

Independent Review of the End of Life Choices (Voluntary Assisted Dying) Bill 2020

Prepared by the Tasmanian
Policy Exchange at the
University of Tasmania

February 2021

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of the End of Life Choices
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ACKNOWLEDGEMENTS

This report has been prepared by the Tasmanian Policy Exchange (TPE) at the University of Tasmania.

The TPE was established by the University of Tasmania as a strategic priority in 2020 to enhance the University's capacity to make timely and informed contributions to policy issues and debates which will shape Tasmania's future.

The Review Panel would like to thank all those who made formal submissions to the Review and to colleagues in Victoria, Western Australia and Queensland who shared their expertise and insights at the Review workshop conducted in early February. We would also like to thank the researchers and staff across the University who contributed their time and expertise to the preparation of this report.

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The University of Tasmania's Independent Review of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020

Terms of Reference

The VAD Review Panel (the Panel) will include health, legal and social sciences expertise and will provide advice to the Tasmanian Government for dissemination to Members of the House of Assembly on specific matters in relation to the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 ('the VAD Bill') tabled in the Legislative Council by the Hon Michael Gaffney MLC on 27 August 2020.

The Panel will conduct research and targeted consultation, through a written submissions process, in relation to the proposed VAD Bill in Tasmania and, in order to inform parliamentary debate, provide an independent and objective report to the Tasmanian Government containing:

- A concise summary of the VAD Bill, following amendment by the Upper House.
- 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.
- An outline of the historical development of VAD legislation in other Australian jurisdictions in terms of scope and protections.
- Synopsis of relevant reports, analysis and material in other Australian states and territories and overseas jurisdictions pertaining to the implementation and administration of VAD reform.
- Objective analysis of:
 - 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.
 - the 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.
 - stakeholder feedback relevant to all matters previously described.

The targeted call for submissions should indicate that submissions are to address the processes allowed by the legislation, safeguards and protections for vulnerable people; and the interrelationship between the VAD Bill and other end-of-life choices.

The Report is to be completed and provided to Government in February 2020

The Review Panel

Professor Richard Eccleston (Chairperson)

Professor of Political Science, University of Tasmania

Prof. Eccleston is a specialist in social and economic policy and has worked on a wide range of policy issues, analysing and developing practical evidence-based solutions to some of the most significant policy challenges facing our community. In recent years, Prof. Eccleston has led projects on a wide range of topics from tax reform, housing affordability, migration and preventive health to the future of renewable energy in Tasmania. He was a Fulbright Senior Scholar based in Washington DC in 2014 and was the Founding Director of the Institute for Social Change at the University of Tasmania.

Professor Fran McInerney

Professor of Dementia Studies and Education, Wicking Dementia Research and Education Centre, University of Tasmania

Prof. McInerney has a professional background in nursing, with higher degrees in social science and public health. She has a wealth of experience in palliative care and end-of-life planning and considers her most important research to be educative. She has been instrumental in creating dementia-centred educational tools in collaboration with the Wicking Centre. She has also developed resources to help those in aged care facilities – staff and families – talk about dementia and death and dying. Her other work includes measurement of dementia literacy and contributions to MOOCs (massive open online courses) about dementia. The University of Tasmania's Understanding Dementia MOOC has been rated one of the top ten of all MOOCs, and number one of all health MOOCs in the world. Prof. McInerney has been a member of the boards of Palliative Care Australia, Palliative Care Tasmania, and Dementia Australia (Vic).

Professor Margaret Otlowski

Professor of Law and Deputy Director of the Centre for Law and Genetics, University of Tasmania

Prof. Otlowski is a distinguished legal scholar and a former Dean of the UTAS Law School. Her research focuses on the relationship between law, health and ethics including voluntary assisted dying and end-of-life choices. Current research projects include regulating genomic data and protecting individuals from genetic discrimination. Reviewing laws and recommending change in light of new ethical questions is a fundamental aspect of her work. She has been engaged by Commonwealth and State governments as a consultant and member of various committees, including the NHMRC's Australian Health Ethics Committee. Prof Otlowski has also been a member of the Tasmanian Anti-Discrimination Tribunal and of the Guardianship and Administration Board and is a Fellow of the Australian Academy of Law.

Associate Professor, Jennifer Presser

**Academic Lead, Bachelor of Medicine Bachelor of Surgery (MBBS),
University of Tasmania**

Associate Prof. Presser started her professional life as a research scientist before embarking on a career as a GP. While working in practices around Australia, she continued an interest in teaching and has worked in general practice specialist training as well as with medical students. In clinical practice Prof. Presser has worked in palliative care in the Northern Territory and completed a Clinical Diploma in Palliative Care. She has enjoyed team-based community work with a particular focus on palliative care, sexual health, Aboriginal and Torres Strait Islander health and mental health. Her research expertise is in the areas of mental health in primary care, doctors' well-being, and training in primary care. Prof. Presser has just completed a term as Chair of the Tasmanian branch of the Royal Australian College of General Practice.

TPE Support Staff

Madeleine Archer – Graduated with a Bachelor of Science and Bachelor of Laws with first class honours in Law from the University of Tasmania in 2020 and worked as a policy intern at the TPE between November 2020 and February 2021. She is currently undertaking the Tasmanian Legal Practice Course.

Sarah Hyslop – Is a policy analyst and project manager at the Tasmanian Policy Exchange and has managed and contributed to a range of significant projects at the University of Tasmania since 2014. She was previously a senior analyst in the Victorian Parliamentary Secretariat.

Hollie Jackson – Graduated with a Bachelor of Arts and Bachelor of Laws with first class honours in Law from the University of Tasmania in 2020 and worked as a policy intern at the TPE between November 2020 and February 2021. She is currently a clerk at Allens Linklaters.

A note on language

Voluntary assisted dying is a complex issue that demonstrates the diversity of views and values held across our community. Given that the language used to describe voluntary assisted dying is itself contested, the Panel considers that it is appropriate to follow the lead of the Victorian Ministerial Advisory Panel (p.7) and clarify the language used in this Report.

The term 'voluntary assisted dying' is used throughout the Report to avoid unnecessary stigmatisation of those seeking to access the proposed new regime, and in preference to alternative terms commonly used in other jurisdictions or contexts (such as voluntary euthanasia, assisted suicide, physician-assisted suicide and medical aid in dying). Voluntary assisted dying, or VAD, is now widely used in Australia and is the term used in the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020. Establishing a clear distinction between VAD and suicide (s.138 of the Bill) is important to avoid sections of the Commonwealth Criminal Code Act (1995) relating to the provision of suicide-related material via telecommunications applying to VAD (Section 3.7.2).

Other terms used in the Report and the associated debate include:

Assisted suicide

This term is sometimes used to describe interventions where patients are prescribed lethal medications that they self-administer. It emphasises the active choice of the person wishing to die. It is not used as frequently as it once was, however, given the importance of distinguishing between VAD and dying from suicide, the latter of which also involves seeking death, but in the absence of a terminal and/or debilitating disease.

Dying with dignity

This is an expression commonly used to describe VAD, particularly in the United States. The Victorian Ministerial Advisory Panel advised against using this term to avoid any suggestion that those who do not access VAD at the end of life (for example, using other forms of health care such as palliative care) may be dying in an 'undignified' fashion (p. 7).

End-of-life care

Palliative Care Australia describes end-of-life care as care that combines the broad set of health and community services that care for people at the end of their lives. Further, it states that quality end-of-life care involves strong networks between specialist palliative care providers, general practitioners, primary specialists and support care providers and the community (PCA 2018b).

Euthanasia

This term means the intentional taking of a person's life by another person, in order to relieve that person's suffering. It is taken from Greek with *eu* meaning good and *thanatos* meaning death. The Human Rights Commission of Australia points out that 'euthanasia' can cover an array of practices including passive voluntary euthanasia, active voluntary euthanasia, passive involuntary euthanasia and active involuntary euthanasia.

Because of this lack of specificity, and also because of connections to historic abuse using involuntary euthanasia, the term 'euthanasia' is less commonly used now than in the past.

Palliative care

This is an approach to health care where a decision has been made not to pursue curative outcomes, usually where there is an acknowledgement that there is no curative treatment available. This approach is based on the premise of neither hastening nor prolonging death, but rather easing suffering.

MAiD

In Canada, voluntary assisted dying is described as Medical Assistance in Dying or MAiD. MAiD covers both assisted suicide and euthanasia for persons who meet specified criteria.

Executive Summary

In November 2020 the Tasmanian Government asked the University of Tasmania to undertake an Independent Review of the End-of-Life (Voluntary Assisted Dying) Choices Bill (2020) which passed the Legislative Council with amendments on 10 November 2020 (the Tasmanian VAD Bill).

The aims of the Review, as set out in the Terms of Reference, are to:

- summarise the key elements of the Tasmanian VAD Bill;
- compare it with relevant voluntary assisted dying (VAD) regimes in other jurisdictions; and
- identify further considerations in relation to the implementation and administration of the Bill, should it pass into law.

The Review Panel has undertaken this work mindful of the fact that VAD raises matters that are central to peoples' values and beliefs and provokes strong feelings across the breadth of our community. The Panel appreciates that establishing a legislative framework for VAD challenges certain long-established norms regarding medical practice and religious beliefs. It also challenges the prohibition on the intentional ending of human life which is a cornerstone of our society and the legal system that underpins it.

The questions raised by VAD and the form that any VAD legislation should take require that the Tasmanian Parliament undertake the difficult task of weighing up the desirability of promoting individual rights and autonomy under circumstances when these rights may conflict with established social and professional ethics and traditions.

Given its Terms of Reference, the Review does not make recommendations as to the whether the Tasmanian VAD Bill should be amended and/or passed into law. Rather, the Review aims to provide the Tasmanian Parliament with analysis and evidence to guide the Parliament's ongoing consideration of the Tasmanian VAD Bill. This Report is designed to complement the extensive research, engagement and debate that has informed the deliberations of the Tasmanian Parliament in recent months.

Reflecting this approach, the Report presents a detailed summary of the Tasmanian VAD Bill and a systematic analysis of how the Bill compares with VAD legislation in other relevant jurisdictions.

The Panel believes that there are three main aspects of the Bill which will require further consideration in order to ensure that the Tasmanian VAD regime strikes an appropriate balance and does not lead to unintended consequences:

- Whether the safeguards included in the Bill to protect vulnerable persons against exploitation and abuse are appropriately balanced with the need to establish a VAD system which is accessible to terminally ill people who are suffering intolerably at the end-of-life
- Whether the proposed regime for organisational non-participation (and the obligations on organisations that decide not to provide VAD services) balances the need to promote individual access to VAD with the ability of organisations to choose whether or not they provide or support VAD services
- The extent to which the Tasmanian VAD Bill should establish guidelines for professional practice, support services and administrative procedures or whether this guidance should be provided by regulation, policy or professional codes

The Panel's approach has been to outline considerations and policy choices associated with these questions and, where possible, identify evidence-based strategies designed to reconcile competing perspectives and policy objectives for further consideration by the Parliament.

Should the Tasmanian VAD Bill pass into law, it will also be important to regularly evaluate and review both the effectiveness of the VAD regime in providing choices for those suffering at life's end and the regime's broader social, ethical and professional implications.

Insights and learnings from other jurisdictions

The Tasmanian VAD Bill has benefited from insights and learnings from other jurisdictions, both interstate and beyond, which have already introduced or drafted VAD legislation.

Section 2 describes how Europe and the United States provided the first examples of VAD regimes and how the Canadian framework has had the greatest influence on contemporary Australian VAD legislation.

Significantly, Canadian legislation influenced the design of the Victorian *Voluntary Assisted Dying Act 2017*, which served as the basis for the Western Australian *Voluntary Assisted Dying Act 2019* and the VAD bills currently before the South Australian and Tasmanian Parliaments.

While undoubtedly jurisdictions have borrowed from each other – an example of policy learning and transfer – there are also elements of the legislation in each of these jurisdictions that are distinct.

This is true of the Tasmanian case, and while it is appropriate that the Tasmanian VAD Bill is largely based on relevant legislation elsewhere, it is important to consider whether legislation from other jurisdictions should be adapted to meet our State's particular needs and concerns. The comparative analysis presented in Section 4 is designed to inform this task.

Public submissions and perspectives on the implementation and operation

This Report seeks to provide a thorough and timely assessment of the specific provisions of the Tasmanian VAD Bill currently before Parliament. Given this scope and the associated timeframes, the Panel's public consultation process focused on written submissions relating to the specific provisions of the draft VAD Bill. The Panel conducted a Review workshop attended by professionals directly involved in the implementation, delivery or oversight of VAD services in Victoria and Western Australia.

Insights from both the written public submissions and the Review workshop were extremely helpful and have guided the Panel's deliberations. Summaries of these contributions to the Review process are presented in Sections 5 and 6 of the Report.

Key features of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020

The Tasmanian VAD Bill is a complex and comprehensive piece of legislation and, at 170 pages, is longer and more detailed than the equivalent Acts in either Victoria (123 pages) or Western Australia (116 pages).

The objectives of the Tasmanian VAD Bill are clear and broadly consistent with the legislation already enacted in Victoria and Western Australia, and with the draft bill currently before the South Australian Parliament. Common features include:

- the principles which inform the operation of each VAD regime;
- the protection from liability each jurisdiction affords to medical practitioners, other health care professionals and pharmacists who do (or do not) participate in the VAD process;
- requirements around medical consultation and referral;
- stipulations around the handling, transfer, storage and disposal of VAD substances;
- the mandatory training and qualifications of participating health practitioners; and
- the criteria a person must satisfy to be eligible to access VAD.

All Australian VAD regimes also explicitly stipulate, either as a legislative eligibility criterion or elsewhere, that a person seeking VAD must have decision-making capacity, be acting voluntarily, meet specific residency requirements and be experiencing intolerable suffering in relation to an illness or health condition expected to cause death within a specified time period.

Section 3 of the Report provides detailed diagrams to illustrate the process prescribed by the Tasmanian VAD Bill during the consultation, assessment and referral phases of the VAD process (see below and Figure 3.1) and the various options for the administration of the VAD substance (Figure 3.2).

A key policy trade-off which must be addressed in VAD legislation is achieving an appropriate balance between establishing sufficient safeguards to ensure that people cannot be coerced or deceived into VAD while ensuring

that eligible people are able to access VAD services and support.

The Tasmanian VAD Bill has numerous provisions to protect individuals and to ensure that access is limited to people who are medically eligible and are acting voluntarily and free from coercion. Indeed, the process proposed in the Tasmanian VAD Bill for requesting, assessing eligibility for and accessing VAD, and the safeguards built into this process, are among the most rigorous in the world (Section 6.3).

Reflecting the ethical implications associated with VAD, the Report also considers the implications of the proposed Tasmanian VAD regime for health and care professionals.

As in the wider community, health professionals and their professional associations hold a range of views on VAD, and this diversity of opinion was reflected in the written submissions to the Review.

Given this diversity of views there is broad support for the principle of protecting the right of any medical practitioner or other health or care professional not to participate in providing VAD services, including on moral or ethical grounds. This principle is reflected in the Tasmanian VAD Bill although additional measures (see Section 6.4.2) could provide further protection to health practitioners from professional discrimination based on whether or not they decide to provide VAD services.

Comparative analysis of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020

Section 4 of the Report provides a comparative analysis of the Tasmanian VAD Bill with legislation and bills relating to VAD in other Australian states and comparable overseas jurisdictions.

This analysis focusses on Victoria, Western Australia and South Australia and the most relevant international comparisons, being Canada and New Zealand. It identifies five key points of difference between the Tasmanian Bill and other Australian jurisdictions, each of which is examined in detail in Section 4.3 and most of which are designed to improve access to VAD in Tasmania. These differences are summarised in the table below.

Considerations for balancing safeguards and access

Achieving a balance between competing objectives is always challenging and particularly so when dealing with

the profound moral and ethical issues at the core of the debate about VAD. As we have noted, some of the central challenges are:

- achieving an appropriate balance between providing individual safeguards and promoting access to VAD services;
- ensuring that health and care professionals are free to choose whether or not they participate in VAD and do not suffer discrimination as a result of this choice; and
- developing a framework which provides organisations (such as private hospitals and aged care facilities) with a choice as to whether they provide VAD services while ensuring that eligible individuals seeking VAD have timely access to the VAD services.

To assist Parliament in balancing these competing objectives the Report identifies four specific aspects of the Tasmanian VAD Bill and its implementation that warrant further consideration.

Support services and systems

The effectiveness of new and complex policy initiatives, such as the Tasmanian VAD Bill, should it pass into law, will depend on both the provisions of the Act and its subsequent implementation and administration. Based on evidence from other jurisdictions and insights from the Review workshop and submissions, it is clear that developing effective VAD support services and systems can promote access and enhance the quality of care by supporting those seeking VAD to navigate the complex process and by providing assistance to health practitioners and organisations who choose to participate in the VAD regime.

VAD support services and systems which are likely to enhance access include:

- specialist services to provide information and support both for people seeking VAD and for health and care practitioners providing VAD services. The emerging Care Navigator model developed in Victoria and being implemented in Western Australia are good examples that warrant consideration in Tasmania;
- developing consistent and user-friendly data portals to reduce the compliance burden on health professionals and to enhance the efficiency of VAD administration. Systems could be shared across jurisdictions;
- providing education and training on the VAD regime to all health professionals and especially to

Distinctive features of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020

Issue	Distinctive feature of the Tasmanian VAD Bill
<p>1. Choices and autonomy in administration method</p>	<p>Eligible persons can indicate their wishes for how the VAD substance will be administered, with three options provided: private self-administration, administration assisted by the Administering Health Practitioner (AHP) or direct administration by the AHP. In practice, the latter two options will only be open to the person if the AHP considers that private self-administration would be inappropriate.</p>
<p>2. Health practitioners eligible to administer VAD substance to persons</p>	<p>Both medical practitioners and registered nurses are able to act as Administering Health Practitioners during the final stage of the VAD process.</p> <p>Three separate requests must be made for VAD by the person seeking access.</p> <p>Four separate eligibility assessments are conducted.</p>
<p>3. Additional features</p>	<p>The VAD Commission must give permission before the VAD substance can be dispensed or administered to an eligible person.</p> <p>Two administration methods are supervised by the AHP. Where self-administration is chosen there is no requirement for a 3rd party contact person.</p> <p>It is prohibited to punish a medical practitioner on the basis of their accepting a request or making a referral pursuant to the Bill.</p>
<p>4. Processes present in other regimes, absent from the Tasmanian VAD Bill</p>	<p>No explicit waiting period between the first and final requests (although the minimum time in which the VAD Commission must complete different elements of the VAD approval process, together with minimum periods prescribed between the first, second and third requests for access represents a de facto waiting period).</p> <p>The Primary Medical Practitioner is not required to conduct a 'final review' of all of the documents previously completed in compliance with the VAD process prior to applying to the VAD Commission for authorisation for administration.</p> <p>No requirement that direct administration (ie self-administration of the VAD substance) be witnessed.</p>
<p>5. Provisions designed to ensure equality of access</p>	<p>The VAD Commission must keep and disseminate a list of trained and willing medical practitioners and connect persons with an Administering Health Practitioner where their Primary Medical Practitioner is unable or unwilling to act.</p> <p>Health practitioners are able to discuss VAD with a person, even if that person has not requested VAD, provided this discussion takes place in the context of a wider discussion about the person's treatment options and likely outcomes.</p> <p>There is no express requirement that medical practitioners who act as Primary Medical Practitioners or Consulting Medical Practitioners have a minimum period of practice in the relevant area.</p>

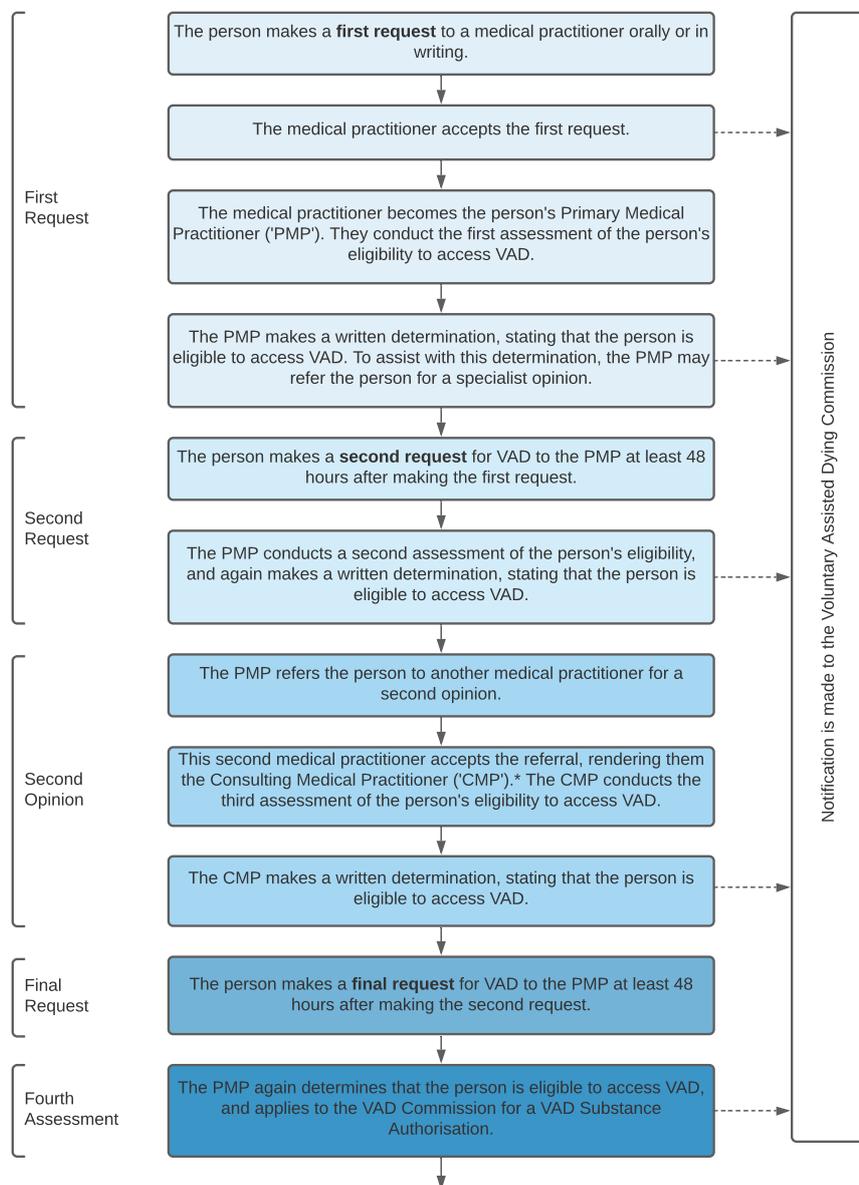
- those providing or willing to provide VAD services; promoting both formal and informal collaboration and information and resource sharing between jurisdictions, including the development of national guidelines for data collection and reporting; and
- developing specialist teams providing VAD support in collaboration with local participating practitioners.

These VAD support services and systems are discussed in greater detail in Section 6.1 of the Report.

Reviewing the number of assessments

Safeguards proposed under the Tasmanian VAD Bill, if enacted in their current form, will be among the most stringent in the world. Specifically, the Tasmanian VAD Bill requires four separate assessments of eligibility

The VAD assessment process under the Tasmanian VAD Bill



See section 3.4 for the proposed steps associated with the administration of the VAD substance.

during the assessment process which is more than any other jurisdiction.

It is a matter for the Tasmanian Parliament to determine the appropriate number of assessments or other safeguards which should be included in the Tasmanian VAD regime, mindful of the trade-offs involved. However, one specific amendment which may be considered is whether RNs performing the Administering Health Professional (AHP) role should be required to conduct a further (fifth) assessment of the person's decision-making capacity or whether simply requiring the AHP to confirm the person's consent would be more appropriate and increase the willingness and ability of RNs to act as an AHP (6.4.4).

Balancing organisational values and rights to access

A significant consideration posed by the Tasmanian VAD Bill is establishing an appropriate balance between an organisation's values and an individual's right to access VAD services. The specific question facing Parliament is whether the ability of hospitals and aged-care facilities not to offer VAD services (and subsequent obligations to persons in their care) should be codified in legislation. The issue of organisational 'non-participation' has been discussed in other jurisdictions, analysed in academic and policy literature, debated in the Legislative Council and raised in 14 submissions to this Review.

The Tasmanian VAD Bill is silent on the issue of organisational non-participation, given that there is no requirement under the legislation for either organisations (such as hospitals or aged care facilities) or individuals to offer VAD services. However, the issue is now on the legislative agenda for a number of reasons. There is a concern that, in practice, organisational non-participation may restrict access to VAD (especially in regional settings) or, in cases where people have to be transferred between organisations in order to access VAD, that it may increase the suffering of those persons. Also, some hospitals and care organisations are seeking greater clarity in relation to their obligations with respect to the provision of services which are inconsistent with their organisational ethos.

Analysis of the issues relating to organisational non-participation is presented in Section 6.5, including the key elements of a compromise model which would not oblige organisations to provide VAD services but would provide greater certainty to patients or residents in non-participating organisations who seek to access VAD. A particularly challenging scenario is providing options for people who are seeking VAD in non-participating organisations who cannot be transferred without subjecting them to additional suffering.

The role of palliative care and end-of-life planning

The Review Panel was asked to consider the interrelationship between the Tasmanian VAD Bill and existing palliative care and Advance Care Directives (ACDs) in Tasmania and the experience of other jurisdictions in relation to these matters.

A core element of contemporary palliative practice is to adopt a holistic approach to maximise the quality of life and alleviate pain for those suffering from a life-limiting condition, but without hastening death. Ethically, this places palliative practice in a different category to VAD and the two approaches are regarded as quite distinct end-of-life options.

Those in the palliative care sector who are opposed to VAD argue that high quality palliative care can significantly reduce or eliminate the need for assisted dying, while many who support assisted dying advocate for better palliative services but argue that there are some cases where a person's suffering cannot be managed at life's end.

Although VAD and palliative care are distinct end-of-life options, research from Palliative Care Australia (2018) suggests that there has been an increased awareness of, and investment in, end-of-life care (including palliative care) in jurisdictions which have introduced VAD.

Advance care planning (ACP) is a separate process that allows individuals to express their future wishes in relation to health care, in order to aid decision making in the event they lose the capacity to communicate. Under the Tasmanian VAD Bill, ACP does not have a role in relation to VAD; an individual cannot request VAD via the ACP mechanism. There is a broad consensus that better end-of-life planning (including ACPs) and more timely access to palliative care (should it be required) will improve end-of-life outcomes and that further community engagement and education is needed in these areas.

Based on the eligibility requirements in the Tasmanian VAD Bill and data on people who have accessed VAD in Victoria (Section 6.2), the vast majority of people who end their lives through VAD will have been suffering from terminal cancer (78%) while those living with dementia would be ineligible (6.2.3). Under a Tasmanian VAD regime, it should be noted that very few people will seek or be eligible to access VAD at the end of life compared to those who will need access to other end-of-life options including high quality palliative care.

Outline of the Report

The Report begins (Section 2) by summarising the evolving approaches to VAD both internationally and in Australia. This overview serves as the basis for a more detailed summary of the Tasmanian VAD Bill (Section 3) and comparative analysis of the VAD Bill with VAD laws and policies in other similar jurisdictions (Section 4). As noted, the Panel sought written submissions on the VAD Bill which are summarised in Section 5. In addition to reviewing the specific provisions of the VAD Bill, the Panel was asked to consider a number of important issues concerning the implementation and administration of a VAD regime in Tasmania. This analysis is presented in Section 6 and is largely based on written submissions on the VAD Bill and the recent VAD experience in Victoria and Western Australia.

Specific amendments for consideration

Based on the considerations and trade-offs outlined above, the Review Panel believes the following specific amendments warrant consideration.

1. Replacing the final AHP assessment with a consent check

Given the person seeking VAD will have undergone four previous assessments by the PMP and CMP, consideration could be given to replacing the fifth and final assessment to be conducted by the AHP with a consent process. This should increase the number of RNs willing to act as AHPs and should improve access. See above and Section 6.4.4.

2. Transfer and access obligations for non-participating organisations

There is support for clarifying the obligations of non-participating organisations to patients or residents seeking to access VAD. In other jurisdictions these issues are generally managed through policies and guidelines but the legislative approach outlined in the Report may be considered. See above and Section 6.5.

3. Additional protections against professional discrimination

The Tasmanian VAD Bill establishes the right of health practitioners to choose whether or not to provide VAD services (ss. 20-21 of the VAD Bill) but it does not provide legislative protections against professional discrimination which may result from making such a choice. No other Australian jurisdiction provides this protection but it is a feature of New Zealand VAD law. Based on concerns

raised in submissions from health practitioners it may be worth adopting protections similar to those available in New Zealand. See Section 6.4.2 and 6.7.2

4. Allowing health practitioners to choose whether they join the central register of participating practitioners to be maintained by the VAD Commission

There are concerns that requiring health practitioners to join a central register maintained by the VAD Commission may deter participation in VAD (s.113 c & d of the VAD Bill). A compromise position which may be considered is providing qualified health professionals with a choice in relation to whether they are recorded on a list of qualified and willing providers proposed under the VAD Bill. See Section 6.4.3

5. Establishing an obligation for non-participating health practitioners to refer people seeking VAD

The Tasmanian VAD Bill does not require a medical practitioner who does not accept a patient's request to provide VAD services to refer that patient to another practitioner or the VAD Commission. While there are professional codes in relation to referral practices, given the precedent in the Tasmanian *Reproductive Health Act 2013*. Parliament may wish to consider establishing referral obligations in the Tasmanian VAD Bill. See Section 6.4.2.

PART ONE. TASMANIA'S END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020: THE CONTEXT

Section 1:

Introduction

The issue of voluntary assisted dying sits at the heart of our values and beliefs as individuals and as a community. It requires us to consider and balance deeply held and potentially conflicting principles concerning the need to protect and preserve life with the desire to prevent suffering and promote individual choice at life's end. Establishing a law under which a human life can, with full consent and the most humane motivations, be ended is of profound consequence and must be carefully considered. The Panel has been extremely mindful of these moral and ethical considerations as we have reviewed the VAD Bill in accordance with our Terms of Reference.

The experience of and prevailing attitudes towards death and dying, both in Tasmania and beyond, have been shaped by a combination of medical, demographic and societal factors. These include:

- Improved and life-prolonging medical and health care
- An ageing population and increasing incidence of chronic disease and age-related illness
- Evolving yet diverse community attitudes and beliefs in relation to dying, death and end-of-life choices

Life-prolonging improvements in healthcare among

other factors have increased life expectancies significantly in Australia in recent years. In 1980, on average, a 65-year-old Australian male would have lived to 78.8 years of age yet only 20 years later (in 2000), this life expectancy had increased to 82.4 (the equivalent increase in life expectancy for women was 1.5-years to 87.3).¹ This trend is especially evident in Tasmania, where over 20% of the population is now over 65 years of age. This is 4% above the national average and represents a doubling of the percentage since the early 1980s (Figure 1.1).

Living longer, more predictable lives is an achievement to be celebrated but, as a population, we are also dying more slowly and are more likely to experience 'extended periods of deteriorative decline'. This changing

Tasmania's Ageing Population, 1976-2019

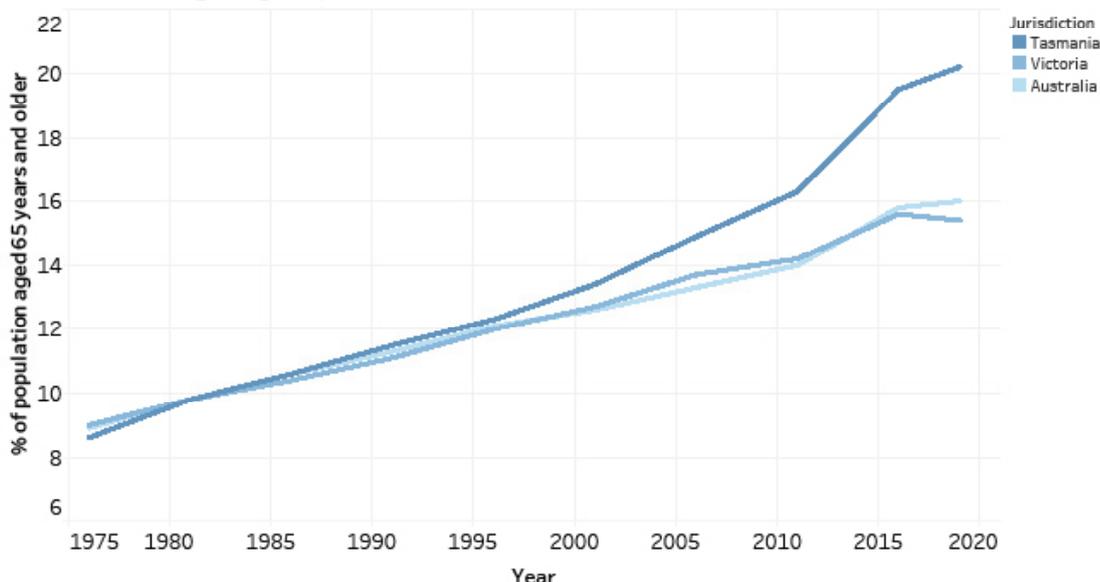


Figure 1.1: Tasmania's ageing demographic profile, 1976-2019 (source: ABS 2016, ABS 2020a)2

experience of death and dying has highlighted the need for better end-of-life planning and care. While there is broad agreement that more should be done to ensure access to high quality palliative care, the issue of whether VAD should be available as an option to those suffering at life's end remains contested among both health professionals and the wider community.

Life-prolonging medical treatments and an ageing population have changed the end-of-life experience for many people. However, it is important to note that the majority of those who seek VAD will be suffering from terminal cancer (76% in Victoria; see Section 6.2) or neurodegenerative diseases (16%). (This 16% is unlikely to include those with dementia as they would not be eligible for VAD – see Section 6.2.3). While the prevalence of these conditions increases with age, the age of those who have accessed VAD in Victoria has ranged from 32 to 100, with an average age of 72.³ While Australia's population is ageing, fortunately the overall mortality from illnesses most common among those seeking VAD is declining although they are more prevalent in Tasmania relative to Australia as a whole (see Figure 1.2 for representation of the decline in mortality from cancer). 'Changing societal attitudes towards death and dying have also shaped the VAD debate and the

timing and content of VAD bills and legislation in other jurisdictions. Given the ethical questions under consideration, community attitudes and beliefs as to whether VAD should be made available under specific circumstances for those suffering at life's end are diverse. However, survey data from a range of sources suggests that an increasing majority of Australians are supportive of legalising VAD (Figure 1.3). As public attitudes have evolved in recent decades, a growing number of Australian and overseas jurisdictions have made provisions for VAD. It is in this context that the VAD Bill is now before the Parliament of Tasmania. Death and dying have also shaped the VAD debate and the timing and content of VAD bills and legislation in other jurisdictions. Given the ethical questions under consideration, community attitudes and beliefs as to whether VAD should be made available under specific circumstances for those suffering at life's end are diverse. However, survey data from a range of sources suggests that an increasing majority of Australians are supportive of legalising VAD (Figure 1.3). As public attitudes have evolved in recent decades, a growing number of Australian and overseas jurisdictions have made provisions for VAD. It is in this context that the VAD Bill is now before the Parliament of Tasmania.

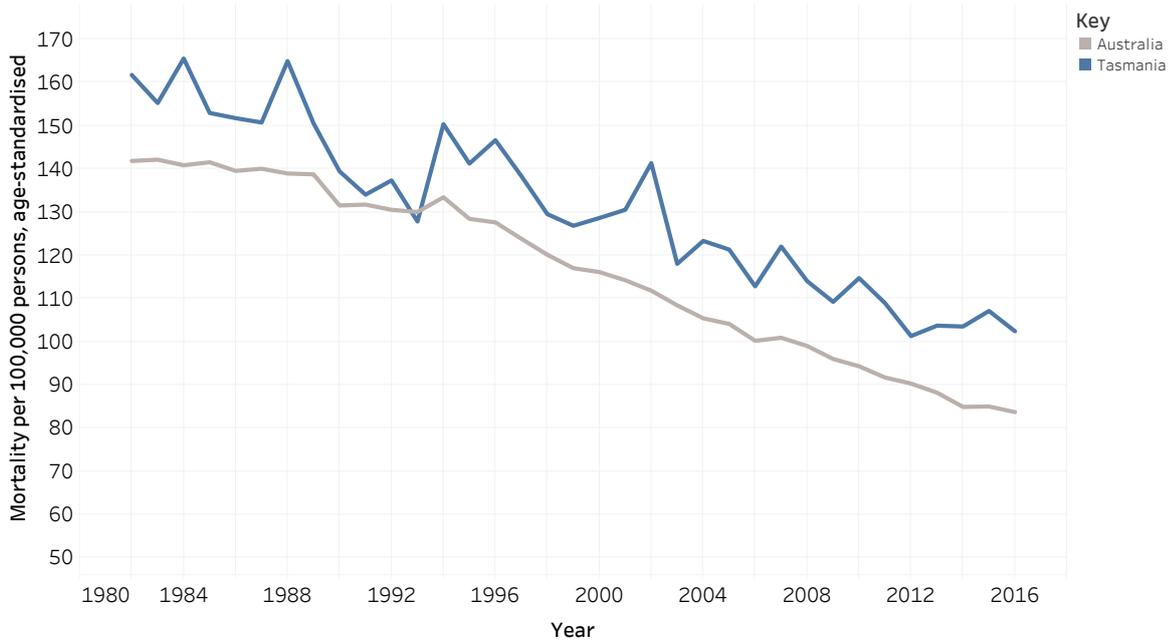


Figure 1.2: Age-standardised mortality from the five most common categories of cancers reported among Victorian VAD applicants, Tasmania and Australia, 1980-2016⁴ (source: Australian Institute of Health and Welfare 2020a)

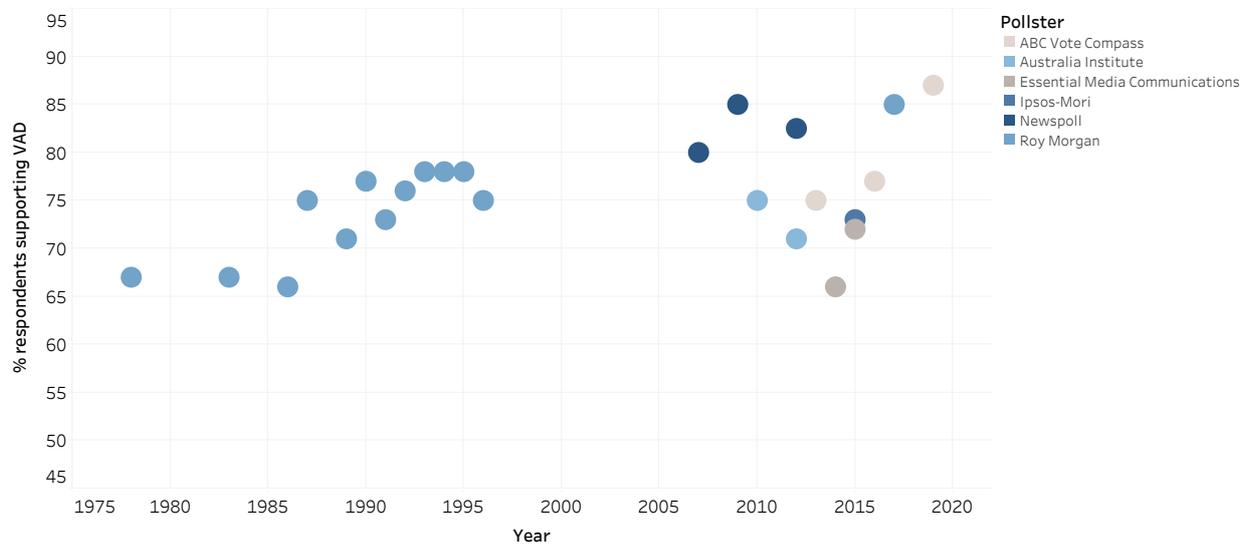


Figure 1.3: Polls recording national support for VAD in Australia, 1976-2019⁵ (sources: ABC Vote Compass 2019, Roy Morgan Research 2017, The Australia Institute 2012, Ipsos 2015, Essential Media Communications 2015, Newspoll 2012).

It is not the role of the Panel to assess the competing moral and ethical perspectives on end-of-life choices, but rather to analyse how these complex issues have influenced the design and administration of VAD regimes in other jurisdictions and apply these lessons in Tasmania. Where possible, based on published evidence and submissions, we have identified several legislative and policy options for the Tasmanian Parliament to consider together with associated strategies designed to help achieve the objectives of the VAD Bill.

The primary objective of this Report is to provide a resource and a reference point for the Tasmanian Parliament as it continues its consideration of the VAD Bill and its implementation. The Report begins (Section

2) by summarising the evolving approaches to VAD both internationally and in Australia. This overview serves as the basis for a more detailed summary of the Tasmanian VAD Bill (Section 3) and comparative analysis of the VAD Bill with VAD laws and policies in other similar jurisdictions (Section 4). The Panel sought written submissions on the VAD Bill which are summarised in Section 5. In addition to reviewing the specific provisions of the VAD Bill, the Panel was asked to consider a number of important issues concerning the implementation and administration of a VAD regime in Tasmania. This analysis is presented in Section 6 and is largely based on written submissions on the VAD Bill and the recent VAD experience in Victoria and Western Australia

Section 2:

The historical development of voluntary assisted dying law

Reflecting the medical, demographic and societal trends described in Section 1, there has been a growing debate and an evolving discourse about VAD across a range of jurisdictions since the mid-20th century. The timing and form of legal decisions and new legislation concerning VAD has been shaped by local political factors, legal traditions and prevailing societal norms in the jurisdictions in question. This section summarises the evolution of VAD provisions internationally, from Swiss laws on assisted suicide in the 1940s through to the European and North American jurisdictions (national and sub-national) that have established legislative frameworks for VAD in more recent years. More detailed analysis of the Canadian and New Zealand legislation is presented in Section 4 given their influence on Australian VAD laws, including the VAD Bill currently before the Tasmanian Parliament.

2.1 THE HISTORY OF VOLUNTARY ASSISTED DYING LEGISLATION IN EUROPE, THE UNITED STATES, NEW ZEALAND AND THE UNITED KINGDOM

2.1.1 Switzerland

Switzerland is the first jurisdiction which established legal provisions for 'assisted suicide'. Rather than having specific legislation, this is provided for in Article 115 of the 1942 Swiss Criminal Code. In contrast to contemporary VAD regimes elsewhere in the world, the Swiss model adopts a minimalist and largely rights-based approach to accessing VAD by decriminalising VAD where a person providing assistance can demonstrate they are doing so from unselfish motives. While the Swiss model has few formal legislative safeguards, in practice it is regulated by ethical guidelines established by formal right-to-die associations. These guidelines set out specific criteria under which a person can access VAD as well as providing for end-of-life support from experienced volunteers.⁶

Perhaps the most controversial and significant element of the Swiss VAD regime is that it is accessible to non-residents, resulting in so-called 'suicide tourism'.⁷ Well documented cases of people suffering from terminal conditions travelling to Switzerland to access VAD have highlighted the situation of those suffering at life's end and promoted debate about VAD in several other countries. A recent high-profile case in Australia involved scientist David Goodall, who at age 104 travelled to

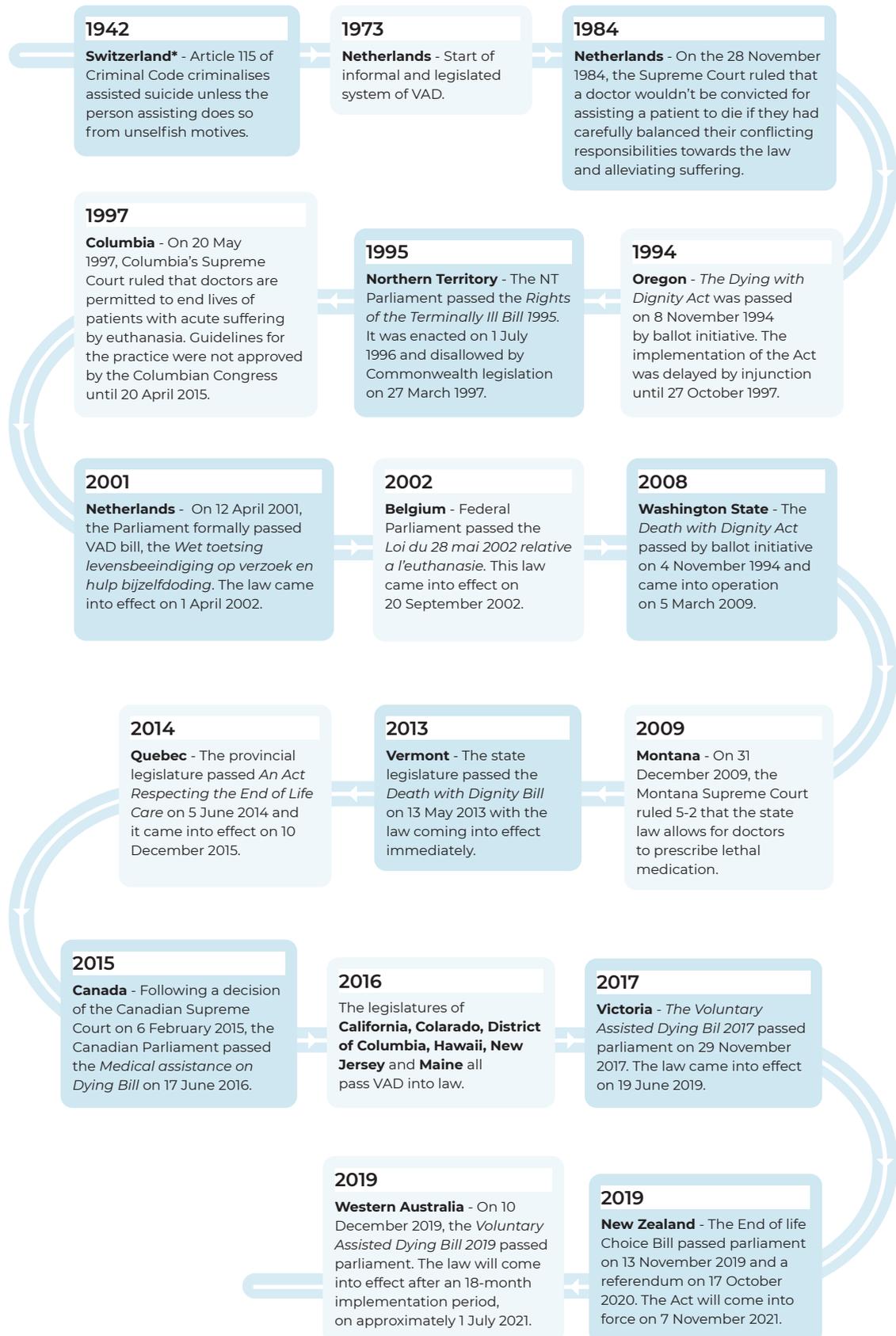
Switzerland to access VAD.⁸

2.1.2 The Netherlands

An informal system wherein a doctor could lawfully assist dying to prevent serious and irremediable suffering was established in the Netherlands in the early 1970s, although initially the legality of this practice and what constituted 'medical assistance' remained unclear. The legal basis for VAD (known as 'voluntary euthanasia' in the Netherlands) became more certain in 1984 when the Dutch Supreme Court ruled that a doctor could not be convicted for hastening the death of their patients if they had carefully balanced their duty to alleviate hopeless suffering with their duty to preserve a patient's life.⁹

In 2002 the Dutch Parliament passed legislation ensuring that doctors cannot be prosecuted if they act with 'due care' as defined in the statute.¹⁰ Unlike the VAD Bill and other Australian legislation, the Dutch legislation does not require a patient to be suffering from a terminal illness in order to access VAD and justifies this approach on the basis that unbearable suffering with no prospect of improvement is not limited to terminal phases of disease.¹¹ Moreover, the Dutch assisted dying regime can be utilised at a minor's request if aged between 16 and 18 and deemed to have a reasonable understanding of their own interests, with the parents or guardians having been involved in the decision-making process.¹² Further, a patient does not need to be competent at the time VAD occurs in the Netherlands if a valid advance care directive was completed at a time when the patient was competent.¹³

Figure 2.1: The development of international voluntary assisted dying laws



Published data suggest that the Dutch regime is the most liberal and accessible in the world with rates of VAD in the Netherlands fluctuating between 2.2 and 3.5 per cent of annual deaths from 1990 to 2010¹⁴, and 4 per cent in 2016.¹⁵ As in other jurisdictions, cancer is the most commonly reported condition of those accessing VAD in the Netherlands (4,137 out of 6,091 in 2016); more than 50% of those accessing VAD were over 70, and 80% died in their own homes.

An independent oversight framework exists in the Netherlands through a system of regional review committees, as specified in Chapter 3 of the Dutch legislation

2.1.3 Belgium and Luxembourg

The Belgian Parliament passed VAD legislation (also referred to as 'voluntary euthanasia' in Belgium) in 2002 after several unsuccessful attempts in the 1980s and 1990s (WA Joint Committee Report).¹⁶ Like the VAD regime in neighbouring Netherlands, the eligibility criteria in Belgium are broader than other existing Australian legislation or the Tasmanian VAD Bill. For example, while a person seeking VAD must be competent when making the request, there is no requirement to be competent at the time of death, as long as the patient has made written end-of-life directions when competent requesting VAD. Under the Belgian law, the request for VAD must be voluntary, considered, repeated, in writing, free from external pressure and of a durable nature.¹⁷ The patient must be in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated.¹⁸

In 2014 the Belgian regime was extended to allow VAD for competent terminally ill people under the age of 18 in restricted circumstances.¹⁹

Compliance in Belgium is monitored by the Federal Control and Evaluation Commission. In 2015, 2,022 people accessed voluntary euthanasia, a slight increase from 1,928 in 2014. Other data for 2014-2015 show that: 62.8% of patients were over 70; no patients under 18 were reported; 67.7% were cancer patients; and 44% accessed VAD in their own home.²⁰

In February 2008 the Grand Duchy of Luxembourg passed a Right to Die with Dignity Law providing voluntary physician assisted dying to those suffering from a terminal illness.

2.1.4 Spain

While VAD is currently illegal in Spain under article 143 of its penal code, recent legislative developments in the National Parliament indicate that it may soon be legalised. A bill was introduced into the Lower House early in 2020 that enshrines the concept of the 'right to a good death', and provides for both physician-administered and self-administered VAD.²¹ Despite strong opposition from religious groups, on 17 December 2020 the Lower House passed the legislation, with 198 votes in favour and 138 opposed. The Bill passed a preliminary Senate vote 208 votes to 140 on 9 February and is expected to become law later in 2021.²²

2.1.5 Oregon and other US states

In the United States, VAD is commonly referred to as 'physician-assisted suicide' or 'aid-in-dying' and is provided for under the laws of certain states. VAD is still illegal in a majority of US jurisdictions, with only nine states plus the District of Columbia allowing VAD at the time of writing. A further 17 states are actively considering VAD legislation. The US jurisdictions which have enacted VAD laws are Oregon, Washington, California, Colorado, Vermont, Maine, New Jersey, Hawaii, Montana and the District of Columbia. All VAD systems in the US (apart from Montana) prescribe similar provisions to those in the Oregon model. They allow mentally competent adults suffering from a terminal illness to request and receive a prescription medication to self-administer when they choose. All the US statutes require that those using a VAD service be a state resident, be a minimum of 18 years of age, have a life expectancy of six months or less, and have made two oral and one written request to a doctor for the service.²³ Most US states with VAD regimes collect and publish comprehensive data on those accessing VAD including patients' age, underlying health conditions, race, sex, education level, and place of residence.

Oregon

In 1994, Oregon citizens voted in favour (51.3% in favour) of the Dying with Dignity Act by ballot initiative – a direct democracy feature common in the US that allows for public votes on certain legislation or constitutional amendments. The Oregon legislation faced some legal challenges including a second ballot initiative to repeal the law (in which 60% voted to retain the law and 40% to repeal it). The Oregon VAD legislation came into operation in 1997.²⁴

As noted above, the regime in Oregon provides for physician-assisted death but only with the patient self-administering the lethal medication. Requirements include two verbal requests, a written request in the presence of two witnesses, a diagnosis and prognosis confirmed by two physicians, a determination that the patient is competent to make decisions concerning health care, that the physician informs the patient of alternatives, and that physicians report all lethal medication prescriptions to the Oregon Health Authority. The Oregon Health Authority publishes an annual report on mandatory data required under the VAD legislation, and these reports provide over 20 years of detailed data. In 2019, 290 people received prescriptions for lethal medications, and 188 people died from ingesting those medications.²⁵

Washington

As in Oregon, Washington state's Death with Dignity Act came into force following a successful ballot initiative in 2008. The Washington VAD legislation is substantially similar to that in Oregon.

Under Washington's VAD law, the Washington Department of Health releases Death with Dignity Data annually. In the most recent available data (from 2018), 267 (up from 212 in 2017) patients had prescriptions written and 203 (up from 164 in 2017) died after ingesting that medication. These prescriptions were written by 158 different physicians and dispensed by 61 different pharmacies.²⁶

2.1.6 Canada

Physician-assisted suicide, generally referred to as 'Medical Aid in Dying' (MAiD) in Canada, was legalised in the province of Quebec on 5 June 2014. Initially this conflicted with Canada's federal Criminal Code, which stated that anyone who assists a person to die is guilty of an indictable offence and is liable for imprisonment for a term of up to fourteen years. However, in February 2015 the Supreme Court of Canada, in the *Carter v Canada* case, upheld a declaration of invalidity of the relevant Criminal Code provision on the grounds of inconsistency with section 7 of the Canadian Charter of Rights and Freedoms. The Supreme Court suspended the operation of the declaration for 12 months to allow the federal government time to develop and pass legislation making MAiD legal.²⁷ On 17 June 2016, a bill legalising MAiD throughout Canada passed the federal Parliament (Bill C-14).

Provinces and Territories of Canada may create additional health-related laws so long as they do not conflict with the provision in the federal Criminal Code stating that a person is not guilty of a criminal offence if they provide or assist in providing medical assistance in dying according to the provisions of the law. This flexibility at the sub-national level in Canada means there is some variation between jurisdictions. For example, Quebec's VAD law only allows physicians to administer MAiD and does not allow self-administration of the lethal medication²⁸. More detailed analysis of Canada's federal VAD legislation (Bill C-14) is provided in Appendix 3.

2.1.7 New Zealand

Since the mid-1990s, four separate bills have proposed a framework for assisted dying in New Zealand. All bills have been Members' Bills (the New Zealand equivalent of Australian Private Members' Bills). The first bill, the Death with Dignity Bill 1995, was introduced on 2 August 1995 by National MP Michael Laws. The bill's first reading was defeated by 61 to 29 votes. The second bill, the Death with Dignity Bill 2003, was introduced on 6 March 2003 by New Zealand First MP Peter Brown and was almost identical to the Death with Dignity Bill 1995. The 2003 bill was narrowly defeated on its first reading by 60 to 58 votes, with one abstention. In 2012 Labour MP Maryan Street entered the End of Life Choice Bill into the ballot of Members' Bills held on 26 July 2012. Street subsequently withdrew that bill, concerned that as it was an election year the bill might not receive the careful attention required.²⁹

On 15 of October 2015 ACT MP David Seymour first entered the End of Life Choice Bill into the ballot of Members' Bills, but it was not drawn from the ballot and introduced until 8 June 2017. It passed its first reading (76 to 44 votes) and was referred to the Justice Committee. The Committee inquiry process was comprehensive, with 35,000 written submissions, 2,000 oral submissions and a tour by MPs to 14 cities to hear community views. In its final report, tabled in April 2019, the Committee made no recommendations, instead explaining that its membership held a diversity of views and so had confined itself to reporting on minor, technical and consequential amendments of the bill only, leaving debate of the policy matters to the House (NZPS, 2019).³⁰ The bill passed its third reading on 13 November 2019 (69 to 51 votes), receiving Royal Assent on 16 November 2019. As stipulated in section 2 of the End of Life Choice Act, the act was then subjected to a national referendum on 17 October 2020. A majority (66%) of New Zealanders voted in favour of the act, thus ensuring it would come into force 12 months after the announcement on 6

Table 2.1: Sub-national voluntary assisted dying legislation in the United States of America

Jurisdiction	Date legislation passed	Legislative process
Oregon	1994	Passed by ballot initiative on 8 November. An injunction delayed implementation of the Act until 27 October 1997.
Washington	2008	Passed by ballot initiative on 4 November and came into effect on 5 March 2009.
Montana	2009	VAD operates under Montana Supreme Court ruling (Baxter v. Montana, 31 December) that no law prohibits a physician from prescribing medication to hasten a patient's death who has requested it, provided they are terminally ill and mentally competent.
Vermont	2013	The Vermont legislature passed the bill on 13 May, making Vermont the first state to pass a VAD law through the legislative process. The law came into effect immediately.
California	2015	Passed by the California legislature on 11 September and came into effect on 9 June 2016.
Colorado	2016	Passed by ballot initiative on 8 November and coming into effect on 16 December 2016.
District of Columbia	2016	Passed by the DC legislature on 15 November and signed into law on 18 February 2017.
Hawaii	2018	Passed by the Hawaii legislature on 29 March and came into effect on 1 January 2019.
Maine	2019	Passed by the Maine legislature on 30 May and came into effect on 1 January 2020.
New Jersey	2019	Passed by the New Jersey legislature on 25 March and came into effect on 1 August 2019.

November 2020 of the final vote. Therefore, VAD will become available to eligible persons in New Zealand from 7 November 2021.³¹ For analysis of New Zealand's End of Life Choice Act see Appendix 4.

2.1.8 The United Kingdom (a countervailing case)

While the number of jurisdictions around the world considering and passing VAD laws has increased in recent years, it is important to note that VAD legislation has not been implemented in most advanced liberal democracies and, with the exception of Columbia, is not yet legally available in developing or middle-income countries.

The United Kingdom is an interesting case in point given its many parallels with Australia. The first attempt to introduce voluntary euthanasia laws in the UK dates back to 1936, with numerous subsequent attempts to introduce laws having been made since the 1960s. In 1994, The House of Lords Select Committee on Medical Ethics spent a year considering the issue before recommending that the law not be changed to provide for VAD due to the risk that it may 'weaken society's prohibition of intentional killing which is the cornerstone of law and of social relationships'.³² In 2012 the UK's non-governmental Commission on Assisted Dying recommended reforms to ensure that under strictly defined circumstances terminally ill people could be assisted to die.³³ The Commission was established to address mounting

concerns that under British law, family members or carers who assisted those seeking to take their own life (including by travelling to Switzerland to access the Swiss VAD regime) could be liable for prosecution under the UK's Suicide Act (1961). In 2015, according to Dignitas, one person per fortnight was travelling from the UK to Switzerland to access VAD.³⁴

In an attempt to clarify the situation, the House of Lords ordered that the UK Director of Public Prosecutions publish guidelines as to the circumstances under which they would seek prosecution.³⁵ There have been a number of subsequent attempts on both sides of politics to legalise VAD in Britain. In 2014, Lord Falconer (Labour) introduced the Assisted Dying Bill 2014-2015 into the House of Lords. The Bill sought to allow competent adults who are terminally ill and are expected to die within six months to have access to assistance at ending their lives.³⁶ In the following year, Rob Marris (Labour) introduced a bill largely based on that of Lord Falconer's into the House of Commons. That bill was defeated by 330 votes to 118.³⁷ In 2016, the bill was reintroduced into the House of Lords, this time by Lord Hayward (Conservative). The bill lapsed when the parliamentary session ended.³⁸ Lord Falconer yet again introduced the bill into the House of Lords on 28 January 2020. At the time of writing, the Second Reading has yet to be scheduled and the bill is still before the House.³⁹

2.2 THE HISTORY OF VOLUNTARY ASSISTED DYING LEGISLATION IN AUSTRALIA

Attempts to legalise and/or decriminalise VAD in various Australian parliaments have been undertaken for almost 30 years. Prior to the introduction of the Voluntary Assisted Dying Bill 2017 in the Victorian Parliament, 57 other VAD-related bills had been introduced into Australian parliaments.⁴⁰

2.2.1 Early Territory reforms and the Commonwealth response

The first VAD bill to be introduced into an Australian parliament was in 1993, by Independent Michael Moore, in the ACT Legislative Assembly. The bill was referred to a Select Committee on Euthanasia. The Committee recommended that the bill not be passed due to inappropriateness and being politically inopportune, leading Moore to remove the bill from the Notice Paper. Moore introduced four more bills attempting to legalise or decriminalise VAD in subsequent years, none of which passed.⁴¹

On 22 February 1995, the Chief Minister of the Northern Territory, Marshall Perron (Country Liberal Party) introduced the Rights of the Terminally Ill Bill 1995. The bill was referred to a Select Committee on Euthanasia. The Committee did not make recommendations on whether the bill should pass or not, but recommended amendments to the bill. After extensive debate, the bill passed the Territory's unicameral parliament on 25 May 1995 and on 1 July 1996 the NT became the first jurisdiction in Australia to enact legislation allowing voluntary euthanasia and also the first jurisdiction in the world to provide a legislative framework that permitted the practice. The NT Legislation was also the first to allow for VAD by either self-administration or physician-administration of the lethal medication.⁴² The NT Act is now considered relatively short by contemporary standards, at only nine pages and 21 sections.⁴³

This NT legislation was only in operation for nine months before federal MP and Chair of the House of Representatives Legal and Constitutional Affairs Committee Kevin Andrews (Liberal) introduced into the Commonwealth Parliament the Euthanasia Laws Bill 1996, which sought to disallow the Territories' rights to enact euthanasia legislation. Despite protest from the NT and ACT Governments, the Andrews bill passed the Senate on 24 March 1997, coming into effect three days later. In the nine months that the VAD legislation was in force in the NT, seven people (all of whom had cancer) applied for VAD under its provisions. Four of these were assisted to die.

Since the federal prohibition on Territories legislating VAD, there have been six unsuccessful attempts in the federal Parliament by members of the Australian Democrats and the Australian Greens to repeal the legislation, as well as an attempt in 2015 by a member of the Liberal Democratic Party to do the same.⁴⁴

In addition to the seven bills attempting to reverse the prohibition on the Territories' powers to legislate for VAD, there have been five state bills attempting to establish referenda on VAD law reform and another 42 state bills proposing legislation permitting VAD under certain circumstances. However, until the passage of the 2017 Victorian bill, all had been unsuccessful.⁴⁵ White and Wilmott (2018) observe that despite this lack of success, the number of related bills introduced into Australian parliaments has been steadily increasing. Of the states, South Australia has seen the most attempts (20), followed by NSW (9), WA (7), Tasmania (3), Victoria (2) and Queensland (1).⁴⁶

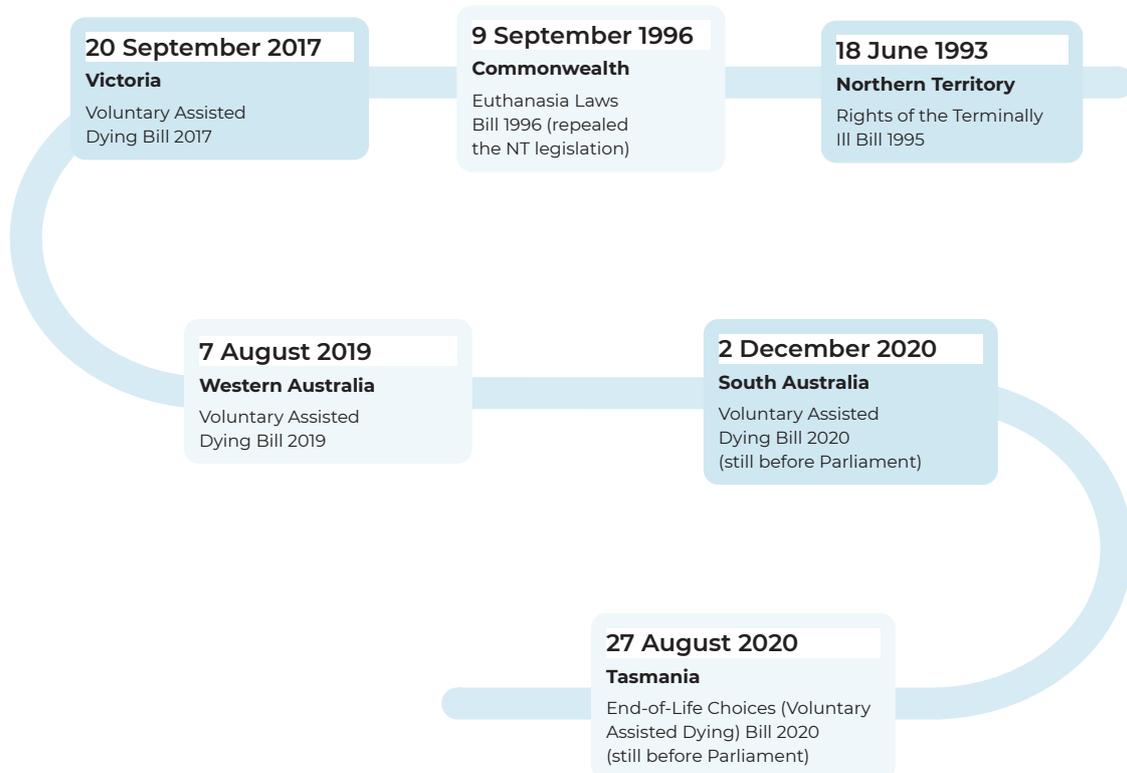


Figure 2.3: The development of voluntary assisted dying legislation in Australia

Despite broad-based and steadily increasing public support across Australia for VAD over the period 1975 to 2020 (Figure 1.3), and many attempts to legalise it (Figure 2.3), the major Australian political parties, up until recently, had not developed policy positions on the issue. Prior to passage of the Victorian bill in 2017, the Australian Greens were responsible for 37% of all VAD bills, the Australian Democrats for 18% and Independents for 31%. All these Independent bills were introduced by just two Independents (Michael Moore and Dr Bob Such). Only six VAD bills had been introduced by the ALP and only one by a member of a conservative political party - the successful bill in the NT.⁴⁷

Stephen Duckett attributes the recent success of the VAD legislation in Victoria to the fact that it was government-supported. This is because government support resulted in a parliamentary inquiry and the work of the Ministerial Advisory Panel, which allowed guidelines and safeguards to be developed effectively and communicated to the community.⁴⁸

Table 2.2: A summary of VAD bills in Australian jurisdictions (adapted from Wilmott et al., 2016)

Jurisdiction	Bill	Date introduced	Who introduced?
Australian Capital Territory	Voluntary and Natural Death Bill 1993 (plus 4 more)	18 June 1993	Michael Moore (Independent)
South Australia	Voluntary Euthanasia Bill 1995 (plus 19 more)	9 March 1995	John Quirke (Australian Labor Party)
Northern Territory	Rights of the Terminally Ill Act 1995	22 February 1995	Marshall Perron (Country Liberal Party)
Northern Territory	Criminal Code (Euthanasia) Amendment Bill 1997	18 February 1998	John Bailey (Australian Labor Party)
Commonwealth	Euthanasia Laws Act 1996	9 September 1996	Kevin Andrews (Liberal)
Commonwealth	Euthanasia Laws (Repeal) Bill 2004 (plus 6 more)	3 March 2004	Lyn Allison (Australian Democrats)
New South Wales	Voluntary Euthanasia Referendum Bill 1997 (plus 8 more)	15 May 1997	Elisabeth Kirkby (Australian Democrats)
Tasmania	Dying with Dignity Bill 2009	26 May 2009	Nick McKim (Australian Greens)
Tasmania	Voluntary Assisted Dying Bill 2013	26 September 2013	Lara Giddings (Australian Labor Party) Nick McKim (Australian Greens)
Tasmania	End of Life Choices (Voluntary Assisted Dying) Bill 2020	27 August 2020	Mike Gaffney (Independent)
Victoria	Medical Treatment (Physician Assisted Dying) Bill 2008	28 May 2008	Colleen Hartland (Australian Greens)
Victoria	Voluntary Assisted Dying Act 2017	20 September 2017	Jill Hennessy (Australian Labor Party)
Western Australia	Voluntary Euthanasia Bill 1997	16 October 1997	Norm Kelly (Australian Democrats)
Western Australia	Voluntary Assisted Dying Act 2019	7 August 2019	Roger Cook (Australian Labor Party)

Note: A more comprehensive version of this table is provided in Appendix 2

Table 2.3: Key reports on VAD in Australia and New Zealand

Jurisdiction	Body/Author	Date	Report
Australia	Parliament of Australia, Senate, Legal and Constitutional Affairs Legislation Committee	November 2014	Medical Services (Dying with Dignity) Exposure Draft Bill 2014
New Zealand	New Zealand Parliament, Justice Committee	April 2019	End of Life Choice Bill: As reported from the Justice Committee
Northern Territory	Parliament of the Northern Territory, Select Committee on Euthanasia	May 1995	The Right of the Individual or the Common Good? Report of the Inquiry by the Select Committee on Euthanasia
Queensland	Parliament of Queensland, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee	March 2020	Voluntary Assisted Dying
South Australia	Parliament of South Australia, Joint Committee on End of Life Choices	October 2020	Report of the Joint Committee on End of Life Choices
Tasmania	Larissa Giddings and Nicholas McKim	February 2013	Voluntary Assisted Dying: A Proposal for Tasmania (Consultation Paper)
Victoria	Parliament of Victoria, Legislative Council, Legal and Social Issues Committee	June 2016	Inquiry into end of life choices: Final report
Victoria	Victorian Government	July 2017	Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report
Western Australia	Parliament of Western Australia, Joint Select Committee on End of Life Choices	August 2018	My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices
Western Australia	Government of Western Australia	June 2019	Ministerial Expert Panel on Voluntary Assisted Dying: Final Report

Note: A more comprehensive version of this table is provided in Appendix 2

2.3 THE DEVELOPMENT OF VOLUNTARY ASSISTED DYING LEGISLATION IN VICTORIA, WESTERN AUSTRALIA AND SOUTH AUSTRALIA

The 2017 Victorian Voluntary Assisted Dying Act was introduced by the Sex Party and supported by the Labor Party, which established a comprehensive Inquiry into End of Life Choices. The government accepted all the Inquiry's recommendations, including the proposal to legalise VAD. In addition to extensive public consultation conducted during the Inquiry, further consultation and analysis were undertaken by a Ministerial Advisory Panel on Assisted Dying established by the Health Minister. The Advisory Panel was charged with looking at how assisted dying might operate in Victoria, not whether it ought to be established.⁴⁹ The Advisory Panel's recommendations are seen by commentators as proposing tight controls over VAD including on issues such as eligibility of people with dementia. Indeed, the Victorian approach, based on the Advisory Panel's recommendations, has been described by some critics as 'overly bureaucratic'.⁵⁰

The Voluntary Assisted Dying Bill 2017 was introduced into the Victorian Legislative Assembly, as a government bill, by the Health Minister Jill Hennessy on 21 September 2017. The Premier, Daniel Andrews, claimed that the bill was the safest and most conservative in the world and included all the 68 safeguards recommended by the Advisory Panel to protect individuals and the community.⁵¹ The bill passed the Upper House on 22 November 2017 with amendments and was re-introduced in the Lower House on 28 November 2017, passing on the same day. The bill received Royal Assent on 5 December 2017 but did not come into force until 19 June 2019.

In August 2019, the Voluntary Assisted Dying Bill 2019 was introduced by the McGowan Labor Government into the Western Australian Parliament. The Parliament established a Joint Select Committee to inquire into the need for laws in WA to allow citizens to make informed decisions regarding their own end of life choices.⁵² The Committee recommended that VAD be available to eligible persons as it regarded the then current lawful options for people experiencing grievous and irremediable suffering were inadequate. The Committee recommended that an expert panel be convened to draft the legislation, similar to the process that occurred in Victoria. The bill passed the WA Parliament on 10 December 2019, making WA the second Australian state to enact voluntary assisted dying laws. An 18-month implementation period immediately took effect with commencement expected in mid-2021.⁵³

In South Australia the Joint Committee on End of Life Choices Report was tabled in Parliament on 13 October, 2020. The report provided findings on the operation of voluntary assisted dying legislation and systems in other jurisdictions, but did not make any recommendations.⁵⁴ The Voluntary Assisted Dying Bill 2020 was then tabled in both houses of the South Australian Parliament on 2 December 2020: in the Lower House by Labor member Hon Susan Close and in the Upper House by Labor Member Hon Kyam Maher. Debate on the bill has been adjourned for the Christmas break and will recommence on 2 February 2021.⁵⁵

2.4 THE HISTORY OF VOLUNTARY ASSISTED DYING LEGISLATION IN TASMANIA

The Tasmanian Parliament and its Committees have considered the issue of VAD on three occasions prior to the current VAD Bill.

In 1996, after the passing of VAD into law in the Northern Territory and the subsequent Commonwealth response, the Tasmanian Parliament referred consideration of VAD to its Community Development Committee. A Mercury opinion poll was conducted at the time which asked respondents whether they would like to see Tasmania legalise voluntary euthanasia. 54% answered in the affirmative, 34% in the negative, and 10.8% were undecided.⁵⁶ Despite this public support for VAD, the Committee reported that it could not recommend VAD on the basis that 'determination for the need for legislation on voluntary euthanasia cannot be made on the basis of a subjective moral choice'.⁵⁷

13 years later, in 2009 Nick McKim, the Leader of the Australian Greens in the Tasmanian Parliament, introduced the Dying with Dignity Bill 2009. The 2009 bill sought to decriminalise voluntary euthanasia in Tasmania. The bill was modelled on the 1996 Northern Territory legislation and allowed a person with 'profound' suffering from a terminal illness to request assistance from a medically qualified person to voluntarily end their life in a 'humane and dignified manner'.⁵⁸ The bill also sought to ensure that a medical practitioner assisting such a person would not be subject to criminal charges. Safeguards in the bill included: that VAD would only be available to terminally ill people facing intolerable suffering who had expressed the wish to die; that a medical practitioner had to be involved; and that the patient be examined by three doctors, including a psychiatrist and a doctor qualified in the treatment of the terminal condition being suffered.

After tabling the Bill, the Deputy Premier Lara Giddings

referred the bill to the Joint Standing Committee on Community Development. The Committee was made up of three independent members of the Legislative Council (including Mike Gaffney) and four Members of the House of Assembly: two Labor party members, one Green and one from the Liberal Party. The Committee tabled its report in October 2009 with no recommendations but made a finding that the bill did not provide an adequate legislative framework. Members of the Committee were divided, with some finding the bill had too few safeguards while others believed there were too many safeguards to allow individuals to access VAD.⁵⁹

Subsequent to the tabling of the Committee's report, the bill was debated in the Lower House and defeated at the second reading 15 to 7.⁶⁰

Despite this defeat, Lara Giddings and Nick McKim continued to work on refining the draft VAD legislation.⁶¹ In February 2013, Giddings (then Premier) and McKim released a discussion paper. The paper proposed a model with certain eligibility criteria, including: that people accessing the VAD regime must be in the advanced stage of a terminal illness; be aged 18 or older; and be Tasmanian residents. In addition, there was to be a 14-day cooling off period; patients had to be mentally competent; give verbal and written consent; and have been assessed by at least two doctors. If granted access to VAD, patients would be able to self-administer or be administered the lethal medication by a doctor.⁶²

A co-sponsored VAD bill based on this model was introduced to Tasmanian Parliament later in 2013. This bill featured more safeguards than the model proposed in 2009. These included that there must be three requests by the patient and the consent of two GPs for VAD to occur. The 2013 bill failed to pass its second reading vote, but received more support than the 2009 attempt, with 11 in favour, 13 against, and one member (the Deputy Speaker) unable to vote.⁶³

PART TWO. TASMANIA'S END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020: KEY ELEMENTS AND COMPARATIVE ANALYSIS

Section 3:

The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020: A summary

The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (the initial Draft Bill) was introduced into the Tasmanian Legislative Council by the Hon Mike Gaffney MLC on 27 August 2020. After a lengthy Committee stage, the initial Draft Bill (as amended) passed the Legislative Council on 10 November 2020.

This section describes the key elements of the VAD Bill as passed by the Legislative Council, including a synopsis of substantive amendments which were either considered or made during the Committee debate. This synopsis serves as the basis for the comparative analysis (see Section 4) of the Tasmanian VAD Bill and similar legislation or bills in Victoria, Western Australia, South Australia, Canada and New Zealand.

3.1 OBJECTIVES AND PRINCIPLES

The VAD Bill outlines the key objectives and principles which inform the design and operation of the proposed legislation. The key objectives of the VAD Bill are to:

- provide an efficient and effective VAD process
- facilitate the making of choices in relation to end-of-life decision-making
- protect persons from having their lives ended unwittingly or unwillingly
- provide protection for registered health practitioners who are involved in the VAD process (s. 3(1))

The VAD Bill sets out 11 principles which must be considered when any person exercises or performs a power or function under the regime proposed in the VAD Bill (s. 3(2)). The primary themes which emerge from this list of 11 principles are those of:

- the equal value of every human life
- promoting patient autonomy
- the need to ensure equality of access to VAD for all Tasmanians, irrespective of their geographical location, cultural practices or language
- the need to protect persons against coercion and abuse
- the right of all persons, including registered health practitioners, to be shown respect for their culture,

religion, beliefs, values and personal characteristics

- the need to support informed decision-making
- the need to encourage open discussion in relation to care, death and end-of-life decisions
- the need to provide high-quality care and support therapeutic relationships

3.2 Eligibility

Section 10 of the VAD Bill stipulates five eligibility criteria, all of which must be met for a person to be eligible to access VAD. These criteria are further explained in Part 3 of the VAD Bill.

3.2.1 Age

Persons seeking to access VAD must be 18 years or older.

3.2.2 Residency

Persons must be either an Australian citizen, or a permanent Australian resident, or someone who has resided in Australia for three continuous years immediately prior to making their first request for VAD. The person must have also ordinarily resided in Tasmania for at least 12 continuous months immediately prior to making their first request (s. 11).

3.2.3 Decision-making capacity

A person has decision-making capacity in respect of a decision made under the VAD Bill when they appear able

to: understand the information that is required to make their decision; remember this information to the extent that they can make their decision; evaluate this information in order to make their decision; and communicate their decision to another, through written, oral, behavioural or other means. The VAD Bill presumes that persons have such decision-making capacity unless it appears otherwise (s. 12(1)-(2)).

Where the assessing and consulting medical practitioners are themselves unable to determine if a person has decision-making capacity, they must refer that person to a medical practitioner, psychiatrist or psychologist who has the relevant training to make such a determination (s. 12(4)). The practitioner may adopt the specialist's determination as their own (s. 12(5)).

3.2.4 Voluntariness

A person acts voluntarily when they are not acting under duress, coercion, or because of a threat of punishment or unfavourable treatment, or a promise to give a reward or benefit to any person (s. 13).

3.2.5 Persistent suffering

The person must be suffering intolerably in relation to a relevant medical condition (s. 14). Under the VAD Bill, persons suffering from a mental illness or a disability alone are not eligible to access VAD (s. 10(2)).

A relevant medical condition is defined in s. 6 of the Bill and comprises a disease, illness, injury or medical condition that is advanced, incurable and irreversible. This condition must be expected to cause the death of the person within six months of their request to access VAD (or 12 months in the case of a neurodegenerative disease). Finally, any reasonably available treatment must be considered unacceptable to the person, and there must be no reasonably available treatment that can cure or reverse the disease or condition and prevent the death of the person from that condition. For the purposes of the VAD Bill a treatment is only reasonably available where the person may access it in Australia within reasonable time and at a cost which is not prohibitive. The person must also consider that their suffering in relation to the relevant disease or medical condition is intolerable. This suffering must be constituted by either actual suffering or the anticipation of suffering arising from the person's relevant medical condition, any treatment of their condition or any complications likely to arise from such treatment (s. 14(b)).

Legislative Council Committee debate and amendments concerning eligibility

The definition of 'relevant medical condition' was determined by an amendment proposed by the Member for Murchison (Hon. Ruth Forrest), passed in an 11:3 division (Legislative Council, *Votes and Proceedings*, 13 October 2020, p. 429). The Member for Mersey (Hon. Mike Gaffney) proposed two unsuccessful amendments to the definition, which would have inserted the words 'on the balance of probabilities' in relation to the expectation of the person to die within six or 12 months and changed the timeframe from six or 12 months to 'within 2 years' (pp. 428-429). The Member for Mersey argued that imposing a timeframe conflicts uncomfortably with the inability of medical practitioners to predict precisely when a person's death will occur (*Parliamentary Debates*, 13 October 2020, p. 59). However, other members wished to preserve the safeguard of a six- or 12-month timeframe, and to remain consistent with other Australian jurisdictions on the matter (p. 59). The first of the Member for Mersey's amendments was therefore negatived without debate, and the second was defeated on a division of 10:4. Despite these unsuccessful amendments, the Member for Murchison proposed a second successful amendment to the definition in response to the concerns raised by the Member for Mersey. This amendment allows the Commission to issue exemptions from the requirement that death be expected within six or 12 months, upon application by the person seeking VAD (Legislative Council, *Votes and Proceedings*, 27 October 2020, p. 479). These amendments are now reflected in section 6 of the Bill.

A successful amendment proposed by the Member for Murchison to remove subclause 142(3) from the draft Bill was passed in an 11:3 division (pp. 474-475). Under subclause 142(3) of the draft Bill, a review was to be conducted to investigate the use of VAD by persons under 18 in other jurisdictions, in order to better understand the processes allowing for this (*Parliamentary Debates*, 27 October 2020, p. 163). The record of debate indicates that Members were concerned that leaving the clause in the Bill may cause controversy and threaten the success of the whole Bill (pp. 162-170).

3.3 CONSULTATION AND REFERRAL PROCESS

3.3.1 Practitioner roles

The VAD Bill contemplates a range of practitioners being involved in the VAD process. Parts 5-14 of the VAD Bill explain the roles and duties of the Primary Medical Practitioner, the Consulting Medical Practitioner, and the Administering Health Practitioner

The Primary Medical Practitioner ('PMP')

A person's PMP is the practitioner who accepts a person's first request to access VAD. This process is described in Part 5 of the VAD Bill. A person can make a first request orally or in writing to a registered medical practitioner when they wish to access VAD and have been given the relevant information. The practitioner must then accept or refuse to accept this request. Acceptance renders the practitioner the requesting person's PMP, though they may withdraw from the role at any time. They may also refuse to accept the request for any reason, including having a conscientious objection to providing assistance to die, and they are not required to give reasons for their decision to accept or refuse (ss. 20-21).

The PMP must determine whether a person is eligible for VAD by meeting all of the eligibility criteria discussed above (3.2) and may refer the person to another medical practitioner to assist with this determination (s. 25).

When 48 hours have passed since the person made their first request for VAD, the PMP may hear and determine the person's second request for VAD. If the PMP finds that the person is eligible to access VAD, the PMP initiates referral to another practitioner (the Consulting Medical Practitioner) for a second opinion (see 3.3.2).

After this referral has taken place, and the person has been found to be eligible to access VAD, the person may make a third and final request for VAD to the PMP (s. 53). This final request cannot be made within 48 hours of their second request. If the PMP determines that the person is eligible to seek VAD, they must next orally or in writing request that the VAD Commission ('the Commission') (see 3.6) issues a VAD substance authorisation, invoking the Commission's role of authorisation in relation to the prescription of a VAD substance. This process is governed by Part 12 of the VAD Bill. Upon receiving this request, the Commission must either issue to the PMP the relevant VAD substance authorisation or refuse to issue the authorisation (ss. 66-68). The Commission must refuse such an authorisation where it has not received all notices and information in relation to the person seeking VAD (as required under the VAD Bill), or where they suspect that the requirements

of the VAD Bill have not been met with respect to that person. If the Commission refuses this authorisation, it must within two business days notify the PMP of the refusal, accompanied by reasons for their decision.

If the Commission issues authorisation to the PMP in relation to a VAD substance, the PMP may then issue a VAD substance prescription and receive the VAD substance from a pharmacist. Prior to filling this prescription, the pharmacist, if they choose to participate, must discuss the person's medical condition with the person in order to assess the suitability for use of the VAD substance in relation to the person (ss. 70-71).

The Consulting Medical Practitioner ('CMP')

The CMP is the medical practitioner who accepts the PMP's referral, after the PMP has found the person eligible to seek VAD pursuant to the person's two requests for VAD.

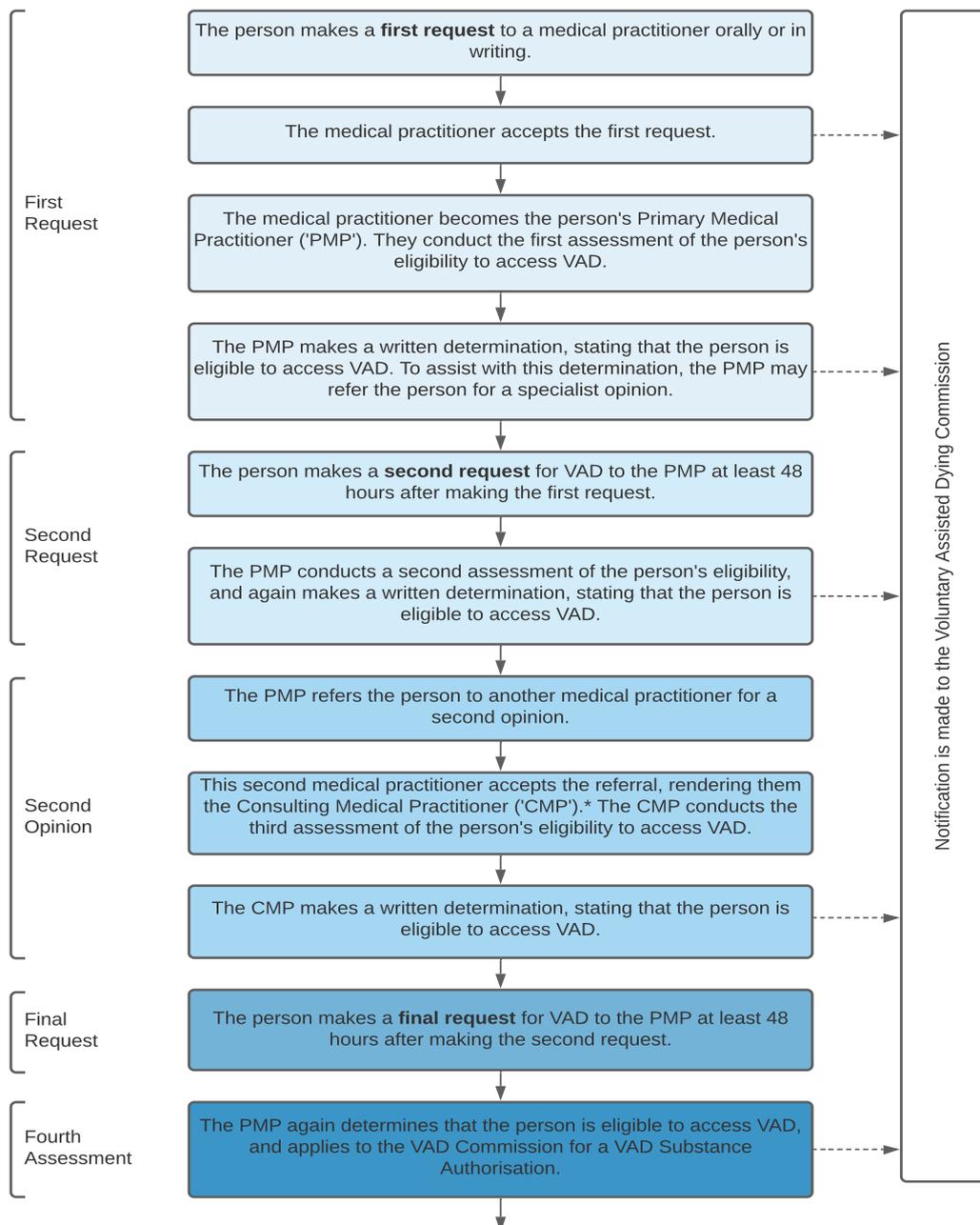
This referral process is elaborated in Part 7 of the VAD Bill. The CMP receives reports and information from the PMP, examines the person making the VAD request, and may refer to another practitioner to assist in their determination of the person's eligibility.

Where the CMP determines that the person is not eligible to access VAD, only one more medical practitioner may be consulted (s. 38). The initial VAD process ends if two CMPs find that the person is not eligible, but the person may subsequently make a new first request for VAD. This subsequent new request cannot be accepted by the same PMP within 12 months after the second CMP's original determination of ineligibility (pt. 9 div. 2). If a CMP determines that the person is eligible for VAD, the person may then give final permission to their PMP in relation to their request for VAD (see 3.4 below).

The Administering Health Practitioner ('AHP')

The AHP is responsible for the administration of the VAD substance. The PMP must decide whether they will be the AHP, or they can request that the VAD Commission appoints an AHP (pt. 11). The role of the AHP is further discussed below in 3.4.

Figure 3.1: The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 consultation and referral process



See section 3.4 for the proposed steps associated with the administration of the VAD substance.

*If the first medical practitioner to whom the person is referred by the PMP refuses to accept the referral for any reason, including, but not limited to their having a conscientious objection to providing assistance to die, the PMP must refer the person to another medical practitioner. The VAD process ends if two CMPs have accepted the referral and have determined that the person is ineligible to access VAD. Such a finding does not prevent the person from making a new first request.

3.3.2 Health practitioner qualifications

The PMP and CMP must be authorised medical practitioners, the requirements for which are contained in s. 9 of the VAD Bill. PMPs and CMPs must be registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession as a non-student; they must either be a vocationally registered general practitioner or hold a fellowship with a specialist medical college; they must have relevant experience in treating or managing the person's relevant medical condition; they must not be a family member of the person; they must not stand to financially benefit as a result of the person's death; and they must have successfully completed an approved VAD training course within the five-year period immediately before the person makes their first request for VAD.

An AHP can be either a medical practitioner or a registered nurse. A person can be an AHP if they have agreed to be an AHP; they have signed a statutory declaration declaring their having completed an approved VAD training course within the five-year period immediately before being appointed as AHP; that they are not a family member of the person; that they have relevant experience; and that they do not stand to receive a financial benefit from the person's death (ss. 62-63).

3.4 ADMINISTRATION OF VOLUNTARY ASSISTED DYING SUBSTANCE

Where a person has made a first, second and final request for VAD, 48 hours prior to that person giving final permission to the AHP, the AHP must undertake a further assessment of the person's decision-making capacity and the voluntariness of their decision to access VAD, and may refer the requesting person to a medical practitioner in order to make that determination (pt. 13). Provided that the AHP finds the person to be acting voluntarily and to have decision-making capacity, the AHP must explain to the person a number of pieces of information, including that the requesting person is entitled to receive assistance to die, the consequences of the administration of the lethal substance, and the need to give final permission if they wish to continue with VAD (s. 81).

The final permission is an instrument in the prescribed form and must indicate the person's wishes in relation to how administration should occur, and what should happen if complications arise during the course of administration where the AHP is present (s. 82).

3.4.1 Types of administration

In the final permission the person is required to provide a statement of their wishes for administration of the lethal substance. The VAD Bill provides for four types of administration to occur, each explained below.

Private self-administration

A person may indicate in their final permission that they wish to self-administer the VAD substance in private. If so, they must make a private self-administration request in the prescribed form to the AHP, signed by the requesting person or a person designated to complete or sign the form for that person. Upon receiving this request, if the AHP is satisfied that the requesting person is capable of self-administering the VAD substance, the AHP must complete and sign a private self-administration certificate, and within 48 hours provide a copy of this certificate to the person, the person's PMP and the VAD Commission (pt. 13, div. 3).

The person seeking to self-administer must then appoint an adult contact person by completing the prescribed form. If they accept, the contact person has obligations in respect of notifying the VAD Commission and, if applicable, the police as to the death of the person, and regarding the return of any remaining quantity of VAD substance.

The requesting person is then supplied with the VAD substance by the AHP and from then on able to administer the substance at a time and place of their choosing (pts. 13-14).

Self-administration with the Administering Health Practitioner present

If the requesting person wishes to self-administer a VAD substance, the person must request from the AHP an AHP Administration certificate. Whilst the person is self-administering the VAD substance the AHP must either be in the same room or place as the person or a nearby place from which any noise made by the requesting person can be heard. The AHP must remain in that close location until the person has died or is removed from the room or place to receive medical treatment as the case may be.

Assisted self-administration

If the requesting person wishes to self-administer with the assistance of the AHP, the person must request from the AHP an AHP Administration Certificate. The VAD Bill provides that such a certificate may only be issued if the AHP is satisfied that self-administration without assistance is inappropriate, taking into consideration any one of the specified considerations which include the person's ability to both self-administer and digest

Legislative Council Committee debate and amendments concerning consultation and referral processes

The Member for Mersey (Hon Mike Gaffney) proposed an amendment which established section 27(4)(a) and (b) of the Bill, which was passed on an 8:6 division (Legislative Council, *Votes and Proceedings*, 13 October 2020, p. 431). Under these subsections, when a person's PMP has decided the person is eligible for VAD, the PMP must, with the person's consent, inform a family member of the person of all relevant facts about the process of accessing VAD. The PMP must also take all reasonable steps to explain to the family member what arrangements can be made to facilitate self-administration, if the person intends to self-administer. Members who chose not to support the amendment did so because they believed that the amendment was legally unnecessary (*Parliamentary Debates*, 27 October 2020, p. 40).

The Member for Rumney (Hon. Sarah Lovell) proposed section 17 which prevents certain people from initiating discussions about VAD unless they follow the requirements set out in the subsections (Legislative Council, *Votes and Proceedings*, 27 October 2020, p. 481). While the Council was divided upon whether to read the clause a second time in a 10:4 division, the amendment was ultimately passed. Once again, Members who voted against the amendment did so because they believed it to be legally unnecessary (*Parliamentary Debates*, 27 October 2020, p. 210).

A failed amendment was proposed by the Member for Huon (Hon. Bastian Seidel) to allow a person to make a request for VAD by way of audio-visual link. The Council was split with a 8:6 division with the majority rejecting the proposed amendment (*Parliamentary Debates*, 27 October 2020, p. 31). Those in support emphasised that it would align the VAD consultation process with the existing regulations and standards of good medical practice and would improve access to care, in particular for those patients living in remote areas of Tasmania. The view was also put that while face-to-face appointments are preferable, COVID-19 has highlighted the need for flexible options such as conducting services via audio-visual links. Those who voted against the amendment pointed to: a belief that at least one face-to-face meeting in the process is important for the doctor to make an accurate assessment of eligibility; the difficulty of assessing coercion when a doctor cannot see who else is in the room, and; concerns with the reliability of telehealth (pp. 14-31).

Legislative Council Committee debate and amendment concerning institutional non-participation

A failed amendment, New Clause D [Conscientious objection by entities providing health care inserted], sought to allow for entities providing health care to refuse to authorise or permit the carrying out of any part of the VAD process at their premises. However, the amendment proposed that such entities, which have an objection to VAD, must advise any persons expressing a wish to access VAD of their refusal to authorise or permit any part of the VAD process on their premises and offer to and undertake reasonable steps to facilitate the transfer of any patient who wants to undertake VAD to a health care facility that does not object to VAD (Legislative Council, *Votes and Proceedings*, 30 October 2020, pp. 496-497). Dr Seidel explained that this amendment was based on a similar clause in the draft VAD Bill for Queensland; and modelled and based on the work by Ben White and Lindy Wilmott from QUT. Dr Seidel argued that without this amendment there would be no chance of access for terminally ill patients if their institution objected to VAD. He continued: 'The amendment aims to ensure that a person eligible for VAD is able to access it, recognising they may need the cooperation of the current institution to achieve this whilst also respecting the position of an institution which does not want to be involved' (*Parliamentary Debates*, 30 October 2020, p. 3).

In the ensuing debate many Members stated that they did not believe this clause was necessary as they could not imagine institutions blocking attempts by residents or patients to access VAD and so were not supportive of the amendment. Indeed, Mike Gaffney remarked that 'I find even the idea that this supposedly caring entity might wish to impose greater suffering on a person to be totally repugnant' (p, 4). Others felt that it would encourage facilities to transfer patients or residents to other facilities thus causing more difficulties for patients at an already very difficult time. MLC Meg Webb did not support the amendment because she felt there was a legal assumption built into the proposed clause, which is that entities have the legal right to prevent people accessing legal health services. The amendment was negated on the voices without going to a division (*Parliamentary Debates*, 30 October 2020, pp. 1-34).

the VAD substance, any concerns the person has about self-administration, and the method of administration which is suitable for the person (s. 86(5)). For assisted self-administration, as is the case with self-administration with the AHP present, AHPs are also required to remain in the same or nearby room or place as the person as for self-administration.

Direct administration by the Administering Health Practitioner

If the requesting person wishes for the AHP to directly administer to them a VAD substance, they must apply to the AHP for an AHP Administration Certificate. The circumstances under which the AHP can issue this certificate are the same as those outlined for assisted self-administration, as are the AHP's obligations after completion of the administration of the VAD substance.

3.4.2. Planning for complications in the voluntary assisted dying process

In the final permission the requesting person must indicate whether, if complications arise in the course of administration by the AHP or self-administration assisted by the AHP, they wish for the AHP to administer to them a substance that will painlessly hasten their death, or whether they wish the AHP to take life-preserving action (s. 82(3)). Should such a complication occur, the AHP must follow the directions contained in the final permission (s. 88).

3.5 LEGAL AND OTHER PROTECTIONS

3.5.1 Key safeguards for the person

Consistent with its overarching objectives and principles, the Bill includes many protections for persons seeking to access VAD.

Two registered medical practitioners are required to certify that the person is eligible to access VAD, a person must make three formal requests for VAD as well as giving final permission, and the person's decision-making capacity and voluntariness is assessed on five separate occasions (three times by the PMP, once by the CMP, and once by the AHP prior to the person giving the final permission). Authorised medical practitioners must have the relevant qualifications, they must not be a family member of the person, and they cannot know or believe that they stand to receive a financial benefit from the person's death (see s. 9 of the Bill).

The VAD process must be well-documented. Requests for VAD made by the person must be made orally or in writing, and any determination of a person's request cannot be made by a medical practitioner unless that

practitioner has met with the person in person or by way of audio-visual link, through which the practitioner has been able to determine the person's decision-making capacity (ss. 27(1), 34(1), 48(1), 56(1)). Requests for VAD which have been made, accepted, refused, or determined must all be notified to the Commission in the approved form, and in many cases, noted on the medical practitioner's medical records in relation to the person. For example, where a PMP accepts a person's first request for VAD they must, within seven days, notify the person of the acceptance of the request, notify the Commission in the approved form of the acceptance, and note the acceptance on the person's medical records (s. 23). A person's requests must be signed by the person or by a designated adult where the person is not able to sign or complete the instrument themselves. The person's signature on their second request for VAD must be witnessed by at least two adults. Only one of these witnesses can be a family member of the person, a person who knows or believes that they stand to financially benefit from the person's death, the person's residential care provider or agent thereof, or a resident of the facility in which the person making the request resides (s. 31).

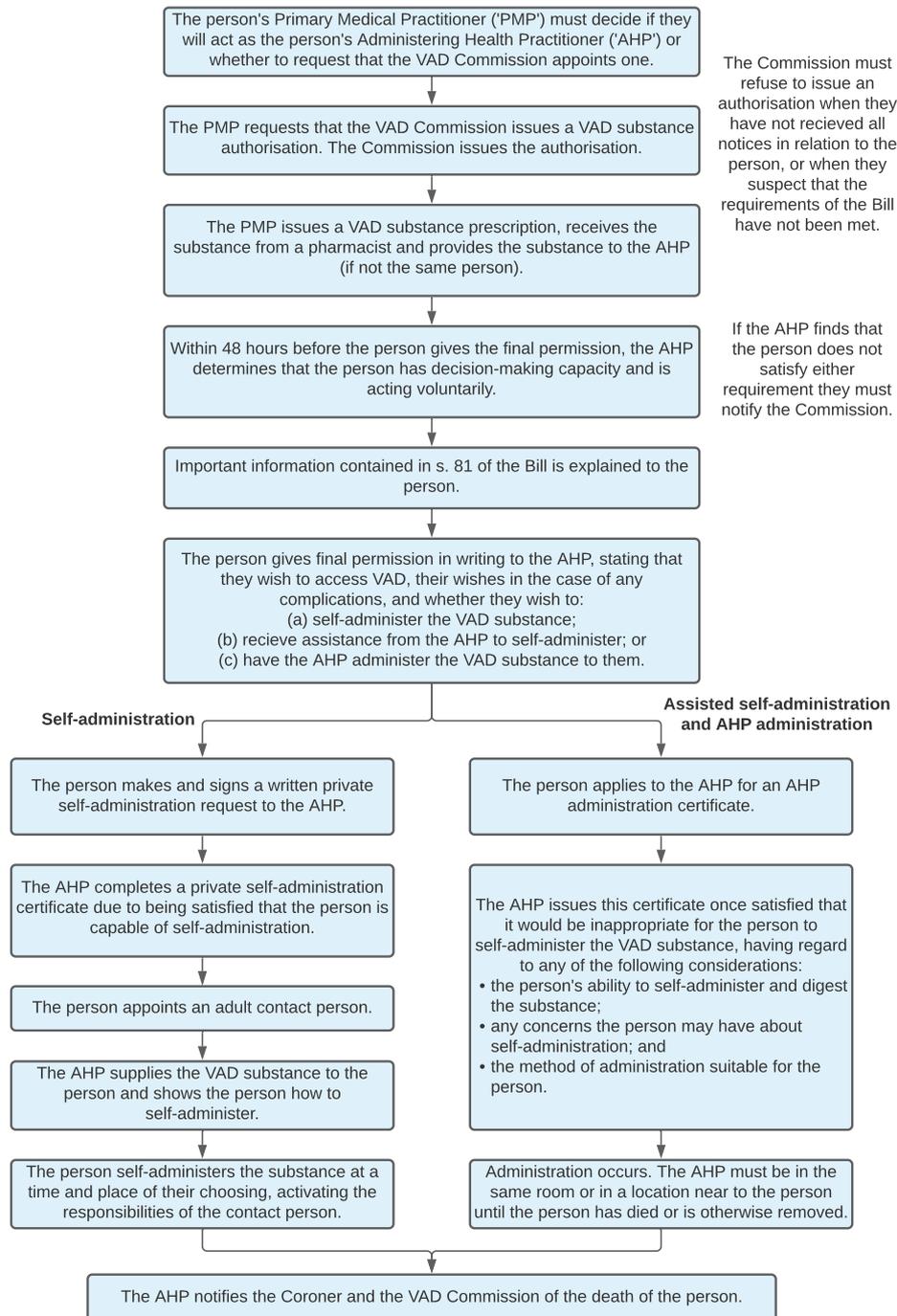
Registered health practitioners are not able to initiate discussions with a patient which relate to the VAD process unless, in this discussion, they also inform the person about the palliative and non-palliative treatment options open to them, and the likely outcomes of those treatments. Health practitioners who are not medical practitioners may also only initiate a discussion about VAD if they inform the person that a medical practitioner would be the most appropriate person with whom to discuss VAD and their care and treatment options. The Bill makes clear that this prohibition does not prevent a registered health practitioner from providing information about the VAD process at a person's direct request (s. 17).

Finally, in Part 18 the Bill criminalises certain instances of conduct in relation to the falsification of records and statements, unfaithful representations, undue influence and dishonest inducement to use a VAD substance.

3.5.2 Protections for health practitioners

Participation of health practitioners in the VAD process is entirely voluntary. Medical practitioners can refuse to accept a person's request for VAD or a referral to determine a person's eligibility for VAD for any reason, which may include their conscientious objection to providing assistance to die, and medical practitioners are not required to provide reasons for refusal to participate. Similarly, pharmacists can refuse to supply a VAD substance (s. 71(3)). PMPs, CMPs and AHPs can cease to participate in the VAD process at any stage, and Part

Figure 3.2: The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 administration process



16 of the Bill makes provision for the eventuality that such practitioners may leave their roles.

Health practitioners who act in good faith and without negligence pursuant to the VAD Bill do not incur civil or criminal liability, nor face professional disciplinary consequences, even where their actions or assistance in the VAD process may otherwise constitute an offence. Medical practitioners are also not liable to any punishment, sanction or censure by any person or body for having made or accepted a referral in relation to the VAD process. Broad legal protection is given to registered health practitioners, registered nurses and Ambulance Service officers who, in good faith, do not administer life-sustaining treatment to a person who has not requested it, believing that the person is dying after the administration of a VAD substance in accordance with the VAD Bill. Such persons are not liable under Tasmanian criminal or civil law, or under any code of conduct, nor may they face professional disciplinary consequences (pt. 19).

Only where registered medical and health practitioners take actions under the VAD regime in bad faith or negligently may their actions be capable of triggering professional disciplinary consequences for the purposes of the Health Practitioner Regulation National Law (Tasmania).

3.5.3 Protections for others

The VAD Bill contains requirements as to how the VAD substance is to be stored, both by the PMP and by persons intending to self-administer the substance. PMPs who receive a VAD substance pursuant to authorisation from the Commission and the dispensing of the substance by a pharmacist have obligations in relation to how the substance is stored. PMPs must ensure that the substance is contained in a locked receptacle that is not readily accessible by any other person, and located at the PMP's usual place of employment as a medical practitioner. These same obligations apply to an AHP when they are in possession of the VAD substance. Exceptions are only provided in cases where the PMP is transporting the VAD substance to another place for provision or administration to the requesting person. Provisions are made in the VAD Bill for the return of the VAD substance to a pharmacist in situations where the PMP or AHP possesses the VAD substance and the substance is no longer required. (pt. 12, div. 3).

Where a person is to self-administer the VAD substance, that person must ensure that the VAD substance is kept in its original packaging and in a locked receptacle, and that the substance is not readily accessible by any other person. Persons who wish to self-administer must also nominate an adult contact person whose duties include returning the remaining VAD substance to the person's

Legislative Council Committee debate and amendments concerning administrative process and legal protections

The Member for Rumney (Hon. Sarah Lovell) successfully proposed an amendment which is now reflected in section 15 of the Bill (Legislative Council, *Votes and Proceedings*, 13 October 2020, p. 432). Section 15 operates to prevent certain persons – such as family members – from communicating on behalf of the person accessing VAD. It is designed to guarantee that the practitioners who communicate with persons accessing VAD can be confident that the person is acting entirely voluntarily (*Parliamentary Debates*, 13 October 2020, p. 131). However, a subsequent amendment was made to section 15 by the Member for Murchison (Hon. Ruth Forrest). This later amendment permits the Commission to grant exemptions to the prohibition in section 15, allowing a person otherwise barred by section 15 to communicate with medical practitioners on behalf of the person accessing VAD (p. 134). The Member for Murchison's amendment arose out of a concern that some circumstances may make communication between medical practitioners and family members necessary (p. 134).

More generally, several amendments were made to strengthen provisions preventing persons involved in the VAD process, such as medical practitioners and family members, from gaining undue financial benefit (Legislative Council, *Votes and Proceedings*, 13 October 2020, p. 431). There were also amendments to ensure that all involved medical practitioners are independent from each other and the persons accessing VAD during the referral and consultation processes. The purpose of these amendments was to ensure greater safeguards against potential abuse of the legislation.

AHP after the person's death and ensuring that the VAD substance is kept in a locked receptacle that is not readily accessible by any other person whilst they have possession of it (ss. 85, 92).

The VAD Bill also affords protection to persons who, in good faith, assist a person or who are present in relation to the VAD process, by providing that such persons do not incur any criminal liability (s. 132).

3.6 MONITORING AND OVERSIGHT

The Voluntary Assisted Dying Commission (VAD Commission) is established in Part 17 of the VAD Bill. It consists of a Chairperson of the Commission and Executive Commissioner, a Deputy Executive Commissioner and at least three other members as necessary for the VAD Commission's functioning (s. 110). The members of the VAD Commission cannot perform a function in relation to a person who is a family member, or in situations where a financial interest may be affected by the exercise of the member's functions.

The VAD Commission has a dual primary function: to regulate and to review the VAD regime's operation. The VAD Commission's primary regulatory functions include monitoring the operation of the regime; disseminating information on the Commission and the operation of the Bill; collecting statistical data in relation to the operation

of the regime; and establishing and maintaining lists of appropriately trained and willing medical practitioners, registered nurses and pharmacists. The VAD Commission may, with consent, disseminate the contact information of these practitioners who are able and willing to be involved in the VAD process (s. 113).

The VAD Commission is also tasked with reviewing the exercise of powers under, and compliance with, the VAD regime and is empowered to investigate and/or communicate to the relevant authorities any concerns about non-compliance or the operation of the VAD regime more generally. It is also the role of the VAD Commission to determine the substances that will be VAD substances and to approve training courses which PMPs, CMPs and AHPs may undergo in order to be qualified to participate in the VAD process. The VAD Commission must provide an initial report to the Minister on the operation of the VAD regime during its initial six months and provide to the Minister annual reports containing details of the administration and operation of the regime. The Minister must table these reports in each House of Parliament within five sitting days of receipt (ss. 116, 142, 119).

In addition to the substantive provisions of the VAD Bill, section 144 establishes a process whereby the Governor, acting on the advice of the Minister, may make regulations for the purpose of the Act.

Legislative Council Committee debate and amendments concerning monitoring and oversight

An amendment to section 113 added a subclause which aims to guarantee the independence of the VAD Commission (Legislative Council, Votes and Proceedings, 27 October 2020, p. 470). Subclause 113(5) clarifies that members of the Commission are not subject to the control of the Minister, and that they may not exercise their power in relation to any family member, or where the exercise of power may be affected by financial or other interests. Other successful amendments established the composition of the Commission, the appointment of its members, the entitlements of the members and the procedures for meetings of the Commission (Legislative Council, Votes and Proceedings, 29 October 2020, pp. 494).

Section 4: The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 in comparative perspective

As required by our Terms of Reference, this section provides a systematic comparison of Tasmania's VAD Bill with legislation and bills relating to VAD in other Australian states and comparable overseas jurisdictions. Given existing Australian VAD legislation and bills are based on the Victorian *Voluntary Assisted Dying Act 2017*, Section 4.1 summarises key elements of the Victorian law. Summaries of the subsequent Western Australian Act, the VAD Bill currently before the South Australian Parliament and the key elements of the Canadian and New Zealand legislation are provided in Appendix 3.

Detailed summary tables describing key similarities and differences between the Tasmanian VAD Bill and the five jurisdictions listed above are presented in Section 4.2. This comparative analysis focuses on the six key elements of VAD legislation identified in Section 3, namely:

- The objectives and principles of the legislation
- The eligibility criteria for accessing VAD
- The elements of the consultation and referral process
- The procedures for the administration of the VAD substance
- The legal and other protections within the VAD legislation
- The monitoring and oversight provisions
- the need to support therapeutic relationships between persons and their health practitioners
- encouragement of open discussions around death and dying
- the provision of support for persons in conversation with others about their treatment and care preferences
- the entitlement of all persons to genuine choices in relation to treatment and care
- the need to protect individuals from abuse
- the right of all persons, including health practitioners, to be shown respect for their culture, beliefs and values

The Section concludes (4.3) with a more focused analysis of the key differences between Tasmania's draft Bill and interstate VAD legislation.

4.1 KEY ELEMENTS OF THE VICTORIAN VOLUNTARY ASSISTED DYING ACT 2017

4.1.1 Objectives and principles

The Victorian Act sets out a list of 10 principles which must be considered by any person exercising a power or performing a function under the Act (s. 5). They include:

- that every human life has equal value
- the need to respect persons' autonomy
- a person's right to be supported in making decisions about their medical treatment options including palliative care
- the need to provide persons approaching the end of life with quality care

4.1.2 Eligibility

The eligibility criteria for accessing voluntary assisted dying in Victoria are contained in Part 2 of the Victorian Act. They are that:

- The person must be 18 years or older
- The person must be either an Australian citizen or a permanent resident, who has been ordinarily resident in Victoria for at least 12 months prior to making the first request
- The person must have decision-making capacity in relation to VAD, which is the capacity to understand, retain, weigh and communicate relevant information. Persons are presumed to have such capacity (s. 4)
- The person must be diagnosed with an incurable, advanced and progressive illness which is expected to cause death within six months, or 12 months in the case of a neurodegenerative illness. This illness must be causing suffering which

cannot be tolerably relieved. Persons are not eligible solely because they have a disability or have been diagnosed with a mental illness (ss. 9(2)-(3))

4.1.3 Consultation and Referral Process

Practitioner Roles

The Victorian Act makes provision for a minimum of two medical practitioners to participate in the VAD process. A person's Coordinating Medical Practitioner is the practitioner that accepts their first request for VAD and conducts the first assessment of the person's eligibility for VAD (pt. 3, div. 3). The Coordinating Medical Practitioner may then refer the person to the Consulting Medical Practitioner who conducts the second assessment of the person's eligibility pursuant to (pt. 3, div. 4). Both practitioners must find the person eligible for VAD provided the requesting person meets the eligibility criteria, understands important information relating to VAD, is acting voluntarily and without coercion, and that the person's request for VAD is enduring. Further, both practitioners must refer the person for a specialist's opinion if they are unable to determine the person's eligibility (ss. 18, 27). If the Consulting Medical Practitioner finds the person ineligible for VAD, the Coordinating Medical Practitioner may refer the person to another registered medical practitioner for a further consulting assessment (s. 31).

If both the Coordinating and Consulting Medical Practitioners find that the person is eligible to access VAD, the person seeking VAD may then make a written declaration, appropriately signed, witnessed, and made in the prescribed form (pt. 3, div. 5). Next, the person can make a final request for VAD to the Coordinating Medical Practitioner, who then conducts a final review of all the forms completed pursuant to the eligibility and assessment process. For the VAD process to continue, the final review must culminate in the Coordinating Medical Practitioner certifying that the request and assessment process has been completed as required under the Act, and the provision of the entirety of this documentation to the VAD Board (pt. 3, div. 6).

Practitioner Qualifications

Both the Coordinating and Consulting Medical Practitioners must hold a fellowship with a specialist medical college or be a vocationally registered general practitioner. One of them must have practised as a registered medical practitioner for at least five years after completing either the fellowship or after having become vocationally registered. At least one of them must have relevant expertise and experience in the

disease, illness or medical condition of the person seeking to access VAD (s. 10), and both must have completed approved assessment training.

4.1.4 Administration of VAD Substance

If the Coordinating Medical Practitioner has certified in a final review form that the request and assessment process has been completed in accordance with the Act, they may apply to the Secretary (the Head of the Department of Health and Human Services) for a VAD permit for the person pursuant to Part 4 of the Act.

Self-administration is the default administration procedure under the Act, and the Coordinating Medical Practitioner may apply for a practitioner administration permit only if satisfied that the person is physically incapable of the self-administration or digestion of the VAD substance. The Secretary may refuse a permit if they are not satisfied that the request and assessment process was properly complied with (ss. 48-49). The issuing of a self-administration permit authorises the Coordinating Medical Practitioner to prescribe and supply the VAD substance to the person, and the person to obtain, possess, store, and self-administer the substance (s. 45). Under the Act, self-administration of the VAD substance does not need to be supervised by a medical practitioner. A practitioner administration permit authorises the Coordinating Medical Practitioner to prescribe the VAD substance, to receive a request for administration from the person in the presence of an eligible witness, and to administer to the person the substance, also in the presence of a witness (s. 46).

4.1.5 Legal and other protections

Under the Victorian Act, registered health practitioners are prohibited from initiating a discussion with a patient which is in substance about VAD (s. 8). Further, persons who seek access to VAD are able to withdraw at any time, and the minimum time in which the process can be completed is 10 days (s. 38). Finally, the VAD process is heavily documented, with prescribed forms required to be completed and submitted to the VAD Board, requirements around who can witness documents, and requirements about the signing of these documents. To support many of these provisions, the Act criminalises conduct that is non-compliant with the Act, including the failure of a contact person to return unused VAD substance after a person's death, and the failure to give copies of documents to the VAD Board (pt. 8).

The participation of registered health practitioners in the VAD process is entirely voluntary. Practitioners are able to withdraw at any time, and they can refuse

requests and referrals on grounds including their having a conscientious objection to providing assistance with VAD (s. 7). Specific protection from liability is afforded to registered health practitioners and others who in good faith and without negligence perform an act or omission under the Act, and is extended to ambulance paramedics who are present after administration of a VAD substance (pt. 7, div. 2).

The Act contains provisions which relate to the secure storage and handling of the VAD substance. Self-administering persons must appoint a contact person to handle any remaining or unused VAD substance (s. 39), and pharmacists must comply with prescribed labelling requirements for the VAD substance. Prior to administration, persons must store the substance in a locked box (pt. 5, div. 1).

4.1.6 Monitoring and oversight

The Victorian Act establishes the VAD Review Board, which reviews and reports to Parliament on the Act and can refer any issues to relevant persons and organisations including the police, the State Coroner, and AHPRA (s. 93). The Secretary (the Head of the Department of Health and Human Services) determines applications for VAD permits and can refuse such permits on the basis that the requirements of the Act have not been complied with (s. 49).

Key resources

- Ministerial Advisory Panel on Voluntary Assisted Dying 2017, *Final Report*
- Parliament of Victoria Legislative Council 2016, Inquiry into end of life choices, *Final Report*.
- White, B, Del Villar, K, Close, E & Willmott, L 2020, 'Does the voluntary assisted dying act 2017 (Vic) reflect its stated policy goals?', *University of New South Wales Law Journal*, vol. 43, no. 2, pp. 417-451.
- Rutherford, J 2020, 'Doctors and the voluntary assisted dying act 2017 (Vic): knowledge and general perspectives', *Journal of Law and Medicine*, vol. 27, no. 4, pp. 952-966.
- McDougall, R & Pratt, B 2020, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation', *BMC Medical Ethics*, vol. 21, no. 1, pp. 1-10

4.2 COMPARATIVE VAD TABLES - PRINCIPLES

Table 4.1: Comparative analysis of the objectives and principles of voluntary assisted dying legislation.

Jurisdictional Comparison: Key Elements	AUSTRALIA				INTERNATIONAL	
	Tasmania	Victoria	Western Australia	South Australia	New Zealand	Canada
	End of Life Choices (Voluntary Assisted Dying) Bill 2020	Voluntary Assisted Dying Act 2017	Voluntary Assisted Dying Act 2019	Voluntary Assisted Dying Bill 2020	End of Life Choice Act 2019	Medical Assistance in Dying Act 2016
Principles						
The equal value of human life	Y	Y	Y	Y	N†	N‡
Patient autonomy	Y	Y	Y	Y	N†	N‡
The need to support informed decision-making	Y	Y	Y	Y	N†	N‡
The need to provide high quality care and treatment to persons at end of life	Y	Y	Y	Y	N†	N‡
The need to support and maintain a therapeutic relationship between the person and their medical practitioner	Y	Y	Y	Y	N†	N‡
Need to support and encourage openness in discussing death, dying, individual preferences and treatment options with family, medical practitioners and others	Y	Y	Y	Y	N†	N‡
The entitlement of persons to genuine choices about their care, treatment and end of life, having regard to their culture and language	Y*	Y	Y*	Y	N†	N‡
Ensuring equal access for both regional and metropolitan residents	Y	N	Y**	N	N†	N‡
Protection of persons against coercion and abuse	Y	Y	Y	Y	N†	N‡
The right of all persons to be shown respect for their culture, religion, beliefs, values and personal characteristics	Y	Y	Y	Y	N†	N‡

* The Tasmanian Bill and Western Australian Act emphasise a person's entitlement to genuine choices about their care, treatment and end of life, irrespective of where the person lives in the State.

** Part 10 of the Western Australian Act provides that the Chief Executive Officer of the Department of Health must issue an access standard setting out how the state intends to facilitate access to VAD for persons ordinarily resident in Western Australia, including how the state intends to facilitate those persons' access to the services of medical practitioners and other persons who carry out functions under the Act and prescribed substances and information about accessing VAD. This access standard must be published on the Department's website.

† The New Zealand Act does not contain a list of principles, rather it provides its purpose is to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives and to establish a lawful process for assisting eligible persons who access that option.

‡ The Canadian legislation also does not contain a list of principles. The legislation provides that its purpose is to amend the Canadian Criminal Code in order to create new offences for failing to adhere to the safeguards within the Act, to facilitate the collection of data for the purposes of fine-tuning the regulation of assisted dying in Canada and to strictly determine the eligibility for people who wish to access assisted dying.

4.2 COMPARATIVE VAD TABLES - ELIGIBILITY

Table 4.2: Comparative analysis of the eligibility provisions in voluntary assisted dying legislation

Jurisdictional Comparison: Key Elements	AUSTRALIA				INTERNATIONAL	
	Tasmania	Victoria	Western Australia	South Australia	New Zealand	Canada
	End of Life Choices (Voluntary Assisted Dying) Bill 2020	Voluntary Assisted Dying Act 2017	Voluntary Assisted Dying Act 2019	Voluntary Assisted Dying Bill 2020	End of Life Choice Act 2019	Medical Assistance in Dying Act 2016
Eligibility Criteria						
Person must be 18 years or older	Y	Y	Y	Y	Y	Y
Person must be either a citizen or permanent resident of, and ordinarily resident in, the relevant jurisdiction immediately prior to making the request	Y*	Y	Y	Y	Y	N***
Person must have decision-making capacity	Y	Y**	Y**	Y**	Y [^]	Y [□]
A person has decision-making capacity when they can understand, use or evaluate and communicate information relevant to their decision	Y	Y	Y	Y	Y	Y
Persons must be acting voluntarily	Y	N [†]	Y	N [†]	N [†]	Y
Person must be suffering from an advanced and incurable illness which is expected to cause death within 6 months	Y [±] Δ	Y [±]	Y [±]	Y [±]	Y	N [~]
Persons are not eligible for VAD only because they have a mental illness or a disability	Y	Y	Y	Y	Y	N [‡]
Further information on the requisite illness	The person must consider their suffering intolerable, and suffering may be constituted by actual or anticipated suffering arising from the illness, its treatment or complications arising from its treatment.	The person's illness must be causing suffering to the person that cannot be relieved in a manner they consider tolerable.	The person's illness must be causing suffering to the person that cannot be relieved in a manner they consider tolerable.	The person's illness must be causing suffering to the person that cannot be relieved in a manner they consider tolerable.	The person must be suffering from a terminal illness which is causing unbearable suffering that cannot be tolerably relieved. The person must further be in an advanced state of irreversible decline in physical capability.	The person's illness must be causing them enduring physical or psychological suffering that is not tolerable and cannot be relieved under conditions that they consider tolerable.

* The Tasmanian Bill provides a third residency option. A person can also have resided in Australia for three continuous years prior to making their first request for VAD.

** The Victorian and Western Australian legislation and South Australian Bill provide that a person must have decision-making capacity "in relation to VAD."

† The Victorian and New Zealand legislation and South Australian Bill do not enumerate the person's voluntariness as a specific eligibility criterion, though voluntariness is assessed at several points during the consultation and referral processes.

[^] In the New Zealand Act, the person must be competent to make an informed decision about assisted dying.

*** In Canada, a person must be eligible for government-funded health services.

□ In Canada, the person must provide informed consent to receive medical assistance in dying, after being told about alternative methods to relieve their suffering by medical practitioners assessing eligibility.

± In Tasmania, Victoria, Western Australia and South Australia, where the person has a neurodegenerative condition, this must be expected to cause death within 12 months.

~ In the Canadian legislation, there is no imposition of a period in which death is expected. Rather, the person's natural death has become reasonably foreseeable.

Note, The Canadian Parliament is considering broadening eligibility criteria under Bill C-7.

Δ Under the Tasmanian Bill, the Commission, upon the application of a person, may determine that the person is exempt from the time requirement (6 months or 12 months in the case of a neurodegenerative illness) if the Commission is satisfied that the person's prognosis is such that this requirement should not apply.

Jurisdictional Comparison: Key Elements	AUSTRALIA				INTERNATIONAL	
	Tasmania End of Life Choices (Voluntary Assisted Dying) Bill 2020	Victoria Voluntary Assisted Dying Act 2017	Western Australia Voluntary Assisted Dying Act 2019	South Australia Voluntary Assisted Dying Bill 2020	New Zealand End of Life Choice Act 2019	Canada Medical Assistance in Dying Act 2016
Consultation & Referral Process						
Number of requests person must make for VAD	3	2	2	2	1	1*
Requests for VAD must be made by the person in person, and cannot be made by another on the person's behalf	Y [†]	Y	Y	Y	Y	Δ
At least one of a person's requests for VAD or declarations in relation to their wish to access VAD must be in writing and signed by the person	Y	Y	Y*	Y*	Y*	Δ
Second opinion on person's eligibility is required through referral to a consultant medical practitioner	Y	Y	Y	Y	Y	Δ
Minimum number of eligibility assessments conducted	4	2	2	2	2	2
Participating health practitioners must have undertaken approved VAD training	Y	Y	Y	Y	N	Y
Medical practitioners must refer the person for a specialist opinion if unable to determine eligibility	Y	Y	Y	Y	Y	Y
The qualifications of health practitioners who can participate in the VAD process are prescribed	Y	Y	Y	Y	Y	Y
Health practitioners who conduct person's eligibility assessments must be medical practitioners	Y	Y	Y	Y	Y	Y
Set waiting period between the first and final requests	N [~]	Y [^]	Y [^]	Y [^]	N	N**
Brief summary of the consultation and referral process	First request made to Primary Medical Practitioner ("PMP"), who conducts first assessment of eligibility. Second request made to the PMP followed by another eligibility assessment. Person then referred for second opinion to Consulting Medical Practitioner ("CMP") who conducts eligibility assessment. Person makes final request to PMP who conducts eligibility assessment. Person then gives final permission for VAD and makes an administration request.	First request made to Coordinating Medical Practitioner who conducts first assessment of eligibility. Person referred for a second opinion to Consulting Medical Practitioner, who conducts eligibility assessment. Person may then make written declaration, followed by a final request. Coordinating Medical Practitioner Conducts final review and applies for a VAD administration permit.	First request made to Coordinating Practitioner who conducts first eligibility assessment. Person referred for a second opinion to Consulting Medical Practitioner who conducts eligibility assessment. Person may then make written declaration, followed by a final request. Coordinating Medical Practitioner conducts final review and, together with the person, makes an administration decision.	First request made to Coordinating Medical Practitioner who conducts first eligibility assessment. Person referred for a second opinion to Consulting Medical Practitioner who conducts eligibility assessment. Person may then make written declaration, followed by a final request. Coordinating Medical Practitioner conducts final review and applies for a VAD administration permit.	Person advises their Attending Medical Practitioner of their wish for VAD and signs relevant form. Attending Medical Practitioner gives first opinion on person's eligibility and requests the contact details of an independent medical practitioner. Person referred to independent medical practitioner who gives second opinion eligibility assessment. Third opinion on eligibility is sought as required. Person chooses the date and time for administration of the VAD substance.	Δ

* In Canada, one initial request must be made to a practitioner, and that practitioner bears the responsibility of obtaining a second opinion by a second independent medical practitioner that the person meets all the eligibility criteria.

† Under the Tasmanian Bill, where a person's request for VAD is made orally, the person must have clearly indicated to the medical practitioner in person, and not by way of audio-visual link that the person wishes to access VAD.

* In Western Australia and New Zealand and under the South Australian Act, a written declaration made by a person must be signed by the person, though if the person is unable to sign, another may sign on the person's behalf, in the presence of the person.

~ Whilst the Tasmanian Bill does not contain a set waiting period, it provides that a person must not make a second request to their Primary Medical Practitioner within 48 hours of having made their first request, and further that a person must not make a final request to the Primary Medical Practitioner within 48 hours of having made the second request. Exceptions may be granted if the Medical Practitioner considers that the person is likely to die within 7 days or is likely to cease to have decision-making capacity within 48 hours.

^ The Victorian and Western Australian legislation, as well as the South Australian Bill, prescribe that a person may not make a final request for VAD before 9 days have elapsed since the making of their first request, and in any case, at least one day after the consulting assessment in which the person was found to be eligible for VAD was conducted. In both jurisdictions, the final request can be made before this period has elapsed if the Coordinating Practitioner considers that the person is likely to die before the expiry of this period and this is consistent with the prognosis of the Consulting Practitioner.

** The Canadian legislation requires that there be a 10-day consideration period between a person making their second request for VAD and when the VAD substance is administered.

Δ Canada's provinces and territories have the autonomy to make their own regulations about VAD requests, the administration of VAD and data collection. This is because the focus of the national legislation is to decriminalise assisted dying by amending the Criminal Code, and not to create a standardised national regime.

4.2 COMPARATIVE VAD TABLES - ADMINISTRATION

Table 4.4: Comparative analysis of the administration of voluntary assisted dying substance in voluntary assisted dying legislation

Jurisdictional Comparison: Key Elements	AUSTRALIA				INTERNATIONAL	
	Tasmania End of Life Choices (Voluntary Assisted Dying) Bill 2020	Victoria Voluntary Assisted Dying Act 2017	Western Australia Voluntary Assisted Dying Act 2019	South Australia Voluntary Assisted Dying Bill 2020	New Zealand End of Life Choice Act 2019	Canada Medical Assistance in Dying Act 2016
Administration of VAD Substance						
Person can indicate their wishes for the mode of administration	Y	N	N	N	Y	Δ
Administration permit/certificate is required	Y	Y	N	Y	N	N
Oversight body has permission function in relation to administration	Y	Y	N	Y	Y	N
Provision made for self-administration	Y	Y	Y	Y	Y	Y
Self-administration may occur in total privacy	Y	Y	Y	Y	N	Y
Contact person must be appointed	Y [†]	Y	Y [†]	Y	N ^{**}	N
Provision made for assisted self-administration	Y ^{***}	N	N	N	N	N
Provision made for administration by a health practitioner	Y ^{***}	Y [~]	Y ^{***}	Y [~]	Y	Y
Health practitioner who administers VAD substance can be a medical practitioner or a nurse	Y ^z	N	Y ^x	N	Y ^x	Y ^x
Practitioner administration must be witnessed	N	Y	Y	Y	N	N
Provision made for person's wishes with respect to any complications in administration	Y	N	N	N	N	Y
Further information in respect of the administration process in each jurisdiction	The person indicates their wishes for administration in the final permission. The PMP applies for the relevant certificate, and the VAD Commission determines whether the certificate should be accepted or refused.	Self-administration is the default administration procedure, but if person is physically unable to administer or digest the VAD substance, the Coordinating Medical Practitioner may apply for a practitioner administration permit instead of the default self-administration permit. The Secretary determines the application for the administration permit.	The person, in consultation with the Coordinating Practitioner, makes an administration decision. Self-administration is the default administration procedure, but practitioner administration may be available. ^{***} The administration decision authorises the Coordinating Practitioner to prescribe the relevant VAD substance. The VAD Board plays no role but has a retrospective review function.	The Coordinating Medical Practitioner applies to the Chief Executive of the administrative unit of the Public Service for a VAD permit. The Chief Executive may issue or refuse to issue the permit. A practitioner administration permit may only be applied for if the person is incapable of self-administration.	The person completed the required form and selects the date and time for administration. Subsequently, the person must choose an administration method. Before administration can occur, the Registrar must check that the requisite process has been carried out and notify the attending practitioner of the outcome.	Δ

Δ Canada's provinces and territories have the autonomy to make their own regulations about VAD requests, the administration of VAD and data collection. This is because the focus of the national legislation is to decriminalise assisted dying by amending the Criminal Code, and not to create a standardised national regime. For example, Quebec's legislation does not permit the self-administration of a VAD substance.

† Under the Tasmanian Bill and Western Australian Act, a contact person must only be appointed where the person is intending to self-administer the VAD substance.

** In New Zealand, no provision is made for the appointment of a contact person. Under the Act, both self-administration and practitioner administration occur in close proximity to the attending medical practitioner or attending nurse practitioner.

~ In Victoria and under the South Australian Bill, a person may only access practitioner administration if the person is physically incapable of the self-administration or digestion of the VAD substance.

*** Under the Tasmanian Bill, a person must have been issued an AHP administration certificate if they intend to have the AHP administer to them a VAD substance, or assist them with self-administering a VAD substance. The AHP may only issue such a certificate if they are satisfied that it is inappropriate for the person to self-administer, having regard to one of: the patient's ability to self-administer or digest the VAD substance, the patient's concern about self-administering, or the method of administration that is suitable for the patient. This position is ambiguous, and discloses a drafting error. Section 86(5) has virtually the identical wording to s56(2) of the Western Australian Act but that deals with practitioner administration only. The confusion lies in the fact that this subsection has been combined as a key eligibility section for an AHP administration certificate, but that is widely defined to cover the three forms of VAD administration in s86(1) which include self-administration and assisted self-administration. Private self-administration has its own certificate provision in s84. In Western Australia, a person may only access practitioner administration if self-administration would be inappropriate in the opinion of the coordinating practitioner, having regard to at least one of: the person's ability to self-administer, the patient's concerns about self-administration, and the method for administering the substance that is suitable for the patient.

z Under the Tasmanian Bill, registered nurses can act as Administering Health Practitioners.

x In Western Australia, New Zealand, and Canada, nurse practitioners can administer a VAD substance to a person.

4.2 COMPARATIVE VAD TABLES - LEGAL PROTECTIONS

Table 4.5: Comparative analysis of legal and other protections in voluntary assisted dying legislation

Jurisdictional Comparison: Key Elements	AUSTRALIA				INTERNATIONAL	
	Tasmania	Victoria	Western Australia	South Australia	New Zealand	Canada
	End of Life Choices (Voluntary Assisted Dying) Bill 2020	Voluntary Assisted Dying Act 2017	Voluntary Assisted Dying Act 2019	Voluntary Assisted Dying Bill 2020	End of Life Choice Act 2019	Medical Assistance in Dying Act 2016
Legal and Other Protections						
Health practitioner prohibited from initiating discussion about VAD [†]	N*	Y	N*	Y	Y	N*
Person free to withdraw from VAD process at any time	Y	Y	Y	Y	Y	Y
Medical practitioners are not able to find a person eligible for VAD unless satisfied that the person has decision-making capacity and is acting voluntarily	Y	Y	Y	Y	Y	Y
Witnesses to formal documents and/or administration of a VAD substance must be eligible	Y	Y	Y	Y	N**	Y
Health practitioners' participation is voluntary, they can conscientiously object at any time	Y	Y	Y	Y	Y	Y
Legal protection is given to medical practitioners who, in good faith and without negligence, provide assistance in relation to VAD in accordance with the legislation	Y	Y	Y	Y	Y	Y
Legal protection is given to others present, such as ambulance officers and health practitioners, where administration of a VAD substance has occurred	Y	Y	Y	Y	Y	Y
Prohibition of discriminatory conduct towards persons who provide assistance in relation to VAD	N	N	N	N	Y	N
Provision is made for the safe handling of the VAD substance, its secure storage and/or labelling	Y	Y	Y	Y	Y	N
Contact person must be appointed to ensure the safe handling of any unused or remaining VAD substance.	Y[~]	Y	Y[~]	Y	N***	N*
Jurisdiction-specific legal protections	Makes explicit that medical practitioners who refer a person or who request for information in relation to a person are not liable to punishment.	Provides for mandatory reporting to AHPRA in respect of a breach of the prohibition on initiating discussion about VAD and gives legal protection to persons making such disclosures.	Where an authorised supplier receives a prescription for a VAD substance, they must verify the authenticity of the prescription and fill out the appropriate documentation.	Provides for mandatory reporting to AHPRA in respect of a breach of the prohibition on initiating discussion about VAD and gives legal protection to persons making such disclosures.	Provides that advance care directives may not provide for VAD and that welfare guardians have no power to make decisions or take actions for a person under the Act.	Δ

[†] In all analysed jurisdictions, medical practitioners can provide information about VAD to a person at that person's request.

* Under the Tasmanian Bill and Western Australian and Canadian Acts, medical practitioners can initiate discussions that are in substance about VAD, if they also provide to the person other information, including the person's palliative and non-palliative treatment options and their anticipated outcomes.

** The New Zealand Act does not require documents or requests to be witnessed.

*** As per 4.2.4 above, the New Zealand Act makes no provision for the appointment of a contact person. This is because the attending medical practitioner or attending nurse practitioner must be present whilst the person self-administers the VAD substance.

[~] Under the Tasmanian Bill and Western Australian Act, a contact person must only be appointed where the person is intending to self-administer the VAD substance.

x The national legislation does not require the appointment of a contact person to ensure safe handling of the VAD substance. However, Canada's provinces and territories have the autonomy to make their own regulations about the administration of VAD and may require this measure.

Δ Canada's provinces and territories have the autonomy to make their own regulations about VAD requests, the administration of VAD and data collection. This is because the focus of the national legislation is to decriminalise assisted dying by amending the Criminal Code, and not to create a standardised national regime.

4.2 COMPARATIVE VAD TABLES - MONITORING AND OVERSIGHT

4.6 Comparative analysis of monitoring and oversight provisions in voluntary assisted dying legislation

Jurisdictional Comparison: Key Elements	AUSTRALIA				INTERNATIONAL	
	Tasmania	Victoria	Western Australia	South Australia	New Zealand	Canada
	End of Life Choices (Voluntary Assisted Dying) Bill 2020	Voluntary Assisted Dying Act 2017	Voluntary Assisted Dying Act 2019	Voluntary Assisted Dying Bill 2020	End of Life Choice Act 2019	Medical Assistance in Dying Act 2016
Monitoring & Oversight						
Establishment of an oversight body(ies)	Y	Y	Y	Y	Y	N
Assessing medical practitioners must notify/provide forms to the oversight body throughout the request and assessment process	Y	Y	Y	Y	Y	Y
Health practitioner conducts a final review of documents created in request and assessment process prior to commencement of administration procedures	N	Y	Y	Y	N	N
Oversight body has permission function in relation to authorisation to prescribe a VAD substance/issuing of a VAD permit	Y	Y	N [†]	Y	Y	Y
Oversight body has function in relation to referring certain matters to relevant bodies (e.g. police, coroner, AHPRA).	Y	Y	Y	Y	Y	Δ
Oversight body's reporting role includes the requirement to make annual reports and lay them before Parliament.	Y [~]	Y [‡]	Y	Y	Y	Y
A named body must maintain a list/register of qualified practitioners willing to participate in the VAD process	Y	N	Y ^{**}	N	Y	Δ

Elaboration on the monitoring and oversight roles of the relevant statutory bodies

The Bill establishes a VAD Commission as the relevant monitoring and oversight body. In addition to its function in accepting or refusing requests from Primary Medical Practitioners for VAD substance authorisations (noted in connection with 'Administration of the VAD substance'), the Commission must also maintain a list of trained and willing medical practitioners, nurses and pharmacists.

Establishes the VAD Review Board, which has wide-ranging powers of review. The Head of the Department of Health and Human Services has an important permission function (noted in connection with 'Administration of the VAD substance') in determining the application by a Coordinating Medical Practitioner for a VAD administration permit.

Establishes the VAD Review Board, which has obligations with respect to review and monitoring, including providing information to a person's contact person outlining their obligations and support services available to them in managing their obligations.

Establishes the VAD Review Board which has wide-ranging powers of review. The Chief Executive has an important permission function (noted in connection with 'Administration of the VAD substance') in determining the application by a Coordinating Medical Practitioner for a VAD permit.

Establishes the end-of-life Review Committee which has functions in relation to monitoring and review. Noted above in connection with 'Administration of the VAD substance,' the Registrar (an employee of the Ministry of Health nominated by the Director-General of Health) must check that the requisite process has been carried out and notify the attending practitioner of the outcome before administration can occur.

Δ

[†] In Western Australia, the VAD Review Board has a retrospective review function instead of permission function, and at various stages is given copies of the request and assessment forms and the forms required to be submitted after administration has occurred.

[~] Under the Tasmanian Bill, the VAD Commission must also report to the Minister on the operation of the Act in its first 6-month period.

[‡] Under the Victorian legislation, the VAD Review Board is also required to produce reports every 6 months on the operation of the Act.

^{**} Under the Western Australian Act, the Chief Executive Officer of the Department must publish an up-to-date list of authorised suppliers and disposers of VAD substances on the Department's website.

^{***} Under the Canadian Act, all participating health practitioners are required to record information about those who access VAD under the Act. However, it is not clear where this information goes or how it is used.

Δ Canada's provinces and territories have the autonomy to make their own regulations about VAD requests, the administration of VAD and data collection. This is because the focus of the national legislation is to decriminalise assisted dying by amending the Criminal Code, and not to create a standardised national regime.

4.3 TASMANIA'S END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020: COMPARATIVE ANALYSIS.

Both in substance and in form, the Tasmanian VAD Bill is largely based on and similar to the legislation already enacted in Victoria and Western Australia, and with the South Australian bill introduced in 2020. Largely consistent features include:

- the principles which inform the operation of the VAD regimes
- the protection from liability each jurisdiction affords to medical practitioners and pharmacists who do and do not participate in the VAD process
- requirements around medical consultation and referral
- stipulations around the handling, transfer, storage and disposal of VAD substances
- the mandatory training and qualifications of participating health practitioners
- the criteria a person must satisfy to be eligible to access VAD. Whether explicitly stipulated as an eligibility criterion or provided elsewhere in the relevant legislation or draft bill, all Australian jurisdictions mandate that the person seeking to access VAD must have decision-making capacity, be acting voluntarily, meet specific residency requirements, and be experiencing intolerable suffering in relation to an illness or condition expected to cause death within a specified (and relatively short) time period

Despite these similarities, there are six key points of difference between the Tasmanian VAD Bill and the enacted or proposed regimes in the other three Australian jurisdictions, each of which is discussed below. Some of these differences help to position the Tasmanian Bill VAD as providing for one of the 'safest' VAD regimes in the world although, as discussed below and further in Section 6, the provision of additional processes in the Tasmanian VAD Bill may make VAD less accessible.

4.3.1 Ability for health practitioners to initiate conversations about voluntary assisted dying

The Tasmanian VAD Bill allows medical practitioners to initiate conversations with patients about VAD as long as

they also provide information about other treatment and palliative care options and the likely outcomes of those treatments (s. 17). In Victoria, New Zealand and in the proposed South Australia legislation, health practitioners are prohibited from raising VAD as an option with patients and can only provide information about VAD if specifically asked about VAD by that patient.

4.3.2 Autonomy and choice in administration method

The substance administration options proposed by the Tasmanian VAD Bill would make it the only VAD regime in Australia to provide what are essentially four administration options for persons seeking to access VAD. Consistent with positions in Victoria, Western Australia and Canada, and with the draft SA Bill, the Tasmanian VAD Bill makes provision for both self-administration and administration of the VAD substance to the person by the Administering Health Practitioner ('AHP'). By contrast with these jurisdictions, the Tasmanian VAD Bill also provides for the person to be assisted by an AHP to self-administer the VAD substance (s. 82). The AHP may be either a medical practitioner or a registered nurse (s. 62), a feature of the VAD Bill which is designed to ensure that a greater number of health professionals are able to provide administration support to persons, especially in regional or remote areas.

A further distinctive yet related feature of the Tasmanian VAD Bill is its provision for a person to indicate their wishes with respect to the method of administration. Under the VAD Bill, when the person completes the formal, written form termed the 'final permission,' they must state whether they wish to self-administer, be assisted by the AHP to self-administer, or have the AHP administer the substance to them (s. 82). Whilst AHPs are constrained by the requirement that self-administration must be inappropriate before the AHP can assist with or administer the VAD substance, this feature gives more autonomy to persons than in the other Australian jurisdictions, where persons are not able to indicate a preference or wish in relation to the method of administration. In Victoria and South Australia, self-administration is the default administration method, and practitioner administration may only occur where the person is physically incapable of self-administration. In Western Australia, practitioner administration can also only occur in the limited circumstances in which self-administration would be inappropriate. In this way, the Tasmanian Bill more closely approximates the New Zealand Act, under which the person in practice has greater scope to indicate their wishes for administration, and autonomously selecting the administration method (s. 19(2)).

4.3.3 Broad range of administering health practitioners

The Tasmanian Bill provides that both medical practitioners and registered nurses are able to administer a VAD substance to eligible persons (ss. 62(2)). This position is consistent with the regimes in Western Australia, New Zealand and Canada. By contrast the Victorian regime and the SA Bill provide that administration may only be undertaken by a medical practitioner.

4.3.4 Additional and absent processes

The Tasmanian VAD Bill has additional checks built into the request and assessment process. The VAD Bill requires that persons must make three separate requests for VAD, and that a person's eligibility to receive VAD must be assessed on four separate occasions. By contrast, the Victorian and Western Australian Acts and the SA Bill all make provision for the person to make two separate requests for VAD, and for the completion of two assessments of the person's eligibility for VAD. In New Zealand and Canada, a person need only make one request for VAD, after which two eligibility assessments are subsequently conducted. The Tasmanian VAD Bill goes to greater lengths than in these other jurisdictions to ensure that a person's wish to access VAD is enduring, and that persons who do not meet the eligibility criteria are not able to access VAD.

The Tasmanian VAD Bill also makes important provision for oversight at the commencement of the substance administration process. The VAD Bill is consistent with the Victorian, South Australian and New Zealand regimes in that the oversight body, namely, the VAD Commission, must give permission before the Primary Medical Practitioner is authorised to prescribe, receive and subsequently dispense or administer a VAD substance to a person (ss. 66-68). This permission step does not feature in the Western Australian legislation nor in the Canadian federal legislation.

The Tasmanian VAD Bill also makes provision for further processes in the cases of AHP administration and assisted self-administration. By contrast to the self-administration regimes in Victoria, Western Australia and the SA Bill which only make provision for medical supervision in the case of direct administration of the VAD substance by the relevant practitioner, three of the four administration methods under the Tasmanian VAD Bill must be medically supervised. The VAD Bill stipulates that during administration by the AHP and during self-administration when the AHP either assists or is otherwise present, the AHP must remain in the room or in a nearby location until the person dies or is otherwise removed (s.

87, see section 3.4). This constitutes a further, incidental safeguard whereby a contact person does not need to be relied upon to handle and return the VAD substance. Rather, the AHP is responsible for handling and disposing of any unused or remaining VAD substance. In this respect, the Tasmanian VAD Bill is similar to the New Zealand Act, under which there is no provision for the appointment of a contact person because all forms of administration under the Act require medical supervision (s. 20). However, in the case of private self-administration in the VAD Bill, there is no requirement for the AHP to be present at the time of self-administration, and a contact person must store and return any unused VAD substance (s. 92).

Finally, greater legal protection is afforded to practitioners who provide assistance in relation to VAD under the Tasmanian VAD Bill than under the Victorian and Western Australian Acts. Consistent with the New Zealand Act and the SA Bill, the Tasmanian VAD Bill explicitly prohibits the punishment of a medical practitioner or AHP on the basis of their making a request or referral in relation to the VAD process (s. 136). Such protection is absent from the Victorian and Western Australian regimes.

Three processes of note which feature in most other VAD regimes are absent from the Tasmanian VAD Bill. First, the Bill VAD does not make provision for a set waiting period between the first and final requests, as is the case in Victoria, Western Australia, and under the SA Bill. Whilst the VAD Bill does stipulate that a person's requests must each be made at least 48 hours apart, the other Australian jurisdictions all lay down a nine-day waiting period after making the first request and before making the final request. The Canadian legislation specifies a ten-day consideration period between the person's final request and the administration of the VAD substance, though the New Zealand Act does not specify a waiting period. Second, the VAD Bill does not require the Primary Medical Practitioner to conduct a 'final review' of all the documents completed in compliance with the VAD process prior to applying to an oversight body for authorisation for administration. Finally, the Tasmanian VAD Bill does not require that administration of a VAD substance to a person by the Administering Health Practitioner be witnessed by a third person. In Victoria, Western Australia and under the SA Bill, practitioner administration must be witnessed by an eligible, independent witness.

4.3.5 Qualifications of participating medical practitioners

The Tasmanian VAD Bill, consistent with the legislation in other jurisdictions, sets out minimum professional qualifications for medical practitioners who wish to

participate in the VAD process. Under the VAD Bill, authorised medical practitioners must either be vocationally registered general practitioners or hold fellowships with a specialist medical college (s. 9). Unlike the Victorian and Western Australian Acts, there is no express requirement in the Tasmanian VAD Bill that medical practitioners have a minimum period of practice in the relevant area, though persons who are either vocationally registered as a general practitioner or who hold a fellowship with a specialist medical college would in practice have at least 5 years' experience as a medical practitioner. The Tasmanian Bill also requires the practitioner to have experience in the patient's condition, which is arguably more relevant than the number of years of practice. The Victorian Act prescribes that either the co-ordinating medical practitioner or each consulting practitioner has practiced as a medical practitioner for five years after completing a fellowship or attaining vocational registration (s. 10(2)), and the Western Australian Act requires that medical practitioners who hold general registration must have practiced the profession for a minimum of 10 years (s. 17(2)).

4.3.6 Attempts to ensure equality of access to voluntary assisted dying

Under the Tasmanian VAD Bill, the VAD Commission is tasked with maintaining and disseminating (with consent) a list of trained and willing medical practitioners, nurses and pharmacists (s. 113). Further, and in contrast to the Victorian and New Zealand regimes, and the South Australian Bill, health practitioners in Tasmania can provide this information, even where the person has not requested it, if such information is provided in concert with information about the other palliative and non-palliative treatment options available to the person and the likely outcomes of those treatments (s. 17). Finally, the Tasmanian VAD Bill explicitly states the need to ensure equality in terms of geographical access as a principle which informs the VAD regime (s. 3(2)), and as discussed at 4.3.2, makes provision for registered nurses to act as AHPs.

Table 4.7: Distinctive features of the Tasmanian VAD Bill

Issue	Distinctive feature of the Tasmanian VAD Bill
1. Choices and autonomy in administration method	<p>Eligible persons can indicate their wishes for how the VAD substance will be administered, with three options provided: private self-administration, administration assisted by the Administering Health Practitioner (AHP) or direct administration by the AHP. In practice, the latter two options will only be open to the person if the AHP considers that private self-administration would be inappropriate.</p>
2. Health practitioners eligible to administer VAD substance to persons	<p>Both medical practitioners and registered nurses are able to act as Administering Health Practitioners during the final stage of the VAD process.</p> <p>Three separate requests must be made for VAD by the person seeking access.</p> <p>Four separate eligibility assessments are conducted.</p>
3. Additional features	<p>The VAD Commission must give permission before the VAD substance can be dispensed or administered to an eligible person.</p> <p>Two administration methods are supervised by the AHP. Where self-administration is chosen there is no requirement for a 3rd party contact person.</p> <p>It is prohibited to punish a medical practitioner on the basis of their accepting a request or making a referral pursuant to the Bill.</p>
4. Processes present in other regimes, absent from the Tasmanian VAD Bill	<p>No explicit waiting period between the first and final requests (although the minimum time in which the VAD Commission must complete different elements of the VAD approval process, together with minimum periods prescribed between the first, second and third requests for access represents a de facto waiting period).</p> <p>The Primary Medical Practitioner is not required to conduct a 'final review' of all of the documents previously completed in compliance with the VAD process prior to applying to the VAD Commission for authorisation for administration.</p> <p>No requirement that direct administration (ie self-administration of the VAD substance) be witnessed.</p> <p>The VAD Commission must keep and disseminate a list of trained and willing medical practitioners and connect persons with an Administering Health Practitioner where their Primary Medical Practitioner is unable or unwilling to act.</p>
5. Provisions designed to ensure equality of access	<p>Health practitioners are able to discuss VAD with a person, even if that person has not requested VAD, provided this discussion takes place in the context of a wider discussion about the person's treatment options and likely outcomes.</p> <p>There is no express requirement that medical practitioners who act as Primary Medical Practitioners or Consulting Medical Practitioners have a minimum period of practice in the relevant area.</p>

PART THREE. END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020: PUBLIC SUBMISSIONS AND FURTHER CONSIDERATIONS

Section 5: Submissions made to the independent Review Panel

Reflecting its Terms of Reference, the Panel sought public submissions in relation to the Tasmanian VAD Bill. Given the Panel's mid-February reporting deadline, the call for submissions was published on 2 December 2020 (<https://www.utas.edu.au/vad-review>), with submissions closing 5pm, 4 January 2021. Given time constraints and the Panel's Terms of Reference, the consultation was limited to written submissions and a workshop attended by those with direct experience in the implementation and administration of VAD regimes in Victoria and Western Australia (Section 6.1). The Panel notes that the VAD Bill itself was informed by extensive consultation and approximately 130 submissions were made to the bill's sponsor the Hon. Mike Gaffney.

Table 5.1: Submissions to the Independent Review

	Tasmanian	Interstate and international	Total
Submission made by individuals (non-health professionals)	8	2	10
Submission made by individual health professionals	10	3	13
Submission made by organisations (general)	4	7	11
Submission made by organisations (health and care)	3	4	7
Total	25	16	41

This Section provides a synopsis of the key themes and issues identified in the 41 submissions received by the Panel. It summarises the most common arguments in support of and in opposition to VAD before considering the specific views held by health practitioners who made submissions. This Section concludes with a summary of the most commonly proposed amendments made in submissions, including those which the Review Panel believe warrant particular consideration. A list of all submissions to the Review is provided in Appendix 1. Other than those identified as being confidential, all submissions will be published on the Panel's website upon public release of this Report.

The Panel would like to thank all of the individuals and organisations who made submissions. In addition to this summary, submissions have also informed the Report as a whole.

5.1 KEY THEMES FROM PUBLIC SUBMISSIONS

The submissions to the Panel reflected the diverse and often deeply held views in relation to VAD held by the wider Tasmanian community. While some submissions expressed a general perspective on VAD, most engaged with the Terms of Reference and provided a more detailed assessment of the specific provisions of the Tasmanian VAD Bill and suggested amendments. Whereas survey data suggests that the majority of Tasmanians support VAD (Section 1), a narrow majority of submissions were opposed to or had concerns about the proposed VAD Bill. The Panel notes, however, that submissions do not necessarily provide a representative sample of community opinion as a whole and, irrespective of the issue under consideration, groups and individuals opposed to legislative change have a greater incentive to mobilise and prepare submissions relative to those who support proposed reforms (Olson 1965).

Of the submissions received, 18 represented the views of organisations and 23 submissions were from individual community members. The Panel received 18 submissions from health professionals, their professional associations and from organisations which provide health and social care services. These submissions provided valuable insights into the implications of VAD for those who would be providing services and support in relation to VAD.

Overall, the views expressed in the submissions are varied and complex, but analysis reveals a number of common themes. Respect for principles of personal autonomy, protection against wrongful death and the importance of high quality and accessible palliative care were common to almost all submissions, revealing a shared desire to improve access to, and quality of, end-of-life care.

5.1.1 Community views supporting voluntary assisted dying

Submissions in favour of the VAD Bill highlighted a range of arguments for supporting the introduction of VAD in Tasmania:

- VAD allows individuals to choose the timing and manner of their death, offering dignity and independence to those who are suffering
- Palliative care has its limits, and is not always an adequate end-of-life option
- There are sufficient safeguards in the VAD Bill against malpractice or abuse
- Choosing to access VAD is a difficult decision, and respect should be given to such considered

expressions of individual autonomy

- There is strong support in the Tasmanian community for the introduction of VAD as an end-of-life option
- VAD laws are already working effectively and safely in many other comparable jurisdictions
- Medical practitioners currently must observe some patients endure ongoing and avoidable suffering, and that is a cause of significant distress to these practitioners
- Religious beliefs held by some members of the community should be respected but should not impinge upon the ability of others to access VAD
- There is no evidence that the introduction of VAD is a threat to vulnerable members of the community
- There is no evidence that the introduction of VAD will encourage 'suicide culture'

Many submissions argued that the VAD Bill contains adequate safeguards to protect vulnerable members of the community, and that safeguards must always be balanced with a need for VAD to be accessible. A commonly expressed sentiment was that unnecessary restrictions should not be added to the VAD Bill in order to placate those opposed to VAD. A significant number of submissions also expressed support for increasing funding to achieve and maintain world-class palliative care services in Tasmania, while arguing that palliative care has inherent limits and should not be the sole option for those suffering at the end of life. Several individual submissions detailed cases where their loved ones suffered unbearably, even while receiving best-practice palliative care, and detailed the enormous impact of this suffering on themselves and their families.

Nearly all submissions in support of VAD did not think organisations should have a right of non-participation although most were silent on whether they endorsed the practice of allowing organisations to elect not to offer VAD services. Many argued that an individual's right not to participate in VAD on conscientious grounds is sufficient to ensure that the religious or moral views held by health practitioners are respected. Moreover, a number of submissions were concerned that if organisations were allowed to refuse to participate in the VAD process, VAD would become less accessible in Tasmania and vulnerable people would be forced to transfer between hospitals to access VAD which may exacerbate suffering. The issue of organisational non-participation is considered in more detail in Section 6.5.

5.1.2 Community views opposing voluntary assisted dying

Submissions opposed to the Bill share a number of common concerns about VAD. These include that VAD is ethically unjustifiable and challenges a long established religious and ethical belief that people (and health practitioners in particular) should not deliberately end the life of another human. Common arguments include:

- People who are very sick and suffering intolerably do not have capacity to make the decision to access VAD
- Referring a patient to access VAD, or administering VAD, will place a significant burden on health practitioners, and cause them distress
- Given there is no recourse there are no safeguards that could possibly protect against all abuse or misuse of the legislation
- High quality and accessible palliative care can adequately address end-of-life suffering and resources should be devoted to improving palliative care options rather than developing a VAD regime
- That legalising VAD may lead to rising suicide rates
- The VAD Bill fundamentally threatens the health and lives of vulnerable people and may exacerbate elder abuse
- Other jurisdictions which have introduced VAD have seen a widening of the criteria of eligibility (this is sometimes referred to by opponents of VAD as a 'slippery slope')
- No health practitioner is able to accurately predict when a person will die, and thus the timeframes provided in the VAD Bill are illusory protections
- Elderly people will feel obliged to seek VAD so as to relieve society of the perceived burden they are placing on family and carers. This may especially be true when the residential aged care sector is in crisis
- VAD will become a forced choice for those who struggle to access and afford palliative or residential aged care

As was noted in the introduction to the Report, the language associated with VAD is highly contested and almost all submissions opposing the Bill referred to 'VAD' as 'assisted suicide', 'euthanasia' or 'physician-assisted

suicide'. Most (but not all) faith-based groups who made submissions argued that VAD threatens the sanctity of life and confounds the deeply held view that no person should end another human's life. These submissions also contended that human dignity is inherent and inviolable, and that VAD is not needed to preserve dignity.

A number of submissions also maintained that in a society which has chosen to condemn capital punishment, VAD legislation represents a moral and ethical double standard. Several submissions also made passionate arguments against allowing people who have a mental health condition or disability to be considered eligible for VAD, even if they are eligible for VAD on other grounds; they argued that these people are among the most vulnerable to potential abuses of the legislation.

Unlike those in favour of VAD, almost all submissions opposing the VAD Bill argued that organisations should have the right not to participate in nor facilitate VAD although not all of these explicitly stated the need for this right to be incorporated into the legislation. Indeed, a number of submissions from health care organisations made clear their intention not to facilitate VAD, premised on the belief that intentionally ending a life is incongruent with their organisational ethos and the goals and practices of health care, and particularly palliative care.

5.1.3 Perspectives from health practitioners

Submissions were received from health practitioners who have practiced in a number of jurisdictions, both overseas and within Australia. Contributions were made from across the healthcare sector including nurses, doctors and specialists. The viewpoints among health practitioners differed significantly, as did submissions that were written on their behalf by various organisations representing health professionals and service providers.

Within the submissions from health professionals, common arguments in favour of VAD are similar to those detailed in s 5.1.1. They are:

- For a small number of patients, palliative care is not an adequate or acceptable end-of-life option, and VAD legislation will address a demonstrated need in the Tasmanian community
- Having choice over the time and manner of death is of paramount importance in preserving the dignity and holistic wellbeing of terminally ill patients who are suffering at life's end.
- Significant stress is placed upon medical practitioners who must watch patients suffer horrifically and needlessly

- There is no evidence, beyond circular arguments, to demonstrate that more vulnerable people are at risk if VAD legislation is introduced
- There are health practitioners within the Tasmanian community willing to participate in the VAD process

The most frequent arguments against VAD in submissions of health practitioners are:

- That legalising VAD will erode the perceived integrity of the medical profession because so doing allows individual autonomy to prevail over long held ethical considerations and professional norms concerned with ending a patient's life.
- In similar regimes, such as Victoria, VAD has impacted upon the cohesion of medical teams, dividing teams into those who support VAD and those who oppose it
- There are health care practitioners in Tasmania who are not willing or able to participate in the VAD process and who will suffer harm if they are required to
- VAD encourages a suicide culture, which is inconsistent with the traditional tenets of the medical profession
- 'Doctor shopping' will occur if VAD is introduced, as people from other jurisdictions attempt to access VAD in Tasmania
- VAD will put pressure on people with chronic illness and disabilities to hasten their death
- Expanded eligibility criteria in the future is likely, and could include children which is unacceptable
- Patients will be fearful of entering care homes or hospitals which have facilitated the VAD process, as they will believe that they will be pressured to consider VAD
- Such problematic legislation must not be introduced for the sake of 'a few hard cases'

Almost all health practitioners advocate for better resourcing of palliative care in Tasmania, to ensure that Tasmanians are not seeking VAD because they cannot access high quality palliative care. A significant number of practitioners, regardless of their support for VAD, supported the introduction of workplace frameworks that offer protection for employees who either choose to engage with VAD or conscientiously object, to promote collegiality and prevent harassment or discrimination.

Submissions highlighted the need for high quality support and training for those healthcare professionals providing VAD services or support. This was also a major theme raised at the VAD review workshop (6.1).

As in other jurisdictions some health professionals and their representative groups are strongly of the view that VAD is fundamentally incompatible with ethical medical practice and that establishing legislation under which a doctor, under certain circumstances, can end a patient's life crosses a fundamental threshold which will erode professional norms, collegiality and patient-doctor relationships. Beyond this fundamental ethical divide, there is also an active debate and a range of views concerning the trade-off between VAD safeguards and the accessibility of VAD for people who seek it. These issues are discussed in greater detail in Section 6.3.

5.1.4 Perspectives from Tasmanian Aboriginal communities

The Panel had some engagement with members of Tasmanian Aboriginal communities who advised that VAD was not a part of their culture. They stressed a strong belief in dying naturally and allowing the land to take them naturally. There are traditional ceremonies around dying and processes to follow which should not, if possible, be interrupted by an artificial and Westernised practice which hastens death.

These views are consistent with views of Aboriginal people who gave evidence to the Senate Legal and Constitutional Legislation Committee of the Australian Senate, where VAD was consistently described as not "the Aboriginal way" (Senate Legal and Constitutional Legislation Committee, Euthanasia Laws Bill 1996, March 1997, p. 46; Also see Fleming, 1999).

More systematic consultation with Tasmanian Aboriginal communities should be undertaken during the implementation of the VAD Bill to ensure consideration of wider range of aboriginal perspectives.

5.2 SPECIFIC AMENDMENTS PROPOSED IN SUBMISSIONS

Given this Review and the submissions made to it are concerned with the specific provisions of the VAD Bill rather than VAD in general, many submissions proposed specific amendments to the VAD Bill. The most significant of these which clearly align with the Terms of Reference are listed below along with a brief justification for the proposed amendment. These amendments reflect a wide range of perspectives and do not necessarily reflect the views of the Panel.

5.2.1 Proposed amendments in relation to the objectives, principles and administration of the Act

- Palliative care in Tasmania must be guaranteed in the Bill as being 'gold-standard', and greater funding should be committed to palliative care training and practice. This is to ensure that no person is accessing VAD because they cannot afford palliative care.
- Community education programs about VAD and its role as an end-of-life option must be designed and implemented. The community must be educated on how to navigate the system to increase familiarity with and acceptance of VAD.
- Wherever occurring in the VAD Bill, 'VAD' should be changed to 'assisted suicide' or 'euthanasia'. That the categorisation of the death may have ramifications for insurance and accuracy is important.
- The principle of ensuring that all Tasmanians should have equal access to VAD services is laudable but unrealistic. The government does not commit to providing equal access to health services across the State and doing so for VAD is problematic and may create unrealistic expectations.

5.2.2 Proposed amendments in relation to the eligibility criteria

Suggestions to restrict the eligibility criteria

- A definition of 'voluntariness' must be included, to ensure clarity and consistency.
- The procedure for determining a person's capacity must be specified and be consistent with the test in the Mental Health Act 2013 (Tas).
- The Primary Medical Practitioner should be responsible for ensuring that all other reasonable treatments have been tried before a person is deemed eligible for VAD. It must be mandatory for persons to have tried other methods of pain management or relief of suffering before they are permitted to access VAD. This is because VAD should be a last resort.
- The power of the VAD Commission to exempt persons from the six-month (or 12-month) timeframe should be removed. To allow this allows a 'creeping' of the eligibility criteria.

Suggestions to broaden the eligibility criteria

- People on long-term visas or those who permanently reside in Tasmania should be allowed to access VAD. This permits greater access to VAD without encouraging 'VAD tourism'.
- Prognostic timeframes should be removed from the Act, or significantly reduced. This is because timeframes merely prolong unnecessary suffering and death cannot be predicted accurately by medical professionals.

5.2.3 Proposed amendments in relation to the consultation and referral process

Suggestions to restrict access to VAD

- There should be a general restriction on all health practitioners from initiating discussions about VAD. This is because not all practitioners have the requisite knowledge to conduct informed conversations about VAD.
- The Consulting Medical Practitioner should be required to provide their own report based upon their own documentation and evidence, and not rely on information given to them by the PMP. This ensures the independence and integrity of the process.
- Organisations should be permitted to refuse to facilitate access to VAD. This is because VAD is contrary to the aims of palliative care, and many of the underlying religious or fundamental beliefs of healthcare services.

Suggestions to enhance access to VAD

- Instead of requiring the PMP to refer to a CMP for a second opinion, the PMP should be required to refer the person to an independent committee of practitioners who are willing to engage in the VAD process. This amendment would reduce the possibility that a person would have to undertake an extended search for a practitioner willing to engage in the VAD process (noting also that the PMP chooses the CMP).
- Provisions for telehealth consultations should be included, and practitioners must be required to record why it was appropriate to allow conference via audio-visual link. This would improve access in Tasmania in situations where it is too dangerous to transport frail people.
- The second request for VAD should be able to be made verbally. It is unnecessarily onerous to require two requests in writing.

- Family members should be eligible to witness the person's second request. This is because there are already provisions in the VAD Bill stipulating that a potential witness is not allowed to benefit from the person's death, so there is no need to exclude family members.
- Organisations should not be permitted to refuse to facilitate access to VAD on the basis of conscientious objection. It is enough that individuals working for those entities could individually conscientiously object if they wished to do so.
- Any organisation that refuses access to VAD must inform patients or residents of that policy prior to admission to the facility, and their position must be advertised. Entities must also facilitate transfer of patients to another facility in a timely and professional manner if the patient wishes to access VAD, and the entity should not be permitted to block any of the steps of the VAD process.
- All forms of administration should require another independent practitioner to be present, or an independent witness. This is to guarantee voluntariness and prevent against abuse.
- VAD substances which are stored in the home of the person before use must be regularly checked by a representative of the VAD Commission to ensure proper storage. This is to prevent against misuse of VAD substances.
- The VAD Bill should be amended to standardise which VAD substance is to be used in Tasmania and in what dose it is used. This is to ensure consistent best-practice.
- On the death certificate, cause of death must be recorded as being VAD. This is to ensure accurate data records, and for purposes of transparency.

5.2.5 Proposed amendments in relation to the implementation and oversight of the Act

Suggestions for practitioners

- The timeframe for doctors to complete VAD training should be amended from being within five years to two years.
- 'Authorised medical practitioners' as defined in the VAD Bill must have at least five years post-fellowship experience into a specialist medical college or be vocationally registered GPs, as in Victoria. This is to help prevent diagnostic errors.
- If a health practitioner conscientiously objects to being involved in the VAD process, they must be required to inform the person seeking VAD immediately and provide contact details of a replacement practitioner. Currently there is no procedure for what should occur after a conscientious objection. Failure to respond in a timely and appropriate manner should be met with a penalty.

5.2.4 Proposed amendments in relation to the administration of the voluntary assisted dying substance

- A person should ordinarily be required to self-administer and only in instances where this is not physically possible, should a health-practitioner assist. The involvement of medical practitioners threatens the integrity of the medical profession, but in extreme circumstance will still ensure access for those who physically cannot self-administer.

- A Secretariat on Palliative and End-Of-Life care must be established to help with raising awareness. Moreover, a 'VAD Care Navigator service' must be established, to assist with questions about the process, and with access to practitioners who have completed the training and are willing to be involved. This is to ensure a smoother administrative experience for practitioners and patients alike.
- Data collection should be introduced to understand the deficiencies in palliative care. This is so there can be data-based improvements to palliative care, to ensure palliative care remains a viable alternative to VAD.

5.3 SPECIFIC AMENDMENTS WHICH THE REVIEW PANEL BELIEVE WARRANT CONSIDERATION

Reflecting the Panel's Terms of Reference, the aims of the VAD Bill and the comparative analysis conducted for this Report, the Panel believes the following submissions warrant particular consideration.

5.3.1 Amendments proposed by the End of Life Choices Society New Zealand

- Like the New Zealand model, PMPs should be required to apply to a Support and Consultation for End-of-Life Choice group for a second opinion, instead of any practitioner who, upon their acceptance, becomes the CMP. This group should

consist solely of practitioners willing to be involved in the VAD process to ensure that the practitioner giving the second opinion does not hold a conscientious objection, and avoiding delay or the frustration of the process for the person seeking VAD. A similar amendment was proposed by Go Gentle Australia.

- A process should be established for what measures must be taken by a practitioner if they conscientiously object. The New Zealand model is to be preferred, which requires a medical practitioner who conscientiously objects to inform the patient of their objection, and the patient's right to seek the name and contact details of a replacement practitioner. The new practitioner should come from a group like the suggested Support and Consultation for End-of-Life Choice group.
- Self-administration should be supervised by the AHP for three reasons: to ensure voluntariness up to the last minute; to ensure that accidental 'out-of-sight' self-administration after a person has lost decision-making capacity does not occur and to prevent accidents occurring during self-administration.

5.3.2 Amendment proposed by Justice William Cox AC

- Greater cohesion and consistency between the sections of the VAD Bill which determine the necessary qualifications for practitioners to participate in the VAD process. Specifically, sections 5, 9, and 42 must be amended to improve integration and to clarify the educational requirements for CMPs, PMPs and AHPs.

5.3.3 Amendments proposed by Go Gentle Australia

- The removal of s 52, which restricts a PMP being involved in a person's request for VAD within 12 months of a previous unsuccessful process as patient's condition may have deteriorated in the interim period, warranting new assessment. Instead, a new section should require the PMP to inform the CMP that the previous application was ruled ineligible by two CMPs.
- Administration of VAD by an AHP should be witnessed by a person that is independent of the administering practitioner. This is an important safeguard protecting both the patient and practitioner.

- Section 94 should be amended to more clearly determine who is eligible to apply for a review. Specifically, it must be decided whether family members or health professionals who disagree could apply in order to frustrate the process.
- An Implementation Taskforce, VAD Care Navigator Service and a Secretariat on Palliative and End-Of-Life care should be established to raise awareness of the range of end-of-life care choices and to support the process of implementing VAD.
- The data to be collected by the VAD Commission should include:
 - The number of people who were receiving palliative care;
 - The numbers of people who apply but do not continue with the process, and their reasons for withdrawing;
 - The numbers of people who die before the end of the VAD process;
 - The location of the death;
 - Any end-of-life concerns held by the patient during the process, such as being a burden, being in pain or feeling a lack of control over the process.

5.3.4 Amendments proposed by MIGA (Medical Insurance Australia)

- Consideration should be given to section 17, and whether certain unprofessional conduct should be subject to criminal penalty.
- Section 18(5) should be amended to provide guidance and lenience for practitioners who are obliged to provide information on VAD but do not feel equipped to do so or may have a conscientious objection.
- Sections 27, 34 and 48 ought to be amended to make it clear that they refer to a practitioner not being able to obtain sufficient information which is reasonably available.
- The concept of an 'agent' in sections referring to applications for review of decisions is confusing. Instead, a 'sufficient interest test' should be used.
- Section 135 should be amended to clarify that any conduct which could be construed as unprofessional conduct or professional misconduct will be left for determination by

regulatory and disciplinary bodies who are best placed to make such decisions.

5.3.5 Amendments proposed by Dr Helen Lord

- Deaths should be recorded on death certificates in a way that references VAD. This is to ensure accuracy of data about disease outcomes.
- A person accessing VAD should be required to write or record an audio-visual statement, documenting their reasons for accessing VAD.
- It should be clarified that an Advance Care Directive cannot be used as any part of a VAD process, and a legal guardian cannot make a request for VAD on behalf of someone. This is to clarify that VAD plays no part in Advance Care Planning (Section 6.6)

Section 6 – Insights and further considerations for voluntary assisted dying in Tasmania

The Report concludes by outlining issues for further consideration concerning the implementation and administration of the Tasmanian VAD Bill. This analysis is informed by public reporting on the operation of VAD regimes in other jurisdictions, the relevant academic literature and the direct experience of professionals involved in the implementation, operation and oversight of VAD in Victoria and Western Australia.

6.1 CONSIDERATIONS FOR THE IMPLEMENTATION AND ADMINISTRATION OF VOLUNTARY ASSISTED DYING

VAD raises complex issues with significant legal implications and consequences for health practice, the provision of end-of-life care and the wider community. The Tasmanian VAD Bill will provide the critically important legislative foundation for provision of VAD services in Tasmania but, like so many other new and complex policy initiatives, the ultimate effectiveness of the legislation is dependent on the implementation and administration of the Bill should it pass into law. While the primary responsibility for the implementation of the VAD Bill lies with the Tasmanian Government, our Terms of Reference require consideration of 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'.

In order to provide insights into issues relating to the implementation and administration of VAD legislation in Victoria and Western Australia, the Panel conducted a workshop with a cross-section of professionals directly involved in the implementation, oversight, administration and delivery of VAD services in Victoria and Western Australia. These accounts of the Victorian and Western Australian experience to date, together with publicly available reports on VAD implementation in these two states, provide insights which are relevant to the design of the Bill and its implementation and administration.

The major themes from this analysis are summarised below while more specific considerations are outlined later in Section 6.

6.1.1 Policy learning and collaboration

The Review workshop identified the extent and value of collaboration, information sharing and policy learning between Victoria and Western Australia both in terms of legislative design and in relation to a broad cross-section of administrative and program design issues. While

some of this collaboration occurs informally between professional groups and their associations (for example, the Victorian VAD Implementation Conference), there is a growing case for greater harmonisation and resource sharing across Australia in relation to VAD data collection and management as well as training and support services.

One of the most significant general lessons from Victoria is that a safe, effective and accessible VAD regime requires a sophisticated and well-resourced administrative system and that such a system takes time to establish. Given that implementation of such a system will take time, it is important to manage community expectations and communicate the fact that while formal safeguards and compliance procedures will be in place when the system is first established, providing the full suite of access and support services will take time.

6.1.2 The role of the Voluntary Assisted Dying Commission

There is broad agreement that establishing a system of independent oversight, reporting and review of any VAD regime is essential. Independent oversight and annual reporting is necessary to ensure public confidence in VAD and to identify emerging issues such as barriers to access. The complexities and possible consequences of VAD require a commitment to subject the Tasmanian VAD regime legislation to independent review on a regular basis to ensure that its operation is consistent with the stated objectives of the VAD Bill and the views of the Tasmanian Parliament and wider community. To this end, the inclusion in the VAD Bill (s. 143), requiring an independent review after three years, and every five years thereafter, is important and appropriate.

The Review Workshop suggested that Tasmania's proposed approach – wherein the VAD Commission (as in WA) will have responsibility for regulation, review and reporting under the Act – was preferred to the original Victorian approach which divided these functions between the VAD Review Board and the Victorian Department of Health.

By their nature, the necessary safeguards and administrative requirements place a significant compliance burden on all professionals involved in the VAD process. There are anecdotal cases where medical practitioners have decided not to participate in VAD due to administrative burdens rather than for reasons of conscience. While the need to provide support services for practitioners involved in VAD is discussed in more detail in Section 6.4, there was broad agreement in the workshop that well-designed portal and data management systems for recording information relating to the VAD process can reduce the compliance burden on health professionals and improve the administrative efficiency of the VAD Commission. Tasmania could benefit from adopting and adapting administrative systems already developed in WA and Victoria.

Those involved in the administration of VAD in Victoria and Western Australia also stressed the importance of developing consistent approaches to data collection and analysis (at least to a minimum common data set). This would allow governments to identify national trends and analyse differences across states.

Medical practitioners involved in the workshop did not believe that the VAD Commission should maintain a formal list of medical practitioners and registered nurses willing to provide VAD services (s.113 c & d of the VAD Bill) arguing that health professionals on such a list may be targeted if the list became public. They considered that a referral process managed by care navigators would be more informal and flexible, and therefore more appropriate (see Section 6.4.3). Neither the Victorian nor Western Australian legislation requires government to maintain a list of participating doctors although section 79 of the Western Australian Act does require the government to maintain an up-to-date list of authorised pharmacists for VAD purposes. Section 25(3) of the New Zealand End of Life Choices Act requires the government to maintain a list of participating doctors and pharmacists. A compromise position which may be considered is providing qualified health professionals with a choice in relation to whether they are recorded on a list of qualified and willing providers proposed under the VAD Bill.

6.1.3 The role of support services in promoting access.

The need to balance access and safety is a central policy challenge for the design of a VAD regime. A key finding from the Review workshop was the critically important role of support services in promoting access. While these support services are described in greater detail in Section 6.3, the most important for promoting access include:

Care navigator services

This service promotes access in a number of ways including providing advice, administrative and pastoral support to people seeking VAD, helping them navigate the complex system, and providing advice and administrative support to health practitioners and organisations to support their provision of VAD services.

Pharmacy services

Given the specific requirements associated with the management of VAD substances and the need to support both those seeking VAD and the AHP, VAD places specific demands on pharmacists. The Victorian approach is to centralise VAD pharmacy services in a tertiary hospital (The Alfred) and operate state-funded outreach services across the state to ensure a small team of pharmacists are trained and experienced in VAD and can provide services across the state. Western Australia is implementing a similar approach.

State funding packages

The provision of safe, person-centred VAD services is resource intensive and requires a significant amount of planning, consultation, pastoral care and travel. While some costs associated with the VAD process can be claimed through Medicare there are many expenses that cannot. To address this the Victorian Government has established funding packages to meet health practitioners' VAD costs which are not covered by the Commonwealth. Funding packages are administered by Care Navigators.

Efficient administrative systems and portals

There is broad acceptance of the need to keep comprehensive and accurate records of the VAD process. However, as noted above, practitioners involved in the process argue that improved administrative systems and data collection would reduce both the compliance costs of health professionals and administrative costs for the VAD Commission. The VAD administrative system in Victoria has been refined and improved over the past two years and Tasmania and other states would benefit from sharing administrative systems.

Providing VAD services is both challenging and rewarding and raises numerous ethical, legal and personal issues. Given these challenges, high quality training and professional support is essential as are collegial and peer support networks. Workshop attendees outlined how training programs from Victoria are being adapted in Western Australia and could be applied to other jurisdictions such as Tasmania.

6.1.4 The benefits of hub and outreach model

A key insight from the Review Workshop was the need to establish well trained and resourced teams who could support and/or provide specialised VAD services. While a broad range of health and care professionals should be aware of and trained in VAD options and processes (and in the case of qualified medical practitioners act as the PMP or CMP), there is a view that care navigation services are best provided by teams located at key service hubs. Given the frailty and vulnerability of most people seeking VAD these services work on an outreach model and travel to people seeking VAD in order to minimise travel and suffering and to allow those seeking VAD to die in a place of their choosing. The Review workshop was of a view that a ‘hub and outreach’ model, where specialist staff work with and support local health care workers, would be well suited to Tasmania given the State’s size and regionally-dispersed population.

6.2 DATA ON VOLUNTARY ASSISTED DYING ACCESS IN VICTORIA AND CANADA

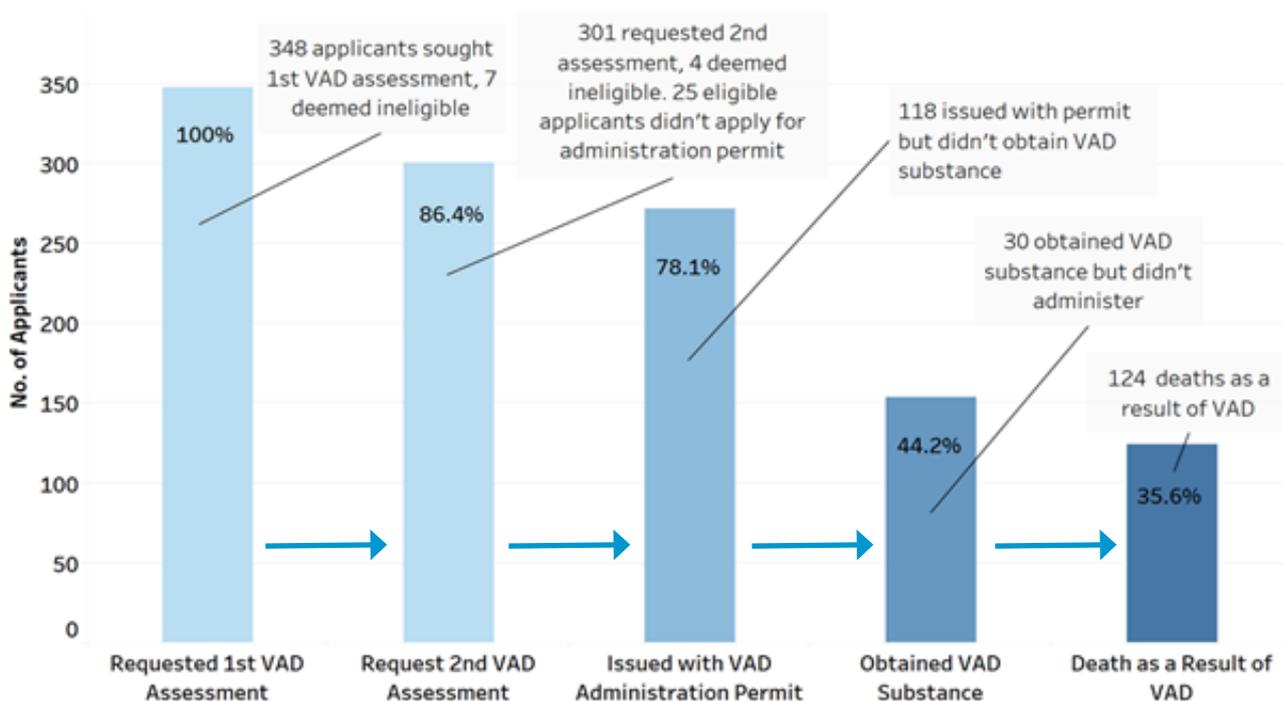
Data on the number of people who have sought VAD in other jurisdictions, their circumstances and the terminal illnesses from which they suffered can help inform the design of VAD legislation and the implementation and administration of VAD regimes. Given they are the most relevant jurisdictions for which data is available, the following section focuses on Victoria and Canada.

6.2.1 Voluntary assisted dying access in Victoria

The Victorian Voluntary Assisted Dying Review Board (VVADRB) has published bi-annual data on VAD in Victoria since it commenced operation in June 2019. Over the 12-month period June 2019-June 2020:

- There have been a total number of 124 confirmed VAD deaths since the commencement of the VAD regime. 46 deaths were recorded in the first 6 months of operation and 78 in the second.
- This represents approximately 0.271% of the 43994 deaths reported in Victoria in 2019.⁶⁴

Figure 6.1: Access to voluntary assisted dying in Victoria, June 2019 to June 2020 (source: Victorian Voluntary Assisted Dying Review Board, *Report of operations, January-June 2020*)



6.2.2 The voluntary assisted dying process

Over this period there were 348 requests for first assessment, of which 341 were deemed to be eligible.

Of the 341 applicants who were deemed eligible on their 1st assessment, 301 requested a second assessment as required under the legislation (of which 297 were deemed eligible).

272 permit applications were received over the period and 231 were approved in the first instance, with the remaining 41 being issued after a second application was made.

154 VAD medications were dispensed. Of these, 124 were administered resulting in a confirmed death.

These data suggest that 97% of those who sought VAD were deemed eligible by assessing medical practitioners. Approximately 36% of those who initiated the VAD process in Victoria died as a result of VAD in the first 12 months of the regime's operation. The VVADRB is now collecting data on non-completion which will be published in subsequent reports. This non-completion rate is slightly higher than recorded in the United States and Canada and may provide assurance that people seeking VAD are able to opt out at any stage of the process. Victorian VAD support workers participating in the Review workshop felt that in some cases those seeking VAD were not able to complete the process because their illness had progressed too quickly. In other cases, people decided not to pursue VAD but took comfort in the fact that it may be an option if their symptoms could not be managed. Some patients may find the process too complicated and lengthy. However, evidence of other reasons for non-uptake is still being collected.

6.2.3 Health and demographic profiles of Victorians seeking voluntary assisted dying

The VVADRB publishes data on the illness, disability or disease suffered by Victorians accessing the Victorian VAD regime (Andrews, 2020). Those who accessed VAD over the reporting period were suffering from the following conditions:

- Malignant cancer 78%
 - Primary lung malignancy 17%
 - Primary breast malignancy 15%
 - Gastrointestinal malignancy 11%
 - Primary pancreatic malignancy 10%

- Other malignancy 25%
- Neurodegenerative disease 17%
- Other untreatable disease 7%

Due to the eligibility criteria to access to VAD under the Victorian legislation, those living with degenerative conditions with a longer trajectory such as dementia are very unlikely to be eligible to access VAD (see text box 'Dementia and voluntary assisted dying').

Like other jurisdictions, VAD has mostly been sought by older Victorians, with those who had accessed VAD ranging in age between 32 and 100 with an average age of 72.⁶⁵

While there are no published data on the social and economic status of those accessing VAD in Victoria, those with direct experience of the regime suggest, as is the case in North America, that those seeking VAD are wealthier and better educated than the population as a whole.⁶⁶

6.2.4 Regional access to voluntary assisted dying in Victoria

As with many health and social services, there is a concern that citizens living in regional and remote communities will lack access available in major metropolitan centres. This is especially true of services, such as VAD, which require timely and coordinated contributions from multiple health professionals.

The Victorian data suggest that just over a third of all Victorians who applied to access VAD lived in rural or regional areas, with a similar proportion of practitioners trained to deliver VAD services practising in rural or regional areas. Given that 71% of Victorians reside in the Melbourne metropolitan area, the percentage of VAD applicants and practitioners from regional communities is marginally greater than the population as a whole.⁶⁷ While this suggests that people living in regional Victoria are able to apply to access VAD, the VVADRB and practitioners who deliver VAD services argue that it is difficult to deliver VAD services in remote communities due to limited access to telehealth services and availability of qualified medical practitioners.

Dementia and voluntary assisted dying

Dementia is a syndrome (or set of symptoms) resulting from neurodegenerative changes in the brain and caused by a variety of disease processes. Alzheimer's disease is the most common cause but there are several dozen other causes that present differently, particularly in the early stages (Kapasi et al. 2017)). Dementia is a progressive and terminal illness (the second leading cause of death in Australia (ABS 2019), with a range of survival of approximately three to 10 years (Todd et al. 2013). Dementia is characterised by impaired memory, thinking, reasoning and communication, and ultimately physical decline. For people with dementia, the ability to make decisions, plan for the future and perform daily self-care ultimately deteriorates as the disease progresses. Dementia is associated with a range of psychological and behavioural symptoms and related suffering. It is also associated with significant physical symptoms, particularly as the condition progresses (Mitchell 2009). Emerging research suggests that many people living with dementia benefit from palliative care as the condition progresses, ideally where advance care planning has been undertaken (Murphy et al. 2016).

In line with Victorian and Western Australian legislation, and the South Australian VAD Bill (and Victorian data showing who has accessed VAD), under the provisions of the VAD Bill, Tasmanians with dementia would rarely be eligible for VAD. This ineligibility is due to the need for the person requesting VAD to be both capable of decision-making and to have a terminal illness (in this case a neurodegenerative illness) from which they are likely to die within 12 months. Due to the nature of dementia's neurodegenerative decline, it is unlikely that many with the condition would be assessed as being both capable of sound decision-making and as likely to die within 12 months. Furthermore, given the eligibility requirements within the Bill effectively prevent the use of advance care directives to access VAD, those in the early stages of dementia will not be able to appoint a person under the provisions of the Tasmanian Guardianship and Administration Act (1995) who could request VAD for them in the future.

Beyond Australia there are circumstances where people living with dementia have been able to use Advance Care Directives to support requests for medically assisted dying, namely in the Netherlands and Belgium (Mangino et al. 2020). For example, a recent study found the practice was limited but had increased between 2008 and 2013, with the authors highlighting the need to provide additional support for both those requesting assisted dying and their physicians (Dierickx et al. 2017). As noted above, this approach is not being considered in Australia.

6.2.5 Other relevant Victorian voluntary assisted dying data

- 50% of applicants completed the entire VAD process within 19 days, 25% of applicants within 11 days, and 68% of specific permit requests were issued within two days (although the entire process including the cooling off period takes at least nine days).
- By June 2020, 422 medical practitioners were registered for VAD training and 125 were approved by the Victorian Health Department to participate in the VAD regime. Of these practitioners, 50% were GPs, and 16% specialised in oncology, with the balance specialising in other fields. Some medical practitioners who complete VAD training do so to familiarise themselves with the process but do not intend to provide VAD services.
- 2.5% of Victorians accessing VAD required an interpreter.

- Of all persons who held a voluntary assisted dying permit, 58% of people died through self-administration, and 11% died as a result of practitioner administration of the VAD substance. The remaining 31% of permit-holders either chose not to administer the VAD substance or died before it was dispensed.
- The inability to utilise telehealth services during the process, due to a conflict with the Commonwealth Criminal Code, has serious implications for some applicants wishing to access the regime (Section 6.7).

6.2.6 The Canadian Experience

Canadian legislation is less prescriptive than that in Australian states. The Canadian regime requires detailed reporting on the VAD process and the socio-demographic profile of those seeking to access VAD, which is reported by the Minister of Health on a regular basis.⁶⁸

Voluntary assisted dying access in Canada

Data on the number of deaths attributed to VAD between 2017-2019 in Canada are reported below. Significantly, the VAD deaths per capita in Canada between 2017-19 are approximately 6 times higher than the deaths per capita in the first year of Victoria’s regime. Moreover, the number of Canadians seeking VAD has almost doubled over the three whole years for which data are available, perhaps due to greater awareness and improved access to VAD.

Health and demographic profile of Canadians seeking voluntary assisted dying

Canada’s Annual Report on Medical Assistance in Dying reports the underlying medical condition causing a person to seek VAD and, like Australia, the most common condition is terminal cancer.⁶⁹

Those seeking VAD in Canada were suffering from the following medical conditions:

- Cancer 67.2%
- Respiratory 10.8%
- Neurological 10.4%
- Cardiovascular 9.1%
- Multiple co-morbidities 9.1%
- Other conditions 6.1%
- Other organ failure 4.6%

6.2.7 Considerations for Tasmania

The above data provide insights into the number and circumstances of Tasmanians likely to seek and be eligible to access VAD under the Tasmanian VAD Bill.

Given the eligibility restrictions and safeguards proposed in the Tasmanian VAD Bill it would be reasonable to

Table 6.3: Numbers of deaths in Canada due to voluntary assisted dying

	Total VAD deaths	VAD deaths as a percentage of deaths
2017	2883	1.1%
2018	2008	1.6%
2019	2009	2.0%

anticipate that per capita demand for VAD would be comparable to Victoria where deaths from VAD have initially represented approximately 0.27% of all deaths. As VAD becomes more established, based on the Canadian experience, this may increase over time. Given there were 4654 deaths in Tasmania in 2019 it could be anticipated (based on the Victorian experience) that approximately 50 Tasmanians may seek VAD assessments in the first 12 months of the regime’s operation with about 15 completing the VAD process.

The vast majority of those seeking VAD will be in the advanced stages of terminal cancer. As in other Australian legislation, the eligibility criteria in the VAD Bill are such that it is extremely unlikely that people with dementia will be able to access VAD in Tasmania. (see text box at 6.2.3).

The Victorian data suggest that people living outside the Melbourne metropolitan area have, as a result of significant investment in systems and services, been able to access VAD services in regional Victoria although in some cases people seeking VAD have been transferred to Melbourne to access services. Service provision in outer regional and remote areas remains a challenge owing to Commonwealth restrictions on using ‘carriage services’ and the Victorian practice that one of the assessing medical practitioners should be a registered specialist in the patient’s illness (Section 6.7.2).

6.3 CONSIDERATIONS FOR PEOPLE SEEKING VOLUNTARY ASSISTED DYING

An overarching objective of the VAD Bill is to provide choice for those who are suffering at life’s end while also protecting against the possibility that VAD could be used to end a person’s life unwittingly or unwillingly (Section 3.1). While protecting health practitioners and the wider community are also important considerations, the Bill is fundamentally concerned with providing choice for people suffering from a terminal illness or condition.

Given these objectives, the needs and interests of people seeking VAD are a central consideration in the design and implementation of the VAD Bill but, like all complex legislation and policy, there are trade-offs which require policy choices. A central aim of this report is to describe these choices and identify policies and strategies which the Tasmanian Parliament and Government may consider in order to deliver effective policy compromises.

6.3.1 Balancing access and safety

The central policy trade-off associated with VAD

legislation identified in Tasmanian parliamentary debate, in academic and policy literature on VAD, and in submissions to this Review, is that of achieving a balance between implementing sufficient safeguards to ensure that people cannot be coerced or deceived into VAD while ensuring that eligible people are able to access VAD.

Concerns about access are especially relevant given that many people seeking VAD will have limited capacity to engage in complex administrative processes and medical assessments owing to their frailty, immobility, and the pain they are experiencing combined with the emotional demands of preparing for death. The risk is that as more safeguards are applied to the VAD process, the more challenging it will become to access and to administer. Furthermore, one safeguard might not seem to be overly onerous when viewed in isolation, but, when considered in combination with other measures might operate to make the overall VAD process more complex making access for eligible people more challenging.⁷⁰

It is a matter for the Tasmanian Parliament to determine which safeguards should be included in the Tasmanian VAD regime. Given that the safeguards included in the VAD Bill are comparable to Victorian and Western Australian VAD legislation, and are among the most stringent in the world, this section outlines legislative measures and policy strategies which can support those seeking VAD in Tasmania to ensure the regime also meets its objective of ensuring access and promoting person-centred choices.

Key safeguards in the voluntary assisted dying Bill

As outlined in more detail in Section 4.3 the VAD Bill contains a number of safeguards to protect the interests of those seeking VAD. These include that:

- A person seeking VAD must
 - be competent, reside in Tasmania, be 18 or over and have an incurable medical condition that has been judged to cause death within six months (or 12 months in the case of neurodegenerative disease).
 - Make three separate requests for VAD and be assessed for eligibility on four separate occasions (more than any other jurisdiction)
 - be assessed by two independent health practitioners
 - be informed of alternative care options

- The VAD Commission has detailed oversight and reporting functions

Reflecting the objective of promoting regional access, the VAD Bill contains the following provisions designed to enhance access:

- Broader range of practitioner qualifications are accepted relative to Victoria
- The 'Administering Health Professional' or AHP can be a Registered Nurse
- There is a greater choice of VAD administration methods
- Health practitioners are able to initiate VAD discussions with patients and suggest VAD as an option, provided that they also discuss other treatment options and their likely outcomes
- Telehealth (expressed as the use of an audio-visual link in the VAD Bill) is able to be utilised for all requests for VAD except for the first request, which must be undertaken in person

6.3.2 Strategies for enhancing access

In addition to the access provisions in the VAD Bill outlined above a number of practical strategies for providing support and guidance for people seeking VAD have been developed during the implementation of VAD in Victoria. The Panel considers these would contribute to a more accessible and person-centred regime in Tasmania.

Care Navigators

As noted in 6.1, a key finding from the Review workshop was the important role of a well-resourced Care Navigator service to provide advice and support for people seeking VAD, as well as for health professionals involved in the VAD process. If Care Navigators provide quality outreach and regional services this greatly enhances accessibility. Care Navigators also provide additional support and pastoral care for those seeking VAD and, with consent, their family and loved ones.

Outreach services

By its nature VAD requires complex medical advice, assessments and support from multiple health professionals. Based on the Victorian experience and the emerging Western Australian model, it appears that the best way to provide these services in a regional context to promote access is through centralised teams providing outreach services to support local health professionals (Section 6.4).

Education and promoting awareness of end-of-life choices over time

There is a broad consensus that as a community we need to promote discussion of death and dying as well as end of life planning and options. While VAD is only one small element of this broader discussion, a greater focus on 'dying well' would reduce the stigma some people experience in relation to death and end-of-life choices. Also, a greater awareness of the trajectory and options for dying would enable better planning and more timely choices. Those involved in VAD stress that it is not an 'emergency option' and many people who seek to access VAD do so too late in their illness and suffer as a result.

Any educational and community engagement strategy in relation to end-of-life choices would have to be carefully developed with broad consultation.

Review and refine from a person-centred perspective

VAD legislation and associated policy is complex and deals with profoundly sensitive topics. The oversight and regular review of the VAD Bill (should it be passed into law) which is to be provided by the VAD Commission should adopt a person-centred perspective and consider the experience of those seeking VAD under the regime and how it could be improved, as well as the experience of involved health practitioners.

6.4 CONSIDERATIONS FOR HEALTH AND CARE PROFESSIONALS

6.4.1 A diversity of views

Just as there are different views on VAD within the community, doctors and other health and care professionals also hold a range of views on VAD. In addition, health practitioner views on VAD are informed by their professional identities. Views range from considering VAD to be incompatible with their roles as healers and an established professional ethic not to deliberately end human life, to considering VAD as an extension of current practice that helps alleviate suffering.⁷¹ Concerns of some health professionals include that the introduction of VAD will erode public trust and community perception of the integrity of health professionals and that it could damage professional relationships and collegiality among health practitioners.

Reflecting this diversity of views, organisations representing health professionals also hold different positions on VAD. For example, the Royal Australian College of General Practitioners (RACGP) position statement recognises that changes to the law are a matter for society and government and that general practitioners hold a wide range of views on VAD.⁷² By

contrast, the Australian Medical Association (AMA), whilst recognising divergent views within the medical profession, is currently opposed to VAD and believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life.⁷³ The AMA Tasmania submission to the Review reiterated this position. Palliative care services in particular may wish to be seen as separate from the VAD process (see Section 6.6) and this position is supported by the Royal Australian College of Physicians.⁷⁴

6.4.2 Conscientious objection by health care professionals

Just as seeking VAD is a choice for those who are suffering at the end-of-life and want to access it, so too health care professionals should be able to elect to not take part in it. The ability of health care professionals to conscientiously object and not to participate in VAD is internationally accepted and is a feature of all Australian VAD legislation and of the Tasmanian VAD Bill (s. 64). Given there may be strongly held and divergent views in relation to VAD within health care teams, robust principles and procedures in workplaces are also needed to support the practice of conscientious objection. Submissions from doctors have highlighted this concern, and this is also the view of health professionals consulted in the VAD Review workshop. There is a debate as to whether health professionals should be provided with additional protection in the VAD Bill against professional discrimination based on whether they choose to engage with VAD, or conscientiously object. Given the very specific terms of the *Anti-Discrimination Act 1998* (Tas), it would be worth considering providing additional protection to health practitioners in the Bill along the lines of the New Zealand Act (Section 6.7.1).

One consequence of healthcare workers' right not to participate in VAD is that it will reduce access to the service, especially in regional settings. The access challenge may be exacerbated by the fact that those seeking VAD are likely to be very unwell, will require timely assistance, and may not be familiar with health systems and services. To balance the rights of doctors and patients, procedures for referring those seeking VAD to practitioners prepared to provide it are required, however, whether such procedures should be included in legislation is a matter of debate. The Tasmanian VAD Bill in its current form does not require practitioners exercising their right to conscientiously object to refer a person seeking VAD to another provider or an organisation which can provide such information, and instead places the onus on the person (perhaps with the support of a Care Navigator) to find an alternative practitioner.

Voluntary Assisted Dying Care Navigators

Care Navigators in Victoria

In Victoria, a state-wide VAD Care Navigator service ('CNS') has been established in order to enable eligible Victorians' access to VAD and to provide information, support and advice to the Victorian community, persons seeking VAD, their carers, friends and family, and health practitioners. Thus far the CNS has operated from tertiary hospitals with two Care Navigators having been appointed at the Peter MacCallum Cancer Centre in Melbourne (McDougall & Pratt 2020), and a further five in the regions. Persons need not be inpatients of the Centre to seek assistance from the CNS, nor must they be suffering from cancer (Department of Health & Human Services 2020). Incidentally, the CNS has been developed during the implementation of Victoria's VAD regime and is not mentioned in the Victorian legislation.

The CNS can provide both general and individualised information to a person about VAD in Victoria, either which can be provided face-to-face or by post, and the service can be contacted by email and phone. For example, the CNS can assist a person to identify the appropriate referral pathways. The CNS also plays an important role in providing and linking people to information and advice about a range of end-of-life care options, and in facilitating access to financial support packages which may be used to, for example, meet the costs of transferring a person seeking VAD from a non-participating to a participating institution. The CNS can also provide assistance, advice and support to people throughout the eligibility process, and in situations in which the person does not have anyone to appoint as a self-administration contact person (Department of Health & Human Services 2020).

The CNS also provides support to health practitioners, with respect to receiving referrals to access support programs. The policy guidelines released by the Victorian Department of Health emphasise the role of the CNS in linking people with participating health services and practitioners, especially where the person has first approached a non-participating institution or medical practitioner (section 6.5, Department of Health & Human Services 2020).

The VAD regime in Western Australia is not expected to be operational until July 2021, though information released by the VAD Implementation Leadership Team indicate that WA will also establish a CNS.

Care Navigators in Canada

In Canada there is no federal care navigator system, and the degree to which the provinces and territories make provision for such a service varies. In Newfoundland and Labrador, Nova Scotia, New Brunswick and British Columbia, regional health authorities play a significant role in coordinating medical assistance in dying ('MAiD'), whereas Manitoba, Saskatchewan and Alberta have established dedicated MAiD coordination systems. Their roles are similar to the Victorian CNS, and mainly consist of providing information, linkage, and referral to facilitate access. Smaller territories' systems are generally less broad-spanning, existing primarily to link patients with MAiD providers (Health Canada 2020).

Mandatory referral provisions are not a feature of VAD legislation in other jurisdictions which rely on policy guidelines and professional codes to ensure referral, but there are precedents in similar legislation concerning another potentially vulnerable patient group requiring timely assistance. The Tasmanian *Reproductive Health (Access to Terminations) Act 2013* (Tasmania) specifies that if doctors and counsellors hold a conscientious objection to abortion, they are required to refer pregnant women seeking information about pregnancy options to another doctor or counsellor without conscientious objection. Most states (with modern termination of pregnancy legislation) also have a legislative requirement for doctors to refer if they have conscientious objections. Doctors are familiar with and accepting of this legislative requirement in the reproductive health context. In contested areas of practice, it can be helpful to individual practitioners and organisations to have an unambiguous legal requirement to undertake an action, rather than such a decision being based on the ethical deliberations of the individual doctor in the context of any employing organisation. This also allows a minimum standard of action for all patients, rather than a different outcome depending upon which practitioner or service is approached. For these reasons it may be considered appropriate to include a legislative requirement for medical practitioners to provide an appropriate referral service to people seeking VAD.

6.4.3 Register of health practitioners

Health professionals are concerned about the requirement under the VAD Bill for the VAD Commission to maintain a list of practitioners who are willing to participate in VAD (s. 113). The concern is two-fold. The first concern relates to the risk that such a list may become public and the second is that a list may imply that practitioners are willing to provide VAD services to all eligible people irrespective of the specific circumstances of the case and their relationship to the person seeking VAD. Given these concerns there is a risk that this provision may deter doctors from participating in the Tasmanian VAD regime. As noted above (6.1), neither the Victorian nor Western Australian legislation includes such a provision, with Care Navigators providing informal referral advice in the absence of a formal list of possible providers. A compromise position which may be considered is providing qualified health professionals with a choice in relation to whether they are recorded on list of qualified and willing providers proposed under the VAD Bill.

6.4.4 The role of registered nurses

Unlike in Victoria and Western Australia, the VAD Bill allows registered nurses (RNs) in Tasmania to

be Administering Health Practitioners (AHPs) in the VAD process. This means that a RN can assess patients' requests for self-administration, assisted self-administration, and direct administration by the AHP. It also allows RNs to directly administer the VAD substance to the patient (in cases where the patient has elected for direct administration by the AHP) or assist the person to self-administer (in cases where the patient has elected supported self-administration).

There was unanimous support among participants in the Review workshop for registered nurses to participate as AHPs, with all seeing this as an improvement on the Victorian legislation that would enhance access to VAD. This is especially important for a small jurisdiction such as Tasmania, where there is limited access to VAD qualified medical practitioners, particularly in regional communities. However, there is a concern that the requirement in the VAD Bill that the AHP must make an additional assessment of eligibility prior to the administration of the VAD substance may be problematic as it may require a complex competency assessment that many RNs may not be comfortable to provide and notwithstanding that eligibility has already previously been assessed and supported by two doctors independently. This requirement may limit the number of RNs willing to act as AHPs, potentially restricting access to VAD services in regional settings. A solution could be to require the AHP (registered nurse or otherwise) to gain the consent of the person immediately prior to the administration of the VAD substance, rather than conducting another full assessment.

6.4.5 Qualifications of medical practitioners involved in assessments

In Victoria both the Coordinating and Consulting Practitioners involved in the VAD process must hold fellowships with specialist medical colleges or be vocationally-registered general practitioners, and one must have at least five years' experience and one must have relevant expertise in the disease, illness or medical condition of the person seeking to access VAD (s. 10). The guidance document for Victorian health practitioners states that 'to have expertise and experience in the patient's medical condition the medical practitioner is required to be a medical specialist in the patient's medical condition'.⁷⁵ In addition, s 27 of the Victorian Act requires that where the CMP is unable to determine whether the person's disease, illness or medical condition meets the requirements of the eligibility criteria, the CMP must refer the person to a specialist who has skills/training in that disease, illness or medical condition. In practice, these stringent eligibility requirements have made it difficult for some seeking VAD to find doctors

qualified in their conditions (see Section 6.1). The situation is quite different in Western Australia, where medical practitioners can act as the Coordinating or Consulting Practitioners if they hold specialist registration and have practised for at least one year, or if they hold general registration and have practised for at least 10 years (or they are an overseas-trained specialist who holds limited or provisional registration) (s.17). While medical practitioners involved in VAD assessments are unlikely to have difficulty establishing that an advanced terminal illness or condition is causing significant suffering, establishing whether death will occur within six months, for example where there are new advanced cancer treatments, is challenging and requires more experience. The view of the Review workshop was that the Tasmanian VAD Bill provides a sensible 'middle path', as it strikes a balance requiring a doctor to have experience in the illness while also recognising that not only specialists can diagnose. For example, GPs and palliative care physicians are not specialists in an illness per se but have had enough experience in certain illnesses to make competent diagnoses and VAD eligibility assessments.

6.4.6 Training and support for health care professionals

Adequate training and resources are key to providing high quality care for people seeking VAD and support for practitioners who are willing to participate in VAD. Training must be made available to various professionals, including doctors, nurses, aged care workers, psychologists, social workers, ambulance officers and interpreters, given their respective roles in care teams. Beyond the mandatory training for those directly involved in providing VAD services, VAD education should be included in undergraduate health care courses as well as professional training provided by the Colleges. This more universal approach to training is necessary because all health practitioners, including those who choose not to take part in the VAD process, will need to understand the law concerning VAD, including referral requirements, and available VAD services. Indeed, a recent survey of 226 Australian geriatricians found that a key concern around VAD was the need for further training to assess patient eligibility.⁷⁶

Support for health care workers involved in VAD from their professional organisations is also important for the provision of high-quality care. Palliative Care Australia found that in jurisdictions where there is no structured support in relation to VAD for health care workers there can be negative effects on those workers, reflecting the fact that providing VAD services is undoubtedly challenging both 'professionally and personally'.⁷⁷ Further studies have shown the detrimental effects on health

practitioners where there is no support from professional organisations.⁷⁸

6.4.7 Funding for voluntary assisted dying services

As noted above (6.1.3), the provision of safe, person-centred VAD services is resource intensive and requires a significant amount of planning, consultation, pastoral care and, in many cases, travel. While the costs associated with some elements of the VAD process can be claimed through Medicare, there are many expenses which cannot. To address this shortfall the Victorian Government also provides support packages to health practitioners providing VAD services to fund aspects of the VAD process that Medicare does not cover.

6.4.8 The ability for health practitioners to initiate discussion of voluntary assisted dying

VAD legislation in Victoria, Western Australia, and New Zealand, as well as the SA Bill, does not allow health practitioners to initiate discussions with patients about VAD. The Victorian Expert Panel in its Report explained that this provision would help ensure a person is not coerced or unduly influenced into accessing VAD and to show that a request for VAD is the person's own wish.⁷⁹ White et al. (2020) found that this exclusion conflicts with the stated policy goal of respecting autonomy; supporting informed decision-making; encouraging open discussions about dying, death and people's preferences; supporting conversations with health practitioners and family about treatment and care preferences; and promoting genuine choices.

The Tasmanian VAD Bill does allow medical practitioners to initiate discussions of the possibility of VAD provided that they also inform the patient about available treatment options and palliative care options and the likely outcomes of those treatments (s. 17(1)-(2)). Further, it allows a registered health practitioner who is not a medical practitioner to initiate discussions about VAD as an option provided that they inform the patient during that discussion that a medical practitioner would be the most appropriate person with whom to discuss the VAD process and care and treatment options (s. 17(3)). The Review workshop participants were supportive of the VAD Bill's provisions in regard to the initiation of VAD discussions. The view was that all people should have access to information so that they can weigh up all options when making their treatment decisions and that discussions about death and dying should be open, transparent and are to be encouraged. Workshop participants also commented that, due to the prohibition on medical practitioners initiating discussion of VAD

in Victoria, in their practice Victorian doctors were concerned about improperly discussing VAD and that sometimes this left patients and families 'in the dark' as some health professionals were reluctant to talk about VAD even after the initial request had been made by the patient.

6.4.9 The impact of the request and assessment process on medical practitioners

The Tasmanian VAD Bill requires that three formal requests be made by the patient for VAD and four assessments be undertaken of a patient's eligibility for VAD before a person can finally self-administer a VAD substance or have it administered to them by an AHP. While this extended request and assessment process will have impacts on persons requesting VAD who are very ill and seeking a timely response, there will also be impacts on medical practitioners. The number of requests required is greater than that in comparable jurisdictions with two required in each of Victoria, Western Australia and in the SA VAD Bill. The number of assessments required in the VAD Bill is double the number required in Victoria, Western Australia, New Zealand, and also in the South Australian VAD Bill. The view among medical practitioners at the Review Workshop, was that the additional requirements of the Tasmanian VAD regime would be a disincentive to medical practitioners to participate in VAD processes. There was also significant concern that the length of time needed for the additional assessments may lead to distress among patients who were very ill and suffering and may be unable to complete the process and access VAD prior to their death.

6.5 CONSIDERATIONS FOR HOSPITALS AND AGED CARE FACILITIES

Available data suggest that the majority of people who access VAD at the end of life do so in their own homes, although it is unclear how many are transferred from hospitals and aged care facilities immediately prior to death. While most people access VAD at home, others, especially those with complex and advanced illness, seek to access VAD in hospital or hospice settings. An estimated 15% of those seeking VAD reside in residential aged care settings. Given the central role of hospitals, hospices and residential aged care facilities in providing end-of-life care, VAD and the VAD Bill raise a number of issues for these organisations. Reflecting recent debate and submissions to this Review the primary focus of this section is on organisational non-participation in VAD.

6.5.1 Organisational non-participation

A significant consideration posed by VAD legislation for hospitals and aged-care facilities is whether, as organisations, their ability not to offer VAD services (and subsequent obligations to residents or patients) should be codified in legislation. The issue of institutional 'non-participation' has been discussed in other jurisdictions, analysed in academic and policy literature, debated in the Legislative Council and raised in fourteen submissions to this Review.

Individual non-participation in VAD on the basis of conscientious objection is an almost universal feature of existing Australian and international legislation, and is provided for in the Tasmanian VAD Bill (ss. 19-20, 39-41). However, the issue of organisational non-participation has not previously attracted legislative attention because organisations are not obliged to offer VAD services. Nevertheless, the issue of organisational non-participation is now attracting more attention out of concern that it may restrict access to VAD (especially in regional settings) or, in cases where people have to be transferred between organisations to access VAD, that it may increase suffering.⁸⁰

The issue of organisational non-participation was debated in the Legislative Council when the Hon. Bastien Seidel proposed an amendment (Clause E) stipulating that if organisations decide not to provide or support VAD services to a patient or resident seeking VAD they would be under a legal duty to facilitate and take reasonable steps to effect the person's transfer to a participating institution (discussed in more detail at 3.3.4). Notably, this amendment was unsuccessful, with Members arguing the amendment was unnecessary because it was not a feature of legislation in other Australian jurisdictions and, rather than affording institutions a positive right to not to participate in VAD, it is preferable to allow individual organisations to opt out of VAD as they see fit. However, it is important to note that the emerging Australian and Canadian academic literature argues that institutional non-participation in VAD could limit access to VAD and that organisational non-participation should be subject to legislation.⁸¹

Under the provisions of the current Tasmanian VAD Bill individual participation is entirely voluntary. However, given the Bill is silent on the issue of organisational non-participation there is no obligation on institutions, such as hospitals and aged care providers, to make other arrangements if patients or residents seek access to VAD. A range of views on organisational non-participation are evident in the submissions the Review received.

Five submissions explicitly argued that entities, unlike natural persons, should not be able to conscientiously object. These submissions commonly cited the desire to put the needs of people ahead of organisational beliefs, the state-funded nature of many health services, and the sufficiency of medical practitioners' rights to conscientiously object as justification for their position. Nine submissions argued that entities should be able to object; Calvary Health Care stated that while accepting that there is a plurality of views on VAD it would not offer such a service, nor would it facilitate or participate in assessments for patients seeking VAD. However, reflecting their core principles, Calvary staff would respond openly and with respect and sensitivity to anyone who wished to consider exploring VAD and 'will actively listen to and accompany any person who is nearing end of life, and will not abandon anyone who is in need of care' (Calvary Health Care Submission, p.4).⁸² Other submissions recognised the right to non-participation while suggesting that any organisation that elected not to provide VAD services should have a legislative obligation to refer the person to a participating organisation. Go Gentle Australia suggested that non-participating institutions must widely publicise their stance in relation to VAD, and inform persons of this position prior to admission.

From the submissions received by the review, it is clear that some (but not all) faith-based hospitals and aged care facilities will pursue a non-participation policy. Moreover, evidence from the workshop conducted by the Review Panel on the implementation of VAD in Victoria suggested that in practice some faith-based providers were prepared to facilitate VAD when it was in a patient's best interest while some secular, for-profit providers did not support VAD services for operational and commercial reasons. The extent to which this will limit access by Tasmanians who seek VAD is uncertain. Victorian anecdotal evidence suggests that private residences are the most likely locations for accessing VAD but detailed data on administration locations is not published, making it difficult to gauge the extent to which non-participating organisations would limit access to VAD.⁸³ Data from Canada show that medical assistance in dying ('MAiD') mainly occurs in hospitals and private residences, followed by palliative care facilities and residential care facilities.⁸⁴ As noted below, approximately 13% of people who accessed MAiD in a major public hospital in Alberta were transferred from faith-based institutions.

As in other Australian states and territories, faith-based and other private organisations make an important contribution to Tasmania's hospital and social care system. Specifically, faith-based institutions (not all of

which will necessarily opt for non-participation) provide approximately one third of all hospital beds in Tasmania and represent approximately 30% of all aged care facilities.⁸⁵

In addition to hospitals and residential aged care facilities, a significant number of Tasmanians receive home-based care and support provided by community care organisations. It is unclear how such care may or may not impact on an individual's preference to access VAD. Given that evidence from other jurisdictions shows that many access VAD in their own homes, this could be an important consideration.

6.5.2 Established approaches to institutional non-participation in Australia

As noted above, Victorian and Western Australian VAD legislation is silent on the issue of institutional non-participation and hospitals and residential care facilities are under no obligation to participate in or support VAD.

In Victoria, at the level of policy, the Department of Health makes explicit reference to the ability for health service providers to object to the provision of VAD.⁸⁶ This policy framework establishes three pathways. It is envisaged that tertiary health services will be able to adopt pathway A and provide VAD within their existing services, whereas smaller health services that currently provide end of life care will be able to adopt pathway B, a partnership service which facilitates the request and assessment process. Health services who lack the ability to provide the aforementioned services, or who opt for non-participation in the VAD regime, are likely to adopt pathway C,⁸⁷ which entails simply providing information and support. This pathway emphasises the role of the VAD Care Navigator (Section 6.1.3), who is contacted by the non-participating health service in order to link the person with information and medical practitioners or health services that can provide access to VAD.⁸⁸ Therefore, the Victorian regime employs the VAD Care Navigator service to mitigate against any impacts legitimate organisational non-participation has on the access of Victorians to VAD. Ultimately however, institutions in Victoria are under no legal duty to refer the patient to someone who can assist them, including a Care Navigator, and the Department simply provides that the health service should inform the person that they will not assist them and should not inhibit a person's access to VAD.

Western Australia's VAD regime is not expected to be operational until July 2021, but its legislation is similar in this respect to Victoria's. Recent information released by the VAD Implementation Leadership Team indicates that, as in Victoria, a Statewide VAD Care Navigator

Service will be established.⁸⁹ This suggests that Western Australia intends to mitigate access issues arising from organisational non-participation in the same way as Victoria.

6.5.3 Established approaches to organisational non-participation in Canada

As in Australia, the Canadian Federal legislation does not compel any person to participate in the VAD process. Though *Carter v Canada* enshrined the right of entities to conscientiously object in limited circumstances, provincial and territorial governments have been afforded some autonomy in determining the extent to which entities are able to object. As such, some provinces have opted to create Care Coordination Services to receive referrals from non-participating organisations, some have delegated the roles of a Care Coordination service to its pre-existing health frameworks, and the smaller territories have adopted less formal measures, largely concerned with ensuring that patients are linked with participating providers.⁹⁰ Some jurisdictions have gone further; for example, the Ontario Ministry of Health provides that non-participating organisations should develop and publicise policies in relation to MAiD, and affirms that clinicians must meet professional referral obligations required by their regulatory colleges. The College of Physicians and Surgeons of Ontario mandates that clinicians refer a person where they conscientiously object to providing assistance in relation to MAiD.⁹¹

The evolving practices and policies in relation to organisational non-participation in Canada have occurred in part because many faith-based organisations, including hospitals, hospices and long-term care facilities, do not allow MAiD on their premises. A study by Sumner highlights the difficulties people have faced in accessing MAiD in faith-based hospitals, including examples where people seeking MAiD have suffered as a result of transfer or have died before receiving MAiD at a participating organisation.⁹² Indeed, in Alberta, of the 842 persons who accessed MAiD in a major hospital facility (between 17 June 2016 and 30 September 2020), 125 of these persons were transferred (15%), and 109 were transferred from a faith-based facility (13% of the total, 87% of those transferred).⁹³ As discussed in greater detail below, the number of Tasmanians who must be transferred between organisations to access VAD should be monitored should the VAD Bill be passed into law.

6.5.4 Compromise models and practical considerations

Notwithstanding the policy approach currently being practiced in interstate and overseas jurisdictions, a growing body of academic research is advocating for a legislative approach to clarifying the extent to which organisations can opt not to participate in VAD.⁹⁴ White et al. have proposed a model which seeks to establish a balance between an organisation's decision to not provide or support VAD, with the need to ensure access to VAD for all persons, and to respect persons' autonomy in seeking VAD.⁹⁵

This approach is a refined version of White et al.'s 2019 model⁹⁶ and aims to provide a 'compromise or reasonable accommodation' model for organisational objection to VAD. This approach involves:

- Establishing legislative obligations of non-participating organisations should they choose not to provide or allow access to VAD services. Legislation would not grant organisations a positive right to refuse to provide access to VAD, (reflecting the concern of Members in the Tasmanian Legislative Council with respect to implicitly recognising or even inducing such objection);
- Requiring that non-participating organisations provide persons with information about VAD and ensure appropriate referral, including to services such as VAD Care Navigator networks;
- Setting out a process which institutions must follow should they not wish to participate in VAD;
- Developing and applying a list of relevant considerations to a determination about whether the person should be transferred to another facility, or remain at the facility with support to leave for VAD-related appointments; and
- Where it is determined that the person should remain at the objecting institution, the facility will be obligated to permit the person to access VAD.

Providing information, as well as referral and transfer services, will enable patients and residents at non-participating organisations to access VAD, although in some cases transfer may be impractical for people seeking VAD and may make it difficult to maintain the therapeutic relationships between a person and their registered health practitioner.

6.5.6 Practical considerations for hospitals and aged care facilities

The VAD Review Workshop conducted as part of the Review process highlighted a number of considerations for hospital and aged care facilities including the need to work with care navigators and other officials supporting VAD to develop clear but flexible policies and practices. Flexibility is important because in many cases hospitals have placed the welfare and wishes of their patients above other considerations. For organisations that decide not to provide VAD services, clear patient access and transfer guidelines should be developed. For organisations that do support VAD, appropriate pre and post VAD briefings and support for all staff involved is important. While it is estimated that less than 20% of VAD occurs in residential aged care settings, those involved in the process recognise that there are particular sensitivities in relation to how other residents and staff may respond to VAD which need to be carefully managed.

6.5.7 Considerations for the Tasmanian Parliament in relation to organisational non-participation

The issue of organisational non-participation was one of the most complex considered by the Review Panel. The Review Panel's conclusions are:

- No organisation or entity should be compelled to participate in or provide VAD even though non-participation limits access, may compromise therapeutic relationships and, where transfers are required, may exacerbate suffering.
- Whether the right to organisational non-participation should be enshrined in legislation is an open question. It is unnecessary in that no organisation is compelled to participate and there are few precedents for it (Oregon is an exception). However, some academic research and submissions to this Review argue that an organisation's obligations to a patient, should they decide not to support VAD, should be set out in legislation.
- In practice, policies and procedures should be developed for referral and transfer procedures from non-participating organisations to facilities which provide VAD services. Evidence suggests the effectiveness of these services depends on access to well-resourced Care Navigators.
- The most challenging scenario is providing options for people who are seeking VAD in

non-participating organisations who cannot be transferred without subjecting them to additional suffering.

It is ultimately the role of the Tasmanian Parliament to weigh the rights and interests of individuals and organisations, a person's autonomy, an organisation's right to self-governance, and the many other intervening considerations of relevance to organisational non-participation.⁹⁷ A further consideration is the extent to which these rights and obligations should be codified in legislation or be allowed to evolve in policy and practice over time.

6.6 CONSIDERATIONS FOR PALLIATIVE CARE AND END-OF-LIFE PLANNING

The Terms of Reference (5.2) required the Review to consider the interrelationship between the Tasmanian VAD Bill and existing palliative care and advance care directives in Tasmania and the experience of other jurisdictions in relation to these matters. Reflecting this objective this Section provides a brief overview of the aims and limits of palliative approaches and the possible implications of introducing a VAD regime.

6.6.1 The origins and aims of palliative care

Palliative care (PC) is a prominent response to the needs of those diagnosed with a life-limiting condition. It is a holistic approach, encompassing physical and emotional needs, designed to reduce symptoms and associated suffering encountered with a range of incurable conditions.⁹⁸ Contemporary PC was first developed in England in the 1960s and was incorporated into healthcare practice in Australia and elsewhere from the 1980s. It came about as a reformist movement in response to the prolonged suffering of those with terminal cancer at the end of their lives, when cure was no longer an option;⁹⁹ it has since progressed to address incurable conditions such as neurodegenerative and other non-malignant disorders.¹⁰⁰

A number of philosophical traditions have informed palliative practice, but a core element of most approaches is commitment not to intentionally hasten death, but rather to maximise quality of life.¹⁰¹ Ethically, this places palliative practice in a different category to VAD, given its goal is, albeit under limited circumstances and with a patient's consent, to induce – and thereby hasten – death. For this reason, it is important to regard PC and VAD as distinct options. Indeed, PC by its nature includes a range of treatments and interventions which may be provided before the final stages of life and, in some instances, may be provided alongside curative treatments.¹⁰²

6.6.2 The debate about the limits of palliative care

Access to high quality palliative care becomes more important as the end of life approaches and curative treatments become progressively futile and are ceased. This is when access to specialist PC and services may be required.¹⁰³ It is not the role of the Review to assess the adequacy of PC services in Tasmania, although numerous submissions advocated for greater investment in PC and the full implementation of the recommendations contained in the Report of the 2017 *House of Assembly Inquiry into Palliative Care* (Section 5).

The central issue in relation to the debate about VAD which was also raised in submissions to this Review is whether high quality palliative care can control symptoms and effectively address suffering, and when it does, are the side-effects desirable and acceptable? There is an agreement that high quality PC may reduce the need for VAD but evidence suggests between 10-20% of end of life symptoms cannot effectively be controlled, contributing to possible cases where VAD still may be sought.¹⁰⁴ Indeed, comparative research conducted by Palliative Care Australia suggests that most patients internationally accessed palliative care before seeking assisted dying.¹⁰⁵

6.6.3 The potential benefits of VAD for palliative care

Palliative care and VAD provide distinct end of life options which should not be conflated. However, jurisdictions with both established palliative care systems and VAD regimes which have been operational for more than 10 years include some US states, Belgium, Luxembourg and the Netherlands.¹⁰⁶ In 2018 Palliative Care Australia (PCA) commissioned a study on the impact of VAD on the PC sector internationally. It found that where VAD had been legalised, rather than having a negative impact on PC services there had been 'an increased focus on, and public policy attention towards, end-of-life care'.¹⁰⁷ Further, PCA states:

It is noted that the implementation of legislation may drive a stronger focus on upholding patient choice and autonomy, and there may be opportunities to introduce system improvements in palliative care, either as a direct or indirect consequence of the planned implementation of assisted dying¹⁰⁸.

This greater focus on end-of-life care includes physicians seeking to improve their knowledge and understanding of end-of-life care support services, and provision of additional funding. On the introduction of VAD in Canada,

the Federal Government committed \$6 billion in funding over 10 years for home and palliative care, a significant increase from previous funding.¹⁰⁹ Indeed, Federal MAiD legislation in Canada requires ongoing review of both VAD provisions and the state of palliative care services to ensure that both options are accessible and well resourced.

6.6.4 The possible tensions between palliative care and voluntary assisted dying

Despite evidence that the introduction of VAD increases awareness of need for and investment in PC and other end-of-life care options, there are associated tensions and issues which need to be considered and addressed. A well-documented challenge for those providing PC is that referrals are often made too late in the development of an illness to provide effective treatment.¹¹⁰ The reasons for this are complex and are thought to include stigma,¹¹¹ equating PC with hopelessness,¹¹² abandonment,¹¹³ and/or imminent death.¹¹⁴ The concern is that in the absence of clear communication and support, the availability of VAD (albeit as a very different option to PC) may further discourage some patients from seeking palliative care because they mistakenly associate it with VAD.

In terms of resources, a recent Canadian study by Mathews et al. (2020) found that despite an increase in federal funding for palliative services noted above, at an operational level, some practitioners felt more resources had been directed to VAD as nurses in particular spent a good deal of time supporting those seeking VAD, while some specialist physicians expected PC teams to provide VAD.¹¹⁵ In Belgium, Bernheim et al. (2017) reported an increased demand for community-based care and extra pressure placed on existing palliative care workforce and resources following the introduction of VAD.¹¹⁶

Considerations for advance care planning

Advance care planning (ACP) is a process to allow individuals to express their future wishes in relation to health care to aid decision making when the person loses the capacity to communicate. These wishes are generally in relation to end-of-life (Australian Government Department of Health, 2021). There is broad agreement that ACP promotes more certain and person-centred care at life's end but more needs to be done to promote and support ACP (Carter et al., 2016).

In Australia, each state has its own ACP/ADC processes and guidelines. For example, in Victoria, the ACP and ACD process has been established under the Medical Treatment Planning and Decisions Act 2016 (Vic) (Eastman et al., 2020). In contrast, in Tasmania, ACDs are currently supported by common law although a bill is being developed to provide a legislative basis for ACDs in Tasmania (QUT, 2021; Archer 2020).

ACP is the process of discussion between the patient, their family, and health professionals about their wishes, while an advance care directive (ACD) is a formal document recording these wishes. The process also involves the appointment of a substitute decision maker (SDM) (known as an 'enduring guardian' in Tasmania) to aid in the communication of these wishes when the individual loses capacity (Carter et al., 2016). In practice, ACD scope extends to consenting to or refusing treatment/s as opposed to any more proactive requests for treatments of any sort (Advance Care Planning Australia, 2021).

In Australia, owing to ACP only coming into operation in the event of the individual losing capacity and a substitute decision maker being appointed, ACP does not have a role in VAD; an individual cannot request VAD via this mechanism. However, as noted above, there are different traditions in relation to palliative care and VAD internationally and via various provisions, advance directives or 'living wills' can be used to request euthanasia in the Netherlands (Rurup et al., 2006) and Belgium (De Bandt, 2003). There is, however, no provision or support for this approach in Australia.

ACP remains an important part of individuals planning for end-of-life care that has relevance for any health care context, and in palliative and aged care in particular (PCA, 2018).

6.7 LEGAL CONSIDERATIONS

Enacting VAD legislation raises significant legal issues as it involves creating a statutory exception to the criminal law prohibition on the deliberate taking of life at a person's request which would otherwise amount to murder under the Criminal Code of Tasmania.

This section focusses on specific legal considerations potentially impacting on the operation of the legislation, in particular:

- Scope of protection for health practitioners for both participation and non-participation in VAD
- Possible restrictions on use of telecommunications in connection with VAD (Commonwealth Criminal Code)
- Legal status of the 'double effect' principle arising in palliative care
- Impact of VAD for individuals in relation to life insurance

6.7.1 Scope of protection for medical practitioners

The Tasmanian VAD Bill includes provisions protecting health care professionals and others from legal liability who, in good faith and without negligence, perform an act or omission under the Act (s134(2)). This is in accordance with the provisions of other VAD legislation and is necessary to ensure that those providing VAD assistance in accordance with the legislation are protected from legal sanction.

The VAD legislation of some jurisdictions goes further in providing legal protection from discrimination to health care professionals for their participation or non-participation in VAD. In particular, the New Zealand *End of Life Choice Act 2019* has a detailed conscientious objection provision (s8) which prohibits an employer from denying an employee employment, accommodation, goods, services or other benefit on the grounds of the employee's conscientious objection to participating in VAD. Further, an employer must not provide employment, accommodation or other benefit conditional upon the employee providing or agreeing to provide VAD assistance. This provision helps to protect health practitioners from being discriminated against by their employer for their participation or non-participation in VAD.

Tasmania has the *Anti-Discrimination Act 1998* but because of its very specific scope of operation, this does not provide protection against all forms of discrimination.

The inclusion of a provision along the lines of the New Zealand protection would help ensure health practitioners do not incur detriment in their employment for their decision to participate in VAD or, conversely, not to participate on the grounds of conscientious objection.

6.7.2 Possible restrictions on use of telecommunications in connection with voluntary assisted dying (Commonwealth Criminal Code)

The VAD Bill includes a number of references to use of audio-visual communications between the PMP and the patient (s34 and 56), between the CMP and the patient (s48) and between the participating pharmacist and the patient (s71). Essentially, the Bill allows for the use of audio-visual link (not defined) in order to meet with the person seeking VAD for the purposes of making determinations under the Act. Notably, however, the use of audio-visual link is expressly excluded for making a first request to access VAD where that request is made orally (s18(2)(b)) and the Bill also specifies that the person must have received the relevant facts in relation to accessing VAD from the medical practitioner in person and not by way of audio-visual link (s18(2)(a)).

The use of telecommunications in the VAD process has been raised as an issue in connection with both the Victorian and West Australian legislation. The West Australian Act includes a number of references to audio visual communication (for example s22(2), s50(20 and s158(2)) however, the Victorian Act makes no specific reference to the use of audio-visual or other forms of telecommunication).

The Department of Health and Human Services Victoria has advised that use of telecommunications in connection with VAD could be a breach of Federal laws which forbid the use of telecommunications to spread 'suicide-related materials,' in particular, section 474.29A of the Criminal Code Act 1995 (Cth)¹¹⁷ which prohibit use of a carriage service (including telephone or internet) to counsel, promote or provide instruction on suicide. The Department has accordingly directed that in person approaches are required. These Criminal Code provisions predated the legalisation of VAD in Victoria and Western Australia and are reported to have been introduced in response to a campaign led by right-to-die activist Dr Phillip Nitschke who was promoting methods for terminally-ill individuals to end their lives.¹¹⁸

The Law Institute of Victoria has written to the Victorian Health Minister, the Australian Health Practitioner Regulation Authority (AHPR) and the Commonwealth Director of Public Prosecutions (CDPP), seeking urgent clarification on whether Victorian health practitioners

who discuss VAD under the *Voluntary Assisted Dying Act 2017* (Vic) with patients via a carriage service such as over the phone, via email or through the use of telehealth, may be in breach of the Commonwealth Criminal Code.¹¹⁹ Similarly, in Western Australia a cautious approach is being taken to ensure that those participating under the legislation avoid breaching the Commonwealth legislation.¹²⁰

Resolution of this issue comes down to an interpretation of the relevant VAD legislation and whether the participation of medical practitioners can amount to provision of material related to suicide. VAD is widely regarded as quite distinct from suicide. This is made clear in the Tasmanian Bill (s138) and the West Australian Act (s12) but no equivalent provision exists in the Victorian VAD legislation. These provisions in the Tasmanian Bill and Western Australian Act are framed in terms of 'for the purposes of the law of this state' VAD is not suicide. There are however, differing legal views on the effect of this vis a vis the Commonwealth law.¹²¹

If it is accepted that death by VAD is legally distinct from suicide, the participation of doctors under the legislation through the provision of information and materials using a carriage service would not be in breach of s474.29A of the *Criminal Code Act 1995* (Cth). However, in view of the legal uncertainty and the cautious approach being taken by authorities in Victoria and Western Australia, the Tasmanian Government may wish to seek its own legal advice on the matter from the Solicitor General. This is potentially a serious issue which could significantly curtail the use of telecommunications for VAD which has been an important part of ensuring regional access.

In clear anticipation of any potential problems in this area, the Tasmanian Bill provides in s 137 that nothing in the Act is taken to authorise the use of a method of communication if, or to the extent that, the use is contrary or inconsistent with a law of the Commonwealth. This would operate to avoid legal inconsistency between the Tasmania VAD Bill and the *Criminal Code Act 1995* (Cth) but does not clarify the current uncertainty as to whether conduct undertaken by health practitioners in accordance with the legislation may amount to a contravention of the provisions prohibiting use of a carriage service to counsel, promote or provide instruction on suicide.

6.7.3 Legal status of the 'double effect' principle arising in palliative care

Elsewhere in this report (Section 6.6), consideration has been given to the provision of palliative care in Australia and its relationship with VAD. For the purposes of this analysis, the focus is on the legal status of the doctrine of

double effect in Australia with the aim of differentiating this from VAD.

The doctrine of double effect, which had its origins in moral theology, recognises that palliative medication administered to a patient with the intention of relieving pain and symptoms will be lawful even if that will have the unintended effect of hastening the patient's death. Central to this doctrine is the focus on intention: provided the primary intention is to relieve pain and symptoms rather than to cause death, the doctrine holds that the medical practitioner or other authorised person administering the palliative medication will not be criminally liable even where death was foreseen. Based on the circumstances of the cases where this doctrine has been relied on, it is generally understood that the doctrine of double effect only applies to a person who is near death.¹²²

Palliative medication administered to a patient with the intention of relieving pain but which may hasten death is an accepted part of medical practice. It is important that this is clearly differentiated from VAD, which involves the intentional assistance to bring about death at the request of the patient. The critical distinction is intention; for palliative medication, the intention of the medical practitioner is to relieve pain, not to cause death. The consent of the patient is not a pre-requisite; indeed, the patient may not be in a position to consent. VAD, by contrast, involves the deliberate and intentional bringing about of the death of the patient at the patient's clear and explicit request further to the detailed substantive and procedural legislative requirements.

Whilst the doctrine of double effect is supported by case law in the UK (Adams Case)¹²³ and other common law jurisdictions, there is no Australian authority directly on this issue. However, South Australia, Queensland and Western Australia have legislated to clarify the law in this area, providing that authorised persons who provide palliative medication will not be criminally liable provided that certain criteria specified in the legislation are met. Under the legislation of Queensland and Western Australia the palliative medication must have been provided in good faith, with reasonable skill and care, and be reasonable having regard to the person's state at the time and in the circumstances of the case (Criminal Code (Qld) s282A; Criminal Code (WA) s259). The South Australian legislation requires additionally that the person is in the terminal phase of a terminal illness and that the palliative medication is administered with the consent of the person or their representative (*Consent to Medical Treatment and Palliative Care Act 1995* (SA) s17).

The introduction of such legislation clarifying the status of palliative medication administered with the intention

of relieving pain but which may hasten death is especially important in Australian jurisdictions which have a criminal code, such as Tasmania. This is because homicide is defined as culpable not only when it is caused by an act intended to cause death or bodily harm, but also where it is caused by an act commonly known to be likely to cause death or bodily harm, and which is not justified under the provisions of the Code (see Criminal Code (Tas) s156). In light of this very specific provision, it is difficult to see how the common law doctrine of double effect can apply. Because of this legal uncertainty, the 2017 Palliative Care Inquiry undertaken by the House of Assembly Standing Committee on Community Development recommended that the Tasmanian Government enact in legislation the common law doctrine of double effect to strengthen legal protection for those who provide end-of-life care (Recommendation 17), but this has not yet been implemented.¹²⁴

In conclusion, even though practices that constitute this double effect and VAD are distinctly different, perhaps because of this very difference, legislation could be considered to clarify the double effect issue.

6.7.4 Influence of voluntary assisted dying for individuals in relation to life insurance

Another legal issue that has raised concern since the introduction of VAD legislation in Australia is the impact of VAD for individuals' life insurance. A quite common provision in life insurance policies is an exclusion for death by suicide, usually specified to apply if it occurs within the first 13 months of taking out the policy. This is allowed under the Life Insurance Act 1995 (Cth) provided that the exclusion in respect of suicide is expressly included in the policy (s228.).

Although there are a number of practical reasons which make it unlikely that this would be an issue. For example, it would be rare for someone to be healthy enough to pass the initial underwriting health assessment required for life insurance and then to qualify for VAD within the next 13 months. Furthermore, life cover also pays out on terminal illness where the person's life expectancy is expected to be less than a year (sometimes two). This means the person would almost certainly be eligible to claim before VAD comes into consideration, it does give rise to the question of whether death by VAD amounts to suicide, such that it may preclude life insurance coverage on death that the person had organised for their family (assuming that the policy has an exclusion for suicide.) The Victorian VAD legislation has been in force since 19 June 2019 (The Western Australia VAD legislation is expected to come into force on 1 July 2021) but to date, there have been no reported cases examining this issue in Australia.

Section 138 of the Tasmanian VAD Bill includes a specific provision to the effect that for the purposes of the law of this state, a person who dies as a result of VAD does not die by suicide (s138). A similar provision exists in the Western Australian legislation (s12). Although the Tasmanian Bill is silent on the issue of recording death following VAD, it appears to be generally accepted that the cause of death is the underlying terminal illness, and should be recorded as such, although the suggestion has been made (via submissions to the Review) that it is important to note that VAD has occurred for the purposes of collecting statistical data on cause of death (the concern being that not recording this information could skew data that is used by clinicians when making decisions about prognosis and outcomes).

The experience from Canada, where medical assistance in dying (MAiD) has been available now for a number of years, is instructive in providing an indication of how life insurers in Australia are likely to deal with VAD. In Canada there is generally an exclusion of life insurance payouts in respect of a suicide applying to policies in place for less than two years. Since the introduction of MAiD, provided that both the health preconditions (terminal illness/palliative condition) and legal requirements of the legislation are met, Canadian life insurance companies have paid claims in full and the case is treated as a usual death. This approach has been formalised through the issuing of Guidelines on Medical Assistance in Dying by the Canadian Life and Health Insurance Association.¹²⁵ Further to those guidelines, member companies would not treat deaths resulting from MAiD as a 'suicide' for policy purposes provided the legislated process has been followed. Other defences available to insurers (such as misrepresentation or other exclusions) would remain open. The Guidelines also state that it will be important for life insurers to be aware of the underlying cause of death in the circumstances, and accordingly have recommended to provincial governments in Canada (which have responsibility for regulating the detail of MAiD), that the underlying cause of death be recorded on death certificates issued in the circumstances of a MAiD death.

To date, the Australian life insurance peak body, Financial Services Council, has not issued any guidelines in relation to VAD. A plain reading of the Tasmanian VAD legislation is that VAD is differentiated from suicide and that persons would not be eligible for VAD unless their condition was terminal and they are expected to die within a period of months. Read together with the specific provision stating that death by VAD is not suicide, there should be no life insurance access issues for persons seeking to avail themselves of VAD.

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Appendix 1: Submissions to the Review

1. End-of-Life Choice Society New Zealand
2. Professor John Burgess
3. Christians Supporting Choice for Voluntary Assisted Dying
4. Australian Christian Lobby
5. Doctors for Assisted Dying Choice (Tas)
6. Dr George Merridew
7. Australian Care Alliance
8. Palliative Care Tasmania
9. Robyn Maggs
10. Australian Catholic Bishops Conference
11. AMA Tas
12. William Cox
13. Annie Fagan
14. Life Choices Tasmania
15. Mary Larnach-Jones
16. Sarah Loft
17. VALE Group
18. Marion Harris
19. Norelle Lickiss
20. Tamara Corbett
21. Dying with Dignity (Tas)
22. Catholic Health
23. MIGA (Medical Insurance Group Australia)
24. Go Gentle Australia
25. Karen Dixon
26. Legana Christian Church
27. Ben White and Lindy Willmott
28. Anglican Church Tasmania
29. Helen Lord
30. Louise Spaulding
31. Calvary Healthcare
32. Live and Die Well
33. ANZ Society of Palliative Medicine
34. Frank Brennan
35. Odette Spruijt
36. Anthea Patterson
37. Christopher Middleton
38. Jeff Malpas
39. Joe Tempone
40. Mike Sladden
41. <Confidential>

Submissions will be published on the Review Panel website - www.utas.edu.au/vad-review

Appendix 2: Complete tables 2.2 and 2.3

VAD bills in Australian jurisdictions

Jurisdiction	Bill	Date introduced	Who introduced?	Notes
Australian Capital Territory	Voluntary and Natural Death Bill 1993 (plus 4 more)	18 June 1993	Michael Moore (Independent)	Between 1993 and 1997 there were 5 unsuccessful attempts to introduce VAD legislation
South Australia	Voluntary Euthanasia Bill 1995 (plus 19 more)	9 March 1995	John Quirke (Australian Labor Party)	Between 1995 and 2016 there were 20 unsuccessful attempts to introduce VAD legislation
Northern Territory	Rights of the Terminally Ill Act 1995	22 February 1995	Marshall Perron (Country Liberal Party)	Repealed by the Commonwealth <i>Euthanasia Laws Act 1997</i>
Northern Territory	Criminal Code (Euthanasia) Amendment Bill 1997	18 February 1998	John Bailey (Australian Labor Party)	Attempt to amend the NT legislation to prevent Commonwealth disallowance
Commonwealth	Euthanasia Laws Act 1996	9 September 1996	Kevin Andrews (Liberal)	This legislation disallows the above NT Law and subsequent laws in NT and ACT
Commonwealth	Euthanasia Laws (Repeal) Bill 2004 (plus 6 more)	3 March 2004	Lyn Allison (Australian Democrats)	Unsuccessful attempt to repeal above Euthanasia Laws Bill 1996 There have been 6 subsequent and unsuccessful attempts to repeal the Commonwealth veto between February 2007 and December 2015
New South Wales	Voluntary Euthanasia Referendum Bill 1997 (plus 8 more)	15 May 1997	Elisabeth Kirkby (Australian Democrats)	Between 1997 and 2017 there were 9 unsuccessful attempts to pass VAD legislation in the NSW parliament
Tasmania	Dying with Dignity Bill 2009	26 May 2009	Nick McKim (Australian Greens)	Bill defeated in the House of Assembly 15 votes to 7
Tasmania	Voluntary Assisted Dying Bill 2013	26 September 2013	Lara Giddings (Australian Labor Party) Nick McKim (Australian Greens)	Bill defeated in the House of Assembly 13 votes to 11
Tasmania	End of Life Choices (Voluntary Assisted Dying) Bill 2020	27 August 2020	Mike Gaffney (Independent)	Passed by Legislative Council 10 November 2020, currently being considered by the House of Assembly
Victoria	Medical Treatment (Physician Assisted Dying) Bill 2008	28 May 2008	Colleen Hartland (Australian Greens)	Bill defeated in its Legislative Council second reading 25 votes to 13
Victoria	Voluntary Assisted Dying Act 2017	20 September 2017	Jill Hennessy (Australian Labor Party)	Parliament passed the Bill on 29 November 2017 and it came into effect on 19 June 2019
Western Australia	Voluntary Euthanasia Bill 1997	16 October 1997	Norm Kelly (Australian Democrats)	Between 1997 and 2010 there were 6 unsuccessful attempts to pass VAD legislation in WA
Western Australia	Voluntary Assisted Dying Act 2019	7 August 2019	Roger Cook (Australian Labor Party)	Parliament passed the Bill on 10 December 2019.

Appendix 2: Complete tables 2.2 and 2.3

Key Australian and New Zealand reports on VAD

Jurisdiction	Body/Author	Date	Report	
Australia	Parliament of Australia, Senate, Legal and Constitutional Affairs Legislation Committee	November 2014	<i>Medical Services (Dying with Dignity) Exposure Draft Bill 2014</i>	The Senate referred the Medical Services (Dying with Dignity) Exposure Draft Bill 2014 to the Committee for inquiry and report, tasking it with considering the rights of terminally ill people to seek assistance in ending their lives, and considering an appropriate framework and safeguards with which to do so. The Committee found some technical issues with the Bill, which it recommended be addressed. It also recommended that if the Senate were to deal with this broad policy issue, Party Leaders should allow a conscience vote.
New Zealand	New Zealand Parliament, Justice Committee	April 2019	<i>End of Life Choice Bill: As reported from the Justice Committee</i>	The Committee examined and reported back on the End of Life Choice Bill, recommending minor, technical and consequential amendments only leaving the issue of whether or not to legalise VAD to what it expected would be a conscience vote.
Northern Territory	Parliament of the Northern Territory, Select Committee on Euthanasia	May 1995	<i>The Right of the Individual or the Common Good? Report of the Inquiry by the Select Committee on Euthanasia</i>	Committee's role was to gather, analyse and summarise the community's views on euthanasia to inform the Legislative Assembly debate on the Rights of the Terminally Ill Bill 1995, rather than to recommend or not recommend VAD
Queensland	Parliament of Queensland, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee	March 2020	<i>Voluntary Assisted Dying</i>	The Committee produced three reports from its Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying – this report being one of those three. The Committee recommended that Queensland use the draft legislation designed by Ben White and Lindy Wilmott as the basis for a legislative scheme, and also set out its preferred framework
South Australia	Parliament of South Australia, Joint Committee on End of Life Choices	October 2020	<i>Report of the Joint Committee on End of Life Choices</i>	The Committee Members held divergent views on VAD but stated that if South Australia were to legalise VAD then Victoria's system would be the preferred on. The Committee recommended that SA monitor and review the outcomes of the systems in Victoria and WA in order to design a system in that state. The Committee also recommended improvements to palliative care and the processes around advance care directives in South Australia.
Tasmania	Larissa Giddings and Nicholas McKim	February 2013	<i>Voluntary Assisted Dying: A Proposal for Tasmania (Consultation Paper)</i>	Giddings and McKim provided this paper to inform debate vis-a-vis their co-sponsored Bill, the Voluntary Assisted Dying Bill 2013
Victoria	Parliament of Victoria, Legislative Council, Legal and Social Issues Committee	June 2016	<i>Inquiry into end of life choices: Final report</i>	The Committee recommended that a VAD system be put in place to cater for the needs of individuals, while ensuring that there are safeguards in place to protect vulnerable people. It also made recommendations for improving palliative care and advance care directives
Victoria	Victorian Government	July 2017	Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report	The Panel's role here was to consider how to put the broad policy direction as recommended the previous year by the Legal and Social Issues Committee into practice
Western Australia	Parliament of Western Australia, Joint Select Committee on End of Life Choices	August 2018	<i>My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices</i>	The Committee recommended that the Government introduce VAD legislation, and emphasised the importance of individual autonomy and choices at end-of-life. The Committee also recommended that a Panel be appointed to undertake consultation and to develop the WA VAD legislation
Western Australia	Government of Western Australia	June 2019	<i>Ministerial Expert Panel on Voluntary Assisted Dying: Final Report</i>	The Panel provided a legislative framework including guiding principles and including points of agreement with the recommendations of the Joint Select Committee report.

Appendix 3: Summaries of voluntary assisted dying legislation in comparative jurisdictions

Australian VAD legislation and bills are largely based on the Victorian Voluntary Assisted Dying Act (2017) which is summarized in Section 4.1

This appendix provides a similar analysis of the subsequent Western Australian Act, the VAD Bill currently before the South Australian Parliament and the key elements of the Canadian and New Zealand legislation.

WESTERN AUSTRALIA: THE VOLUNTARY ASSISTED DYING ACT 2019

Objectives and Principles

The Act contains 11 principles which must be considered when a person exercises a power or performs a function under the Act (s. 5). These principles are similar to those contained in the Victorian Act (4.1.1(i)):

- the equal value of every life
- respect for persons' autonomy
- the right of persons to be supported in making decisions about their treatment and palliative care options
- the right of persons approaching the end-of-life to high quality care
- the need to support therapeutic relationships between persons and their health practitioners
- the need to encourage open discussions around death and dying and end-of-life preferences
- the need to support persons in conversations with others about their treatment and care preferences
- the entitlement of persons to genuine choices about their care, treatment, and end-of-life regardless of where in Western Australia the person lives, having regard to their culture and language
- the entitlement of all residents to equal access to VAD
- the need to protect persons from abuse and coercion
- the right of all persons to be shown respect for their culture, religion, beliefs and values.

Eligibility

The eligibility criteria for VAD under the Act are contained in s 16. The person must:

- be 18 years or older
- be either an Australian resident or a permanent resident who has been ordinarily resident in Western Australia for at least one year at the time of making their first request
- have decision-making capacity in relation to VAD. This means they must have the capacity to understand, consider, and communicate a decision about VAD. Persons are presumed to have such capacity (s. 6)
- be acting voluntarily and without coercion, and their request for access to VAD must be enduring
- be diagnosed with an advanced and progressive illness that will cause death within six months, or 12 months in the case of a neurodegenerative condition. The illness must not be able to be tolerably relieved. Having a disability or a mental illness alone will not satisfy this requirement.

Consultation and referral process

The Act makes provision for a minimum of two medical practitioners who participate in the VAD process. A person's Coordinating Practitioner accepts their first request for VAD and conducts the first eligibility assessment. Provided that the person meets the eligibility criteria, and understands the information about their prognosis, palliative and non-palliative treatment options and likely outcomes contained in s 27(1), the Coordinating Practitioner must then find the patient eligible for access to VAD, and refer the person to another medical practitioner for a consulting assessment (pt. 3, div. 3). The Consulting Practitioner accepts the referral, and conducts the second assessment of the person's eligibility, termed the consulting assessment. If either the Coordinating or Consulting Practitioners are unable to determine whether the person is eligible to access VAD, they must refer the person to a registered health practitioner with the appropriate skill and training to make the determination (ss. 26, 37).

If the Consulting Practitioner finds the person ineligible for VAD, the Coordinating Practitioner may refer the person to another registered medical practitioner for a further consulting assessment (s. 41). If the Consulting Practitioner finds the person eligible, and understands the information explained to them about their prognosis and treatment options contained in s. 27(1), the Consulting Practitioner must find the person eligible to access VAD (pt. 3, div. 4), following which the person may make a written declaration to the Coordinating Practitioner in the approved form, appropriately signed and witnessed, declaring their voluntariness and understanding of the nature of their declaration (pt. 3, div. 5). The person may then make a final request to the Coordinating Practitioner for access to VAD at least nine days after the day on which they made their first request. This prompts the Coordinating Practitioner to conduct a final review, whereby they review the first assessment report form, all consulting assessment report forms, the written declaration and to complete the final review form (pt. 3, div. 6).

Practitioner qualifications

A medical practitioner is able to act as a Coordinating or Consulting Practitioner if they hold specialist registration and have practised the medical profession for at least one year; or they hold general registration and have practised the medical profession for at least 10 years; or they are an overseas-trained specialist who holds limited or provisional registration. Coordinating and Consulting Practitioners cannot be family members of the person, nor stand to financially benefit from the person's death (s. 17). Practitioners able to act as Administering Practitioners are medical practitioners eligible to act as Coordinating Practitioners, and nurse practitioners who have practised the nursing profession for a minimum of two years. Administering practitioners must have completed the approved training, and be independent of the person (pt. 4, div. 1).

Administration of voluntary assisted dying substance

Once the final review has been certified by the Coordinating Practitioner, the person, in consultation with the Coordinating Practitioner, makes a decision about the form of VAD they are seeking; either a self-administration decision or a practitioner administration decision (pt. 4, div. 2).

A practitioner administration decision can only be made if self-administration is inappropriate having regard to the ability of the patient to self-administer, the patient's concerns about self-administering or the method for

administering the substance suitable for the patient. A practitioner administration decision authorises the Coordinating Practitioner to prescribe the VAD substance, the authorised supplier to possess, prepare and supply the VAD substance, and the Administering Practitioner to administer the substance to the person in the presence of an eligible witness, provided their request for VAD is enduring, they are acting voluntarily and have decision-making capacity (s. 59). A self-administration decision authorises the Coordinating Practitioner to prescribe a VAD substance, the authorised supplier to supply the substance to the patient, and the person to self-administer (pt. 4, div. 2). As is the case under the Victorian Act, the Western Australian Act does not require medical supervision during self-administration.

Legal and other protections

Healthcare workers must not initiate a discussion about VAD nor suggest VAD to a person, unless the person requests this information, or the healthcare worker provides this information in concert with the person's treatment and palliative care options and likely outcomes (s. 10). Persons are free to withdraw from the VAD process at any time. The Act is prescriptive with respect to the information that must be conveyed to the person at various stages, and requires that the VAD process be heavily documented, official documents be signed and witnessed, and the VAD Board informed of the progression of each request. Importantly, where an authorised supplier receives a prescription for a VAD substance, they must verify the authenticity of the prescription and fill out the appropriate documentation (pt. 4, div. 4). Further, the Act criminalises certain instances of non-compliance with the Act, including inducing a person to request VAD, by advertising certain poisons as VAD substances, and failure to give the VAD Board relevant documentation (pt. 6).

Registered health practitioners' participation in the VAD process is entirely voluntary, and they may refuse to participate where they have a conscientious objection to VAD or for any other reason (s. 9). In Part 8, the Act gives legal protection to practitioners who, in good faith and without negligence, assist a person in the VAD process or who are present during administration. Protection is also given to ambulance officers who do not administer lifesaving treatment to persons where they believe on reasonable grounds that the person has ingested a VAD substance in accordance with the Act, and where the person has not requested lifesaving treatment.

Further, the Act is prescriptive with respect to the handling, storage, labelling and disposal of the VAD substance. Persons intending to self-administer

must appoint a contact person who must return unused or remaining VAD substance to an authorised supplier, and failure to do so is a criminal offence (s. 105).

Monitoring and oversight

The Act establishes the VAD Board in Part 9 whose functions include monitoring and reporting on the operation of the Act, and referring matters to persons or bodies including the Police, the Coroner, and the AHPRA. Medical practitioners and authorised suppliers are required to complete and send copies of relevant documentation to the VAD Board, including the final review form completed pursuant to s. 51.

SOUTH AUSTRALIA: THE VOLUNTARY ASSISTED DYING BILL 2020

Objectives and principles

The Bill (tabled in the SA Parliament on 2 December 2020) contains a list of 10 principles which must be considered by a person exercising a power or performing a function under the Act (s. 7). These are:

- every life has equal value
- respect for persons' autonomy
- the right of persons to information about medical treatment options and to be supported in making informed decisions about their medical treatment
- the need to provide every person approaching the end-of-life with quality care
- the importance of maintaining therapeutic relationships between persons and their health practitioners
- the need to encourage persons to openly discuss death and dying and their treatment and care preferences with others; the entitlement of all persons to genuine choices regarding their treatment and care
- the need to protect persons from abuse; and the right of all persons, including health practitioners, to be shown respect for their culture, beliefs, values and personal characteristics

Eligibility

The eligibility criteria for access to voluntary assisted dying ('VAD') are contained in s 13 of the Bill. To be eligible, persons must:

- be aged 18 years or older

- be an Australian citizen or permanent resident who has been ordinarily resident in South Australia for one year prior to making the first request
- have decision-making capacity in relation to VAD, which is the ability to understand, retain, weigh, and communicate relevant information. Persons are presumed to have such capacity (s. 4)
- have an incurable, advanced and progressive illness that is expected to cause death within six months or 12 months in the case of a neurodegenerative illness. This illness must be causing suffering to the person which cannot be tolerably relieved. Persons are not eligible only because they are diagnosed with a mental illness or disability.

Consultation and referral process

The Bill makes provision for a minimum of two medical practitioners who participate in the VAD process. A person's Coordinating Medical Practitioner accepts their first request for VAD, and conducts the first assessment of the person's eligibility for VAD (pt. 3, div. 3). If the Coordinating Medical Practitioner finds that the person is eligible to access VAD, they must refer the person to another registered medical practitioner for a consulting assessment (pt. 3, div. 4).

A person's Consulting Medical Practitioner is the registered medical practitioner who accepts the Coordinating Medical Practitioner's referral for a consulting assessment, and conducts the consulting assessment. Both the Coordinating and Consulting Medical Practitioners must find that the person is eligible to access VAD if the person satisfies the eligibility criteria, if they understand the information provided to them under s 23 of the Bill, if they are acting voluntarily and without coercion, and if their request for VAD is enduring. Both practitioners must refer the person for a specialist opinion if they are unable to make the requisite determination (ss. 22, 31). If the Consulting Medical Practitioner finds the person ineligible for VAD, the Coordinating Medical Practitioner may refer the person to another registered medical practitioner for a further consulting assessment (s. 35). If the person is determined to be eligible to access VAD, the person may then make a written declaration, appropriately signed and witnessed (pt. 3, div. 5), followed by a final request, whereupon the Coordinating Medical Practitioner undertakes a final review of all of the documentation completed thus far (pt. 3, div. 6).

Practitioner Qualifications

Each Coordinating and Consulting Medical Practitioner must either hold a fellowship with a specialist medical college or be a vocationally registered general practitioner. One of them must have practiced as a registered medical practitioner for at least five years post-fellowship or vocational registration, and either one of them must also have relevant expertise and experience in the illness expected to cause the death of the person being assessed (s. 14). Both practitioners must also have completed the approved assessment training (ss. 21, 30).

Administration of voluntary assisted dying substance

Under the Bill, the Coordinating Medical Practitioner may apply to the Chief Executive of the administrative unit of the Public Service for either a self-administration or practitioner administration permit for the person. The Chief Executive may issue or refuse to issue a VAD permit, and refusal may be on the basis that the request and assessment process has not been completed as required by the Bill (s. 53).

Self-administration is the default procedure under the Bill, and the Coordinating Medical Practitioner may apply for a practitioner administration permit only if satisfied that the person is physically incapable of the self-administration or digestion of the VAD substance. If the Chief Executive approves the practitioner administration permit, a person may make an administration request in person to the Coordinating Medical Practitioner, who may later administer the VAD substance to the person, if satisfied that the person has decision-making capacity in relation to VAD and if their request for VAD is enduring. The Coordinating Medical Practitioner may only administer the VAD substance to the person under these circumstances in the presence of a witness. If the Chief Executive issues a self-administration permit, the Coordinating Medical Practitioner may prescribe a VAD substance for the person to self-administer (pt. 4, divs. 1-2). This Bill, similar to the Acts in Victoria and Western Australia, does not require medical supervision of the self-administration of the VAD substance.

Legal and other protections

Registered health practitioners are prohibited from suggesting VAD to a person, and from initiating a discussion about VAD with a person, except in response to a person's direct request (s. 10). The Bill gives legal protection to persons who disclose to AHPRA instances of non-compliance with this prohibition (pt. 7, div. 1). Persons are free to withdraw from the VAD process at any time (ss. 16, 48), and the

VAD process is required to be heavily documented, with copies of official documents all sent to the VAD Board, and provision made for the eligibility of persons to act as witnesses to a person's signature on written instruments (e.g. ss 30-40). The Bill criminalises certain instances of non-compliance with the Bill (pt. 8), including falsifying forms and failing to give copies of documents to the VAD Board, and the failure of a contact person to return any remaining VAD substance once the person has died.

The participation of registered health practitioners in the VAD process is entirely voluntary, and those with a conscientious objection to VAD may refuse to participate or be present during administration (s. 9). Broad protection is given under the Bill to registered health practitioners who, in good faith and without negligence, act pursuant to the Bill, which is extended to ambulance officers present after the administration of a VAD substance (pt. 7, div. 2). The Bill also makes provision for legally pursuing persons who harass or discriminate against a person who provides, or who will provide, information pursuant to the Bill (s. 112).

Finally, the Bill makes provision for the secure handling, storage, labelling and disposal of prescribed VAD substances (pts. 4-5), including the need for persons to appoint a contact person with obligations in respect of the return of unused or remaining VAD substance (ss. 43-44).

Monitoring and oversight

The Bill establishes the VAD Board (pt. 9), whose functions include collecting and disclosing forms and information provided in accordance with the Bill and referring any issues to the relevant body including the police, the State Coroner, and AHPRA.

The Bill requires that the Coordinating Medical Practitioner conducts a final review of the forms that have been completed in the request and assessment process, and sends copies of all the completed documents to the VAD Board (s. 45). Further, the Chief Executive determines applications by Coordinating Medical Practitioners for VAD permits. The Chief Executive may refuse to issue a VAD permit if they are not satisfied that the request and assessment process was completed in accordance with the Bill (s. 53).

CANADA: THE MEDICAL ASSISTANCE IN DYING ACT (2016)

The Canadian VAD regime pre-dates the Australian legislation and is primarily concerned with decriminalising assisted dying and providing a framework

for provincial legislation. See Section 2.X for further information on the history of Canada's VAD legislation.

Objectives and principles

The Canadian Medical Assistance in Dying Act (2016) commits to recognising the autonomy of those who suffer from grievous and irremediable medical conditions, by allowing those suffering to seek assistance in dying. The Act amends the Canadian Criminal Code to create exemptions from the offences of culpable homicide, of aiding suicide and of administering a noxious thing. A significant part of the Act is dedicated to determining the criteria of eligibility and creating new offences for failing to adhere to the safeguards within the Act.

Eligibility

- A person may only be medically assisted in dying if they meet all criteria set out in section 241.2(1) of the Act. A person must:
 - Be eligible for government-funded health services
 - Be a minimum of 18 years old and be able to make decisions about their health.
 - Have a grievous and irremediable medical condition
 - Have made a voluntary request for medical assistance in dying that was not made as a result of external pressure
 - Provide informed consent to receive medical assistance in dying after being informed of the different means that are available to them to relieve their suffering, including palliative care

Section 241.2(2) details the criteria that must be met for a person to be considered as having a grievous and irremediable medical condition. These criteria include that the person's natural death must have become reasonably foreseeable (ss d). However, at the time of writing, a Bill before the Canadian Parliament (C-7, 2020) seeks to implement the 2019 ruling of the Supreme Court of Québec in *Truchon v Canada* (AG) (2019, QCCS 3792). This case established that the requirement death be 'reasonably foreseeable' was unconstitutional and must be repealed. A Third Reading of the Bill in the Senate, and the giving of Royal Assent, is expected within the first quarter of 2021. The Bill (C-7, 2020) seeks to:

- Clarify that those suffering solely from mental illness are ineligible to access VAD
- Allow access to VAD even where death is not reasonably foreseeable.

- Introduce additional safeguards to protect those who wish to access VAD despite their death not being reasonably foreseeable
- Permit VAD to be provided to a person who has lost the capacity to consent due to unsuccessful self-administration of the lethal medication; and
- Permit VAD to be provided to a person who has lost the capacity to consent, provided that the death is reasonably foreseeable, the person has made an application to be exempt from the 'final consent' requirement, and two assessing medical practitioners have determined that the person is otherwise eligible to access VAD

Consultation and referral process

A person wishing to access VAD is required to make one request to a medical practitioner, but it is the responsibility of the medical practitioner to seek a second opinion to ensure that the person fulfils all eligibility criteria (s 241.2(3)(e)). The medical practitioner who receives the initial request is also responsible for ensuring that the request was signed and dated in the presence of two independent witnesses who also signed and dated the request (s 241.2(3)). Where a person is unable to sign and date their request for medically assisted dying, as required by the procedural safeguards, then another person may do it for them, in accordance with the safeguards in section 241.1(3). Finally, the medical practitioner must allow 10 clear days between the day the request was signed by the person and the day that medical assistance in dying is provided, or the substance is given for self-administration (s 241.2(3)).

It is important to note that the national legislation is heavily supplemented by additional regulations that are made by the provinces and territories of Canada. Canadian provinces and territories have the jurisdiction to decide the processes around administering VAD, the requirements for accessing VAD and how data should be collected, providing that the regional regulations are consistent with the requirements in the national legislation. This arrangement accounts for the brevity of the national legislation.

Administration of voluntary assisted dying substance

In the national legislation, the term 'medical assistance in dying' is defined to mean '...the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, which causes their death; or the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their

request, so that they may self-administer the substance and in doing so cause their own death' (s 241.1(a) and (b)). It is therefore clear that a medical practitioner or nurse practitioner may administer medication inducing death or prescribe the medication for self-administration. However, it ought to be noted that in some provinces of Canada, such as Québec, self-administration is not permitted.

The involved medical professionals also have an important administrative role to play. Before a person accesses the Canadian VAD program, the administering medical professional must ensure that the relevant safeguards are adhered to (s 241.1(3)), and afterwards, must ensure that the relevant authorities have all the required information that is necessary to keep comprehensive records (s 241.31(1)).

Legal and other protections

The key safeguards for the person wishing to access medically assisted dying are set out in s 241.2(3). Before a medical professional provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must:

- Hold the opinion that the person meets the criteria for eligibility
- Ensure that the person's request for VAD was made in writing, is signed and dated by the person, after the person was informed that they have a grievous and irremediable medical condition
- Be satisfied that the request was signed and dated in the presence of two independent witnesses who also signed and dated the request
- Ensure that the person requesting assistance in dying has been informed they can at any time and in any matter, withdraw their request
- Ensure that a second independent medical professional has provided a written opinion confirming that the person meets all the criteria for eligibility
- Ensure that there are at least 10 days between the day on which the request was signed by the person and the day upon which medical assistance in dying is provided, unless both consulting practitioners believe that the person's death or the loss of their capacity to consent is imminent
- Immediately before providing assistance in dying, give the person an opportunity to withdraw their request

- In situations where the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

There are no specific provisions in the Act which provide protections to the medical practitioners involved in the process. However, the primary aim of the Act is to adjust sections of the Canadian Criminal Code so that medical professionals, aides and witnesses to requests are not criminally liable for medically assisting someone in dying when they act in accordance with the eligibility criteria and safeguards in the Act. Moreover, many of the safeguards to protect the person accessing VAD double as a safeguard for involved medical practitioners.

Monitoring and oversight

Subsections 241.31(1) and (2) require involved medical practitioners and pharmacists to disclose certain information, to allow accurate and comprehensive data collection to occur under the regulations, which later operates to inform a number of reviews. Under s 9(1), an independent review commenced 180 days after Royal Assent of the Act, to investigate issues arising from mature minors requesting medical assistance in dying, advance requests and instances where mental illness was the sole underlying medical condition. The findings of the independent review, completed by the Council of Canadian Academies in December 2018, are reflected in the proposed amending Bill (Bill C-7), particularly in relation to the decision to expressly prohibit those suffering solely from mental illness to be eligible for VAD. Moreover, total review of the Act must occur during the fifth year after the Act received royal assent, which is 2021 (s 10(1)).

NEW ZEALAND: THE END OF LIFE CHOICE ACT 2019

The End of Life Choice Act (2019) will come into force in November 2021 following a binding referendum in which the majority of New Zealanders voted in support of the Act.

Objectives and principles

The purpose of the Act is to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives, and to establish a lawful process for assisting eligible persons who exercise that option (s. 3).

Eligibility

The eligibility criteria are contained in s 5 of the Act. To be eligible for voluntary assisted dying ('assisted dying' or 'AD') under the Act, the person must:

- be 18 years or older
- be either a New Zealand citizen or a permanent resident
- be competent to make an informed decision about AD, which means being able to understand, retain, use and communicate information about AD decisions (s. 6)
- be suffering from a terminal illness that is likely to end the person's life within six months, which is causing unbearable suffering that cannot be tolerably relieved. The person must further be in an advanced state of irreversible decline in physical capability

Persons are not eligible for AD by reason only that they are suffering from a mental disorder or illness, or have a disability or are of advanced age (s. 5(2)).

Consultation and referral process

The Act makes provision for a minimum of two medical practitioners to participate in the VAD process.

A person's Attending Medical Practitioner receives the person's initial request to exercise the option of receiving AD, confirms this request in the requisite form, and gives the first opinion on the person's eligibility to access AD (ss. 11-13). If the Attending Medical Practitioner finds that the person is eligible for AD, or that the person would be eligible if it could be established that they are competent to make an informed decision about AD, the Attending Medical Practitioner may then ask the Support and Consultation for End of Life in New Zealand ('SCENZ') Group for the name and contact details of an Independent Medical Practitioner and ask the Independent Medical Practitioner for a second opinion in relation to whether the person is eligible for AD (s. 14). If either or both of the Attending and Independent Medical Practitioners have found that the person would be eligible if their competency to make decisions could be established, then they must jointly ask the SCENZ group for the name and contact details of a psychiatrist, and obtain a third opinion from that psychiatrist on whether the person is competent (s. 15).

Practitioner qualifications

A medical practitioner is a health practitioner who is, or deemed to be, registered with the Medical Council of New Zealand as a practitioner of the profession of medicine and who holds a current practising certificate. An independent medical practitioner is a medical practitioner who in relation to the person who has requested AD is independent of the person and of the person's attending medical practitioner, and who has held, for at least the previous five years, a practising certificate, or the equivalent certification from an overseas authority responsible for the registration or licensing of medical practitioners. A psychiatrist under the Act is a medical practitioner whose scope of practice includes psychiatry. A nurse practitioner is a health practitioner who is or is deemed to be registered with the Nursing Council of New Zealand as a practitioner for the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions and who holds a current practicing certificate. Nurse practitioners are able to act as an attending nurse practitioner where they act under the instruction of an attending medical practitioner (s. 4).

Administration of voluntary assisted dying substance

If the person is found to be eligible for AD, they must complete the approved form choosing the date and time for the administration of the medication (ss. 17-18). Next, the person must elect one of the four administration methods available under the Act, which are: ingestion triggered by the person, ingestion triggered by the attending medical practitioner or nurse practitioner, intravenous delivery triggered by the person, or injection administered by the relevant practitioner (s. 19). This allows the Attending Medical Practitioner or Attending Nurse Practitioner to write the appropriate prescription. The Registrar must check that the requisite processes have been complied with and notify the Attending Medical Practitioner accordingly before administration can occur (s. 19(4)-(5)). At the time of administration, the Attending Medical Practitioner or Attending Nurse Practitioner must check that the person still wishes to receive the medication at that time, and enacts the person's wishes with respect to administration. The attending practitioner must be in the same room or area as the person or in close proximity to the person until the person dies, or arrange for another medical practitioner or attending nurse practitioner to be so (s. 20).

Legal and other protections

Health practitioners must not initiate discussion with a person that is in substance about AD, nor suggest AD to the person unless the person requests information (s. 10). Eligible persons under the Act are able to withdraw their request to receive AD at any time, and have the Attending Medical Practitioner cease the process in relation to the person. This does not prevent the person from making a new request for AD at a later time (s. 21). Further, any provision that a person makes for AD in an advance directive or contract will be invalid, and welfare guardians have no power to make decisions under the Act for the person for whom they are appointed (ss. 33-34). If at any stage the Attending Medical Practitioner suspects that the person is being subject to pressure or coercion, they must take no further action in the VAD process, and notify the Registrar (s. 24). The Act also clarifies that it does not affect the right of any person to receive nutrition or hydration nor their right to refuse treatment, nor the duty of a medical practitioner to alleviate suffering (s. 32). Further, the Act criminalises the wilful failure of a medical practitioner, nurse practitioner or psychiatrist to comply with the Act (s. 39).

Health practitioners' participation in the AD process is voluntary, and health practitioners are under no obligation to assist a person with AD if they have a conscientious objection, though they must inform the person of this objection and tell the person they may obtain information on AD from an alternative medical practitioner. Employers must not discriminate against practitioners on the basis of either their willingness to provide assistance in relation to AD or on the basis of their non-participation on grounds of conscientious objection (ss. 8). The Act gives immunity from criminal liability to health practitioners for providing assistance with AD (s. 37).

The Act also provides for the safe disposal of AD medication, and gives legal protection to persons who, in good faith, assist a person who wishes to exercise the option of AD in the AD process (ss. 37-38).

Monitoring and oversight

The Registrar must be satisfied that the requisite processes have been complied with before administration can occur under the Act (s. 19(4)-(5)). Further, the Act makes provision for the appointment of an end-of-life Review Committee, consisting of a medical ethicist and two health practitioners, one of whom must be a medical practitioner who practises in the area of end-of-life care. The Committee reviews reports sent to it after a person has died pursuant to the Act's administration procedures, and reports to the Registrar

on whether its contents demonstrate satisfactory compliance with the Act. The Committee may compel the Registrar to investigate information which appears non-compliant (s. 26).

The Act also makes provision for the nomination of an employee of the Ministry as Registrar. The Registrar must establish and maintain a register recording approved forms, the Review Committee's reports to the Registrar, and the Registrar's reports to the Minister. The Registrar may receive and refer to the appropriate body, including the police, complaints about the appropriateness of the conduct of health practitioners under the Act (s. 27).