some ability to refer to another service where that could be accessed.

The reason I hesitate is that I appreciate that, practically, that is challenging. The reality is that the prospect of going through the process of changing facility just so they could access other services could be very daunting for someone who is already at the end of their mental and physical strength.

Ms Gearon: I do not feel I could answer that question from the perspective of Speech Pathology Australia. Personally, I can say that I live in rural Queensland. We have one residential aged-care facility in our town, so there is not the option or the choice for people. If we are looking at equal access, that would need to be considered.

Mr MOLHOEK: Thanks for being here today. I appreciate some of your candour and your commentary. One of the concerns that was raised earlier today by the Royal Australian and New Zealand College of Psychiatrists—I know it is a different profession—was around the fine line of influence through counselling services. Is that an area of concern for you as psychologists in that there is this requirement that people who want to access voluntary assisted dying basically have to ask for it as opposed to being guided into it? I imagine there would be many clients and families who are regular visitors to a psychologist for counselling and support. Are you concerned about that requirement within the legislation and the impact in that it could put psychologists into an area of fault or conflict with the legislation and, therefore, maybe incur a penalty of some sort?

Dr Murray: Psychologists routinely deal with patients and with clients who have a diversity of opinion or belief or background. It is one of the hallmarks of the profession and it is very much embedded within the code of ethics of the profession to support an individual's therapeutic journey. If that was somehow coercive or leading or unduly influencing someone's decision or ability to come to that decision themselves, I would say that is antithetical to the code of practice.

Mr MOLHOEK: I think the legislation almost goes so far as to say that you cannot suggest it; they would have to bring it up with you first. That is that fine line, I guess.

Dr Murray: Yes. I appreciate that that is complex and that is not straightforward. In a therapeutic relationship there is an iterative process of coming to a decision and coming to realisations. I think that again calls on the importance of training and having a capable workforce who really understand that line and can be professionally supported to maintain that line.

Mr MOLHOEK: Do you think the line is too harsh? We have heard from doctors and other health professionals who have all said, 'We have a relationship with our clients. We know our clients. We have an ongoing role in their lives in terms of their care.' Is it almost unreasonable to have that as a requirement or a restriction?

Dr Murray: Can I take that question on notice?

Mr MOLHOEK: Sure.

Dr Murray: I would like to consider that and get some input on that if that is okay.

Mr MOLHOEK: I do not think I would want to see practitioners actively campaigning to say, 'Hey everybody, VAD is a great idea.'

Dr Murray: No.

Mr MOLHOEK: However, I think there would be many instances where the relationship between the practitioner and the patient is such that there has been a relationship over time and regular contact and so it would not be unreasonable to be having those conversations.

Dr Murray: No, and I would support the idea that a therapeutic context with a psychologist is a very good place to have those conversations. I understand that this point of it being initiated from the client as opposed to from the psychologist is a very important point. Again, as I mentioned before, there is a very strict code of ethics in that psychologists should not be unduly influencing their clients to be doing anything. I would like to take that particular point on notice, if I could.

Mr MOLHOEK: I guess there is also a reverse risk and that is that—I am trying to be careful here—there are some patients who are perhaps not so composed. They might go back to their family and say, 'Oh well, I saw my psychologist today and we talked about this and they think it's a great idea.' That may not be what they have said at all, but they could be misrepresented and then potentially that puts the psychologist at risk. That is my concern. That is the concern I am alluding to.

CHAIR: We will leave that one as a comment.

Mr MOLHOEK: That is fine, but if you could respond, that would be great.

Dr Murray: I am happy to.

CHAIR: If there are any questions on notice, we do require answers back by close of business on Thursday, 22 July. We thank you both for your significant contributions here today. They are informing the committee in its work and deliberations on the bill. Thank you so much.

Dr Murray: Thank you for the opportunity.

TURNER, Professor Jane, Private capacity

CHAIR: Welcome. Would you like to make an opening statement before we move to questions?

Prof. Turner: My name is Jane Turner. I am a consultation liaison psychiatrist. I have been working clinically in cancer care for 30 years. My concern about the Voluntary Assisted Dying Bill is the failure to develop a nuanced understanding of the concept of suffering. Suffering seems to be interpreted as very much a binary thing, either present or absent. The notion often seems to be that suffering has an entirely physical basis. Suffering is complex. It is existential. It is about loss of function; it is about demoralisation. It may be about depression, which is a treatable mental illness, but not just 'mental illness'. It concerns me that a person who experiences suffering that they find intolerable should be able to access VAD without being able to access interventions which may be of enormous benefit, particularly dignity therapy or other interventions. The legislation suggests that patients should be offered palliative care, but there is very poor health literacy in the community about what palliative care can offer. There is no mention that they should be offered psychosocial care, which I think is a major oversight.

CHAIR: Thank you very much, Professor. You have dealt with people in the oncology area in your career, as well, people at end of life?

Prof. Turner: The majority of the patients I treat have advanced disease. I have treated many people who have died. I have been in contact with their family members after they have died. I have been present at the moment of death of several patients.

CHAIR: We have had some similar professions in front of us today. Some GPs say that in rural, remote and regional Queensland, it is very difficult to access specialist care for people who are diagnosed with terminal illness. Quite often they do not want to leave their communities and they want to stay surrounded by loved ones. What do you say about the availability of specialist care, such as psychologists, in dealing with these particular cases?

Prof. Turner: I would say that it is a shame. I think it is a terrible shame and an indictment on our community. We have a shortage of psychiatrists. We are not so badly supplied with psychologists. The OECD average is 15.6 psychiatrists per 100,000 population. In Australia, that figure is 12.8. Eighty per cent of psychiatrists work in capital cities in this country.

It is appalling that patients do not have access to that specialised care. I would add, however, that is not just the province of people in rural areas. I currently am the only psychiatrist providing a clinical service to cancer care services at Royal Brisbane and Women's Hospital, which is one of the largest hospitals in this state. At the end of this year, when I retire, it is anticipated that my role may be filled by someone offering a four-hour weekly outpatient service—possibly, if they can get the money.

Mr ANDREW: Are there are opportunities that require funding?

Prof. Turner: It is interesting. There is actually a critical shortfall of psychiatry. We have trouble attracting people into our training program for a lot of complex reasons. There is still stigma about mental health. If you look at remuneration, it is a lot less than in procedural specialities. We are struggling for that reason. Even if we have enough psychiatrists, the focus is on acute mental illness and acute mental health problems like schizophrenia. If you go to any public hospital in Australia, the inpatient beds are dominated by people with psychosis, severe depression and dementia. We have very little capacity, even with expanded health service providers, to be able to attend to the nuanced needs of these patients, many of whom do not have a diagnosable mental illness.

Mr ANDREW: We did hear in Rockhampton that people may access this as a result of hopelessness and not receiving palliative care. It is obvious, from what you are telling us too, that some of these issues are not being addressed.

Prof. Turner: Absolutely. I watched a video from the Victorian program; there are some training videos for health professionals. The training, even for GPs or other people involved in the process, is very limited. I watched a video today—it seemed to be best practice—of a patient who said that she was tired of living. She could not eat; she was not sleeping well. She could not do the things she would normally do—functional decline. I presume it was a nurse who said, 'We can offer you something to help you sleep.' The patient said, 'Well, look, I am really sick of it. I want to end it all,' and the nurse said, 'Well, the legislation has changed and there are things we can do about that.' That was two minutes into an interview. There was no exploration of what the nature of her suffering was or of the meaning and integrity of her life—just VAD.

CHAIR: The draft legislation is very clear on its eligibility criteria. People accessing voluntary assisted dying must be terminally unwell.

Prof. Turner: Yes and the woman in this case was. My point is that there was a rapid response to say, 'Well you can access VAD,' rather than exploring what the needs of this woman were from an emotional and spiritual point of view. The offering she got was sedation to help her sleep at night, nothing to do with her existential distress and demoralisation.

Ms KING: The legislation also requires that people's full range of treatment be canvassed in the course of conversations.

Prof. Turner: But there was no mention of psychosocial care.

Ms KING: Thank you for being with us, Professor. It is very much appreciated and you obviously do very good work. I can imagine that the service you provide is very valuable to your patients, so thank you. I am interested in this idea of the nuanced understanding of suffering. In the criteria for access to voluntary assisted dying that is outlaid in the draft bill, as you know, one of the criteria is that the person is experiencing suffering that is intolerable to the person. My understanding is that contemporary understandings of pain and suffering are person centred in that the person is the barometer of their own pain or suffering—

Prof. Turner: Yes.

Ms KING:—as opposed to a doctor deciding what is painful or not painful, which may have been the case in the past. Could you give us more commentary around that?

Prof. Turner: A person comes to a diagnosis of a terminal illness with multiple determinants of how they will respond. It depends on their past life, their exposure to trauma, abuse—all of those sorts of things. Their ability to communicate distress may be limited. I can recall an example a couple of years ago of a patient who had a cancer which was being treated with curative intent. He had a nasogastric tube inserted, which he found very unpleasant. I was asked to urgently assess him, because he said he was going to kill himself if the nasogastric tube was not removed.

When I went to speak with him—and he was a man who had complex learning difficulties and developmental delay—I said, 'I am wondering if you are scared that we don't understand how awful this is for you. I am wondering if you felt you had to say something like that to get us to sit up and listen to what was concerning you.' He burst into tears and he said, 'I felt I was in a corner. No-one was listening.' They were all saying, 'Oh it is fine, we'll just put it down.' His suffering was very severe for what would be seen as a medically trivial intervention. That is the whole point. We need to respond and see that within the person's perspective but also understand we can do things about it.

Ms KING: Absolutely.

Mr ANDREW: Is there anything else you would like to discuss about the bill? Is there anything that would provide further clarity from your perspective?

Prof. Turner: The only other thing I am concerned about is the issue of conscientious objection, and the notion that if a practitioner has a conscientious objection they should refer that patient to another practitioner. By the very act of doing that, they are complicit in a process to which they are conscientiously opposed. I think they should be able to state that they conscientiously object and to advise the patient that they need to seek alternative information. The onus on referral is inappropriate.

CHAIR: If there are no other questions, we thank you for your time. We have one final submitter coming in today. It is the five o'clock time slot.

Prof. Turner: You need a cup of tea, a Bex and a lie down, I suspect!

Ms PEASE: I don't think they make Bex anymore, do they?

Prof. Turner: They do not. Interestingly, I was recently in South Australia at d'Arenberg winery and they have a little box of old medications with Phenacetin and a packet of Bex.

Ms PEASE: It is probably not a bad thing that it is not available anymore.

Prof. Turner: It did cause a lot of renal failure.

CHAIR: Professor Turner, we thank you very much for your contribution today.

Prof. Turner: Thank you so much.

NITSCHKE, Dr Philip, Exit International (via videoconference)

CHAIR: We welcome from Exit International Dr Philip Nitschke. I understand it is a different time zone where you are, but we appreciate you speaking with the committee on the draft bill. Do you want to go to an opening statement? Then we can ask questions.

Dr Nitschke: Yes, sure. Thanks very much. This is a different time zone. I am talking to you from Amsterdam, where I now live. I would like to make a few quick comments. I have looked at the development of bills like the one Queensland is proposing but also, of course, am watching closely what happened in Victoria and in Western Australia. My concerns were really expressed in the submission that I made that I am a little worried by the fact that we see effectively a following on of this medicalised model that in a sense I was involved in pioneering back in the Northern Territory 25 years ago. Since that time we have learnt, and I have been watching closely around the world, problems with this model which prioritises the medical approach and I think leads to some unintended consequences which I am afraid we will be seeing play out in places like Victoria and Western Australia and eventually Queensland as we will see a walking back of the legislation, such as we are seeing take place here in the Netherlands right now, until we get closer and closer to what I would see as a much more appropriate model which is the model that is used in Switzerland. That is my basic premise and that is why I wrote about it in my submission. I am very happy to answer any questions that the committee might have.

CHAIR: Thank you very much, Doctor. The bill that you see drafted by the Queensland Law Reform Commission has been pretty well considered. We were the former health committee that undertook broad consultation throughout Queensland and recommended a bill be established. What elements of the bill as drafted and before us do you have concerns with? Is it around eligibility, is it around access or the conscientious objection that we keep hearing about, particularly around institutional conscientious objection?

Dr Nitschke: I can see there are issues with conscientious objection on conscientious grounds, but it is really to do with eligibility. What we are prioritising, in fact what we are insisting is the only eligibility criteria, is serious medical illness with the condition of expected death as part of the prerequisite for a person's eligibility. What that does, of course, is disenfranchise everybody else who does not fit those criteria. When you get a series of elderly people with a lot of little criteria which would lead them to a point in time where they believe that they have reached the end of their life and they now want to be able to end it, they would simply not meet those very strict criteria.

It also means that a person who wants to seek this option has to present themselves for some assessment in terms of whether or not they pass these requirements. There is a problem with that. It may be the only model which is politically feasible in terms of getting it passed. Certainly we saw that play out earlier first off in the Northern Territory but then of course in Victoria when it first finally managed, after 20 years, to get the first legislation through. These were necessary additions to pass through the parliamentary process, but there are going to be difficulties. We have seen that with the trail of people who continue to come to Switzerland. The passage of legislation such as you are proposing will not change that. Also along with that goes the large numbers of people that we are well aware of who will continue to import their own drugs so that they have access to the decision-making process themselves so they will not be subjected to some form of scrutiny and assessment by people they simply feel do not have any right or a role to play in this.

Dr ROBINSON: Thank you, Dr Nitschke. Following the points you make on eligibility, where would we draw the line? Where do you see the line should be drawn or any kind of boundary? For example, if you go to the other end of the spectrum, people talk about having had a completed life. They do not have a terminal condition and they do not have a condition that is incurable, but they feel that they have come to a point where they have had enough of life for whatever reason and they want to access a VAD type service. Where do we draw the line as regulators, as lawmakers?

Dr Nitschke: That is a good point. What we have seen play out in the Netherlands, for example, is that the laws introduced there in 2001 were very similar in a sense to what is being proposed here in Queensland. There were strict criteria. What we have seen play out over the next 20 years is the fact that there has been a walking back of that as people say, 'Well, I don't quite fit or meet the criteria of being terminally ill, but I am sick. I have a lot of little conditions that make my life intolerable and unpleasant.'

What is now being argued in the Dutch assembly—and I have been following this closely, of course, since I am here—is this idea that the passage of tired-of-life legislation is being considered, where there are no criteria other than age and soundness of mind—so-called mental capacity. If you are of sound mind and over the age of 70, it would be your right—not some form of medical privilege for the very sick—to have access to these drugs to be able to take them if you wish. That is being played out here now and I am predicting, in fact, that sooner or later Australia will find itself confronted with this same issue.

My suggestion is that you can bypass a lot of these issues if one were to adopt the model such as the Swiss have whereby they simply do not have any criteria, or certainly no medical criteria. You have to be of sound mind and you have to be an adult, and that is really it as far as Switzerland is concerned. You can receive the assistance, provided you can do it yourself. You have to be able to carry out the process yourself—press the button if it is an intravenous infusion; drink the drugs if they are provided to you as an oral medication—and you have to be able to pass some form of assessment to ensure you are a person of sound mind, but there are no medical criteria. That has been working successfully since the 1930s.

The trail of people who are travelling from Australia to Switzerland—and we have a number now leaving Australia to come to Switzerland—is because they do not really want to wait around until they become sick enough to be eligible to meet, for example, the Victorian requirements—the idea of sitting there waiting until you get to that point. They say, ‘I want to be in control. I want to have the full ability to make this decision myself.’ That is not possible under any of the models we are seeing introduced in Australia.

I am sure this legislation that you are proposing will pass, and I certainly hope it does, but I think what you will then see is a succession of challenges to it. That has been played out around the world. Canada is an example where that has been challenged by people with psychiatric illness, for example. What if you have a psychiatric illness but you have mental capacity? The Canadian authorities have decided, ‘Well, that is fair enough. You may well be suffering from a psychiatric illness and have mental capacity and in those circumstances should be able to receive the assistance of the legislation.’ It is a series of court challenges that will play out in the courts which I think will take place when one goes down this model, which tries to codify the exact medical conditions which determine eligibility.

Ms PEASE: Doctor, thank you for speaking to us today. You mentioned that there are a number of people who are travelling overseas to undertake voluntary assisted dying. Do you have any figures on what those numbers are?

Dr Nitschke: A lot of people are having trouble leaving Australia right now. I can see that everyone is masked up there. That causes some problems. I just bring this up quickly and briefly. The last couple were a couple from Queensland: two people who wanted to die together. This is only a few weeks ago. They had great difficulty getting permission to leave Australia, having to argue with homeland security to say that they were leaving for so-called medical treatment unavailable in Australia. A couple of points come up over this. Switzerland, for example, allows couples to die together, even though often one is not sick, if they have been together for a long period of time. That is never going to be envisaged in any of the models being considered—your model or Australian models, the idea that two people might die together. In terms of people leaving, that couple left about a month ago after getting special permission by lying about their situation for travelling to Switzerland. They were able to get out of Australia. There are several people at this stage—when I say ‘several’, I would say about three, as far as I know, from different states of Australia—who are currently going through that process of trying to work out whether they can get permission to leave the country.

CHAIR: I might ask you a question that has been raised time and time again over the last week in particular. This is around institutional conscientious objection. We heard from faith based groups. They had great difficulty in coming to terms with this, although the Uniting Church yesterday said that they would allow a practitioner to come in if it was needed. Do you have a view on institutional conscientious objection versus the person’s right to choose?

Dr Nitschke: Yes, it is a difficult one. I have watched as we have seen some of these institutions’ objections play out and the difficulties it causes, especially in the US where I have seen most of these issues cause difficulty. I do not know what can be done to effectively encourage an institution to take an active and participatory role or allow people who are part of that institution to access the sorts of options that people who are not part of that institution can access. I do not see any easy solution to this. I am annoyed by it, of course. I think individual doctors, for example, certainly should have the ability to dissent and to play no part in such a procedure, but the idea that a person might find themselves as part of or being looked after in a certain institutional setting and then find that that complete institution decides that they want no part in this particular role makes it extremely difficult for people and it will ultimately mean, I suppose, that they will have to try to think about these issues before they decide on what might be the limit in institutional options available anyway.

CHAIR: How did other jurisdictions sort through the issue?

Dr Nitschke: In no easy way that I can see. I have not seen any easy solution. We have seen people digging their heels in somewhat—institutions insisting that they have this ability, individual staff members within the institution feeling annoyed and aggrieved about the position as taken but nevertheless being unable to influence it, individuals within those institutions sometimes finding themselves having to move out of those institutions and into what might be considered more hospitable or friendlier environments where such options could be considered as viable. You see all of that stuff play out, but I do not see any easy solution. For instance, I cannot imagine that one could put pressure on the institution to simply say that, because this is now considered to be the law, you as an institution must in some way find the ability to deal with the rights of the people within your institutions in this regard. I do not see an easy answer to it.

CHAIR: Finally, do you think the provisions in the bill as drafted around a health practitioner having a conscientious objection being required to refer to the care navigator service strikes the right balance in terms of choice?

Dr Nitschke: Yes, I think it probably does. There is always going to be that balance. It is not a bad course to take.

Mr MOLHOEK: Broadly, do you think the Queensland legislation is right? Have we got it right?

Dr Nitschke: There is a question about ‘right’, meaning in some ways people say that a law that passes is the right law. I can see that there are real political constraints on these legislative strategies. I have spent some 20 years trying to get legislative initiatives through the various states of Australia, all of them failing. We had some 20 failed attempts following the overturning of the Northern Territory law I was involved in. It was so damn difficult so I was thrilled when Victoria finally came up with a model that actually got through the parliamentary process. I am not sitting around saying, ‘Oh, well, I know what’s best,’ because I know there are real constraints in terms of trying to find a model which is going to be acceptable, and by ‘acceptable’ I mean something that will pass. I have seen so many of these bills rejected. In that sense, you probably have a very good model there which will probably pass.

I note with some interest that an issue that was considered to be political poison for so many years has now become something which is almost seen as a political plus. We have almost seen a stampede of the states of Australia now to join in. Since the dam was broken by Victoria, all other states want to join in and it is seen that it is actually positive politically to be part of one of these legislative initiatives. My concern, though, is that the model that is being adopted, rather slavishly followed, is this rather problematic medicalised model which prioritises disease as the only available access point. That is an issue which is not going to be solved here, but ultimately you will find yourselves being confronted with it in years to come.

Mr MOLHOEK: I was just having a quick look online at the ‘tired of life’ legislation you mentioned in Holland. I have to say that I find that concept quite disturbing. That is just a whole other step further. In some respects, I wonder if our ability to keep people alive so well and advances in modern medicine have in no small part created some of the ethical dilemmas that we have now with people saying, ‘I don’t want to be kept alive any longer. Can you please stop helping me?’ I would appreciate your comment on that.

Dr Nitschke: Many people will say—and I think it is quite correct—that many of the issues we find ourselves discussing and debating are effectively a by-product of modern medicine which has allowed people to be kept, if you like, technically alive but with a rather decreasing quality of the life that is being experienced. In these societies where life expectancy has been pushed up thanks to the developments and advances in modern medicine, there are people who are effectively now saying, ‘I’m living, but I don’t want to live.’ That leads to this issue of ‘tired of life’. It is not an issue, but we only have to go back a century to see that everyone is dying at the age of 50 from infectious disease, but now it is being played out and people are demanding this option. As I said, they are seeing it as a right. I am afraid that the legislative models that are going through are prioritising it as a medical privilege for the very sick. It is a product of modern medicine, modern Western society and access to Western medicine that we are seeing this.

The world’s first legislation was in the Northern Territory of Australia. It is quite interesting that, of all the places in the world where something which is in a sense inevitable, I would argue, in Western society, took place here in Australia and, of all places, in the Northern Territory. But the world is changing and so are the legislative strategies that are trying to deal with it. As I have said several times, I wish that people had taken a bit more notice of what was happening in Switzerland, where I think they have managed to get it right. I might point out here that we have a trail of people from the Netherlands heading to Switzerland to take advantage of this option; for example, the David Goodalls of this world. David was a 104-year-old from Perth who, you may recall, was not sick and insisted on not playing the sick role. He said, 'Don't make me say I'm sick. I am 104, but I'm not sick. Surely I have earned the right to die. I've got to the point where now I want to end my life, but I'm not going to have to try and play this role of being sick.' Switzerland can accommodate that, but your model and the models in most places in the world simply cannot.

Mr MOLHOEK: You mentioned Western society or Western culture. What is happening in the rest of the world in other cultures such as in Asia, South Africa or other African countries, non-European and non-Western countries?

Dr Nitschke: There are embryonic movements towards changing end-of-life legislation occurring in most countries around the world. We are seeing initiatives in South America taking place as recently as this week in Colombia, for example. The issue is a live one. I do not know whether it will take on the importance and significance it does in countries where we do have this growing cohort, essentially of baby boomers, who are now reaching their twilight years. They are used to running the show. They do not like being patted on the head by some medical professional and told, 'There, there. Let's do the worrying for you.' It is in those societies where it really starts to play out in such an extreme way. There are active movements in South Africa; for example, there is a trial going on in Cape Town right now. Around the world we are seeing it, but the places where it is playing out mostly are the Western nations such as the US and Australia and, of course, Europe, where I am now located.

Mr MOLHOEK: And the UK?

Dr Nitschke: Oh, yes, the UK. The UK has been holding back. It will be an interesting one. We will see those changes. They would have legislation, I would suggest, very similar to yours, and I would say it is not going to take that long. For example, the biggest number of people we receive in Switzerland who are coming from outside of Switzerland come from the UK. It is something which is constantly forcing people to address the issue. The usual way it plays out is that someone is extremely sick—this is in a country that has no legislation at present—and then there will be a media focus on the degree of suffering and people will say, 'We shouldn't allow this to happen.' That is, of course, what has happened in Australia, and that can be addressed by legislative models such as you are proposing. As I have said, once you have taken that step and allowed the very sick to get access to this it will not address the underlying problem.

CHAIR: Dr Nitschke, thank you very much for your time and joining us all the way over in Amsterdam. We appreciate your background and expertise in this area and helping us consider the bill before us. I now declare this public hearing closed.

The committee adjourned at 5.36 pm.