



**SUBMISSION TO THE UTAS REVIEW PANEL IN RELATION TO
THE END OF LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL
2020**

JANUARY 2021

INTRODUCTION

Dying with Dignity Tasmania has been very closely involved in the development of the last three voluntary assisted dying Bills in Tasmania, the Voluntary Assisted Dying Bill 2013, the Voluntary Assisted Dying Bill 2016 and the End of Life Choices (Voluntary Assisted Dying) Bill 2020. This included asking Mike Gaffney if he would be the proponent of the latest Bill and working closely with him for over two years to get to this point where the Bill is close to being passed by both Houses of Parliament. We are aware of the enormous amount of work he did on the Bill, the extent of his consultation with the Tasmanian community and with local, national and international experts and his commitment to making it safe and effective in meeting the needs and wishes of Tasmanians.

The significant and valuable role played by DwDTas in relation to the current and past Bills has been acknowledged in past debates and in the current one, eg in Mike Gaffney's Second Reading speech and other speeches in the debate on the Bill in the Legislative Council, and in a number of Second Reading speeches in the House of Assembly.

Our close involvement has been as an organisation and through the personal involvement of Margaret Sing, President for 10 years until mid-2020, who has undertaken the bulk of the research, analysis and preparation of detailed information and advice. This has been backed up by other members of the Committee and active members of DwDTas who have brought to the issue a wealth of relevant professional and personal experience, knowledge and skills, as well as their commitment to legal VAD choice being available to Tasmanians as it is in so many other jurisdictions.

Our current President and long-term Committee member, Hilde Nilsson, has had many years' experience as a nurse including working in end of life care. Vice-President, Robyn Maggs is a clinical psychologist of long experience. Margaret Sing, our previous long-standing President, is a former senior public servant with over 40 years' experience in policy and legislation in a range of areas and in a range of positions and has brought to the issue high level knowledge, skills and commitment to the standards required for good policy and legislation. Others involved have included doctors (eg Dr Helen Cutts, and for many years our actively involved Patron was Professor Colin Wendell Smith), nurses and those with other professional, business and personal knowledge and skills.

DwDTas has argued consistently for well-informed, principled and evidence-based decision-making and debate on VAD legislation, particularly by MPs, based on the best available evidence, advice, analysis and reasoning. We have close links with and consult with other similar organisations and with experts in the field, and have followed closely the development and debates on VAD legislation elsewhere, including Canada, Victoria and WA and other States.

We have argued for legislation which best meets the needs and wishes of Tasmanians, and which is safe and as effective as possible, on the basis of in-depth research on all aspects of the issue, including data about voluntary assisted dying legislation around the world. We have provided MPs, such as Mike Gaffney, with information and advice on all aspects of the Bill.

SUMMARY

Based on our in-depth research, knowledge and understanding of VAD legislation generally and of the EOLC (VAD) Bill 2020 in particular, DwDTas supports the Bill as amended and passed by the Legislative Council (https://www.parliament.tas.gov.au/bills/pdf/30_of_2020.pdf), and argues that it should be passed by the House of Assembly as is, because:

1. It provides for a rigorous, systematic, legal framework for voluntary assisted dying in Tasmania that is consistent with proven practice and the best available evidence of the components of a VAD system that provide adequate safeguards and protections against feared risks, eg to vulnerable people.

Comment: The effectiveness of the safety of VAD legislation and in preventing risks of feared abuses comes from the VAD system as a whole, with components (or “safeguards”) working together to provide checks and re-checks of voluntariness, decision-making capacity, and the consistency and persistence of people’s requests. This is demonstrated by comparisons of the Bill with other key legislation – see Comparisons of VAD legislation section below. The evidence is also very clear that risks to “vulnerable people” are vastly over-stated by opponents of VAD legislation.

2. The Bill has fewer unnecessary hurdles and barriers to fair, equal and timely access to VAD than in Victoria.

Comment: We were very pleased by the very important points made by Sarah Courtney, Member for Bass, in her Second Reading speech in the House of Assembly and summing up:

- On 3 December: *While this bill has a number of safeguards in it to protect vulnerable Tasmanians, I look forward to the advice from the University of Tasmania and the state government agencies as to whether there are any further improvements that could potentially be made. However, while I state that, I do not want this legislation to have barriers for access that are so high that we end up disadvantaging those who we are trying to assist. This is because I believe we also have an obligation to protect those vulnerable Tasmanians who are sick and suffering and want to make a lucid and tested decision to end their lives in the way that they choose.*

- On 4 December: *The role of parliament is to put in legislation that protects our most vulnerable and ensures that the standards and protocols legislated reflect community expectations. It is not our role to make legislation that removes choice.*

Extra restrictions won’t make the legislation “safer” but make laws less effective and increase other risks to those who are eligible for VAD, including paternalistic controls unreasonably restricting the choices of competent adults. Recommendation by the Review Panel of “further improvements” need to be underpinned by thorough risk evaluation based on reliable evidence and reasonable assumptions, and assessment and choice of risk prevention options that do not decrease the workability and fairness of the legislation.

3. It provides for legislation that will prevent some of the problems occurring in Victoria and make the Tasmanian VAD law more effective by:

- Helping more people to achieve their choice of VAD without compromising the safeguards that prevent proven or potential risks but by not including unnecessary hurdles or barriers (eg bureaucratic processes such as permits; ‘gag’ clause on doctors)
 - Reducing the risks to fair, equal and timely access to VAD by those who are eligible (eg no provision for ‘conscientious objection by entities’)
 - Making it more practical and workable in the Tasmanian environment (eg nurses’ involvement; telehealth)
 - Providing for greater personal choice at the time of administration of VAD substance including by supported and accompanied self-administration and health practitioner administration, or private self-administration.
4. Being closer to the Canadian approach than other Australian legislation to date, despite the fact that some amendments have reduced the effectiveness of that approach. DwDTas continues to support the Canadian model as much more suited to Australian circumstances than the US or European models because of the similarities between Canada and Australia that are historical and cultural and in our medical, legal and political systems. The Canadian model is a human rights-based model, consistent with rights assumed in Australia but not recognised in a formal Charter of Rights and Freedoms as in Canada. The Quebec provincial legislation and the national Canadian legislation resulted from a long period of thorough consultation and consideration, including for example a peer-reviewed report, [End of life decision-making](#), by the prestigious organisation, the Royal Society of Canada, Parliamentary inquiries, Canadian Medical Association involvement and support (eg its policy document, [Principles-based Recommendations for a Canadian Approach to Assisted Dying](#)), and significant court judgements in *Carter vs Canada* (eg [Supreme Court](#)) and the more recent [judgement in the Truchon case](#). We also note the details and progress of the amendment Bill C-7 which has now passed the House of Commons and will be debated in the Senate. Among other things the Bill puts into place the requirements following the Truchon judgement and provides for access to MAiD for people whose deaths are not reasonably foreseeable. For full details see the [Bill C-7 Charter statement](#).
5. Provision in the Bill for review after three years operation in which relevant data can be considered as the basis for any needed changes.

TERMS OF REFERENCE

This submission addresses many of the requirements of the independent and objective report to be provided to the Tasmanian Government by the Utas review panel:

1. A concise summary of the VAD Bill, following amendment by the Upper House.

We have not provided a summary but refer you to the Objects of the Bill and the Second Reading speech by the key proponent, Mike Gaffney.

2. Comparison of Tasmania’s proposed VAD Bill to legislation (including Bills) relating to voluntary assisted dying, however described, in other Australian states and territories and overseas jurisdictions, including but not limited to the processes allowed by the legislation, safeguards and protections for vulnerable people.

A major focus of this submission is a comparison by DwDTas of the EOLC (VAD) Bill 2020 with key Australian and overseas laws, and comparisons done for preparation of this and other Bills. In Attachments 1 and 2, we have also provided links to information on the outcomes of VAD legislation, including findings of multiple thorough reviews and inquiries and detailed data, that need to be taken into account when comparing VAD legislation in relation to both safety and effectiveness in meeting the needs and wishes of the Tasmanian community.

3. An outline of the historical development of VAD legislation in other Australian jurisdictions in terms of scope and protections.

We refer you in particular to the Queensland Law Reform Commission Consultation Paper, [“A legal framework for voluntary assisted dying”](#), October 2020, which contains the information you may find sufficient to meet this requirement. The preceding, [Queensland Parliamentary inquiry report](#), “Voluntary assisted dying: Report No. 34, 56th Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, March 2020” also includes from page 13 a significant overview of the development of the VAD legislation in Victoria and WA.

4. Summary of relevant reports, analysis and material in other Australian states and territories and overseas jurisdictions pertaining to the implementation and administration of VAD reform.

Attachment 1 for this submission includes references and links to many reports relevant to this requirement. In the Summary section, point 3 above we also mention other relevant and important Canadian material for which links can be provided.

Attachment 2 for this submission which provides data on the outcomes of key existing laws also provides links to annual/biennial reports for those jurisdictions – Oregon, the Netherlands, Belgium, Canada and Victoria.

5. Objective analysis of:
 - (a) the safeguards put in place in other jurisdictions relating to the impact of VAD legislation on medical practice and practitioners, allied health and care professionals, family and social relationships, and provision for and practices in aged care.

While we have a lot of research material including published academic publications related to this issue, we have not had time to collate the material. We note some key material as follows:

- Annual reports of the Review committees in the Netherlands contain important information on the roles of the committees in continuing professional development, guidelines and standards that assist and support medical practice and practitioners. (See Attachment 2 for links)

- There are also arrangements in Belgium for specially trained groups of medical practitioners to provide VAD or to act as consulting medical practitioners.

- In Canada a valuable role is played by the Canadian Association of MAiD Assessors and Providers - <https://camapcanada.ca/>. See for example, clinical guidance documents on Oral MAiD - <https://camapcanada.ca/publications/>

- In the US, a valuable role is played by the American Clinicians Academy on Medical Aid in Dying - <https://www.acamaid.org/introduction/>. See for example, Dancing with Difficult Prognoses, <https://vimeo.com/427851325>, and an assisted death, <https://vimeo.com/388148923>.

- In Victoria, a Voluntary Assisted Dying (VAD) Community of Practice (CoP) has been formed that includes Tasmanians. We understand that it provides an online forum for VAD-trained doctors to share their experiences regarding the provision of VAD assessments. Dr Cam McLaren, a Medical Oncologist at Monash Health in Melbourne, is one of the Clinical Moderators of the Victorian CoP. A 2019 report by DwDVic states: "The Department of Health and Human Services has funded the Victorian and Tasmanian Primary Health Network Alliance to establish a Voluntary Assisted Dying Community of Practice for medical practitioners who have undertaken the training. The Community of Practice is administered by the Western Victoria Primary Health Network and will commence in early November.

It seeks to assist in the development of a cohort of medical practitioners who are confident and supported in helping patients who request information about or access to voluntary assisted dying in Victoria. If you are a medical practitioner who has undertaken the training and would like to join the Community of Practice email the WVPHN at: vadcommunity@westvicphn.com.au.

The Statewide Care Navigators have also established a Community of Practice for health service staff with voluntary assisted dying in their roles. The aim is to share experiences, lessons and support between participants. The second meeting is to be held on Friday 15 November. If you want to find out more, please contact the Care Navigators by phoning 0436 848 344 or emailing: vadcarenavigator@petermac.org. [Source: *DHHS Voluntary Assisted Dying Newsletter*] (<https://www.dwdv.org.au/news/voluntary-assisted-dying-community-of-practice>)

(b) any interrelationship between the VAD Bill and existing palliative care and advance care directives in Tasmania and the experience of other jurisdictions in implementing VAD legislation to identify matters that might need to be addressed or monitored should the legislation pass into law.

DwDTas is strongly supportive of palliative care and advance care planning and directives in Tasmania and improvements in those areas are extremely important in addition to VAD legislation. Attachment 1 to this submission includes more comment in section 6, PALLIATIVE CARE, ADVANCE CARE WISHES AND VAD – ALL ARE NEEDED NOT 'EITHER/OR'.

DwDTas made a submission in October 2020 to the consultation on the Government's *Guardianship and Administration Amendment (Advance Care Directives) Bill 2020* (the draft Bill), largely supporting the Bill. Details of the draft Bill and the consultation are

available at <https://www.justice.tas.gov.au/community-consultation/closed-community-consultations2/guardianship-and-administration-amendment-advance-care-directives-bill-2020>.

(c) stakeholder feedback relevant to all matters previously described.

Although the views expressed in this submission are those of DwDTas, they are based on significant knowledge of the views expressed by Tasmanians in the lead-up to the EOLC (VAD) Bill.

COMPARISONS OF VAD LEGISLATION

For every recent VAD Bill in Tasmania, DwDTas has contributed to or prepared comparisons of key existing legislation to guide the development of soundly-based Bills. This includes, for example, the comparison in the 2013 Consultation Paper, [Voluntary Assisted Dying: Proposal for Tasmania](#), and the DwDTas paper, [Comparison of Safeguards Across Legislation](#), March 2018 update. We have also done a recent update of that paper to include the WA VAD law. It can be provided on request.

For this submission, a table, Comparative guide to assisted dying legislation in selected jurisdictions, has been done based on the comparative guide in Appendix C of the Queensland Law Reform Institute Consultation Paper, [“A legal framework for voluntary assisted dying”](#), October 2020 (pages 174 – 176). In the highlighted section, DwDTas has added the relevant information from the Tasmanian EOLC (VAD) Bill. For space reasons, the Luxembourg information has been excluded.

The comparison shows that the Tasmanian Bill, as passed by the Legislative Council, is closest to the *WA Voluntary Assisted Dying Act 2019*. This was the result of considerations for the Tasmanian Bill, as first moved by Mike Gaffney and a result of a number of amendments made in the Committee stage of the debate in the Legislative Council. Some of the amendments reflects aspects of the WA law which improved on the Victorian *Voluntary Assisted Dying Act 2017*.

The Tasmanian Bill includes some aspects which DwDTas argues have improved further on the WA law in order:

- to address problems which have emerged in Victoria since the WA law was developed and passed;
- to contribute to workability and fair, equal and timely access to VAD in the Tasmanian environment.

Following the table are notes on particular sections in the Tasmanian Bill where a slightly different approach has been taken from that Victoria and/or WA. We also comment on a number of other issues considered in Tasmania as part of the community and Parliamentary debate, eg telehealth and the responsibilities and rights of religious-based health and residential care organisations. The DwDTas focus is on:

- provisions in the Tasmanian Bill which we believe have improved on those in other State laws by being more understanding, considerate, caring and respectful of the people who need and want VAD because of their intolerable end of life suffering, and which improve the chance of fair, equal and timely access to VAD by Tasmanians; and

- prevention of requirements which are unnecessary to prevent unproven risks of abuse to some people regarded as vulnerable (eg coerced into making non-voluntary requests for assisted dying) but which increase the risks for the people with intolerable end of life suffering who are vulnerable to prolonged unnecessary suffering and what they consider to be bad deaths (including deaths by violent suicide).

Multiple thorough reviews and inquiries have found no evidence to support repeated claims unsupported by evidence that VAD legislation represents a risk to “vulnerable people”. The evidence is very clear that proven, systematic legal frameworks for VAD prevent the feared risks to people who don’t want VAD and are not eligible because their requests are not voluntary. This has been confirmed repeatedly and consistently by multiple, thorough reviews and inquiries in Australia, including the Queensland inquiry, and in Canada. No matter how many times inquiries reach this conclusion and argue it on the basis of thorough consideration of the evidence and relevant issues, opponents of VAD continue to use the political tactic of highly emotive claims about risks to people, described as “vulnerable” on the basis of discriminatory stereotypes about the person’s age (old and young), “disability” regardless of the nature of the “disability”, mental illness or disorder, and various other characteristics such as “loneliness”. These fears and claims have been found to have no basis in evidence, reasoned risk evaluation and prevention, or other reasonable assumptions.

The unproven risk to vulnerable people has dominated in the discourse and response of legislators in Australia to VAD legislation. This has resulted in political compromises on Bills and laws to accept excessively restrictive requirements that have no justification in evidence or reasonable assumptions and which are even contrary to the thoroughly considered and argued findings and recommendations of the prior inquiries. For example, none of the Parliamentary inquiries in Victoria, WA or Queensland have recommended timeframe prognoses be requirements for access to VAD. The Queensland inquiry specifically recommended against them: *“Recommendation 5: The committee recommends that any voluntary assisted dying scheme in Queensland should not propose precise timeframes for a person’s anticipated date of death within which voluntary assisted dying may be accessed due to the complex, subjective and unpredictable nature of the prognosis of terminal illness.”* (p 120, of the Committee report).

Australian laws are therefore likely to be less effective than successful laws in comparable jurisdictions in meeting the proven needs and wishes of the community in Australian States for an effective as well as safe legal VAD choice.

In the development of the EOLC (VAD) Bill 2020, much greater consideration was given to the people the legislation is designed to assist – people with intolerable and unrelievable end of life suffering and their doctors who want the option of compassionate, respectful, safe, workable and effective VAD choice – and to rational risk identification, assessment and prevention of all the risks, including those to the people the legislation aims to assist.

In our view, insufficient attention and priority has been given in Australian VAD legislation to preventing risks to compassionate, respectful, fair, equal and timely access to VAD, reflecting:

1. empathetic consideration and care for the people in this situation, recognising how seriously ill they are, the nature and level of their intolerable suffering and how close to death they are likely to be. (DwDTas research – see Attachment 2.)
2. respect for people’s autonomous wishes without patronising or paternalistic controls “for their own good”. For example, the prognoses requirements prevent people dying “too early” in the view of politicians and others. They prevent people with intolerable and unrelievable end of life suffering from accessing VAD **at their chosen time of when to end their serious suffering** with the support of their doctors, but require them to go on enduring that suffering until two doctors agree they only have 6 or 12 months left to suffer.

There are significant and unacceptable risks to people who need and want VAD as a result of burdensome requirements which do nothing to prevent feared risks to people who don’t want VAD and are not eligible because their requests are not voluntary. Unnecessary extra restrictions don’t make VAD laws safer; they make them less effective, help fewer people and cause even greater suffering for some people, eg delays due to bureaucratic ‘red tape’ which results in prolonged suffering, potentially loss of decision-making capacity and may then prevent them accessing VAD as the way of dying they wanted, when, where and with whom they wanted that to be.

There are important lessons to be learned from Victoria. As Dr Nick Carr has commented: “the process is cumbersome and time consuming, often taking three to four weeks to complete. Several patients that I have been helping have died before the process could be completed. For some, their deaths were OK, but others died alone or in distress, both of which could have been avoided had they had VAD.” (Source: <https://www.crikey.com.au/2020/06/18/voluntary-assisted-dying-laws-one-year-on/?fbclid=IwAR3K1u8cayFru6m3XgawdsWAgIZI0AxMhD2JhF1VvK8ntiXclEUZedB0B8>)

DwDVic has documented many cases in Victoria, details of which can be provided.

Current Australian laws and the Tasmanian Bill include requirements that occur in no other VAD legislation or in the least effective and least suitable legislation for the Australian situation. This is despite the fact that multiple, thorough inquiries have shown, all current legislation elsewhere is working safely. Laws with extra burdensome hurdles are no safer but they will be less effective than other similar relevant laws, eg Canada. It is disturbing that many of these hurdles have resulted from amendments proposed by opponents of VAD in order to restrict access to legal VAD so that it helps fewer people, even when the hurdles have been previously rejected by thorough preceding inquiries on the grounds of principles, evidence and reasoned arguments. They have generally been accepted because of political compromises to get the legislation through.

Comparative guide to assisted dying legislation in selected jurisdictions

		TAS	VIC	WA	Netherlands	Belgium	Canada (Federal)	Oregon (USA)
	Guiding principles in legislation	✓ (as in WA)	✓	✓			✓	
Criteria for access to assisted dying	18 years or more	✓	✓	✓			✓	✓
	Resident in jurisdiction	✓ (12 m) (some differences from Vic and WA) * Note 1	✓ (12 m)	✓ (12 m)				✓
	Person has decision-making capacity in relation to assisted dying	✓	✓	✓	✓ ¹	✓	✓	✓
	Person is acting voluntarily and without coercion	✓	✓	✓	✓	✓	✓	✓
	Decision is enduring	✓ (implicit)	✓	✓	✓ ¹	✓		
	Diagnosed with an eligible disease, illness or medical condition (eg, advanced, incurable, progressive, will cause death)	✓ *Note 2	✓	✓		✓	✓	✓
	Disease, illness or medical condition is expected to cause death within a specified timeframe	✓ (6 m, 12 m for a neuro-degenerative condition, with exemption possible) See Note 2	✓ (6 m, 12 m for a neuro-degenerative condition)	✓ (6 m, 12 m for a neuro-degenerative condition)				✓ (6 m)
	Person is suffering	✓	✓	✓	✓	✓	✓	
	Express provision that mental illness or disability alone is not an eligible disease, illness or medical condition	✓	✓	✓				✓ (disability)
	All criteria must be met	✓	✓	✓	✓	✓	✓	✓
	Review by tribunal of some criteria (eg residency, decision-making capacity or voluntariness)	✓ (See Note 8)	✓	✓				
Request to access assisted dying	Health practitioner must not initiate discussion about voluntary assisted dying	✓ (similar to WA) *Note 3	✓	✓				
	Person themselves must make request	✓	✓	✓	✓	✓	✓	✓
	Person can make a request in an advance directive				✓	✓		
	Person must make three requests	✓	✓	✓				✓
	One request must be in writing	✓	✓	✓		✓	✓	✓
	Two witnesses to written request	✓ (or by a commissioner for declarations) *Note 4	✓	✓			✓	✓
	Waiting period between first and final requests	✓ (unless likely to die or lose capacity)	✓ (unless likely to die)	✓ (unless likely to die or lose capacity)			✓	✓
	Any interpreter must be independent and accredited	✓	✓	✓				
	Person may withdraw request at any time	✓	✓	✓	✓	✓	✓	✓

		TAS	VIC	WA	Nether-lands	Belgium	Canada (Federal)	Oregon (USA)
Assessment for access to assisted dying	Assessment of criteria for access is carried out by medical practitioners	✓	✓	✓	✓	✓	✓ (or nurse practitioners)	✓
	Two independent assessments by two medical practitioners	✓	✓	✓	✓	✓	✓ (or nurse practitioners)	✓
	Referral to another medical practitioner if eligibility cannot be determined (eg there is uncertainty about the person's diagnosis or decision-making capacity)	✓	✓	✓				✓ (capacity)
	Person must be given particular information (eg about their diagnosis, options and the taking of the substance)	✓	✓	✓	✓	✓	✓	✓
Assessing medical practitioners	Meet minimum requirements about qualifications and experience	✓ *Note 5	✓	✓				
	Complete mandatory training before assessing person	✓	✓	✓				
	Conscientious objection	✓ (See also Note 12)	✓	✓	✓	✓	✓	✓
	If conscientiously object, refer or provide information			✓ (give person information)		✓ (transfer file on request)		
	Mandated to report at points throughout the assisted dying process	✓	✓	✓	✓	✓	✓	✓
Administration of substance	Additional approval process — permit required to prescribe and supply, or possess and administer, voluntary assisted dying substance		✓					
	Self-administration is primary or default method	✓ (as in WA, not Vic)	✓	✓				✓
	Practitioner administration permitted	✓ (as in WA under the same conditions; may also be by registered nurse) *Note 6	✓ (if patient physically incapable of self-administration)	✓ (if self-administration is clinically inappropriate)	✓	✓	✓	
	Requirement for administration to be witnessed		✓ (practitioner administration)	✓ (practitioner administration)				
	Provisions governing the management of the voluntary assisted dying substance eg, must be prescribed in accordance with requirements	✓	✓	✓				✓
	A contact person must be appointed	✓ (For 'Private self-administration') *Note 7	✓	✓ (self-administration)				

		TAS	VIC	WA	Nether-lands	Belgium	Canada (Federal)	Oregon (USA)
Offences and protections	Offence to induce a person, through dishonesty or undue influence, to request assisted dying	✓	✓	✓				✓
	Offence to induce a person, through dishonesty or undue influence, to self-administer the substance	✓	✓	✓	✓			
	Offence to falsify records, or take make a false or misleading statement	✓	✓	✓			✓	✓
	Offence to fail to report on assisted dying	✓	✓	✓			✓	
	Offence to administer the substance when not authorised to do so		✓	✓				
	Offence for contact person to fail to return unused substance	✓	✓	✓				
	Protection for a person who assists in or facilitates access to assisted dying	✓	✓	✓				
	Protection for health practitioners acting in good faith and without negligence	✓	✓	✓	✓		✓	✓
	Protection for health practitioners present at time of self-administration	✓	✓	✓			✓	✓
Oversight	Review by tribunal of some criteria for access (eg residency, decision-making capacity or voluntariness)	✓	✓	✓				
	Oversight by an independent body	✓ *Note 8	✓	✓	✓	✓		
	Implementation period for legislation	✓	✓	✓			✓	
	Review of legislation	✓	✓	✓		✓	✓	

	VAD is not suicide	✓		✓				
	Telehealth	✓ (for 2nd and final requests and consulting medical practitioner) *Note 9		✓				
	Conscientious objection of 'entities'	*Note 10						

Notes

All references to the Tasmanian EOLC (VAD) Bill 2020 are to the Bill as passed by the Tasmanian Legislative Council on 10 November 2020 and available at https://www.parliament.tas.gov.au/bills/pdf/30_of_2020.pdf.

Note 1: Residency requirements in the Tasmanian EOLC (VAD) Bill (Clauses 10 (b) - When person is eligible to access voluntary assisted dying, and Clause 11 - When person meets residency requirements)

The residency requirements in the Tasmanian Bill are the same as those in the Victorian *Voluntary Assisted Dying Act 2017* and those in the WA *Voluntary Assisted Dying Act 2019* in most respects. Additional sub-clauses have been added to the Tasmanian Bill to improve on them based on evidence of problems that have already emerged in Victoria that have prevented fair, equal and timely access to VAD for people who are otherwise eligible.

The differences include:

1. Clause 11 (1) (a)(iii) “has been resident in Australia for at least 3 continuous years immediately before the person makes the relevant first request”.

This provision is a response to the evidence from Victoria that some people who would otherwise have been eligible for VAD have been denied that choice because they have been unable to prove citizenship, despite living in Victoria for many years. The most heart-wrenching example of this was publicised by Dr Nick Carr in his article in *Australian Doctor* - <https://www.ausdoc.com.au/news/i-sat-my-desk-sobbing-gps-grief-his-patients-lonely-suicide>.

2. Clause 11(2), (3) and (4) - provisions for the VAD Commission (see Note 10) to determine if a person does or does not meet the residency requirements, if the Primary Medical Practitioner is unable to do so.

It is hoped that this provision will reduce time delays due to any difficulties for a medical practitioner to determine residency when that is not related to their professional medical expertise, and to ensure more consistent decisions about the requirement.

3. Clause 11(5) – evidence of being ordinarily resident in Tasmania.
4. See also PART 15 – REVIEW OF DECISIONS

Minimum timeframe for residency in the State: The Tasmanian Bill includes the same 12-month timeframe residency in the State as required in Victoria and WA.

At this stage, DwDTas is not arguing that the requirement be changed but will argue for careful monitoring of the impact of the requirement. One of the issues that came up in the debate in the Legislative Council, but which was not resolved, is the impact of the residency requirement on family members returning to the State for end of life care by their families and then not being able to access VAD to end their intolerable suffering and achieve the time and way of dying that they want. If there were no minimum residency timeframe, this would be less of a problem, especially if it could be combined with a discretionary power for the VAD Commission (similar to that in relation to the prognoses requirement – see Note 2) to exempt people from the minimum timeframe residency

requirement for compassionate reasons, eg to come home to Tasmania to die or for end of life care. The Victorian Ministerial Advisory Panel on that State's VAD law "noted that there is no minimum period of residency required by the legislation in most other jurisdictions and considered that such a requirement would be administratively burdensome and onerous for the dying and suffering person" (QLRC Consultation paper, p 58). We also note the argument put forward by Professors White and Willmott in Queensland in relation to their draft Bill that "requires only that a person must be ordinarily resident in the jurisdiction: *as this is sufficient to achieve the policy goal of preventing non-residents having access to voluntary assisted dying in [the] State. The additional time-based requirement ... creates a further hurdle to access voluntary assisted dying for otherwise eligible persons and is unnecessary to prevent cross-border requests.*" (QLRC Consultation paper, p 60)

Note 2: Relevant medical condition, prognoses requirements and exemption in the Tasmanian EOLC (VAD) Bill 2020 (Clause 6 - Relevant medical condition)

Timeframe prognoses requirements, as in Victoria and WA, were added to the EOLC (VAD) Bill 2020 as a result of an amendment moved during the debate and supported by a majority of the Legislative Council. The requirements were not in the Bill as originally moved and were strongly opposed by the proponent of the Bill, Mike Gaffney.

At this stage, DwDTas is not arguing that the requirement be changed but will argue for careful monitoring of the impact of the requirement and the use of the discretionary power of the VAD Commission provided for in Clauses 6(3), (4) and (5). DwDTas has consistently and strongly opposed timeframe prognoses requirements and provided substantial evidence and arguments against this requirement to Mr Gaffney and other MPs, as did many others including by Drs Cam McLaren and Nick Carr, key Victorian doctors who provide VAD in that State and who know the problems that the prognoses requirement have caused. (This material can be provided to the Utas panel on request).

The prognoses requirements are not necessary as safeguards against risks to vulnerable people. DwDTas has estimated that nearly 90% of assisted deaths in 2018, under existing VAD legislation, were in jurisdictions without a timeframe prognosis. We also note the *Truchon v Attorney General of Canada* judgement which states: "*Neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope or even heightened risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying.*"

We support the compromise accepted by Mr Gaffney as an amendment moved by Ruth Forrest, Member for Murchison, which was passed by the Legislative Council, which would allow the VAD Commission to provide an exemption from the timeframe prognoses requirement:

Clause 6(3), (4) and (5) –

(3) The Commission, on the application of a person, may determine that the person is exempted from the requirement of paragraph (c) of the definition of relevant medical condition in subsection (1).

(4) The Commission may only determine that a person is exempted from the requirement of paragraph (c) of the definition of *relevant medical condition* in subsection (1) if the Commission is satisfied that the prognosis of the person's relevant medical condition is such that the paragraph should not apply in relation to the person.

(5) The Commission may, so as to assist the Commission to decide whether or not to make a determination under subsection (2) in relation to the person –

- (a) request a medical practitioner, who has specialist knowledge as to a relevant medical condition that is a relevant medical condition in relation to a person, to advise the Commission in relation to the relevant medical condition; and
- (b) request a medical practitioner to provide to the Commission medical records, in the possession of the medical practitioner, in relation to the person.

In speaking to her amendment, Ms Forrest said: *This gives a person who may not fit that prognostic time frame - they still have a terminal illness as per the rest of the requirements to access VAD, but may not have a prognostic time frame of six months or 12 months for neurodegenerative conditions; things that are rarer conditions or where the prognostic capacity is more difficult. The person can make an application to the commission to have that requirement of a six-month or 12-month prognostic time frame for neurodegenerative conditions waived and can actually start the process. It does not remove any other steps in the process. It enables them to make a first request and continue on that pathway if they desire to do that.*

In making that determination, I am not suggesting in any way that a commissioner should be making medical determinations. They may have medical practitioners on the commission. We do not know who is going to be on that, but they would be required to consult with a relevant medical practitioner to determine whether that is a reasonable request, why that should be waived and, if they agree, they can notify the person of that, and they can then make that first request and start the process.

As the member for Mersey said, it is a reasonable compromise. I believe it is because there are some conditions where it is more difficult to determine the actual life expectancy of a person. This gives that little bit of flexibility where it enables people who fall outside that quite strict framework we are putting in place for all the right reasons, to potentially access it. (Hansard, Tasmanian Legislative Council, 27 October 2020)

Note 3: Initiation of discussion about VAD in the Tasmanian EOLC (VAD) Bill 2020 (Clause 17 - Certain persons not to initiate discussions about voluntary assisted dying)

We support Clause 17 as a significant improvement on the unacceptable Victorian ‘gag’ clause and also on the WA approach.

One of the most controversial and opposed sections of the Victorian VAD Act is what has been called the ‘gag’ clause preventing doctors from raising the issue of legal VAD choice unless it is first raised by the patient. This provision occurs in no other VAD legislation anywhere in the world.

An amendment to the EOLC (VAD) Bill was moved in the Legislative Council debate by Dr Bastian Seidel which would have inserted in the Bill the same clause as that in the WA VAD Act which lessened the negative aspects of the Victorian section. There was considerable debate on this issue as available in Hansard and negotiation of a further amendment which was subsequently passed as Clause 17.

Note 4: Witnesses of second request in the Tasmanian EOLC (VAD) Bill 2020 (Clause 30 - Person may make second request and 31 Certain persons may not witness a second request)

Clause 30 provides for a person to make a second request in writing and includes the requirement for witnessing the request. Cl 30(3)(b) requires the request to be “witnessed, in the presence of the person, by at least 2 adults, **or by a commissioner for declarations, within the meaning of the Oaths Act 2001,**

who have observed the instrument being completed and signed in accordance with paragraph (a)” (our emphasis).

The highlighted part was added through an amendment in the Legislative Council. The original amendment moved by Leonie Hiscutt, Member for Montgomery, would have required a commissioner for declarations as an extra or third witness. She then agreed with Mike Gaffney to change it to “or” rather than “and” by a commissioner for declarations. We believe this is a good compromise.

Note 5: Requirements for assessing medical practitioners in the Tasmanian EOLC (VAD) Bill 2020 (Clause 9)

The requirements for assessing medical practitioners are a great improvement on those in Victoria, and better than those in WA. They resulted from an amendment moved and argued for by Dr Bastian Seidel, Member for Huon, who as a GP and a former national President of the RACGP, brought very valuable knowledge and expertise to this issue. His arguments can be found in the Hansard, Legislative Council.

We support the requirement on the basis of those arguments but note that difficulty of accessing participating doctors is one of the greatest barriers to access to VAD by those who are eligible under existing legislation. Once again this is an aspect of the legislation that will need to be monitored carefully.

Note 6: Administration of the VAD substance

The EOLC (VAD) Bill 2020 follows the WA approach in creating a separate role of Administering Health Practitioner (AHP), but allows registered nurses (not just Nurse Practitioners) as well as medical practitioners to be the AHP.

DwDTas regards the provision for registered nurses to act as AHPs as a big positive to improve fair, equal and timely access to VAD and to support people’s choice about who they want to be with them at the end. In some regional and remote areas, medical practices are staffed by a series of locums. In such places the community nurse is often the only stable part of the healthcare team with a trusting and established relationship with the community. It is obviously preferable, not only for the person concerned, but also for those attending their loved one in their final hours, to have a trusted and familiar nurse administering VAD, rather than a doctor whom they barely know.

Note 7: Practitioner administration and role re self-administration and Private self-administration

DwDTas supports the provisions in the Bill that allow for greater choice for people than in Victoria through supported and accompanied VAD through health practitioner administration of the drugs (which as Attachment 2 shows is the method preferred and used in the vast majority of VAD); self-administration with a health practitioner present or through private self-administration.

Note 8: Oversight - VAD Commission in the Tasmanian EOLC (VAD) Bill 2020 (Chiefly PART 17 – VOLUNTARY ASSISTED DYING COMMISSION but references throughout the Bill)

The Tasmanian EOLC (VAD) Bill provides for a VAD Commission which has much broader powers and responsibilities than in Victoria, WA or other jurisdictions, including discretionary decision-making on

some issues, eg exemption from prognoses requirements and other discretionary decisions. Review of decisions is one of the powers of the Commission (dealt with in Victoria by VCAT and in WA by the State Administrative Tribunal). The EOLC (VAD) Bill 2020 needs to be considered in detail to see the range of powers and responsibilities of the VAD Commission.

Note 9: Telehealth

DwDTas strongly supports access to medical practitioners through telehealth for VAD consultations, as a means to increase fair and equal access to the VAD process, recognising the serious illness and suffering of those who will be eligible for VAD. Allowing the second and final requests to take place via audio-visual link is also a big positive. People requesting VAD are gravely ill. It would be unreasonable to require these people to travel to the doctor again, especially for those living in remote places where it would necessitate a journey of some length. For these very ill people a trip to the doctor may well require the services of an already stretched ambulance service. It would also be totally unreasonable to expect a doctor to leave their busy practice to travel to them. The first request has been made face to face, subsequent requests should be just a confirmation of what has gone before. Telehealth is now well established and accepted, especially since the advent of COVID 19.

Dr Bastian Seidel contributed a great deal to the debate on this issue from the perspective of an experienced, practising GP.

Note 10: Conscientious objection by individual health practitioners but not 'entities'

DwDTas remains adamantly opposed to the Tasmanian VAD legislation containing a provision that would allow health and residential care facilities to disadvantage people in their facilities and to prevent their fair and equal access to the VAD process, to compassionate and timely access to VAD if they are eligible and to prevent medical and other health practitioners from providing the legal service they wish to provide to their patients. We are very pleased that the Legislative Council rejected a proposed amendment to the EOLC (VAD) Bill 2020 that would have made provision for an entity providing health and residential care services to refuse people access to have any part of the voluntary assisted dying process within its facility.

No existing VAD laws contain such a provision. The amendment to the EOLC (VAD) Bill 2020 was moved similar to the clause in a Queensland draft Bill prepared by Professor Ben White and Professor Lindy Willmott, and argued for by Dr Bastian Seidel, Labor Member for Huon, using arguments from them. While we appreciate the intention of the proponents, we do not consider it well thought through. The issue was debated at length and the amendment was defeated.

DwDTas members and others had lobbied hard against the amendment. A large proportion of residential aged care facilities in Tasmania are run by religious organisations which object to VAD on religious grounds. The residents regard these facilities as their home, and are indeed encouraged to do so, and therefore have the freedom to choose, as they would if they were still living in the family home. The absence of a provision for these organisations to conscientiously object does not mean they have to get involved in the process, if a resident requests VAD. They cannot, however, forbid outside medical or other health professionals to administer VAD care, i.e. carrying out the assessment and the administration of the VAD drugs. If a clause allowing institutions to forbid VAD on their premises were to be added to this Bill it would have dire consequences for their residents. In fact, most of them would be denied access to VAD, as a transfer out of the facility would be both impractical and inflict more suffering on very vulnerable people.

Very good arguments against the provision were made by Legislative Councillors but the strongest arguments against it in the debate were put by Meg Webb, Independent Member for Nelson and we include a major section of her comments from Hansard, Legislative Council, 30 October 2020:

Extract from Hansard, Tasmanian Legislative Council: Speaker, Meg Webb, Independent Member for Nelson.

“What we have not focused on, and the member has not focused on, is the assumption built into this new clause, which is these entities have the legal right to prevent people accessing their services or living in their homes to access a legal health service. That is assumed in this clause. If this were to pass, it would become a legal precedent that the assumption is there - it is okay and legally correct for these entities to prevent access to what would then be a legal health service.

I do not accept we should make that assumption. I do not accept the legal case has been made that assumption is valid. I do not accept we have fully understood what the implications of this might be in setting this precedent. What we have is a clause that says, we will accept it is okay for an entity - and it is likely to be a religious faith-based entity - to prevent access to a health service for people who are accessing their services or living in their residence. I do not believe we as a community, broadly, would regard that to be okay. We would understand that a faith-based entity may wish to do this because what will be a legal health service if it passes, is one they do not agree with. They would like to be able to prevent people from accessing it, but to actually do that, my understanding is they would have to seek an exemption from our anti-discrimination legislation.

When faith-based organisations want to in some sense discriminate, for example, in hiring staff or other sorts of activities that they may want to put conditions on that relate to their faith, they have to seek exemptions to do that, and in many cases are granted exemptions to do that.

These entities, for example, which may be providing residential services to people, do have conditions involved in that. I am interested to know: to what extent is it required that they seek exemptions for those conditions? This is an entirely new matter to be contemplated in this space. VAD is not something that has been addressed or prosecuted through, for example, our anti-discrimination legislation, or matters to do with what conditions can and cannot be put on people accessing services, by entities.

It is entirely new. It is yet to be tested. I do not believe that inserting this new clause allows us to come at that, fresh and unadulterated, once this law passes - if it is to pass. If we insert this clause it will set up an assumption that it is already sanctioned for an entity to make this decision on behalf of its residents and put in this restriction, preventing them from accessing what would then be a legal health service.

We know that a conscientious objection is already available to individuals in all sorts of circumstances around this matter and within this bill. There would not be a situation in which staff members of these entities would have to be involved in this process. They would be able to exercise their personal conscientious objection.

There is nothing to say that the entity itself needs to be an active participant. We have a resident, for example - if we are talking about a residential aged care facility - who is already accessing health services in a range of ways. The entity itself does not have to be involved in that. It does not have to organise it for them necessarily. It does not have to facilitate that. In this circumstance, the entity itself does not have to facilitate that access. The resident personally can be responsible for that, and under this circumstance I believe they could still be responsible for that.

Mr Valentine - Or the resident's family, if they existed, too.

Ms WEBB - Or the resident's family indeed.

It is very problematic for us to set up an assumption that an entity can exercise a conscientious objection in some sense and be allowed to legally prevent certain things to individual citizens - to prevent access to certain things like legal health services.

I am not sure that it is even possible for an entity to have a conscientious objection. I think it is entirely agreed that individuals can exercise that conscientious objection, but I am quite concerned that we are not necessarily legally settled on whether an entity can exercise a conscientious objection.

I am also interested more specifically in proposed new clause A(4)(b), which relates to the transfer matters, where it says -

an offer is made to the person to arrange a transfer of the care or residence of the person to a health service establishment at which, in the opinion of the relevant service provider, a medical practitioner who does not have a conscientious objection ...

Now, 'in the opinion of the relevant service provider' is the other interesting thing. Can an entity have an opinion? I am not sure if an entity can have an opinion, but we seem to be giving it the opportunity to have an opinion about where the person might likely be able to access VAD elsewhere in order to transfer them. That is an interesting side matter in terms of a specific element of this new clause.

We are mostly thinking of this in terms of faith-based organisations, but also other sorts of entities could object to this for other sorts of reasons. It might not be faith-based. What do we then set up as a precedent? If I ran a boarding house and I had a personal objection to VAD, can I then, as the person who runs that facility, prevent in a similar way all the residents in my boarding house, for example?

Mr Valentine - It could be a funeral service.

Ms WEBB - Could a funeral service do that? Could a body corporate come to the decision that they are not going to let their residents access VAD? It is not clear to me what this sets up in terms of potential further ramifications and further iterations beyond the ones that we are assuming here, for the purposes of the conversation today, which is largely centering around things like a faith-based organisation that runs a residential aged care facility.

Other members have made this point well. I am absolutely in agreement that this is a matter that affects people at a highly vulnerable time in their life. They are terminally ill. Imminently terminally ill. They are very sick. They are very vulnerable. They may have been living in their home within a particular facility for a long time. There might be a longstanding care arrangement there, longstanding relationships with staff and others who are involved in their care, and what this provides is an assumption that they can be evicted, effectively, at that most vulnerable and most critical time in their health. Evicted to where?

This is the question that has been raised and I raise it too. Where will they go if there is not a similar facility that does not have an issue with VAD available to them? Where will they go if there is not something available in a hospital? Where will they go if there are no family members who will take them? Where will they go if they live in a part of our state where the only option is a faith-based option for this sort of residential arrangement?

From my reading of this new clause, people are left entirely in limbo if there is no option. I think there is an absolute 'get out of jail free card' here for the entity to only have to have a bit of a look and see

if, in its opinion, there is an appropriate alternative facility that is likely to have a medical practitioner who would assist the person access this process. There are so many gaps and questions there that this highly vulnerable person can, and I would expect would, fall through in many instances if this was allowed to occur.

I have thought a lot about this proposed clause. It disturbs me highly and I contacted to a few particular people who I wanted to seek thoughts from, partly because I was contemplating what further implications it might have. One of the people I contacted is Rodney Croome - a previous Tasmanian of the Year and a well-known advocate for LGBTIQ rights. Rodney was happy to share some of his thoughts with me, including that this provision is cruel for people seeking VAD, especially if they are in aged care because it would force them out of their familiar environments and away from friends and staff they know at precisely the time they need those people around them. He feels it would set a terrible precedent by giving organisations the right to conscientious objection, something the LGBTIQ community opposed strongly during debate on the final marriage equality legislation. He feels that faith-based organisations that receive public funding should provide the same services as publicly owned services, and that faith-based organisations would subsequently seek conscientious objection exemptions for other things if this were to pass, especially in relation to LGBTIQ people. He thinks this is putting bishops' sensibilities ahead of patients' needs, and the powerful ahead of the vulnerable and that we should be ashamed of ourselves if this were to pass.

That was Rodney's suggestion to me. I agree with that. I agree this is putting particular rights for one group of people ahead of the rights and the compassionate needs of people who are the most highly vulnerable.

I absolutely cannot support this new clause. We should think long and hard about the precedent it sets, about the implications it could have beyond this issue. There will be an issue where particular organisations will feel uncomfortable about VAD happening in any extent in their facility. That is going to be there. We know that. It is new to us to contemplate this. The right way for us to step through is, first, to have this legislation passed - let us assume it will be - and become then legal in this state to access VAD as per the legislation ultimately passed.

Then we will have a conversation about how this will be dealt with in relation to these entities who may not wish it to occur. They may wish to put conditions and then we can have a conversation about what requirement there will be on those entities in putting those conditions. Is there an anti-discrimination matter to be addressed? It is a new thing. We have not talked it through yet in terms of anti-discrimination. It has not been tested here under our state anti-discrimination laws. We will have a conversation about what conditions can be put. Whether those entities, for example, can grandfather those conditions on their existing residents or only apply them to new residents. That would be an interesting one for us to have to think through and contemplate.

If necessary, there could be a legal test that occurs in relation to this and perhaps it is important that does occur. Yes, it might be difficult and awkward for that to have to play out but what we are talking about here is new ground we have not yet tested. Often, when that happens we do have to go through a process to test the legal parameters of it. It is appropriate we do that.

This clause short-circuits what should be a well-thought out, careful move forward. I cannot support the clause and encourage others also to think about what we need to do to ensure we have not assumed a legal right that is not necessarily there.”

ATTACHMENTS

- **Attachment 1:** DwDTas paper, VAD Current Situation November 20 update.
- **Attachment 2:** Data on VAD legislation in 5 jurisdictions.

CONCLUSION

DwDTas is happy to provide additional information, comment or advice required to add to the material in this submission or to assist the panel to quickly access information on other matters.