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Professor Richard Eccleston
Chairperson
End-of-Life Choices (Voluntary Assisted Dying) Review
University of Tasmania

Via email – VAD.Review@utas.edu.au

Dear Prof Eccleston

MIGA submission – Tasmanian voluntary assisted dying bill

MIGA appreciates the opportunity to provide a submission to the Independent Review of the End-of-Life Choices (Voluntary Assisted Dying Bill) 2020 (**the VAD bill**).

MIGA's position

MIGA takes no position on the introduction of voluntary assisted dying (**VAD**). This is an issue for the Tasmanian Government, medical and other healthcare professions, and the community.

Its submission is directed to the practical implications, particularly from a medico-legal perspective, of introducing a VAD regime.

MIGA seeks

- Clarity of obligations and expectations on doctors and other healthcare providers
- Broad consistency with other VAD regimes in Australia where possible and appropriate for the Tasmanian context
- Clear provisions for conscientious objection consistent with those operating generally in healthcare
- Appropriate protections for
    - Doctors and other healthcare providers acting with reasonable beliefs and in good faith
    - Vulnerable persons, including around undue influence, duress and elder abuse
- Comprehensive professional guidelines, education and training for the healthcare sector on any regime
- Any complaints being handled within existing mechanisms
- An appropriate transition period between bill passing and VAD regime commencement – it supports the proposed 18 month period.

MIGA's interest

MIGA is a medical defence organisation and medical / professional indemnity insurer advising, assisting, educating and advocating for doctors, medical students, healthcare organisations and privately practising midwives throughout Australia.

With over 36,000 members and a national footprint, MIGA has represented the medical profession for over 120 years and the broader healthcare profession for over 17 years.

It regularly advises and assists its members and clients on a broad range of end-of-life issues. It provides education to enhance the knowledge of its members, clients and the broader profession around issues impacting on end-of-life care.

MIGA advocates for its members and the professions on various medico-legal and health regulatory issues. It has undertaken significant work around end of life issues and elder abuse, including contributions to various state inquiries and reviews into introducing voluntary assisted dying.

Section 5 - Practitioner terminology

Choice of the term "*primary medical practitioner*" (**PMP**) for the doctor which accepts a first VAD request offers potential for confusion.

The term "*co-ordinating practitioner*" or "*co-ordinating medical practitioner*" is used for the comparable role under Victorian and Western Australian VAD regimes. Notably the draft VAD bill uses the term "*consulting medical practitioner*", correlating with those other regimes.

Where there is no apparent reason for use of a different term, MIGA considers the term "*co-ordinating practitioner*" should be used instead of PMP in the interests of national consistency and to reduce the risk of confusion, particularly for doctors working across states and territories.

Section 6 – Relevant medical condition

Use of the term "*incurable*" in the definition of "*relevant medical condition*" offers inherent uncertainties.

It leaves scope for arguments that any potential treatment that offers the prospect of a cure, however remote and whatever its efficacy or side effects, would render the relevant disease, illness or medical condition ineligible. Sub-section 6(2), indicating that any treatments would need to be reasonably available and acceptable to the person seeking VAD, does go some way to addressing this issue. However the potential for confusion in what is a complex definition remains.

MIGA suggests

- Using the Western Australian approach of a disease, illness or medical condition which is advanced, progressive and will cause death avoids the inherent uncertainties of an "*incurable*" condition, or
- If the "*incurable*" criterion was used, a 'for the avoidable of doubt' provision should be included in the final VAD bill, setting out that it is not intended to exclude diseases, illnesses or medical conditions where there is no reasonable expectation of cure.

Section 11 – Residency requirement

Doctors should not be expected to verify a patient's compliance with a residency requirement.

There are challenges in assessing whether someone is "*ordinarily resident*" in Tasmania and has been resident in Australia continuously. A range of views on whether a residency requirement is satisfied in individual circumstances is easily conceivable.

Assessing whether a drivers' license, electoral roll information, property dealings or statutory declaration satisfy a residency requirement is not something which should be expected of doctors. It could be challenging, time consuming and would essentially place a doctor in the role of a lawyer or administrative decision-maker. This should not occur.

Verification would be more appropriately undertaken by the VAD Commission.

Although there is scope for the PMP to seek VAD Commission advice on the issue, this is where the PMP is unable to determine residency. This implies an expectation that such advice should only be sought in a limited number of circumstances.

The recent case of *NTJ v NTJ (Human Rights)* [2020] VCAT 547 illustrates the difficulties caused for doctors around assessing compliance with these requirements, particularly as the tribunal adopted a mixed objective-subjective test to determine residency.

If doctors are to have a role in determining eligibility based on residency there should be

- Clear guidance on what steps are required to verify residency
- A good faith defence for a doctor if they reasonably believe a patient satisfied residency requirements – proposed good faith protections generally under s 134 of the VAD bill are insufficient where what would constitute an expected standard of care (ie lack of negligence) is unclear.

Section 12 – Capacity

MIGA supports a presumption of capacity, but considers the test for capacity should be consistent with that used more broadly in Tasmanian healthcare contexts.

It supports use of the test for capacity under s 7 of the *Mental Health Act 2013* (Tas), which the Tasmanian Law Reform Institute recommended be used in broader healthcare contexts.[i] This is consistent with generally accepted tests for capacity in healthcare, well-understood and commonly used by doctors and other healthcare providers.

Section 13 – Acting voluntarily

MIGA is concerned that the proposed definition of whether a person is acting "*voluntarily*" is too narrow.

It is concerned the definition is unnecessarily complex and not well-tailored to the range of subtle signs of coercion which could arise in individual circumstances.

Notably neither the Victorian nor Western Australian regimes define what constitutes acting voluntarily.

MIGA proposes

- The definition be removed
- References to "*acting voluntarily*" in the final VAD bill be amended to read "*acting voluntarily and without coercion*", consistent with terminology used in Victoria and Western Australia
- Detailed guidelines be developed, in consultation with peak professional groups, on what constitutes "*acting voluntarily and without coercion*", using a range of examples and case studies.

Section 17 – Initiating discussions about VAD

From a medico-legal perspective, MIGA endorses the approach in s 17 of the VAD bill, consistent with that in Western Australia, permitting initiation of a discussion about VAD if information about various available healthcare options is provided.

Consensus professional guidance, developed with the input of professional stakeholders and using case studies, will be needed to guide doctors and other healthcare providers on how to ensure they can comply with a provision that is inherently open to interpretation.

MIGA strongly opposes inclusion of sub-section 17(5), indicating that a contravention of the prohibition on initiating discussions about VAD is capable of being unprofessional conduct under the *Health Practitioner National Law* (Tas) where

- The inevitable uncertainties around how sub-section 17(2) would be interpreted make such a provision entirely inappropriate. In particular, it is unclear whether it would be interpreted as requiring a certain amount or content of information, which would be difficult to determine across a broad range of circumstances
- The provision is unnecessary, as the definition of "*unprofessional conduct*" under s 5 of the National Law is already wide enough to encompass a breach of s 17 of the VAD bill. The National Law is already well-equipped to deal appropriately with such breaches, accounting for the variety and complexities of any individual cases
- Whether such conduct has occurred should be left for determination by professional regulatory and disciplinary bodies
- Inclusion of a 'signal' provision such as sub-section 17(5) poses risks of a decision-making body perceiving that alleged breaches of s 17 are likely to constitute unprofessional conduct, which is inappropriate.

Section 18 – Requirement to provide information on VAD

MIGA is concerned that sub-section 18(5) of the VAD bill effectively imposes a duty on all doctors to provide information on VAD if a patient is attempting to request VAD even though the doctor may

- Not feel equipped to give this information, given their training, expertise and experience
- Have a conscientious objection to VAD.

Expecting a doctor who feels they lack sufficient training, expertise and experience to provide information on VAD, particularly where they would not be eligible to be a PMP or CMP under the VAD bill, poses significant medico-legal problems. It potentially exposes them to a claim, complaint or other adverse action based on inadequate information provision.

The obligation of a doctor that conscientiously objects to VAD should be consistent with that in healthcare contexts generally, which are set out by the Medical Board of Australia as

- Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal
- Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.[1]

The Victorian and Western Australian models, and the 'White & Wilmott' model proposed as a starting point for a Queensland VAD regime, are essentially consistent with the Medical Board position.

MIGA proposes

- Sub-section 18(5) be amended so as to require only a doctor willing to be a PMP to provide required information on VAD
- Consensus guidance be developed in consultation with professional groups (including MIGA) on what doctors should do in situations where patients request VAD, but they feel unable to provide, or object to providing, the required information.

Sections 27, 34, 48, 56 and 137 – Audio-visual consultations and electronic communications

MIGA considers the issue of whether and when consultations relating to VAD can occur via audio-visual means to be a matter for clinical professional interests.

From a medico-legal perspective important issues to explore include whether

- The lack of a face-to-face consultation compromises the assessment and consent process, including capacity assessment and discussion of options
- There is any compelling reason why a telehealth consultation is required, such as in situations involving remote patients, or need to access a limited number of relevant specialists.

Clear consensus guidance, developed in consultation with professional interests (including MIGA) will be needed to guide doctors on when consultations should occur face-to-face, and expectations for how audio-visual consultations should be conducted.

MIGA is concerned about providing clear authority in the VAD bill for consultations to occur via audio-visual means where it remains uncertain whether doctors in doing so would expose themselves to possible criminal sanction under Commonwealth laws.

The Tasmanian Government, in conjunction with other states which have or are contemplating VAD regimes, should encourage the Commonwealth Government to clarify the legality of using telehealth for the voluntary assisted dying process, including through any necessary legislative change.

Until such clarity is available, it needs to be made clear to Tasmanian doctors and the community that the legality of audio-visual consultations remains to be resolved.

Section 27 – Providing information to family

Sub-section 27(4) of the VAD bill, requiring a PMP to provide various information to a person's family member if the person seeking VAD consents, poses potential for confusion around whether there is a positive duty on a PMP to inform family members of specific information, and around who those family members are.

The provision should be amended so that such information is provided by a PMP on request of a person seeking VAD.

[1] Cls 3.4.6 and 3.4.7, Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, available at www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

Sections 27, 34 and 48 – Sufficiency of information to determine VAD eligibility

Preclusions on determining VAD ineligibility on the basis of lacking sufficient information poses potential for confusion in situations where sufficient information cannot be obtained, such as where prognosis cannot be determined at that time.

To avoid this potential for confusion, sub-sections 27(2)(a), 34(2)(a) and 48(2)(a) should be amended to indicate that a PMP or CMP (as relevant)

> *… must not make a determination under* [the relevant sub-section] *that the person is not eligible to access voluntary assisted dying, by reason only that the* [PMP / CMP] ~~*does not have*~~ ***cannot obtain*** *sufficient information* ***which is reasonably available*** *to enable the* [PMP / CMP] *to determine that the person is eligible to access voluntary assisted dying …*

Sections 94, 95, 110, 113 and 120 – VAD Commission constitution and powers

MIGA supports the oversight role of the VAD Commission, but opposes it operating as an investigative body and as the primary body for review of decisions under the VAD bill.

Instead it supports the model of an oversight body as under the Victorian and Western Australian regimes, and as contemplated for a Queensland regime.

It would be preferable to divide oversight and review powers between separate bodies.

A range of decision-making powers, particularly where matters are in dispute, should be given to the Tasmanian Civil and Administrative Tribunal (**TASCAT**).

Clear criteria should be developed for the oversight body around referral of issues to other bodies, particularly to ensure only appropriate referrals are made reflective of the functions of other bodies.

In terms of standing of an applicant for review, the concept of an "*agent*" is potentially confusing and should not be used. The standing of those purporting to act on behalf of the relevant person is best determined by TASCAT using a "*sufficient interest*" test. The concept of "*special interest*" may impose too high a threshold, particularly for family members acting in good faith.

Section 128 – Potential impact on advice given by PMP or AHP

MIGA is concerned that s 128 of the VAD bill, imposing a criminal penalty on unduly influencing a person to self-administer a VAD substance, could be misinterpreted and be to invoked where there are issues raised around the advice given by a doctor on whether an VAD eligible person should chose VAD substance self-administration over AHP administration.

To address this, MIGA proposes a 'for the avoidance of doubt' provision, indicating that the provision does not apply to situations where a practitioner involved in the VAD process for an eligible person under the VAD bill is providing advice on methods of VAD substance administration.

More broadly MIGA is concerned about unnecessary encroachment of the criminal law on decisions made in good faith by doctors and other health practitioners involving voluntary assisted dying.

Except in cases of wilful or reckless conduct, there should not be criminal penalties for doctors who act in good faith and with reasonable belief of regime compliance, but who may breach the obligations of the regime or related professional standards. Such matters should be dealt with via professional disciplinary processes or civil claims, not the criminal law.

Section 129 – Civil penalty for failure to provide notice to the VAD Commission

Section 129 of the VAD bill, creating an offence which imposes a civil penalty for failing to give any notice required to be given to the VAD Commission, should have a reasonable excuse provision, particularly for situations beyond the control of a doctor or other healthcare provider.

Section 134 – Protections for doctors and other healthcare providers acting in good faith

MIGA supports the scope of protections contemplated for doctors and other healthcare providers in s 134 of the VAD bill.

To ensure the protections operate as contemplated, it proposes the following clarifications

- Sub-sections 2(a) and 4(d) – change to read "***to be considered as having engaged in*** ~~*liable for*~~ ***unsatisfactory professional performance,*** *unprofessional conduct or professional misconduct"* – this addresses potential uncertainties around the scope of the phrase "*liable for*", and the breadth of possible adverse findings under the *Health Practitioner Regulation National Law* (Tas)
- Sub-section 2(c) – change to read – "***to be considered as having contravened*** ~~liable for contravention~~ of any code of conduct or professional standards"
- Sub-section 3(a) – change to read "*a breach of professional ethics or standards or any principles of conduct applicable to the person's employment* ***or other engagement to provide services***"
- Sub-section 3(b) – change to read – "*professional misconduct,* ***unsatisfactory professional performance*** *or unprofessional conduct*"
- Sub-section 3 generally – change end of provision to read *"…and the person may not be sanctioned, censured, or otherwise penalised, by a person or body whose function is to regulate the professional conduct of a registered health practitioner or a registered nurse****, or otherwise have adverse action taken against them by their employer or other entity with whom they have an engagement to provide services***"
- Sub-section 4(f) – change to read "***to be considered as having contravened*** ~~*liable for contravention of*~~ *any code of conduct* ***or professional standards***".

Section 135 – Contravention of Act by health practitioners

As indicated above, MIGA strongly opposes provisions such as s 135 of the VAD bill that would signal potential unprofessional conduct or professional misconduct under the *Health Practitioner Regulation National Law* (Tas).

The potential characterisation of any failure to take reasonable care leading to a breach of the Act as unprofessional conduct, let alone professional misconduct, is inappropriate under a complex regulatory regime involving a broad range of requirements, many of which are open to a wide range of interpretations.

Use of the concept of professional misconduct under the National Law, which involves egregious conduct indicative of a practitioner not being a fit and proper person to hold registration, should not occur in such a broad context of potential breaches of the final Act.

Whether such conduct has occurred should be left for determination by professional regulatory and disciplinary bodies, who are best placed to make such judgments without any need for 'signals' within legislation.

If you have any questions or would like to discuss, please contact Timothy Bowen, 02 8905 3476 / timothy.bowen@miga.com.au.

Yours sincerely

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[i] Tasmania Law Reform Institute, *Review of the Guardianship and Administration Act 1995 (Tas)* (Final Report No 26, December 2018), rec 6.3 – available at www.utas.edu.au/__data/assets/pdf_file/0005/1178762/Guardianship-Final-Report.pdf