ANZCA
FPM

President
Australian and New Zealand
College of Anaesthetists

Friday 27 November 2020

Justice Peter Applegarth AM
Chair, Queensland Law Reform Commission
PO Box 13312, George Street Post Shop
Brisbane QLD 4003

By email: lawreform.commission@justice.qld.gov.au

Dear Justice Applegarth,

Consultation Paper WP 79 - A legal framework for voluntary assisted dying

Thank you for inviting the Australian and New Zealand College of Anaesthetists (ANZCA) to make a written submission in relation to the Queensland Law Reform Commission's Consultation Paper, *WP 79 - A legal framework for voluntary assisted dying*.

ANZCA, including the Faculty of Pain Medicine, is committed to setting the highest standards of clinical practice in the fields of anaesthesia, perioperative medicine and pain medicine. As one of the largest medical colleges in Australia, ANZCA is responsible for the postgraduate training programs of anaesthetists and specialist pain medicine physicians, in addition to promoting best practice and ongoing continuous improvement that contributes to a high quality health system.

The issues of legalised assisted dying and end-of-life choices are of great significance to anaesthetists and specialist pain medicine physicians, who may be involved in end-of-life discussions and decisions. ANZCA approaches the issue of assisted dying from the perspective of patient advocacy; to protect patients' rights and to ensure that patients can exercise these rights; and from a health advocacy standpoint, to ensure that research and investment into palliative care is not an unintended casualty of this process.

The college is also concerned to ensure that medical practitioners, in particular anaesthetists and specialist pain medicine physicians, are appropriately protected under any legislation, and not required to undertake activities which they deem contrary to their personal beliefs or their professional responsibilities towards their patients.

ANZCA's feedback on the consultation paper is attached. Should you require any further information, please do not hesitate to contact the ANZCA policy unit in the first instance at policy@anzca.edu.au.

Thank you again for the opportunity to comment on this important issue.

Yours sincerely

Dr Vanessa Beavis
President

ANZCA House
630 St Kilda Road, Melbourne VIC 3004
+61 3 9510 6299
president@anzca.edu.au

Response of the Australian and New Zealand College of Anaesthetists (ANZCA) to the Queensland Law Reform Commission's consultation paper: A legal framework for voluntary assisted dying.

ANZCA responses (A) to consultation questions (Q) and proposals (P):

CHAPTER 3: PRINCIPLES

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

A

Patient choice

- The voluntary assisted dying (VAD) process should be patient-centred.
- Alleviation of patient suffering should take priority; no period of intolerable suffering is "acceptably short".
- A patient suffering debilitating pain may be unable or unwilling to travel long distances to seek appropriate advice and care and should have the same rights and choices as an individual living in a metropolitan area.

Legal protections for medical practitioners

- A medical practitioner should be permitted to be present at the time the patient self-administers the lethal dose of medication if this is requested by that patient.
- A medical practitioner treating a patient who has chosen to self-administer a lethal dose of medication should be obliged to follow and respect the patient's wishes, and to act with the high a degree of professionalism that is expected when providing usual care.
- The recorded cause of death should be the underlying disease process or primary diagnosis that made the patient eligible for VAD.
- Death as a result of VAD should not be reportable if undertaken in accordance with the legislative requirements, as the death would not meet the criteria of being unexpected or illegal.
- Unusual or suspicious circumstances surrounding a death should be dealt with in the usual manner, including a report being made to the coroner.
- A report to the relevant oversight body should facilitate practitioner support, rather than investigation.
- An oversight body should refer a matter to another agency (such as the Coroner's Court) when there are concerns about irregularities including: acting outside the scope of practice; acting outside the law; family coercion; or misuse of a lethal drug.
- This oversight body should not have investigatory powers and any investigation should be conducted by existing independent agencies.

Palliative care

- Legalised assisted dying must not become a substitute for good palliative care nor diminish research into palliative care.

- Support should be shown for the concept of death with dignity and comfort, and the right of terminally ill patients to receive expert palliative care.
- There should be resourcing for alternative therapeutic and palliative care services and for rural/remote areas, including access to suitably-qualified healthcare professionals.

Safeguards

- All safeguards in the framework should be applied meaningfully and not just as an administrative process to complete.
- Safeguards to protect vulnerable patients are crucial.
- "Subtle coercion" and the difficulty in identifying it are of concern. Family members or parties known to have an interest, including pecuniary interests, in whether the patient lives or dies should not be able to be witnesses to the request process.
- The form of storage and the location of the lethal dose of medication must be documented to ensure accurate accounting of whether or not the patient has ingested it.

Conscientious objection

- Participation by medical practitioners and health services in VAD should be voluntary with no need for any objection to be qualified.
- There may be difficulties in compelling medical practitioners to make a personal referral to another medical practitioner when a patient requests VAD information or assistance. Some medical practitioners will consider such a referral to be a violation of their personal values.

Rural and remote considerations

- People in rural and remote areas are disadvantaged by inter-related issues of distance, travel and access to services.
- Medical practitioners who live in rural and remote areas and who agree to be part of the assisted dying process may face ostracism by the community where they live and practise.
- A patient suffering debilitating pain may be unable or unwilling to travel long distances to seek appropriate advice and care but should have the same rights and choices as an individual living in a metropolitan location.
- Rural patients may be disadvantaged by difficulties of access to services (for example, a palliative care physician or palliative care services, obtaining two independent medical reviews and psychiatric or other specialist referral), and difficulties in accessing their wishes due to lack of access to advanced care plans, living wills, statements on electronic health records and websites in urgent care situations.
- Mechanisms should be developed to ensure access to information on assisted dying at any medical facility a patient might present to (in their own community or in a centre away from home in cases of a rapid deterioration or trauma while travelling).

Other aspects of VAD

- Mandatory psychiatric assessment for all patients considering VAD is not necessary. Psychiatric assessment should be required only where there is reasonable doubt or concern relevant to the patient's capacity so that support can be provided in borderline or complex cases.
- Predictions for end of life are often inaccurate and any minimum timeframe should be applied with caution to avoid prolonging suffering.

- “Homicide” is a very severe term and should not be applicable to VAD legislative requirements. It should be reserved for deliberate abuses of the legislation.
- Two appropriately-qualified practitioners from different specialties who are trained in the legislative requirements of VAD should undertake the VAD patient assessments and provide information.
- As the dispenser of the lethal dose of medication from a community or hospital pharmacy, the pharmacist will play a key role in the understanding of, and adherence to, the VAD legislation.
- Appropriate compensation for medical practitioners involved in the assisted dying process will need to be considered. The process will be time-consuming and emotionally draining. Separate Medicare Benefits Schedule item numbers or alternative state-based compensation may be required.
- Ongoing discussions with the community should be encouraged and facilitated alongside the discussions regarding assisted dying, such as the issue of ‘futile or low value surgery’ as part of the spectrum of discussions around respecting the rights of the patient to accept death.
- How the process should be governed will be influenced by some details yet to be determined, such as the type of medications used. Further consultation may be required as these details are established.
- It could be useful to establish an advisory group for medical practitioners to provide support with issues related to VAD independent from the legal process.
- It may occasionally be necessary to provide pain-relieving procedures and/or anaesthesia (and surgical) services to an individual who has chosen and been approved for assisted dying. Consideration must be given to either suspension of such wishes during the acute period of medical care (as in advance care directives) or a specific acknowledgement of the limitations of resuscitation to be undertaken. This is in recognition that an individual may not ‘have reached the time’ for ending their life.
- Consideration must be given to the obligations of, and legal protections for, health practitioners (including paramedics) in cases where the lethal dose of medication is not effective for any reason, particularly in the absence of the patient having an advance care directive.

Q-2 Should the draft legislation include a statement of principles:
(a) that aids in the interpretation of the legislation?
(b) to which a person must have regard when exercising a power or performing a function under the legislation (as in Victoria and Western Australia)?

A

(a) A statement of principles that aids in the interpretation of the legislation will assist in decision-making in the case of situations that have not been predicted.

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

A

Not applicable.

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

For example, should the statement of principles include some or all of the principles contained in:
(a) section 5(1) of the Voluntary Assisted Dying Act 2017 (Vic);
(b) section 4(1) of the Voluntary Assisted Dying Act 2019 (WA); or
(c) clause 5 of the W&W Model?

A

The principles in the Western Australian Act include reference to equality of access, particularly for people in regional areas, which accords with ANZCA's position that those living remotely should have the same rights and choices as individuals living in metropolitan locations.

However, we recognise that there may be conflict between the right of a medical practitioner to conscientiously object and the ability for remote patients to access voluntary assisted dying.

CHAPTER 4: ELIGIBILITY CRITERIA FOR ACCESS TO VOLUNTARY ASSISTED DYING

Q-5 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that:
(a) is incurable, advanced, progressive and will cause death (as in Victoria); or
(b) is advanced, progressive and will cause death (as in Western Australia)?

A

(a) ANZCA proposes that "end of life" should be based on the incurable nature of a disease with a known rapid progression and when a patient's suffering cannot be effectively alleviated by medicine. A second specialist opinion on the terminal nature of the condition and futility of treatment should be required.

Q-6 Should the eligibility criteria for a person to access voluntary assisted dying expressly state that a person is <u>not</u> eligible <u>only</u> because they: (a) have a disability; or (b) are diagnosed with a mental illness?

A

ANZCA considers that safeguards to protect vulnerable patients will be critical in any VAD legislation. It will also be essential to ensure that all safeguards in the framework are applied meaningfully, rather than simply becoming an administrative process to complete. However, safeguards must also be balanced against reasonable access, so that vulnerable patients are protected without being discriminated against in terms of access to VAD.

If additional safeguards are required to protect vulnerable people, one further option would be to allocate advocates to patients who have the role of ensuring the patient's rights are protected. Such advocates should be independent of both the patient's family, and the patient's medical team.

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

A

ANZCA's position is that prospective predictions for end of life are often inaccurate and any minimum timeframe should be applied with caution, as these create the risk of prolonging avoidable suffering.

Alleviation of patient suffering should take priority; no period of intolerable suffering is "acceptably short". Critically, a patient's perception of their intolerance to suffering and their decision to end their life are more important than a specified time in days or years. A higher degree of specificity should not inadvertently block reasonable access to VAD.

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

A

See response to Q-7.

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

A

Yes.

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

A

This would accord with legislation in Victoria and Western Australia.

Q-10 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be:
(a) an Australian citizen or permanent resident; and
(b) ordinarily resident in Queensland?

A

Citizenship need not be a prerequisite. However, “ordinarily resident” needs to be clearly defined, as “end of life tourism” may become an unintended consequence.

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

A

See response to Q-10.

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

A

ANZCA strongly supports the proposal that explicit provision be made to prevent coercion or undue influence, for example, by family or by socioeconomic factors.

In particular, the matter of “subtle coercion” is of concern and difficult to identify. ANZCA advocates that family members or parties known to have an interest, including a pecuniary interest, in whether the patient lives or dies should not be able to be witnesses.

Suggestions to ensure that no coercion by other parties occurs include:

- Use of impartial witnesses: Use of two independent witnesses such as healthcare professionals, Justices of the Peace, legal guardians, or patient advocates to establish competence in the patient’s decision making.
- Role of patient’s doctor: Requests should be made in the presence of the patient’s doctor or (usual) medical practitioner (for example, their GP or treating specialist, depending on the condition and frequency of appointments).
- Use of independent doctors: Independent assessment from either multiple new doctors or a government-appointed panel who will receive no financial gain.
- Use of advance care directives: To safeguard the patient’s wishes.
- Patient request: Requests should be made by the patient by declaration or written consent. There may be situations where a patient is unable to make a written request (for example end-stage motor neurone disease). Recordings of consent (video or audio) could be used for patients no longer able to write. The patient is to be interviewed by a number of experts (medical and otherwise) on at least two occasions, separated by at least a week and separate from family and friends.
- ANZCA strongly supports that an expert review (for example, by at least one palliative care physician) should be completed so alternatives are adequately explored.

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

A

See response to Q-12.

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

A

While the decision-making capacity test in legislation such as those mentioned is generally viewed as sufficient, these acts were not originally developed with VAD in scope. Feedback collated from across ANZCA suggests further consideration is required

regarding the sufficiency of the existing decision-making test, as decisions about VAD should not be in the same category as those regarding other medical interventions.

ANZCA suggests specifically including reference to the person's ability to:

- understand the facts relevant to their illness or condition
- understand the medical treatments and other options available to them, including palliative care
- retain the information to the extent necessary to make the decision
- communicate the decision in some way (speech, gestures or other means).

ANZCA proposes the commission also considers the following:

- adequate steps must be taken to communicate with those with impairment including neurological disease, English as a second language, and hearing or visual impairment.
- family members should not assume interpreter status.
- cognitive assessment may be needed in addition to psychiatric assessment.
- a minimum of two appropriately qualified witnesses to the decision process.

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

For example:

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

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

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

A

A person who loses their decision-making capacity should not become ineligible to access voluntary assisted dying, but this should be planned for as per para (c).

As previously indicated, ANZCA supports the use of advance care directives to safeguard the patient's wishes.

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

A

See response to Q-13.

CHAPTER 5: INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING

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

A

No comment.

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

A

See response to Q-15.

CHAPTER 6: THE VOLUNTARY ASSISTED DYING PROCESS

Requesting access to voluntary assisted dying
Witnessing requirements for the written declaration

Q-17 Should the draft legislation provide that the person who makes a written declaration must sign the written declaration in the presence of:
(a) two witnesses (as in Western Australia); or
(b) two witnesses and the coordinating practitioner (as in Victoria)?

A

ANZCA suggests there should be a minimum of two appropriately qualified witnesses to the decision process.

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

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

(b) know or believe that they:

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

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

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

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

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

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

A

Family members or parties known to have an interest, including pecuniary interests, in whether the patient lives or dies should not be able to be witnesses to the request process.

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

A

See response to Q-18.

Waiting periods

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

A

ANZCA acknowledges that the balance between setting prescribed waiting periods against rapidly diminishing capacity and intolerable suffering will not always be easy to timetable.

While it is acknowledged there needs to be a time period and request process framework in place to support VAD, paramount to any process are the following considerations:

- Timing and continuity of independent witnesses: The length of time between requests and familiarity with the patient's case are important points in ensuring that the re-affirmation of the final decision has been given due respect.
- Waiting times: Building in a waiting period can be seen as artificial and prolonging intolerable suffering for the sake of process. ANZCA does not support putting a patient through further traumatising questioning where there is an unpredictable or rapid progression of the disease, Therefore the waiting times should be "reasonable" and determined by individual circumstances.
- No time limit; "Sufficient time" will vary depending on the patient and the circumstances.

Q-21 If yes to Q-20, should the draft legislation provide that the final request can be made before the end of the prescribed period if:
(a) the person is likely to die within that period; or
(b) the person is likely to lose decision-making capacity for voluntary assisted dying within that period?

A

See response to Q-20.

Eligibility assessments
Requirement for the eligibility assessments to be independent

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

(a) the consulting assessment must be independent from the coordinating assessment (as in Victoria and Western Australia); and
(b) the coordinating practitioner and the consulting practitioner who conduct the assessments must be independent of each other?

A

ANZCA recommends that a patient who requests assistance should be assessed by at least two appropriately qualified practitioners and makes the further the recommendation that they be from different specialities (for example, palliative care, oncology, or the patient's usual GP).

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

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

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

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

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

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

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

A

Psychiatric assessment should be required only where there is reasonable doubt or concern relevant to the patient's capacity (for example, cognitive impairment or significant decline, evidence of psychiatric illness or existing psychiatric treatment) so that support can be provided in borderline or complex cases.

ANZCA supports the requirement for a set of standard assessment tools to determine cognitive capacity and whether a psychiatric assessment is required. A psychiatric assessment would then determine that a patient (a) is not suffering from a psychiatric disorder which might impact on valid decision-making and (b) has the intellectual capacity to make an informed decision.

In circumstances such as substance abuse, a psychiatrist or addiction medicine specialist may be required to certify that the patient is not under the influence of drugs that may affect cognitive ability to make this particular decision (regarding VAD).

Further comments from ANZCA in relation to this issue include:

- It should not be assumed that a patient who wishes to pursue VAD is depressed, suicidal or unreasonable.
- Assessment may be needed to identify treatable depression or mood-disordered thinking which may be reversible (for example, as a result of disease or concurrent medication).
- It is unreasonable to request a psychiatric review when the suffering is from a current terminal disease that causes depression (that is, it should not be assumed that a patient with depression has diminished capacity).

- It is a patient's right to decide and focus on the degree of suffering (the condition and course of illness).
- Extensive tests should not be imposed without justification.
- The same criteria should be used as for other medico-legal issues, consent for other procedures and setting up a living will.
- Formal cognitive assessment may be required, for example, in patients who have cerebral manifestations of their terminal illness.
- It may be useful to involve geriatricians.

Other requirements

Q-24 Should the draft legislation provide (as in Western Australia) that the coordinating practitioner, the consulting practitioner, any health practitioner (or other person) to whom the person is referred for a determination of whether the person meets particular eligibility requirements, or the administering practitioner must not:
(a) be a family member of the person; or
(b) know or believe that they are a beneficiary under a will of the person or may otherwise benefit financially or in any other material way from the person's death?

A

Yes.

Review of certain decisions by Tribunal

Q-25 Should the draft legislation provide for an eligible applicant to apply to the Queensland Civil and Administrative Tribunal for review of a decision of a coordinating practitioner or a consulting practitioner that the person who is the subject of the decision:
(a) is or is not ordinarily resident in the State (as in Victoria);
(b) at the time of making the first request, was or was not ordinarily resident in the State for a specified minimum period (as in Victoria and Western Australia);
(c) has or does not have decision-making capacity in relation to voluntary assisted dying (as in Victoria and Western Australia);
(d) is or is not acting voluntarily and without coercion (as in Western Australia)?

A

No comment.

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

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

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

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

A

Not applicable.

Reporting requirements for health practitioners

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

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

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

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

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

A

Feedback from College respondents on **when** reporting should occur included:

- In the early stages (for example, when a patient has requested assistance or first consents to the process).
- After the patient has died. Reporting to the board should not unduly delay the patient's wishes.
- At three stages: When the decision to assist the patient has been made; when the medication has been dispensed; and, when the patient has died.
- When any questions or concerns are raised about the process.
- At all stages in the decision-making process; when the lethal dose is prescribed; and when the patient takes possession of the lethal dose. This should minimise ambiguity and the need for referral to other agencies.

Feedback from the College's respondents for **what** should be reported to an oversight body include:

- Medical records including the underlying condition and treatment provided.
- A record of alternative options discussed.
- The nature and length of the practitioner's relationship with the patient.
- A record of requests for assisted dying, consent and dates of approval; and of who has been involved in the decision.
- Details relating to the prescribing and dispensing of the medication; record of the act of assisted dying.

- Security of medication information, for example, dates of return or destruction if applicable.
- The time of death.
- Any complications and lessons from the process.

Additional approval process

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

A

ANZCA is not opposed to the requirement for a permit, provided this does not constitute an undue burden. This could be included as part of the reporting process.

Administration of the voluntary assisted dying substance
Self-administration or practitioner administration

Q-29 Should the draft legislation provide that practitioner administration is only permitted if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance (as in Victoria)?

A

Many respondents expressed discomfort with the role of a health practitioner actively administering a lethal dose of medication. ANZCA's position is that additional safeguards should be required when a medical practitioner administers the lethal dose of medication.

There must be disclosure in the legislation of the type, dose and formulation of the lethal dose of medication to be administered and of the alternative methods that may be used if the patient is unable to self-administer or ingest or absorb the lethal dose of medication.

ANZCA proposes that there should be professional input – ideally determined by a panel of experts – as to whether the patient requesting VAD can physically administer the lethal dose of medication.

ANZCA also asks the commission to consider why, in a situation where the patient is unable to self-medicate, it should be a medical practitioner who administers the lethal dose of medication.

Q-30 Alternatively to Q-29, should the draft legislation provide (as in Western Australia) that:

(a) the person can decide, in consultation with and on the advice of the coordinating practitioner, whether the voluntary assisted dying substance will be self-administered or practitioner administered; and

(b) practitioner administration is only permitted if the coordinating practitioner advises the person that self-administration is inappropriate, having regard to one or more of the following:

(i) the ability of the person to self-administer the substance;

(ii) the person's concerns about self-administering the substance; or

(iii) the method for administering the substance that is suitable for the person?

A

See response to Q-29.

Requirements for self-administration

Q-31 Should the draft legislation provide that the coordinating practitioner or another health practitioner must be present when the person self-administers the voluntary assisted dying substance?

A

A medical practitioner should **be permitted to be** present at the time the patient self-administers the lethal dose of medication if this is requested by that patient.

A medical practitioner treating a patient who has chosen to self-administer a lethal dose of medication should be obliged to follow and respect the patient's wishes, and to act with the high degree of professionalism that is expected when providing usual care.

ANZCA suggests the commission also consider the following in relation to self-administration:

- Is self-administration the responsibility of a medical practitioner?
- What action would the medical practitioner be required to take if the lethal dose of medication was not effective?

Requirements for practitioner administration

Q-32 Should the draft legislation provide that a witness, who is independent of the administering practitioner, must be present when the practitioner administers the voluntary assisted dying substance?

A

There should be one final proclamation or affirmation by the patient that they want to go ahead with administering the lethal dose of medication and that an impartial witness (for example, another medical practitioner or a registered health practitioner) be present to ensure that the medication has been administered at the request of the patient and that the legally required paperwork has been completed and signed-off to indicate this.

Community, cultural and linguistic considerations
Requirements for interpreters to be accredited and impartial

Q-33 Should the draft legislation provide that an interpreter who assists a person in requesting or accessing voluntary assisted dying must be accredited and impartial, in similar terms to the legislation in Victoria and Western Australia?

A

For reasons previously outlined, family members should not assume interpreter status.

Procedural requirements

Q-34 Are there any other issues relating to these or other procedural matters that you wish to comment on?

A

Provision of information:

The legislation should provide guidelines on what information a medical practitioner must provide, but the actual content should be prescribed by the specialist medical colleges.

ANZCA proposes that this information should include discussion about:

- difficulty of predicting likely time course, change in symptoms, response to treatments and what new treatment modalities may soon be available
- palliative care options
- the consequences of taking an incomplete dose of the lethal medication

There should be a provision for the patient to acknowledge that the information received is adequate.

These resources should be disease-specific and evidence-based internet resources made accessible to the public. These would be accompanied by booklets and video presentations plus a “hotline” to answer queries and redirect people to other helpful services. All resources must have multilingual options.

Monitoring a prescribed lethal dose of medication

The documentation required to effectively monitor a prescribed lethal dose of medication should be minimal and not place undue pressure on either prescriber or patient; for example, as per the Oregon State Public Health Division’s Pharmacy Dispensing Record Form (see http://bit.ly/2npd7v9).

As the dispenser of the lethal dose of medication from a community or hospital pharmacy, the pharmacist will play a key role in the understanding of, and adherence to, the VAD legislation.

Suggestions regarding effective monitoring of a prescribed lethal dose of medication include:

- Prescribed lethal dose of medication must be dispensed, held and administered under supervision so that it is tracked at all times.
- The form of storage and the location of the lethal dose of medication must be documented to ensure accurate accounting of whether or not the patient has ingested it.
- The lethal dose of medication could be held in a lockable receptacle or safe in the house.
- The legislation should take into consideration that time-restricting possession of the drug may place the patient under undue pressure.
- Management of the medication should prevent inadvertent ingestion (for example by a child) or deliberate ingestion by a third person.

ANZCA requests that the following be considered in relation to how a prescribed lethal dose of medication be effectively monitored:

- Whether it is the prescribing medical practitioner's responsibility to ensure that the lethal dose of medication is actually taken as intended.
- The recovery of unused doses of the lethal medication could be quite complex. For example, would there be a simple voluntary surrender by a carer, nurse or pharmacist. Alternatively, a search of the premises by an authorised agent? What if the medication cannot be found?

Indication that a person has chosen to take a lethal dose of medication

Notification to the medical practitioner and family could be either verbally or by availability of appropriate documentation, as there will be occasions when direct communication is difficult or impossible. This documentation should be independently witnessed by a medical practitioner, pharmacist or lawyer.

ANZCA proposes that this process should include the opportunity to bypass resisting family members. This is based on feedback from College respondents who advised the following need to be considered:

- Consent or intention to deliberately ingest lethal medication must be documented, and should be witnessed.
- Recordings of consent (video or audio) could be used for patients no longer able to write.
- Patients' decisions should be made and communicated while they are still alert and competent.
- A wrist band be provided when the lethal dose of medication is dispensed and put on by patient prior to ingesting the medication to signal their intention and desire not to be resuscitated.
- Use of distinctive labelling of container once released from outer packaging.

CHAPTER 7: QUALIFICATIONS AND TRAINING OF HEALTH PRACTITIONERS

Minimum qualification and experience requirements of coordinating and consulting practitioners

Q-35 Should the draft legislation provide that only a medical practitioner can act as a coordinating practitioner or a consulting practitioner and assess the person's eligibility for access to voluntary assisted dying?

A

Two appropriately-qualified practitioners from different specialties (for example, palliative care, oncology, or the patient's usual GP) should undertake the assessments and provide information.

At least one of the two medical practitioners must have experience and expertise in the disease, illness or medical condition expected to cause the death of the person making the assisted dying request.

Any healthcare provider involved should be trained in the legislative requirements of VAD.

Q-36 Should the draft legislation set out minimum qualification and experience requirements that a medical practitioner must meet in order to act as a coordinating practitioner or a consulting practitioner?

A

If the legislation prescribes specialist expertise required for medical practitioners to participate in VAD, this must be guided by input from relevant specialist medical colleges.

Medical practitioners should receive the required training to be appropriately trained to participate in VAD and to be able to provide appropriate advice to those seeking it.

Medical practitioners who participate in VAD should have familiarity with the patient and his or her medical state, as well as the expertise required to guide the VAD process.

ANZCA proposes that in drafting VAD legislation, consideration should be given to:

- Finding ways to ensure access to medical practitioners with expertise in the legislative requirements as this will be a relatively rare event for most medical practitioners.
- Guarding against the branding of medical practitioners who do participate as "death doctors", or similar negative terms.
- Ensuring that patients in rural and remote areas are not disadvantaged when a decision is made regarding the required specialist expertise.

Q-37 If yes to Q-36, what should the minimum qualification and experience requirements be? For example, should it be a requirement that either the coordinating practitioner or the consulting practitioner must:
(a) have practised as a medical specialist for at least five years (as in Victoria); and
(b) have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed (as in Victoria)?

A

See response to Q-36.

Role of other health practitioners

Q-38 Should the draft legislation provide that the voluntary assisted dying substance can be administered by:
(a) the coordinating practitioner (as in Victoria and Western Australia);
(b) a medical practitioner who is eligible to act as a coordinating practitioner for the person (as in Western Australia); or
(c) a suitably qualified nurse practitioner (as in Western Australia)?

A

See response to Q-29.

Mandatory assessment training

Q-39 Should the draft legislation require health practitioners to complete approved training before they can assess a person's eligibility for access to voluntary assisted dying?

A

See response to Q-36.

CHAPTER 8: CONSCIENTIOUS OBJECTION

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

(a) provide information about voluntary assisted dying;
(b) participate in the request and assessment process;
(c) if applicable, apply for a voluntary assisted dying permit;
(d) prescribe, supply, dispense or administer a voluntary assisted dying substance;
(e) be present at the time of the administration of a voluntary assisted dying substance; or
(f) some other thing (and, if so, what)?

A

Participation by medical practitioners and health services in VAD should be voluntary with no need for any objection to be qualified.

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

A

Medical practitioners with a conscientious objection to VAD should declare their conscientious objection to the patient at first point of contact in the treatment for a life threatening illness and refer the patient to another appropriate registered health practitioner.

There may be difficulties in compelling medical practitioners to make a personal referral to another medical practitioner when a patient requests VAD information or assistance. Some medical practitioners will consider such a referral to be a violation of their personal values.

Medical practitioners with a conscientious objection to VAD could register their objection with an accessible government body so that they can refer the patient request to that body to identify an alternative practitioner who can assist in the VAD process. This need not constitute a formal referral, but should provide access to a pathway.

Medical practitioners who conscientiously object could also declare their objection at annual renewal of medical registration using a tick box within this registration process to allow for public access to this information.

Q-42 Should the draft legislation make provision for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility? If so, should the entity be required to:
(a) refer the person to another entity or a medical practitioner who may be expected to provide information and advice about voluntary assisted dying; and
(b) facilitate any subsequent transfer of care?

A

No comment.

CHAPTER 9: OVERSIGHT, REPORTING AND COMPLIANCE

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

A

Any oversight body should not have investigatory powers and any investigation should be conducted by existing independent agencies.

A report to any oversight body should facilitate practitioner support, rather than investigation.

When there are concerns about irregularities, including acting outside the scope of practice; acting outside the law; family coercion; or misuse of a lethal drug, the oversight body should be required to refer these matters to other existing agencies.

Q-44 If yes to Q-43, should the oversight body have some or all of the functions and powers conferred on:
(a) the Voluntary Assisted Dying Review Board under the Voluntary Assisted Dying Act 2017 (Vic); or
(b) the Voluntary Assisted Dying Board under the Voluntary Assisted Dying Act 2019 (WA)?

A

See response to Q-43.

Q-45 Should notifications to the Health Ombudsman of concerns about health practitioners' professional conduct relating to voluntary assisted dying:
(a) be dealt with by specific provisions in the draft legislation, as in Victoria, which provide for mandatory and voluntary notification in particular circumstances; or
(b) as in Western Australia, be governed by existing law under the Health Practitioner Regulation National Law (Queensland) which states when mandatory notification is required and voluntary notification is permitted?

A

No comment.

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

A

Current law covers a range of professional obligations for medical specialists including specialist anaesthetists and specialist pain medicine physicians. While our Fellows are aware of the range of current offences, ANZCA is unable to provide specific legal commentary on the adequacy of the current offences, the definitions and their applicability to VAD, as this is not the College's area of expertise. However, the introduction of specific legal responsibility and offences relating to VAD may affect families in dispute with each other, access to VAD and heath practitioner willingness to be involved in VAD.

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

A

ANZCA strongly supports the concept that medical practitioners (and others) acting in good faith and without negligence in accordance with the Act are immune from liability in civil or criminal proceedings.

Feedback from our Fellows and trainees generated other suggestions including:

- Ensuring documentation requirements for VAD are clearly stated in the legislation, and toolkits or checklists developed to assist medical practitioners to comply with these requirements.
- Aligning cause of death with the underlying illness.
- Encouraging medical defence organisations to clarify their position on VAD, and to educate their members about rights and responsibilities for maintaining defence cover.

As well as protecting medical practitioners in terms of liability, ANZCA also suggests that consideration be given in the legislation to protect medical practitioners from harassment. Examples provided include making it an offence to protest within a certain radius of where assisted dying services are accessible and making it an offence to publish the personal details of practitioners providing this service.

It could be useful to establish an advisory group for medical practitioners to provide support with issues related to VAD independent from the legal process.

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

A

A regular review of the legislation and its policy objectives by an independent governance committee could be considered.

CHAPTER 10: OTHER MATTERS

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

A

The recorded cause of death should be the underlying disease process or primary diagnosis that made the patient eligible for VAD.

Death as a result of VAD should not be reportable if undertaken in accordance with the legislative requirements, as the death would not meet the criteria of being unexpected or illegal. However, unusual or suspicious circumstances surrounding a death should be dealt with in the usual manner, including a report being made to the coroner.

Even in circumstances when the death is not reportable, data should be maintained for monitoring and recording purposes**.**

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

A

No comment.

<End of submission>