Voluntary Assisted Dying – Reflections on the law reform process

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The Hon. Justice Peter Applegarth AM
Chair
Queensland Law Reform Commission
Voluntary Assisted Dying legislation and the process of law reform

Thank you for the invitation to speak. I was reluctant to accept. The Commission that I chair has a policy of letting its reports speak for themselves. Once we deliver a report, our work is done, and we move to the next reference that has been given to us. We let the democratic process take its course.

The reason I decided to speak tonight is my respect for the people at the Australian Centre for Health Law Research, under the leadership of Professors White and Willmott, whose research, reflections, and writing did so much to assist the Commission’s work.

Our voluntary assisted dying review seems so long ago. The Commission is now developing a legal framework for decriminalisation of the sex work industry. We have moved from death to sex. What might be next: drugs and then rock & roll? Neither sex, drugs nor rock & roll is on our list. The several topics on our “wish-list” for a future reference include the outdated Transplantation and Anatomy Act, 1979; processes for granting mining leases; self-defence; and a few other matters in urgent need of law reform. That is just our short list. You should see our long list. Currently, we only can do one review at a time. We do not choose our references: they are given to us by the Attorney-General and often they are not on our proposed program of law reform.

In terms of democratic process, that is a good thing. But it means that the Law Reform Commission occasionally is asked to catch a political hot potato like termination of pregnancy and voluntary assisted dying.

With voluntary assisted dying, our task was not to say whether there should be legislation, but to devise a framework for a new law. We were like engineers acting for a client who wants to build a bridge. But there are many ways to design a bridge, and we faced many design choices.

That proved to be a mammoth task. It led to a huge report which had to be produced in a much shorter time than we would have liked.

Mark Twain is attributed with the saying: “If I’d had more time, I would have written a shorter letter”. The same applies to our report. It runs to 739 pages, to which we added a 113-page draft Bill. We did a 50-page report summary, a two-page summary of the summary, and two pages of diagrams.

I’ve been asked to talk tonight about the law reform process, so I will concentrate on it rather than the detail of our report, which I have included in the later part of this paper, drawing largely on the report summary. My remarks tonight will touch on:
The democratic process

The reference to the QLRC followed a long and detailed investigation by a Parliamentary Committee into voluntary assisted dying and palliative care. Based on extensive public consultation, a majority of that committee supported such a law. We built on its work but did not always agree with the detail of its recommendations.

Our report and draft Bill were considered by a Parliamentary Committee, and became the subject of debate and a conscience vote in the Parliament.

In short, having voluntary assisted dying legislation was not our idea. The Commission’s role was to develop detailed architectural or engineering drawings. That was the part we played in a democratic process. We were on tap, not on top.

The consultation process

We took a few months to research the law and practices in other jurisdictions and concentrated on what I would describe as the Australasian model. We produced a substantial consultation paper that posed many questions. We received many detailed submissions that we carefully read and analysed. The voluntary assisted dying lobby, if I can call it that, did not speak with a single voice. Nor did opponents of any new law.

May I dispel some assumptions about supporters and opponents? Some atheists opposed any such law on grounds of principle or public policy. There were Christians for VAD and Christians against VAD. It is a complex matter that divides opinion.

On many policy or design choices, for example, what the anticipated timeframe until death to be eligible should be, or whether there should be a timeframe at all, there were different views and no obvious right answer.
Evidence-based law reform

The consultation process did not end with the paper. It continued until the end. We spoke with opponents and supporters of VAD in places like Victoria and Western Australia. They included nurses and doctors who deal with death each day of their working lives. We derived great assistance from the Voluntary Assisted Dying Board and the Care Navigators in Victoria, whose reports, both written and oral, gave us an understanding of how the law in that State works in practice. We spoke to people in Western Australia who were preparing for the start of the law’s operation in that State about the challenges of rolling out a law in a huge State. That occurs against the background of uncertainty created by a federal law that did not target VAD laws. That legal uncertainty impedes giving advice or information by tele-health.

The value of academics and their research

The term academic may be used in a pejorative way. I don’t. As I tell my colleagues and friends, I’d like to be an academic when I grow up.

As the part-time members of the Commission reflected on the issues and submissions, we refined our thinking, and changed our minds about the shape and detail of the draft Bill. We had the advantage of evidence-based research, practical experience and the deep thinking of brilliant academics. Professors White & Willmott and their fellow researchers informed our thinking about matters of principle as well as the nuts and bolts of any new law.

We were fortunate to have Dr Jayne Hewitt from Griffith University, a nurse and academic, seconded to the Commission to explain to us how things work in the real world. She gave us invaluable advice.

Taking things out of the “too-hard” basket

In developing the legislation’s architecture, decisions had to be made about whether a matter should be addressed in the statute itself (at the risk of making it long and complicated), in regulations (that the executive government make and can easily change), or in non-enforceable guidelines.

One such matter was non-participation by entities. Predictably, the Bill we proposed provided for conscientious objections by individual health professionals, and the obligations of individuals who decline to be involved in the VAD process.

A harder topic was non-participation by entities, both public and private. Other jurisdictions did not feel the need to address this in a statute. After all, you do not need to state in law that Hospital X has a right not to participate in orthopaedic surgery or obstetrics. It makes decisions based on the services it wishes to deliver at that hospital. Similarly, you do not
need to state in law that Hospital X has a right to not participate in VAD. It just does not participate, either because its staff do not have the qualifications and experience or because that entity’s principles do not allow it.

We accepted that entities should not be forced to participate in VAD by conducting eligibility assessments or in administering substances.

In Victoria and Western Australia, the issue of participation by entities is addressed in guidelines about what entities should do if a patient asks for information about or access to VAD. That is one approach. But we thought that such an approach leaves a large cloud of uncertainty and misunderstanding, and therefore the potential for disputes at the hospital bed when patients insist that they have a legal right to access VAD, and the entity says: “Yes, you do, but not here”.

As a result, we proposed laws that try to reconcile competing rights, by stating what the response should be in terms of facilitating transfers where that is reasonably practical, or allowing qualified persons reasonable access to premises to conduct an assessment where transfer is not practical. The provisions are detailed because the places include aged care facilities that are a person’s own home, as well as hospitals that people should know have a policy of not participating in the VAD process, where the default is an obligation to facilitate transfer.

**Laboratories of democracy**

It would have been simpler to start with legislation from Victoria, Western Australia or New Zealand and tinker with it. Instead, we started with governing principles and worked from there.

We did not feel compelled, in the interests of consistency, to adopt interstate provisions that were the result of political compromises, that seemed wrong in principle, that the evidence suggested were not practical, or that did not seem suited to Queensland conditions. Still, our suggested model had much in common with other Australasian models.

There is a democratic dimension that applies in a federation like ours. I am a fan of Justice Louis Brandeis. He regarded States as ‘laboratories of democracy’ in which different policies can be enacted and tested in a state, as in a scientific experiment. If the policy is a failure, it does not affect any other state. If, however, the policy is a success, it might be expanded to another state. If improvements are made in that next state, they might be adopted in another.

The result is not necessarily uniform legislation across the states that adopt the policy. The idea is that a state can identify the strengths and weaknesses of laws that were enacted in another.
Putting legal frameworks in perspective

Our task was to recommend ‘the best legal framework’ for people who are suffering and dying to choose the timing and circumstances of their death. Legal frameworks are important because they determine what people are allowed to do. However, the practical operation of any law is also governed by human behaviour and practices.

Most people want to live for as long as possible without experiencing intolerable suffering. This includes individuals with a terminal illness who are eligible to access voluntary assisted dying. The fact that they are eligible does not mean that they will proceed to prove their eligibility and proceed to administration as soon as possible after becoming eligible.

Laws might allow people to access voluntary assisted dying during what are expected to be the last 6 or 12 months of their lives. However, people who are eligible may leave it to the final weeks of their life to access voluntary assisted dying.

Others may be assessed to be eligible and able to proceed to administration, but choose not to. Voluntary assisted dying may be kept as an option. Another end of life option, such as continuing palliative care, may be chosen.

Laws operate in a therapeutic context. For example, it is unlikely that an individual who is eligible for voluntary assisted dying will suddenly request it, without first receiving medical care and advice about their condition, their prognosis and treatment options.

If experience in other places like Victoria is any guide, many people will begin a discussion about voluntary assisted dying with their treating practitioner some time before they make a formal request to access it. Many will not request it until their condition is well-advanced, sometimes too far advanced to complete the process before they die.

Legal requirements set certain periods: for example, the minimum time between the first and last request is a requirement that confirms that the request is enduring. This does not mean that most cases will complete the process in that minimum period. In fact, the nature of the process, with the need for two independent assessments and a formal written declaration by the person certified by two eligible witnesses, may mean it will take much longer.

One can have a legal framework that does not match reality. After all, there are Bills of Rights that are not worth the paper they are written on in totalitarian countries.

The practical operation of any VAD law depends on resourcing for palliative care and for VAD, with qualified and trained people resourced to inform people of their options and to help them navigate their way through a necessarily complex process.

In a State like Queensland, it depends on access to practitioners who are qualified and prepared to do this difficult and financially unrewarding work, including helping people in far-flung locations, where the local doctor or the local hospital does not provided that service. That is why we urged clarification of an unnecessarily uncertain federal law that
impedes doctors using a phone, let alone an email or a video-camera, to provide advice and information to people in remote places.

Some personal reflections

The balance of this paper attempts to summarise the contents of a very detailed QLRC report and the Bill that the Commission drafted. That piece of legislation is necessarily long because it addresses a complex matter that requires detailed regulation.

I will conclude my oral remarks with some personal observations about being involved in the law reform process.

It sounds like a cliché to say that people have diverse views about voluntary assisted dying. The divide in opinions is not what you might expect. It is not along religious or political lines. The topic divides opinions in families and between friends.

During the QLRC review I encountered a range of opinions. Some people I encountered in lifts and on footpaths asked me “What is all the fuss?” Somewhat cynically they would say, things like:

“We all know that doctors hasten death all the time, they say they are increasing doses to prevent pain, but really they are putting people and their families out of their misery. They don’t have to get second opinions and jump through a lot of hoops. So why don’t we just convert the present reality into something just as simple?”

Their attitude raises this question: What is the difference between in fact hastening death by administering a massive dose of a pain killer, knowing that it will hasten death, but not specifically intending to cause death, and hastening death with such an intention to relieve suffering?

For some citizens, that is not an important distinction. For many others it is a fundamental ethical line that should never be crossed.

Many palliative care specialists say:

“We don’t in fact hasten death, we ease the passing. Anyway, the difference between intending to hasten death and not having that intention is fundamental.”

It is the difference between hastening death without intent to kill (which might be manslaughter in the absence of legal protection of the kind given by s 282A of the Criminal Code) and intending to kill, which is murder.

Some see the distinction as a fundamental matter of law and ethics. It is a line that many think we as a community should not cross.
Others see the law that creates these distinctions as anomalous and hypocritical. The English jurist, Sir Stephen Sedley published a recent article called “A Decent Death”. He discussed the anomalies that existed in the law before suicide was decriminalised in the UK in 1961. He noted:

“..by the mid 19th century the law had got itself into such a tangle that a person injured in a failed attempt at suicide could be indicted for wounding with intent to kill, an offence for which Parliament had thoughtfully provided the death penalty.”

As for present day anomalies, he wrote:

“the age-old common law of trespass to the person entitles a competent adult to refuse invasive treatment – intubation, injection, transfusion – even if their refusal is irrational, the treatment is simple and painless, and the result of refusal is that they will die. Yet the ability of a rational individual in unbearable and untreated distress to opt for terminal medication remains beyond the pale of the law.”

Supporters of voluntary assisted dying laws say many things, including that those laws remove this kind of anomaly. A key feature of the laws the Commission was asked to draft is that they apply to people who are already dying and experiencing intolerable suffering.

The hope is that better-resourced palliative care will reduce the number of people who feel the need to access this new, lawful end of life option.

I was very fortunate to work with a team at the Queensland Law Reform Commission who produced such a comprehensive report and draft legislation under huge time pressure. We were fortunate to have a Secretariat and people seconded to the Commission who displayed a high level of skill in legal research and analysis, and policy development. The Commission’s staff and members worked tirelessly between July 2020 and May 2021.

During the review, we informed ourselves through meetings with experts and other individuals whose views were based on experience. This involved video conferences with health practitioners in Victoria and Western Australia, with people who had served on expert panels in those States, and with public servants who had been involved in the implementation of legislation. We also consulted with the Voluntary Assisted Dying Review Board and the Voluntary Assisted Dying Care Navigator Service in Victoria.

We spoke to busy palliative care specialists, oncologists, physicians, general practitioners, and other health care professionals, who had different views about voluntary assisted dying. Some work in tertiary hospitals that do not provide access to voluntary assisted dying; others work in aged care facilities or in the suburbs. Their time is valuable. We were fortunate that they generously gave their time to speak to us and to inform our thinking.
It was a challenging reference for the Commission to complete in such a short time. One of the benefits of being part of the review was the opportunity to meet dedicated professionals who care for people who are dying. Some were advocates for voluntary assisted dying. Others opposed it. Irrespective of the positions adopted by those health professionals, one could not doubt their sincerity or their deep commitment to reducing the suffering of individuals who are dying.

The Essence of the QLRC Report

A voluntary assisted dying law gives individuals who are suffering and dying an additional end of life choice.

It allows eligible people who are dying to choose the timing and circumstances of their death. It gives an option that can limit suffering at the end of life. It is not a way to end life for those who are not dying.

**VOLUNTARY:** the decisions to request access and to continue with the process must be made voluntarily and without coercion (including improper influence).

**ASSISTED** by doctors and nurses. If a person is eligible and chooses to go to the final stage, they either self-administer a substance prescribed by a doctor or have an experienced doctor or nurse administer the substance so as to hasten, at the person’s request, their death.

**DYING:** To be eligible the person must be suffering and dying.

The person must be separately and independently assessed by two doctors (who meet the law’s qualification and training rules) to be eligible.

To be eligible the person must:

1. have an eligible condition
2. have decision-making capacity
3. be acting voluntarily and without coercion
4. be aged at least 18 years
5. fulfil a residency requirement.

To satisfy 1, the person must have been diagnosed with a disease, illness or medical condition that is:

- advanced, progressive and will cause death,
- expected to cause death within 12 months, and
- causing suffering that the person considers to be intolerable.
The timeframe of 12 months makes it clear that VAD is an option only for those who are at the end of life. The VAD scheme is not a choice between life and death but a choice for those who are in the process of dying and wish to choose the time and circumstances of their death.

The scheme has many safeguards. The process of request and assessment involves three separate requests that are clear and documented. The process has a waiting period of at least 9 days between the first and final request. The person must also be told, more than once, that they may decide at any time not to continue the voluntary assisted dying process. After the request and assessment process, the substance is prescribed and dispensed if the person chooses to proceed to the substance administration stage.

Most people want to live for as long as possible without experiencing intolerable suffering. This includes individuals with a terminal illness who are eligible to access VAD.

Allowing eligible people who are dying to begin the process during what is expected to be the last 12 months of their lives does not mean that they will proceed to obtain the substance and administer it as soon as they become eligible. Experience shows they are likely to wait until they are closer to death.

Also, some people may leave the process of assessment until it is too late. They may lose capacity or die before the process can be completed.

Doctors, nurses and other health practitioners who have a conscientious objection to VAD will have the right to choose not to participate.

The Commission also recognised that entities, either public or private, should not be forced to participate in the process by providing voluntary assisted dying services.

Therefore the Commission recommended processes to regulate and accommodate the competing rights of:

- individuals seeking to access a lawful end of life choice; and
- entities not wishing to provide services, such as assessments of eligibility or administration.

An Oversight Board and existing authorities will ensure the law is being complied with.

A Statewide Care Navigator Service will give information and assistance to people and help patients, their families and friends, and health practitioners navigate the process.
The Commission was asked to recommend ‘the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland’ should voluntary assisted dying become law in this State.

Its report details the principles on which the draft Bill was based, VAD laws in other places, and how they work in practice in Victoria. It identified strengths and weaknesses in those laws so as to inform the democratic process in Queensland.

The Commission’s aim was to develop a draft law for Queensland that is compassionate, safe and practical.

This paper does not debate the need for VAD laws. Its aim is to introduce you to the thinking behind the Queensland Law Reform Commission’s major report and draft Bill.\(^1\) The draft Bill was adopted by the Queensland Parliament after a lengthy debate without amendment. The new law is expected to come into full operation on 1 January 2023.\(^2\)

The operation of the legislation depends on implementation, funding for the care navigator service and other services, the training of doctors and nurses who are prepared to qualify to act in the defined and demanding roles, and whether a Commonwealth law is amended to allow people who cannot access practitioners in person to receive advice and information by tele-health.

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Person makes first request to access voluntary assisted dying.

First doctor accepts first request and does first assessment.

If first doctor finds person eligible, refers person for a second, independent assessment.

Second doctor does second assessment.

If second doctor finds person eligible, person may make second request to first doctor.

Person may make final request to first doctor.

Self-administration

Practitioner administration

Administration follows choice of process, prescription and supply of substance.

Request must be clear and made personally. It may be verbal, by gestures or other means of communication.

If unsure if the person is eligible, the first doctor may refer an issue to another doctor.

If unsure if the person is eligible, the second doctor may refer an issue to another doctor.

Request must be a written declaration, signed in the presence of 2 witnesses and certified by them.

Request must be clear and made personally. It may be verbal, by gestures or other means of communication.

Key

Person’s request
Assessment process
Administration stage

Person may choose at any time not to continue with the process.

Person must meet all eligibility criteria.

Registered health practitioners must be suitably qualified and trained to be involved in the process.
The Proposed Process in Detail

Person makes first request to access voluntary assisted dying.

Doctor who accepts first request becomes the Coordinating Practitioner and does first assessment.

If Coordinating Practitioner finds person eligible, refers them to a second doctor for an independent assessment.

If second doctor accepts referral, becomes the Consulting Practitioner and does a second, independent assessment.

If Consulting Practitioner finds person eligible, person may make second request in a signed, witnessed declaration.

Person may make final request to Coordinating Practitioner at least 9 days after the first request unless exception applies.

Person makes administration decision with Coordinating Practitioner for self-administration or practitioner administration.

Coordinating Practitioner prescribes voluntary assisted dying substance and gives prescription to Authorised Supplier.

Authorised Supplier gives the substance to the person, their Contact Person or agent.

Person self-administers the substance.

Contact Person notifies Coordinating Practitioner that the person has died.

Authorised Supplier gives the substance to Administering Practitioner.

Administering Practitioner administers the substance in the presence of an eligible witness.

Administering Practitioner completes practitioner administration form.

Mandatory report to the Board by the Coordinating Practitioner or Consulting Practitioner.

Key

- Person’s request
- Assessment process
- Administration stage
- Oversight

Person may choose at any time not to continue with the process.

Person must meet all eligibility criteria.

Registered health practitioners must be suitably qualified and trained to be involved in the process.

Self-administration

Practitioner administration

Registered health practitioners must be suitably qualified and trained to be involved in the process.
The background to the QLRC Report

The Commission’s task was to recommend ‘the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland’ should voluntary assisted dying become law in this State. Our task was not to consider the desirability of introducing voluntary assisted dying legislation. It was to recommend the contents of an appropriate voluntary assisted dying scheme and draft a Bill based on those recommendations.

Our review started on 1 July 2020 with an original reporting date of 1 March 2021. Due to the size and complexity of the task, the reporting date was extended to 10 May 2021. The process leading to our final report is outlined below.

*Timeline of Queensland’s consideration of voluntary assisted dying legislation*

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>November 2018</td>
<td>Parliamentary Committee Inquiry established</td>
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<tr>
<td>March 2020</td>
<td>Parliamentary Committee Inquiry reports tabled</td>
</tr>
<tr>
<td>July 2020</td>
<td>QLRC starts review</td>
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<tr>
<td>October 2020</td>
<td>QLRC consultation paper released</td>
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<tr>
<td>May 2021</td>
<td>QLRC final report and draft legislation completed</td>
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<tr>
<td>September 2021</td>
<td>Legislation passed unamended</td>
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VALUES AND PRINCIPLES

The scheme for people who are ‘suffering and dying’ is based on values and principles, discussed in the report and stated in the Act. There are many and they conflict to some extent. They must therefore be reconciled and balanced. This includes reconciling:

- respect for personal autonomy; and
- safeguarding the vulnerable from coercion or exploitation.

A person’s autonomy includes autonomy in determining end of life choices.

Protection of the vulnerable requires safeguards and eligibility criteria to ensure that, if the person has a disease, illness or medical condition making them eligible to access the scheme, they:
• have **decision-making capacity**;
• make decisions that are **voluntary and made without coercion**;
• make choices that are informed about other end of life options, such as further treatment and palliative care; and
• demonstrate that the choice to request voluntary assisted dying is **enduring**.

This last point means that access to voluntary assisted dying should not be available simply after one request. The request should be a settled one and endure over a reasonable period.

**PALLIATIVE CARE**

The Commission’s terms of reference stated that the provision of ‘compassionate, high quality and accessible palliative care for persons at their end of life is a fundamental right of the Queensland community’. The importance and value of palliative care for people experiencing unrelenting pain or suffering from terminal illness or a degenerative condition was also noted by witnesses to the Parliamentary Committee’s inquiry. Many referred to the benefit of palliative treatment as a part of end of life care for patients.

The Parliamentary Committee recognised that palliative care ‘needs to be adequately resourced and supported irrespective of whether voluntary assisted dying legislation is introduced’ and, ‘if it is introduced, it is imperative that people have the full range of options available to them so that they can make an informed choice’.

The Commission agreed. It recommended that any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care.

**LEGISLATIVE DESIGN**

As required, we had regard to the Parliamentary Committee’s report about voluntary assisted dying and to legislative and regulatory arrangements in other Australian and international jurisdictions.

The legislative schemes in Australian and some overseas jurisdictions, such as New Zealand and Canada, have a similar basic architecture. In simple terms they provide:

• **eligibility criteria** for access to voluntary assisted dying, such as age, residency, a condition that will cause death and causes suffering that cannot be relieved in a way that the person considers tolerable. There usually are criteria about decision-making capacity and acting voluntarily.
• **a process for independent assessment** of eligibility by two suitably qualified and experienced health practitioners.

• **administration of a substance**, either self-administration of a prescribed lethal dose of a voluntary assisted dying substance (possibly but not necessarily in the presence of a health practitioner) or administration by a health practitioner at the person’s request.

• **conscientious objection** by health practitioners who do not wish to participate in the scheme.

• **accountability** by oversight provisions that include reporting obligations, monitoring by an oversight body and provisions to enforce compliance.

The legislative models also differ in some respects. For example, the Victorian Act requires that the relevant condition be ‘incurable’, whereas the Western Australian Act does not. This is because the view was taken in Western Australia that the words ‘advanced, progressive and will cause death’ clearly emphasise ‘the terminal nature of the illness or disease’. Despite these kinds of differences, the eligibility criteria across the legislative models are largely the same and seek to achieve the same policy goals.

**VIEWING THE PROPOSED LEGISLATION AS A WHOLE**

A system of regulation operates as a whole. As Professors White and Willmott and their co-authors have observed:

> a system of regulation operates holistically. This means that looking at a single aspect of the eligibility criteria without understanding its role in the framework can be misleading. That is, it is important to examine eligibility criteria cumulatively and in context.... Taking a holistic view is also an important consideration more generally when designing [voluntary assisted dying] regulation. While it may be politically attractive to add numerous safeguards to [voluntary assisted dying] legislation, including in the eligibility criteria, there is a risk of what we have called elsewhere ‘policy drift by a thousand cuts’ if the cumulative effect of these individual safeguards is not properly considered. For example, it is possible that a series of provisions designed to make [voluntary assisted dying] legislation safe, when aggregated, can in fact make access to [voluntary assisted dying] cumbersome or even unworkable.³

THE BEST LEGAL FRAMEWORK FOR QUEENSLAND

In recommending the best legal framework for a voluntary assisted dying scheme in Queensland, the Commission was not constrained by similar laws in other Australian states. We noted the desirability of achieving reasonable consistency with the legislation in other Australian states and in comparable countries like New Zealand. However, the proposed law was designed to be the best it could be to serve the Queensland community.

It would have been a simpler task to adopt, with some minor modifications, legislation from another state or overseas jurisdiction. However, this was not our task.

We developed recommendations about a scheme for Queensland by first identifying the values, principles and policies that should underpin any scheme.

Legislation must suit Queensland’s unique conditions, including its geography, population diversity, access to qualified health professionals and public and private hospital systems. Legislation that may operate in a place like New Zealand or Victoria may not be suited to a large, decentralised state like Queensland, many of whose citizens live in remote areas.

It was important that Queensland not adopt provisions from another jurisdiction that, on analysis, are unnecessary or run counter to the policies that the legislation aims to implement.

The draft Bill was informed by the ongoing research and writing by experts who have thought deeply about these issues and who have studied the experience of similar legislation in other jurisdictions.

We tried to base our recommendations on the operation of legislation in other jurisdictions. This included consideration of reports of the Victorian Voluntary Assisted Dying Review Board about the operation of the Victorian Act, discussions with participants in schemes in comparable jurisdictions, and consideration of the research of independent scholars into the implementation and practical operation of those schemes.

The aim was to develop draft legislation that is compassionate, safe and practical.

WHAT IS VOLUNTARY ASSISTED DYING?

Voluntary assisted dying is an end of life choice. As noted, it refers to the administration of a prescribed substance, either by self-administration or by a registered and suitably qualified health practitioner, with the purpose of bringing about the person’s death. It is based on the person’s voluntary request, and follows a process of requests and assessments.

Other end of life choices include continuing with treatment to try to remedy the condition, or receiving palliative care.
**Palliative care** aims to improve the quality of life of patients and their families in dealing with a life-threatening illness, through the prevention and relief of suffering. It does this by the treatment of pain and other problems, physical, psychosocial and spiritual.

Administering medication to relieve intolerable pain and suffering may have the effect of hastening death. The health practitioner does not intend to hasten death. Voluntary assisted dying, on the other hand, involves administering a substance to intentionally hasten death, and thereby stop suffering that is intolerable.

As the law currently stands and will remain until the Act comes into full operation, the self-administration of a substance to kill oneself, and which results in death, is suicide. Persons, including health practitioners, who assist that process of self-administration commit the offence of aiding suicide. Depending on the circumstances, a person who administers the substance at the person’s request may commit the offence of murder or manslaughter.

In the absence of voluntary assisted dying laws of the kind enacted in Queensland and most other Australian States, the enforcement of these criminal laws depends on prosecutorial discretion. A former Lord Justice of Appeal, Sir Stephen Sedley, has recently discussed the problems associated with applying existing criminal laws about assisted suicide to a wide range of circumstances and prosecutorial guidelines that apply in the United Kingdom.4

Voluntary assisted dying legislation alters in defined circumstances existing criminal laws governing homicide and assisted suicide.

Voluntary assisted dying laws provide that someone who ends their life in accordance with the process does not commit suicide, and that the health practitioners who assisted them to die are not liable for homicide or the crime of assisting suicide.

**LANGUAGE**

The Commission used the term ‘voluntary assisted dying’ because it is the term used by the Parliamentary Committee whose report was the precursor to our review, in our terms of reference and in legislation in Victoria and Western Australia. It is a fitting description.

Legislation in Tasmania and New Zealand uses different terms in their titles. For example, the New Zealand law is titled *End of Life Choice Act 2019*, but uses the term **assisted dying** which is defined to mean:

(a) the administration by an attending medical practitioner or an attending nurse practitioner of medication to the person to relieve the person’s suffering by hastening death; or

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(b) the self-administration by the person of medication to relieve their suffering by hastening death.

Canadian legislation, which adopts a similar model, uses the term **Medical Aid in Dying** (‘MAiD’). In the United States, voluntary assisted dying is often referred to as **physician-assisted suicide or aid-in-dying**.

Other terms that are sometimes used in this context include ‘euthanasia’ and ‘assisted suicide’.

**Euthanasia** refers to the intentional taking of a person’s life by another person in order to end intolerable suffering. Euthanasia covers various practices including:

- passive euthanasia where medical treatment is withheld or withdrawn;
- active euthanasia where medical intervention takes place.

Within each of these categories, euthanasia may be voluntary (at the person’s request) or involuntary. Therefore, the term ‘euthanasia’ covers different ways of deliberately ending a person’s life to stop their suffering: passive voluntary euthanasia, active voluntary euthanasia, passive involuntary euthanasia and active involuntary euthanasia. Because of its generality and historic connections to involuntary euthanasia, the term ‘euthanasia’ is not commonly used to describe voluntary assisted dying.

**Assisted suicide** refers to circumstances in which a person causes their own death after being given the means or knowledge to do so by another person. For example, the person providing the assistance may provide a lethal dose of medications or information to assist a person to take their own life. As noted, assisting suicide is a crime. It does not require medical assistance: it may be assistance given by a family member, a friend or a stranger, including by information supplied over the internet. Another important distinction between assisted suicide and voluntary assisted dying, is that the person whose suicide is assisted by someone may not be dying and suffering intolerably.

The model of voluntary assisted dying legislation developed by the Commission therefore differs from assisted suicide in general. It is confined to a person who suffers from a condition that will cause death and who experiences suffering that cannot be relieved in a way that the person considers tolerable. The assistance to die is given by health practitioners. If the assistance is authorised by legislation, then, in law, the death is not treated as a suicide and the health practitioner is not treated as having assisted a suicide.

**VOLUNTARY AND ASSISTED**

Voluntary assisted dying is an active and voluntary practice. This distinguishes it from passive practices not intentionally directed towards causing death, such as withholding or
withdrawing life-sustaining medical treatment. It is a voluntary practice in that it is undertaken at the person’s request. More than one request is required. The decision to access the process must be made freely and without coercion. The assistance is provided by health practitioners, hence the alternative expression ‘medical aid in dying’. Medical practitioners assess eligibility and may prescribe the voluntary assisted dying substance. Usually, the person self-administers the substance, but in some circumstances the law allows, at the person’s request, practitioner administration.

SOME KEY TERMS IN THE LEGISLATION

Some frequently used terms are as follows:

- **Coordinating practitioner** is the doctor who accepts the person’s first request for voluntary assisted dying, conducts the first assessment and coordinates the process.

- **Consulting practitioner** is the doctor who independently completes the consulting assessment of the person.

- **Administering practitioner** is the doctor or nurse who administers the voluntary assisted dying substance to the person. The administering practitioner will be either the coordinating practitioner or the person to whom the role of administering practitioner is transferred.

- **Eligibility criteria** is the set of requirements that a person must meet to access voluntary assisted dying.

- **Request and assessment process** consists of the following steps:
  - a first request;
  - a first assessment;
  - a consulting assessment;
  - a second request; and
  - a final request.

- **First request** is the clear and unambiguous request a person makes to a doctor for access to voluntary assisted dying.

- **First assessment** is the assessment completed by the coordinating practitioner to determine if a person meets the eligibility criteria for voluntary assisted dying. If the person is assessed as eligible, they will be referred for a consulting assessment.

- **Consulting assessment** is the independent assessment completed by the consulting practitioner to determine if a person meets the eligibility criteria for voluntary assisted
dying. The consulting assessment occurs after the person has been assessed as eligible by the coordinating practitioner during the first assessment.

- **Second request** is the written request for access to voluntary assisted dying that a person makes after being assessed as eligible by the coordinating practitioner and the consulting practitioner. A second request, in the approved form, is witnessed by two eligible witnesses.

- **Final request** is the third clear and unambiguous request a person makes to the coordinating practitioner for access to voluntary assisted dying.

- **Final review** is the review of the request and assessment process that the coordinating practitioner must complete after receiving the final request.

- **Administration decision** is the decision a person makes in consultation with their coordinating practitioner to either self-administer the prescribed substance or have it administered by a medical practitioner or nurse practitioner.

- **Self-administration** is where a person receives, prepares and ingests the substance.

- **Practitioner administration** is where a person is administered the substance by a doctor or nurse who is trained and qualified to act as administering practitioner.

**A DYING PERSON WHO CHOOSES THIS OPTION DOES NOT DIE BY SUICIDE**

Some will call voluntary assisted dying a form of suicide. The Act, like the Commission’s draft Bill, does not.

The Commission took the view that the legal option for a dying person to hasten their death by having medical assistance to decide its precise timing should be treated for what it is. Health practitioners who follow an exacting process to assist a dying person to choose the timing of their death should not be characterised as assisting suicide.

If experience from other jurisdictions is a guide, persons who are eligible to access voluntary assisted dying will choose to have a substance administered only when they are very close to death from the condition that made them eligible. Administration allows a person to determine the timing of their death by hastening it so as to end intolerable suffering when a person is close to death.

The draft Bill drew on provisions in Western Australia and New Zealand. The Queensland legislation states that the person is taken to have died from the disease, illness or medical condition from which they were dying, and which made them eligible at the end of their life to access voluntary assisted dying.
It also states that a person who dies as a result of the self-administration or administration of a substance in accordance with the law does not die by suicide.

**INSIGHTS FROM THE OPERATION OF THE VICTORIAN ACT**

The operation of the Victorian Act has been monitored and reported on by the Voluntary Assisted Dying Review Board in that State. The Board was established as an oversight body in July 2018 to review and monitor voluntary assisted dying in Victoria. The Board collects data about voluntary assisted dying. After reporting to Parliament about the operation of the Act every six months for the first two years of operation, it now reports annually.

The contents of its three six-monthly reports are informative. The following summarises parts of them to give a snapshot of how the Victorian Act has operated, particularly who has accessed it and some problems that have been encountered.

**Persons accessing voluntary assisted dying**

Between the commencement of the Victorian Act on 19 June 2019 and 30 December 2020:

- 562 people have been assessed as eligible in the first assessment;
- 483 people have been assessed as eligible in the consulting assessment;
- 405 administration permits have been issued; and
- 224 people have died after administration of the substance.

Notably, of the people who were granted an administration permit and have subsequently died, 32 per cent did not ultimately administer the substance. This supports anecdotal reports that some people engage in the voluntary assisted dying assessment process to have administration as a fallback option at the very end of life.

**Demographics of applicants**

Data collected by the Voluntary Assisted Dying Review Board gives an insight into the demographics of applicants, including:

- **Age**: ranged between 20 and 100 years, with an average age of 71 years;
- **Gender**: 52.4 per cent were male, 47.4 per cent were female, and 0.2 per cent were self-described;
- **Place of birth**: 70.3 per cent were born in Australia, 26.9 per cent were born overseas, 2.8 per cent did not report their place of birth;
- **Metropolitan, regional or rural**: 64.4 per cent were living in metropolitan Victoria and 35.6 per cent were living in regional or rural Victoria; and
• **Living situation**: 87.2 per cent were residing in a private household, 8.9 per cent were in a long-term care or assisted living facility, and 3.4 per cent were in a health service.

**Diagnoses**

Of the people who had been issued an administration permit and have since died:

- 77 per cent were diagnosed with cancer;
- 14 per cent were diagnosed with a neurodegenerative disease; and
- 9 percent were diagnosed with another disease (such as pulmonary fibrosis, cardiomyopathy, or chronic obstructive pulmonary disease).

**Number of qualified, registered and actively involved medical practitioners**

The availability of qualified and willing medical practitioners was reported to be a barrier to accessing voluntary assisted dying. The number of medical practitioners who are qualified and actively involved in voluntary assisted dying cases has steadily increased. Still, only a few hundred practitioners have been involved in one or more cases as either a coordinating or consulting medical practitioner.

The availability of qualified and willing medical practitioners in regional and remote areas is an issue. The Board reports that 36 per cent of medical practitioners registered in the portal are in regional and rural Victoria, reflecting the proportion of applicants who live in those areas. However, the spread of qualified and registered medical practitioners across regional and rural Victoria is inconsistent. The Board reports a lack of such medical practitioners in Eastern and Western Victoria.

Of the medical practitioners who have acted as either a coordinating practitioner or consulting practitioner:

- 122 (53.3 per cent) specialise in **general practice**;
- 36 (15.7 per cent) specialise in **oncology**;
- 10 (4.4 per cent) specialise in **neurology**;
- 8 (3.5 per cent) specialise in **general medicine**;
- 6 (2.6 per cent) specialise in **respiratory and sleep medicine**;
- 6 (2.6 per cent) specialise in **haematology**;
- 5 (2.2 per cent) specialise in **palliative medicine**; and
- 36 (15.7 per cent) specialise in **another specialty**.
There remains a need for more qualified and registered specialists, such as neurologists, to assist in the process, particularly in rural and regional Victoria.

**Care Navigator Service**

The Care Navigator Service is a central component in the Victorian regime. Since the commencement of the Act, the service has provided support to over 1000 people seeking information about voluntary assisted dying. In response to feedback received in the first six months of the Act’s operation, the service was expanded to include additional care navigators across regional Victoria.

**Compliance**

The Board analyses forms submitted to it and takes other steps to monitor compliance. Its data show 95 per cent of cases were compliant with the Act. Between July and December 2020, six cases were identified as non-compliant. However, the Board determined that those cases were clinically appropriate, all eligibility requirements were met, and a misunderstanding had occurred that did not raise a concern about the completion of legal requirements.

**Known unknowns**

The limited data available to the Board means certain information is unknown, including the number of people who are:

- unable to find a qualified medical practitioner to assist them;
- assessed as ineligible by a medical practitioner;
- in nursing homes or private or public hospitals and are not supported in accessing voluntary assisted dying; and
- told that if they wish to access voluntary assisted dying, they will have to leave the facility in which they are residing or are being cared for, such as a nursing home, hospital, or palliative care ward or organisation.

**COMMONWEALTH LAWS THAT IMPEDE ACCESS**

Access to information and advice about voluntary assisted dying is critical to the operation of any scheme.

Chapter 20 of the report addresses in detail the uncertain possible application of Commonwealth ‘carriage service’ offences to conduct that is authorised by state voluntary assisted dying laws. This uncertainty is unsatisfactory. It led to the then Victorian Health Minister instructing doctors and other practitioners involved in voluntary assisted dying
services to conduct all discussions, consultations and assessment face-to-face, so as to avoid potentially breaching the Commonwealth law.

The Victorian Board has made repeated calls for the Commonwealth to make an exemption to allow Victorians, especially those in regional Victoria, to be able to have ‘important conversations about voluntary assisted dying over the phone or via teleconference’.

In general, it is preferable for all requests for, and provision of, information and advice about voluntary assisted dying to occur in face-to-face personal communications between the health practitioner and their patient. However, this may not be possible because of the location of the person and their inability to travel possibly long distances to consult a health practitioner or the inability of the health practitioner to travel to speak to them in person. In such cases, information may need to be given by telephone, videoconference, email or some other form of electronic communication.

The need to use those forms of communication to request and provide information and advice will be greatest when the patient lives in a remote location. Without access to those forms of communication, persons living in remote and regional parts of the state may have greatly impaired access to voluntary assisted dying.

The Victorian experience of the Commonwealth law’s inhibition on access to a lawful end of life option is instructive for Queensland. The uncertain application of the Commonwealth law has the greatest effect on individuals who are suffering and dying in remote and regional areas.

**LEGAL FRAMEWORKS, PEOPLE AND PRACTICES**

The Commission’s task was to recommend ‘the best legal framework’ for people who are suffering and dying to choose the timing and circumstances of their death.

Legal frameworks are important because they determine what people are allowed to do. However, the practical operation of any law is also governed by human behaviour and practices.

**The law and personal choices in practice**

Most people want to live for as long as possible without experiencing intolerable suffering.

This includes individuals with a terminal illness who are eligible to access voluntary assisted dying. The fact that they are eligible does not mean that they will proceed to prove their eligibility and proceed to administration as soon as possible after becoming eligible.
Laws might allow people to access voluntary assisted dying during what are expected to be the last 6 or 12 months of their lives. However, people who are eligible may leave it to the final weeks of their life to access voluntary assisted dying.

Also, some people may leave the process of assessment until it is too late. They may lose capacity or die before the process can be completed.

Others may be assessed to be eligible and able to proceed to administration, but choose not to. Voluntary assisted dying may be kept as an option. Another end of life option, such as continuing palliative care, may be chosen.

**Legal frameworks**

Voluntary assisted dying laws operate within a legal framework according to the individual preferences of patients and the professional practices of registered health practitioners.

The laws also operate in a context. For example, it is unlikely that an individual who is eligible for voluntary assisted dying will suddenly request it, without first receiving medical care and advice about their condition, their prognosis and treatment options.

If experience in other places like Victoria is any guide, many people will begin a discussion about voluntary assisted dying with their treating practitioner some time before they make a formal request to access it. Many will not request it until their condition is well-advanced, sometimes too far advanced to complete the process before they die.

Legal requirements set certain periods: for example, the minimum time between the first and last request is a requirement that confirms that the request is enduring. This does not mean that most cases will complete the process in that minimum period. In fact, the nature of the process, with the need for two independent assessments and a formal written declaration by the person certified by two eligible witnesses, may mean it will take much longer.

Another example is the minimum qualifications of practitioners. The minimum will not be the average. That is unsurprising. If experience in Victoria is a guide, the practitioners who qualify and who are prepared to undertake the specific training to do eligibility assessments are likely to have had considerable experience in dealing with patients who are dying and much more experience than the minimum required by law.

**Practical issues: people and resources**

A body like the Commission may recommend a ‘legal framework’ for voluntary assisted dying. The practical operation of any such scheme depends, however, on people and resources.
Any system must be properly resourced with information services, a care navigator service and information technology to support people who are dying (and also their families and friends) and the dedicated health professionals who are prepared to do this difficult work for little or no reward.

It depends on having sufficient qualified practitioners who are trained to undertake assessments or administer substances, or both.

Training about voluntary assisted dying should not be limited to coordinating and consulting practitioners. It should be given to junior doctors and to nurses who receive the initial queries from patients about voluntary assisted dying, and who provide ongoing support to a patient and their family through the process.

Other resourcing issues include:

- Communication services including qualified and trained interpreters;
- The establishment of a Statewide Pharmacy Service that can efficiently dispense prescribed substances and ensure their safe transportation, including to remote areas of the State;
- Telehealth and other services for particular use for patients in remote areas, or patients who cannot otherwise easily access face-to-face consultations with medical practitioners;\(^5\)
- The provision of places in hospitals or hospices at which persons seeking to access voluntary assisted dying can be transferred for the purpose of assessment or administration.

The process of implementing any legislation will be demanding and time-consuming if the Victorian and Western Australian experiences are a guide.

These resourcing and implementation issues are discussed in detail in Chapter 21 of the Commission’s report. The present point is that a legal framework is simply that: a framework. It needs to be built upon. People and resources are needed to make any scheme work in practice.

The Commission emphasised that resources required to ensure that any legislated scheme for voluntary assisted dying operates safely and compassionately should not be at the expense of palliative care services.

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\(^5\) The scope to use telehealth and other forms of electronic communications for certain consultations is the subject of consideration in Chapter 20 of the report in the context of the carriage service provisions of the Commonwealth Criminal Code.
INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING

Some think that health practitioners should be prohibited from initiating a discussion about voluntary assisted dying. They regard this as an extra safeguard against persons being unduly influenced to access it. To others, such a prohibition prevents health practitioners from doing their professional duty of telling patients about their end of life options and prevents persons making properly informed decisions.

The possible policies on this issue were:

- to have no such prohibition, leaving what a health practitioner says to be governed by professional duties and standards;
- to have a strict prohibition (as in Victoria) on health practitioners initiating a discussion about voluntary assisted dying;
- to have a qualified prohibition (as in Western Australia), which allows a medical practitioner or nurse practitioner to initiate a discussion about voluntary assisted dying, provided at the same time there is a wider discussion about the person’s treatment and palliative care options and their likely outcomes.

The Commission recommended the third option. We also proposed that, as in other states, a prohibition should not apply if information about voluntary assisted dying is provided to a person at the person’s request.

ELIGIBILITY

Chapter 7 of the report identifies who may access voluntary assisted dying in Queensland. After a detailed analysis of expert reports and legislation in other places, and the extensive submissions made, we recommended five eligibility criteria. A person must:

1. have an eligible disease, illness or medical condition;
2. have decision-making capacity;
3. be acting voluntarily and without coercion;
4. be aged at least 18 years;
5. fulfil the residency requirement.

All five criteria, and each element within each criterion, must be met.

To fulfil the first criterion the person must have a condition that is advanced, progressive and will cause death, is expected to cause death within 12 months, and is causing suffering that the person considers to be intolerable. The timeframe of 12 months makes it clear that voluntary assisted dying is an option only for those who are at the end of life. It maintains
the principle that the scheme is not a choice between life and death but a choice for those who are in the process of dying and wish to choose the time and circumstances of their death.

The person must be suffering intolerably. This level of suffering is to be determined by the person concerned. Suffering caused by the condition may be physical or mental, and it may be caused by treatment for the condition.

The second criterion—decision-making capacity—means that the person must understand the nature and effect of decisions about voluntary assisted dying; be capable of freely and voluntarily deciding to access the scheme; and be able to communicate that decision. For this reason, people who lack decision-making capacity (such as people suffering from dementia) or who lose decision-making capacity during the process are not eligible.

The third criterion serves to underline the voluntary nature of the scheme. The person must demonstrate that they are acting voluntarily and without coercion at all stages of the process.

The fourth criterion limits the scheme to adults. This is consistent with other relevant Queensland laws and the approach taken in other Australian states that permit voluntary assisted dying. It is based on the presumption that children do not have the capacity to understand fully what is proposed by voluntary assisted dying.

The final criterion is based on concern that, without it, the right of a Queensland resident to access the scheme and to access high quality end of life care might be compromised by excessive demand by persons from other jurisdictions on end of life care in Queensland hospitals. However, we propose that the legislation allow exemptions for difficult cases—for example, where a person lives near the Queensland border and has close family or treating doctors in Queensland.

As one of many safeguards to protect the vulnerable, the request and assessment process incorporates a substantial waiting period. Access to the scheme should not be available simply after one request. The request should be a settled one and endure over a reasonable period. This means people requesting access must discuss their desire with their health practitioner and make separate requests at separate times.

At various points during the process, the person must be assessed as still having decision-making capacity. The person must also be told, more than once, that they may be decide at any time not to continue the process. These rules and their timing ensure that any request to access voluntary assisted dying is clear, communicated, and enduring.

As the requirement for the request to be enduring is firmly embedded in the legislation, it was unnecessary to make it an additional eligibility criterion. The process of request and
assessment also means that the scheme will not be accessible by people whose suffering is merely temporary.

Persons are eligible only if they satisfy all five eligibility criteria. For example, a condition that will cause death but is in its early stages will not be ‘advanced’. Even being diagnosed with what might be described as a ‘terminal condition’ that is advanced, progressive, and expected to cause death within 12 months is insufficient. Anyone being treated for the condition or receiving palliative care, and not experiencing intolerable suffering, will not be eligible.

**Criterion One: Eligible disease, illness or medical condition**

After considering many submissions, we concluded that the person must have been diagnosed with a disease, illness or medical condition that is expected to cause death within 12 months.

A specific timeframe until expected death makes it clear that voluntary assisted dying is an option only for those who are at the end of life. It maintains the principle that voluntary assisted dying is not a choice between life and death but a choice for those who are dying to exercise some control over the timing and circumstances of their death. A specific timeframe gives clear guidance to the community and the health profession about who is eligible.

A timeframe of 12 months is consistent with current health care practice and the end of life and palliative care framework in Australia. It also takes account of the clinical trajectories of different diseases, illnesses or medical conditions that are advanced, progressive and will cause death. A timeframe of six months may be more consistent with an end of life clinical trajectory for most advanced cancers. However, a timeframe of 12 months also encompasses the clinical trajectories of people with other types of eligible diseases, illnesses or medical conditions, including neurodegenerative diseases such as motor neurone disease, or chronic illnesses such as chronic heart failure.

We agreed with the expert panels in Victoria and Western Australia. We thought it preferable for the draft Bill to specify a single timeframe of 12 months, rather than discriminate between types of diseases, illnesses, or medical conditions, as occurs under legislation in other States.

Adopting different policies for different diseases, illnesses or medical conditions is undesirable as a matter of principle. For example, it is hard to see why a person who is dying and experiencing intolerable suffering from chronic heart failure or cancer should have to wait longer to qualify for access than someone who is dying and experiencing intolerable suffering from a motor neurone disease like multiple sclerosis.

We acknowledged the concerns of some that a timeframe is arbitrary and could potentially prolong a person’s suffering until the person can satisfy this eligibility criterion. We
considered, however, that a timeframe of 12 months is a compassionate and balanced response.

In those jurisdictions that do not include a specific timeframe until death, most people do not access voluntary assisted dying until they are close to death. Allowing people to begin the process during what is expected to be the last 12 months of their lives does not mean that they will proceed to the administration stage as soon as they become eligible. They are likely to wait until they are closer to death.

Whether a person has a condition that is expected to cause death within 12 months is a clinical determination based on the person’s particular circumstances, including condition, comorbidities, and treatment choices.

We noted the concerns of some that determining a person’s prognosis can be complex, subjective, and unpredictable. While it is not possible to predict precisely when someone will die, a person who has been diagnosed with a condition that will cause death is usually given a prognosis and treatment options, and the expected outcomes of those options. Medical practitioners commonly use prognostication assessment tools to predict the likelihood of death within 12 months.

In summary, a timeframe of 12 months is a compassionate and balanced response. It will enable people who are dying to begin the voluntary assisted dying process at a time that suits their individual circumstances including the trajectory of their particular condition and level of suffering. At the same time, it ensures that eligibility is limited to people who are at the end of life.

**Level of suffering**

The eligibility criteria provide that the person’s condition is causing intolerable suffering. Whether the person’s suffering is intolerable is a subjective assessment, to be determined by the person requesting access to voluntary assisted dying.

The person’s suffering must be causally linked to the person’s disease, illness or medical condition. However, it is not limited to the physical pain or symptoms caused by the condition. The legislation states that suffering may include physical or mental suffering, or suffering caused by the treatment provided for that condition.

This approach recognises that suffering is a personal experience best determined by the person themselves, and that it may take various forms. It respects the person’s autonomy, reflects a person-centred approach to care and is consistent with the value of reducing suffering.
The Commission noted concerns that a person should not be able to access voluntary assisted dying only because, for example, they feel like a burden or are lonely. While the person’s suffering may take many forms, including both physical and mental suffering, it must be caused by a disease, illness or medical condition that is advanced, progressive and will cause death, and that is expected to cause death within 12 months. Unrelated and pre-existing conditions like loneliness do not qualify.

The inclusion of a higher threshold requiring the person’s suffering to also be ‘enduring’ was considered to be unnecessary and inconsistent with the compassionate purpose of the law. The separate requests required by the request and assessment process indirectly ensure that the intolerable suffering that prompts those separate requests is enduring, not temporary.

Mental illness or disability

To avoid doubt and to allay any concerns, the law states that a person is not eligible for access to voluntary assisted dying only because they have a disability or a mental illness. However, a person who has a disability or a mental illness may be eligible for access to voluntary assisted dying if they meet all the eligibility criteria (including that they have decision-making capacity for voluntary assisted dying). This makes it clear that people who have a disability or a mental illness have the same rights and protections as other members of the community, and should not be discriminated against or denied access to voluntary assisted dying if they meet all the eligibility criteria.

In some circumstances a person with a mental illness will lack the decision-making capacity to access voluntary assisted dying. Like anyone else who lacks the required decision-making capacity, such a person is ineligible.

Criterion Two: Decision-making capacity

Access to voluntary assisted dying should be limited to people who have decision-making capacity in relation to voluntary assisted dying.

This is one of the fundamental safeguards in the legislation. It recognises and protects individual autonomy. In conjunction with other safeguards, the requirement to have decision-making capacity will assist in ensuring that a person’s decision is voluntary and protect people who might be vulnerable to coercion or exploitation.

The law states that, for the purposes of the legislation, a person has decision-making capacity in relation to voluntary assisted dying if the person is capable of three things:

- understanding the nature and effect of decisions about access to voluntary assisted dying; and
- freely and voluntarily making decisions about access to voluntary assisted dying; and
• communicating decisions about access to voluntary assisted dying in some way.

In addition to defining decision-making capacity, the law sets out a number of factors that are of particular relevance in determining whether or not a person has decision-making capacity for voluntary assisted dying. This list is not exhaustive, but highlights some important factors:

• a person may have decision-making capacity to make some decisions but not others;
• capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it;
• it should not be presumed that a person does not have decision-making capacity:
  – because of a personal characteristic such as age, appearance, or language skills;
  – because the person has a disability or illness; or
  – because the person makes a decision that others think unwise.

The legislation also provides that a person is capable of doing any one of the three things required to have decision-making capacity if the person is capable of doing it with ‘adequate and appropriate support’. Examples of support include:

(a) using information or formats tailored to the particular needs of a person;
(b) communicating or assisting a person to communicate the person’s decision;
(c) giving a person additional time and discussing the matter with the person;
(d) using technology that alleviates the effects of a person’s disability.

This approach is consistent with voluntary assisted dying legislation in Victoria and Tasmania. It is also generally consistent with the Guardianship and Administration Act 2000 and the associated Queensland capacity assessment guidelines.6

Victorian guidelines explain that a medical practitioner should give a patient relevant information about their diagnosis, prognosis, and the options available and then ‘check’ their capacity. This may involve, for example, asking the patient to paraphrase their understanding of the information, explain their thoughts or views, and give reasons for their chosen option. These matters should be the subject of similar guidance to practitioners in Queensland in assessing whether a person has decision-making capacity for voluntary assisted dying.

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6 These were recently discussed in a different context in Adamson v Enever [2021] QSC 221.
Adults who lack or lose decision-making capacity

The law requires that a person must have decision-making capacity for voluntary assisted dying at each stage of the process. In particular, decision-making capacity is required at each stage of the request and assessment process, and also at the stage of practitioner administration. This, therefore, renders ineligible persons who lack decision-making capacity because of some condition (such as dementia), or who, having decision-making capacity at the start of the process, subsequently lose it and do not regain it.

A complex issue is whether a person who, at a certain stage, had the required decision-making capacity but lost it before the process could be completed should be allowed to access voluntary assisted dying on the basis of an advance health directive (or similar instruction) that was made when they still had capacity. The broader issue is whether the law should permit advance decision-making about voluntary assisted dying.

We addressed the complexities of that issue in Chapter 7 of our report. Many difficult issues arise that have not been satisfactorily addressed in other places. To give just one example, what should be the position if a person makes an advance decision about voluntary assisted dying but, at the time when the criteria for administration are met, objects to the administration? These issues might be particularly relevant to people who have dementia. It would place a terrible burden on a medical practitioner to decide whether a person should be administered a voluntary assisted dying substance in such a situation, despite the person’s advance direction when they had decision-making capacity.

We were sympathetic to the views of respondents who advocated for decisions about voluntary assisted dying to be made in advance and those who identified concerns about people with dementia. However, we remained of the view that access to voluntary assisted dying should be limited to people who are assessed to have decision-making capacity at all stages throughout the voluntary assisted dying process. Protection of the vulnerable requires this. This should remain the position until the complexities of making an advance directive about voluntary assisted dying are addressed and carefully considered.

In summary, our reasons for not making recommendations in this area were:

- This is a complex issue that has not been adequately addressed elsewhere and, as such, requires further careful thought, based on research.

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\(^7\) In forming these views, the Commission reviewed and considered a broad range of material about this topic. This includes academic literature, the views expressed by other bodies such as the Victorian Ministerial Advisory Panel, Western Australian Ministerial Expert Panel, Council of Canadian Academies and Parliamentary Committee, and the views expressed in submissions and evidence given to the Parliamentary Committee. This material is cited in Chapter 7 of the report.
• The appropriateness of an advance decision about access to voluntary assisted dying warrants careful assessment in conjunction with consideration of the scope and contents of advance health directives.

• The current difficulties associated with the operation of the *Powers of Attorney Act*. These relate to the limitations that Act places on the circumstances in which an advance health directive will be followed. Regardless of any approach that might be taken to advance decision-making for voluntary assisted dying, these broader issues should be resolved first. These matters were the subject of a QLRC report more than a decade ago and were commented on by the Parliamentary Committee that considered voluntary assisted dying. They are overdue for attention.

• A new voluntary assisted dying scheme in Queensland will face enough challenges in being implemented for adults who have capacity at all stages of the process without having to deal in its initial years with additional complex and unresolved challenges of persons who lack capacity or lose it during the process.

Therefore, the scheme proposed by the Commission relates only to adults who have, and are shown to have, decision-making capacity to request voluntary assisted dying and who clearly request it at different times as part of the process.

**Criterion Three: Voluntary and without coercion**

A person should be acting voluntarily and without coercion at all stages of the process, including when requesting access, undergoing the assessment process, making the decision to proceed, and having the substance administered.

The legislation’s requirement that the person must be acting voluntarily and without coercion is in addition to the requirement that, to have decision-making capacity, a person must be capable of freely and voluntarily making decisions about access to voluntary assisted dying. As explained in Chapter 7 of the report, this additional criterion specifically relates to the person’s actual condition when making decisions, rather than to their capacity to make such decisions. It is another key safeguard.

The term ‘voluntary’ is an ordinary word and refers to something that is done ‘of one’s own accord or by free choice’.

We recommended that the term ‘coercion’ in this context be defined to include ‘threats, promises or intimidation of any kind, including by improper use of a position of trust or influence’. The requirement that the use of a position of trust or influence be ‘improper’

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8 See further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (Qld), Voluntary Assisted Dying, Report No 33 (March 2020) [21.4.1], 410, 421–2, Rec 76; QLRC, A Review of Queensland’s Guardianship Laws, Report No 68 (2010) vol 2, Rec 11-3, and see generally ch 11. See also QLRC Consultation Paper No 79 (2020) [4.120]–[4.127].
makes clear that the provision is directed at influence that is exploitative of a vulnerable person. It would not apply to the proper and well-intentioned exercise of influence. Many forms of well-intentioned and good advice by a friend, family member, or health practitioner (in whom a person justifiably places trust or confidence) will be inclined to influence a decision.

This third eligibility criterion also must be assessed as part of the process. It must be demonstrated that a person’s choices and requests are made freely and of their own accord. Any vulnerability should not be exploited by coercion of any kind, and that includes improper use of a position of trust or influence.

**Criterion Four: Aged at least 18 years**

Access to voluntary assisted dying should be limited to adults; that is, people who are at least 18 years of age. Limiting access to adults is consistent with other relevant laws in Queensland and with laws in most other jurisdictions that permit voluntary assisted dying.

Having an eligibility criterion that someone must be at least 18 years-old to access voluntary assisted dying may seem arbitrary, and especially harsh on a mature 16- or 17-year-old who is suffering and dying. Any age requirement in a law, whether it be a law about wills or medical treatment, may have seemingly arbitrary and harsh outcomes. However, age requirements have a purpose.

In this context, the age requirement is designed to limit voluntary assisted dying to persons who are presumed, because of their age, to have sufficient understanding and intelligence to understand fully what is proposed, and to be able to give informed consent to a process that will end their lives. Children are not presumed to have such a capacity.

The issue of when a child has capacity to understand fully what is proposed, and to give voluntary and informed consent to it, is complex enough in the context of consent to medical treatment. It is more complex in the context of access to voluntary assisted dying.

Guidelines for deciding ‘Gillick competence’ for health-related decision-making may need to be adapted to the different context of voluntary assisted dying, which is an active process. These are important issues that have not been satisfactorily resolved to date in jurisdictions with comparable laws. At present, there are gaps in the scientific, evidence-based research to inform the development of policy in this area.

The legislation, once implemented, will establish a new legal framework for access to voluntary assisted dying by eligible adults in Queensland. The Commission recommended that any new legislation be properly reviewed and evaluated before any future consideration is given to the conditions on which access to the scheme might be permitted to minors with ‘Gillick competence’.
**Criterion Five: Residency**

The final criterion is based on concern that, without it, the right of a Queensland resident to access the scheme or to access high quality end of life care in Queensland hospitals might be compromised by excessive demand by persons from other jurisdictions. However, we proposed that the legislation allow exemptions for difficult cases—for example, where a person lives close to the Queensland border and has close family or treating doctors in Queensland.

The eligibility criteria require that:

(a) the person:
   
   (i) is an Australian citizen; or
   
   (ii) is a permanent resident of Australia; or
   
   (iii) has been ordinarily resident in Australia for at least three years immediately before making the ‘first request’; and

(b) the person has been ordinarily resident in Queensland for at least 12 months immediately before making the ‘first request’.

The law also provides that the Director-General of the Department of Health or a delegate of the Director-General may exempt a person from the residency requirement if satisfied that the person has a substantial connection to Queensland and that the circumstances justify the granting of the exemption on compassionate grounds.

The inclusion of a residency requirement in any legislation should be reviewed as part of a future review of the legislation’s operation.

We recommended that regulations, guidelines and forms should be developed to meet proof-of-residency requirements.

*The request to access voluntary assisted dying is enduring*

The request and assessment process, which includes a waiting period, ensures the choice to access voluntary assisted dying is not a fleeting one. The legislation requires repeated requests over a substantial waiting period. At various points, the person must be assessed to have decision-making capacity. The law provides that a person may choose not to continue with the process at any time. They must be told this more than once. The law’s processes, and their timing, ensure that any request to access voluntary assisted dying is clear, communicated, and enduring.
The policy that a person requesting access to voluntary assisted dying has, over time, discussed it with their health practitioner, and has made many requests of the same nature, is ensured by a process that achieves that goal. We thought it unnecessary to include a requirement that the request be ‘enduring’ as part of the eligibility criteria. It is firmly embedded in the legislation.

**ELIGIBILITY CRITERIA IN PRACTICE**

Chapter 7 of the Commission’s report undertakes an extensive comparative analysis of eligibility criteria in different jurisdictions, with attention to similarities and differences between the legal frameworks in Australian states that have enacted voluntary assisted dying laws. The purpose of that analysis was to develop, with the benefit of the extensive submissions we received, the best legal framework for eligibility criteria in any Queensland law and to identify who can access voluntary assisted dying.

Two resources may help in understanding how these criteria might be expected to work in practice.

The first are the reports of the Voluntary Assisted Dying Review Board in Victoria, which identify the types of diseases, illnesses, or medical conditions that have qualified persons to access voluntary assisted dying in that State. For ease of reference, the figures earlier quoted are repeated at this point.

Of the people who have been issued an administration permit in Victoria and have since died:

- 77 per cent were diagnosed with cancer;
- 14 per cent were diagnosed with a neurodegenerative disease; and
- 9 per cent were diagnosed with another disease (such as pulmonary fibrosis, cardiomyopathy or chronic obstructive pulmonary disease).

Of those diagnosed with cancer, 21 per cent had a primary lung cancer, 11 per cent had primary breast cancer, 11 per cent had primary pancreatic cancer, 9 per cent had a primary colorectal cancer, 9 per cent had other gastrointestinal tract cancer, and 39 per cent had a range of other cancers.

The second resource is a recent article by several academics, including Professors White and Willmott, titled *Who is Eligible for Voluntary Assisted Dying? Nine Medical Conditions Assessed against Five Legal Frameworks.*

The authors had earlier analysed eligibility criteria across five legal frameworks—laws in Victoria, Western Australia, Oregon, and Canada, along with the

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White and Willmott Model. Their companion article analysed whether each of the nine selected medical conditions could give an individual with the condition access to voluntary assisted dying.

Of the nine medical conditions analysed, access to voluntary assisted dying was found to be possible for:

- Cancer;
- Motor Neurone Disease;
- Chronic Obstructive Pulmonary Disease; and
- Chronic Kidney Disease.

The authors found that access was highly unlikely (at least under the Australian frameworks) for:

- Alzheimer’s Disease;
- Anorexia;
- Frailty;
- Spinal Cord Injury; and
- Huntington’s Disease.

Their analysis showed a clear distinction between the Canadian model and all other models.

The reasons why these five conditions were thought by the authors to be very unlikely to make a person with any one of them eligible under the Australian frameworks are explained in detail in the article. In short summary:

- **Alzheimer’s Disease**: the requirement to have decision-making capacity, and at the same time have a condition that is advanced and expected to cause death (with or without a timeframe until death) makes it very unlikely that the person will have decision-making capacity once Alzheimer’s is at an advanced stage.

- **Anorexia**: a mental illness is not an eligible condition, and to the extent that physical conditions could be seen as distinct from the mental illness, an advanced case that was life-threatening would impair the person’s decision-making capacity for voluntary assisted dying.

- **Frailty**: is not a single medical condition that will cause death.

- **Spinal Cord Injury**: disability alone is not an eligible condition; and the medical condition, while incurable, is not progressive.
• **Huntington’s Disease**: This is a progressive neurodegenerative disease, and by its advanced stage the person would likely have lost decision-making capacity due to progressive cognitive decline.

The eligibility criteria we recommend were essentially the same as those in Victoria, Western Australia, and Tasmania. One would expect a similar profile of qualifying conditions to those in Victoria. These conditions align with the medical conditions that Professors White and Willmott and their co-authors analysed as possible across the legal frameworks they analysed. Importantly, the criteria are very unlikely to permit access by persons with certain conditions, such as Alzheimer’s disease, because decision-making capacity for voluntary assisted dying is very unlikely to be retained by the time the condition reaches an advanced stage.

One difference between the eligibility criteria we recommended and the eligibility criteria that apply in Victoria is that we recommended a single timeframe until death of 12 months, whereas Victoria has a timeframe of six months or 12 months in the case of a person with a neurodegenerative condition. An important conclusion of the comparative analysis undertaken by Professors White and Willmott and their co-authors is that the existence of a specific timeframe until death is unlikely to alter the medical conditions that make access to voluntary assisted dying possible. Therefore, the recommended single timeframe is unlikely to alter the kind of medical conditions that may permit access to the scheme from those conditions that have allowed access in Victoria.

In summary, a timeframe of 12 months avoids some of the problems associated with prognosis and is consistent with health care practice and the end of life and palliative care framework in Australia. It will allow people to begin the process of accessing voluntary assisted dying during what are expected to be the last 12 months of their lives, rather than continue to experience intolerable suffering for many months until medical practitioners are prepared to certify that death is expected within six months. One consequence of adopting a shorter six-month timeframe for certain conditions is that it may delay a person from embarking on the process of accessing voluntary assisted dying. An unexpected, or even expected, deterioration in their condition, coupled with certain forms of treatment, may mean that the person is not able to complete the voluntary assisted dying process before death or the loss of the required decision-making capacity.

Therefore, we recommended a timeframe of 12 months, as a compassionate and balanced measure.

**ELIGIBILITY CRITERIA IN COMBINATION**

Persons are eligible for access to voluntary assisted dying only if they satisfy all five eligibility criteria.
Each element within a criterion must be satisfied.

As noted, even being diagnosed with what might be described as a ‘terminal condition’ that is advanced, progressive, and expected to cause death within 12 months is not enough. If the person is being treated for the condition or receiving palliative care and not experiencing intolerable suffering, they will not be eligible.

In developing ‘the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland’, we explained that a system of regulation operates as a whole.

Some will regard our recommendations about eligibility criteria and other matters as overly conservative and placing too many hurdles in the path of people who are suffering and dying. Others will say that our recommendations do not go far enough to limit access.

The critical point is that our recommendations about eligibility and other matters, including the request and assessment process, operate as a whole.

The recommendations on eligibility identify who can potentially access voluntary assisted dying. Other parts of the draft Bill identify what those persons must do to be assessed as eligible, and, if they choose, continue through the process.

The eligibility criteria do not permit access to all persons who are suffering and dying.

Some will say that we should have extended our eligibility recommendations to:

- people with stable but devastating conditions that render their suffering intolerable;
- mature minors who have enough understanding to give informed consent to voluntary assisted dying;
- people who come from overseas or interstate to access voluntary assisted dying in Queensland; or
- people who lack or lose decision-making capacity for voluntary assisted dying but have given an advance directive about accessing it.

Our recommendations were determined by our terms of reference, which related to ‘people who are suffering and dying’. They did not relate to people who suffer from conditions that make their lives unbearable but who are not dying.

Our recommendations about eligibility, like our other recommendations, sought to achieve a balance between the values of personal autonomy and protection of vulnerable individuals.
REQUEST AND ASSESSMENT

We recommended that access should be governed by a staged request and assessment process, similar to the process that is followed in Victoria, Western Australia and Tasmania.

Chapter 8 of the report explains the process for making requests and having two independent eligibility assessments done by doctors who accept the roles of ‘coordinating practitioner’ and ‘consulting practitioner’. We also recommended a minimum waiting period of 9 days between the first and final request.

The ‘first request’ to access voluntary assisted dying must be clear and unambiguous. It must be made personally, not by someone else on the person’s behalf. It may be verbal, by gestures or other means of communication available to the person.

If the doctor is qualified and willing to accept the request, the doctor becomes the ‘coordinating practitioner’ and conducts an eligibility assessment. If the person meets the eligibility requirements they must be given certain information (set out in the legislation), including:

- their diagnosis and prognosis;
- the available treatment and palliative care options and their likely outcomes; and
- that they may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying.

If the person chooses to continue with the process, their eligibility is independently assessed by another doctor who is qualified and willing to act in the role of ‘consulting practitioner’.

If either the coordinating practitioner or the consulting practitioner is unsure whether the person has an eligible condition or has decision-making capacity for voluntary assisted dying, the practitioner must refer the person to a registered health practitioner who has appropriate skills to determine the matter. For example, if the doctor is unable to determine whether the condition is expected to cause death within 12 months, the issue would be referred to an expert in that specific condition. This referral process is a necessary safeguard to ensure that anyone who is assessed as eligible for access to voluntary assisted dying (or who goes on to access it) is in fact eligible.

A requirement to refer a person elsewhere when a practitioner cannot determine a matter is also consistent with good medical practice.

If the consulting practitioner finds that the person is eligible, they must also inform them of many matters. The person can then choose to make a ‘second request’. It is a formal declaration, witnessed and certified by two eligible witnesses. Ineligible witnesses include a
person who knows or believes that they are a beneficiary under a will of the person making the request; or may otherwise benefit financially or in any other material way from the person’s death. An eligible witness must certify that the person appeared to be making the declaration freely and voluntarily.

If the person chooses to continue the process, they can then make a third (and final) request. Again, it must be clear, unambiguous and made personally to the coordinating practitioner. That doctor then must submit a final review form that certifies that the request and assessment process was completed in accordance with the legislation’s requirements and that the doctor is satisfied that the person:

- has decision-making capacity in relation to voluntary assisted dying; and
- is acting voluntarily and without coercion.

That concludes the ‘request and assessment process’, after which a person may choose to proceed to the administration stage.

To some extent, the operation of the request and assessment process will naturally involve a period of time over which a person can consider (and must sustain) their decision. For example, the time required for two doctors who are prepared to conduct independent assessments may be significant. Still, we considered that, as in Victoria and Western Australia, there should be a minimum time that must elapse between a person’s first and final requests.

A waiting period of nine days between the person’s first and final requests represents an appropriate balance between the need to ensure a decision is well considered and to avoid prolonging a person’s suffering.

In some circumstances a period of nine days may be too long. The waiting period may be reduced if the person is likely to die or lose decision-making capacity for voluntary assisted dying within that period (for instance because their condition deteriorates and pain treatment for it will result in a loss of capacity). To require a person likely to lose decision-making capacity to wait would unreasonably preclude them from access, and also mean that the person will continue to suffer for some time afterward if their death is not imminent.

The law makes clear that participation in the process is voluntary and that a person may choose at any time not to continue with it. A person who has completed the request and assessment process and has been found eligible for access is not obliged to take any further step.

The law contains extensive reporting requirements for relevant practitioners to submit approved forms to the Review Board within a short period.
ADMINISTRATION OF THE SUBSTANCE

The final stage of the voluntary assisted dying process is the administration of the voluntary assisted dying substance. Chapter 10 of our report addresses:

- the choice between self-administration and practitioner administration;
- authorisation of the prescription, supply and administration of the substance; and
- requirements that must be met at the time of administration.

A person who is eligible, completes the request and assessment process, and wishes to proceed further, makes an ‘administration decision’.

The options

The person may decide to take a voluntary assisted dying substance (‘self-administration’) or have a health practitioner administer it (‘practitioner administration’). After that ‘administration decision’, the substance is prescribed and supplied.

To be clear: a health practitioner may be present with a person who self-administers, just as the person may choose to have a family member or friend present while they self-administer.

An important reason to offer the option to self-administer is to give autonomy to a patient at a time when the disease or illness from which they are dying is outside of their control.

As the aim of a voluntary assisted dying framework is to give individuals who are suffering and dying control over the timing of their death, self-administration should be the default method. The person chooses when the substance is administered, unaffected by any perceived need to meet the availability and timing of a busy health practitioner.

Self-administration has been described by the Victorian Panel as ‘a powerful safeguard to ensure voluntary assisted dying is in fact voluntary’.

Laws and practices differ around the world. In Victoria, practitioner administration is allowed only if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance. In Western Australia and Tasmania, practitioner administration is permitted in broader circumstances, if self-administration is inappropriate. In the United States, self-administration is the required method. In other places, the person may choose either method.

Although in Canada persons can choose either, for historical reasons almost all cases are by practitioner administration.

In Victoria, 18 per cent of cases have been by practitioner administration.
There is a suggestion (largely based on a study of a limited number of cases in the 1990’s) that practitioner administration is safer than self-administration. The evidence on that issue is discussed in Chapter 10 of the Report which states that the findings of the study should be treated with caution. Reported complications from self-administration are few in number, and their nature are discussed in that chapter.

Different processes of administration are typically adopted as between self-administration and practitioner administration. In the case of self-administration, the person (or someone acting at their request if the person is unable to) prepares the substance, usually by mixing a powder and a liquid. However, the person must take the substance themselves. Not even a medical practitioner who is present may administer the substance to the person. Practitioner administration is usually by injection.

**The choice between self-administration and practitioner administration**

In recommending what any law in Queensland should be, our starting point was that a person should be able to make an informed decision about the method of administration best suited to them.

Self-administration should be the default method, as the act of self-administering the substance is itself another indication that the person is acting voluntarily. This option maximises the dying person’s autonomy to control the timing and circumstances of their death.

The person should, however, be able to choose to have the substance administered to them if self-administration is inappropriate, subject to additional safeguards to ensure voluntariness. Practitioner administration should not be limited to where the person is physically incapable of self-administering or digesting the substance. It should be permitted in broader circumstances, and the relevant practitioner should have regard to the person’s concerns about self-administering.

We adopted an approach similar to Western Australia. A practitioner administration decision may be made only if the coordinating practitioner advises the person that self-administration is inappropriate having regard to any of the following:

- the ability of the person to self-administer the substance;
- the person’s concerns about self-administering the substance;
- the method for administering the substance that is suitable for the person.

This means that the person will discuss their wishes and concerns with the doctor and make an informed choice about the method of administration best suited to them. This approach
maximises the person’s autonomy, while also ensuring that the method of administration is clinically appropriate for the person.

**Authorisation process**

As with laws in other states, we proposed controls to ensure that the prescription, supply and administration of a voluntary assisted dying substance is authorised only after the requirements of the request and assessment process have been complied with, and an administration decision has been made. At a later stage the person can change their administration decision, for example to request practitioner administration.

**Requirements for self-administration**

In other Australian States with VAD legislation there is no requirement for the coordinating practitioner or another health practitioner to be present when the person self-administers. We also favoured this approach.

If it is appropriate for the person to self-administer and this option is chosen, the person should be able to receive the substance and take it at a time of their choosing. A person ultimately may choose not to self-administer. For some people, simply having the substance available and in their control can reduce their suffering. This approach maximises the dying person’s autonomy to control the timing and circumstances of their death, including who is present.

Under the new Queensland law, the presence of the coordinating practitioner or another health practitioner is neither required nor precluded.

We were also persuaded by respondents who submitted that a requirement for the practitioner to be present may cause difficulties in rural, regional and remote areas where the medical workforce is limited. Such a requirement would be a significant obstacle to access for voluntary assisted dying in many parts of Queensland.

The law also contains provisions to ensure the safe collection, storage, return and disposal of the voluntary assisted dying substance supplied for self-administration.

**Requirements for practitioner administration**

We recommend additional requirements for practitioner administration to ensure the person is acting voluntarily and to provide transparency. The law provides that the ‘administering practitioner’ is authorised to administer the substance, in the presence of an eligible witness, if the administering practitioner is satisfied at the time of administration that:

- the person has decision-making capacity in relation to voluntary assisted dying; and
- the person is acting voluntarily and without coercion.
The administering practitioner must certify these things and give a copy of the form to the Board within two business days after administering the substance.

Requiring a witness for practitioner administration is an extra safeguard for the person and also for the administering practitioner. At the same time, the witness requirements should not be so onerous that they create a barrier to access or are unduly obtrusive. A person is eligible to witness the administration if at least 18 years of age. The witness may be a family member of the person accessing voluntary assisted dying, another health practitioner or some other adult.

The witness is required to certify in the required form that the person appeared to be acting voluntarily and without coercion, and that the practitioner administered the substance in the presence of the witness.

The requirement to have an eligible witness present may intrude on a person’s preference to die without anyone other than the practitioner present. Still, the witness may be someone they know well: a family member or a friend.

Administering the substance is likely to be challenging, emotionally, for the administering practitioner, especially if they have been the patient’s treating doctor for a long time. Experience suggests that an administering practitioner may appreciate the presence of another practitioner for emotional support. While that may mean that such a person may be perceived to be less independent to act as a witness than someone who is a total stranger to both patient and practitioner, such a person should not be ineligible to act as a witness. Their presence may be more welcome to the patient and their family than a stranger who is asked to act as a witness.

MANAGEMENT OF THE SUBSTANCE

The Commission addressed the best way to regulate the prescription, supply, storage, administration and disposal of the voluntary assisted dying substance. The law which follows our draft Bill contains extensive provisions about those matters. These include a requirement for a person to appoint a ‘contact person’.

We thought that the law should support a person to self-administer, without requiring the coordinating practitioner or another health practitioner to be present, and ensure the voluntary assisted dying substance is managed safely. To enable this, the legislation provides for the appointment of a contact person where a self-administration decision has been made, ensuring a clear chain of responsibility for the substance once it has been supplied, and in particular, the safe return and disposal of any unused or remaining substance.

A key aspect of a contact person’s role where a self-administration decision has been made is to return the voluntary assisted dying substance, or any unused or remaining substance, to an
authorised disposer as soon as practicable or within 14 days of the person’s death or decision not to self-administer.

A contact person also acts as a point of contact for the Board, assisting in its oversight and monitoring role.

We recommended that where a self-administration decision has been made and not revoked, the contact person must inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or some other cause. Where a practitioner administration decision has been made and not revoked, the contact person must inform the coordinating practitioner if the person dies from a cause other than practitioner administration of the substance.

NOTIFICATION AND CERTIFICATION OF DEATH

The death of a person as a result of accessing voluntary assisted dying raises questions about how the death should be recorded and registered with the Registry of Births, Deaths and Marriages. It was also necessary to determine how the Voluntary Assisted Dying Review Board will be notified of the death.

Respect for privacy of the deceased person’s family, as well as ensuring accurate and consistent reporting of the cause of death were important considerations.

Chapter 12 of the report gives an overview of the death notification, registration and certification process. It considers how a death through access to voluntary assisted dying is recorded, the potential impact on insurance and superannuation contracts, and other policy implications.

Its recommendations about the contents of medical certificates of cause of death are consistent with the general principle contained in the legislation that a person who dies as a result of administration of a voluntary assisted dying substance in accordance with the legislation:

- does not die by suicide; and
- is taken to have died from the disease, illness or medical condition from which they were dying and which made them eligible to access voluntary assisted dying.

HEALTH PRACTITIONERS’ QUALIFICATIONS AND TRAINING

Chapter 13 of the report addresses the minimum qualifications, experience and training required for health practitioners to perform particular roles. It backgrounds the regulation and experience of registered health practitioners. The chapter then addresses the requirements for the coordinating practitioner and the consulting practitioner who must
assess the person’s eligibility for access to voluntary assisted dying. It also considers the requirements for health practitioners to be authorised to administer a voluntary assisted dying substance in the role of administering practitioner.

Given the nature of voluntary assisted dying, inexperienced practitioners are not eligible for any of those roles. Practitioners must meet specified eligibility requirements. In addition to minimum qualification and experience requirements stated in the Act, to perform the relevant role the practitioner must also meet requirements approved by the chief executive of the Department of Health.

The Commission’s recommendations seek to ensure that practitioners who undertake eligibility assessments have appropriate skills and qualifications, and that these requirements do not act as a barrier to access voluntary assisted dying. The doctors who have the minimum qualifications to perform these roles will typically have spent many years in practice, gaining experience in end of life care.

The law also provides that to be eligible to act in any of these roles, the practitioner must have completed approved training about voluntary assisted dying.

It would be an unnecessary barrier to a dying person’s access to the scheme to require practitioners who undertake eligibility assessments, in addition to having the required qualifications and experience, to be a specialist practitioner in a specific disease, illness or medical condition. For example, a highly experienced doctor who has spent several years in specialist training in hospitals to be an oncologist or a highly experienced doctor who has treated many patients dying of cancer over the years, should be eligible to act if they meet all the requirements.

If a coordinating practitioner or consulting practitioner is unable to determine a specific matter related to eligibility, they must refer the matter to another practitioner for determination. This might be the case if a coordinating practitioner or consulting practitioner is unsure about the expected period before the person dies of a certain cancer. They can refer the matter to an oncology specialist to determine.

This balances the need for practitioners to meet specified minimum qualification and experience requirements, and the need for access.

Requiring the coordinating practitioner or consulting practitioner to be a specialist in a specific disease could be a barrier to access the scheme, particularly in regional and remote areas of Queensland. Instead, the opinion of a specialist in a specific field can be sought. This is also consistent with good medical practice.

The law provides that to act as a coordinating practitioner or consulting practitioner a medical practitioner must:
• hold specialist registration and have practised for:
  – at least one year as the holder of that registration; or
  – at least five years as the holder of general registration; or
• hold general registration and have practised for at least five years as the holder of that registration; or
• be an overseas-trained specialist who holds limited registration or provisional registration.

To have the last form of registration, an overseas-trained specialist must be enrolled in a specialist pathway. They must also meet the medical practitioner requirements approved by the chief executive of the Department. Those requirements ensure that any overseas-trained specialist has the necessary knowledge, clinical skills and professional attributes to perform the role. This form of registration facilitates having suitably qualified specialists in areas of need in regional, rural and remote areas.

To qualify on any of these bases, the medical practitioners probably will have practised for several years before attaining the registration.

The expertise and experience required at the administration stage is different. The administering practitioner, unlike the assessing practitioner, does not have to assess whether the person has an eligible disease, including the expected timeframe until death.

The law provides that to act as an administering practitioner the person must be:
• a medical practitioner who is eligible to act as a coordinating practitioner; or
• a nurse practitioner who meets the approved nurse practitioner requirements; or
• a registered nurse who has practised in that profession for at least five years and meets the approved nurse requirements.

Administering practitioners must also meet any additional requirements approved for this purpose by the chief executive of the Department of Health and complete the approved training. These additional requirements will ensure that nurse practitioners and registered nurses who participate in the administration of substances will have relevant and current experience and expertise.

The law states the minimum qualifications and experience a practitioner must have. If experience in Victoria is a guide, the practitioners who qualify and who are prepared to undertake the specific training to participate in the voluntary assisted dying process are likely to have experience well in excess of the minimum required. They may be specialists in general practice or other fields where the scope of their practice brings them into contact
with people who are dying. They may be experienced doctors who have been working for years in hospitals in areas like oncology, acute care of patients with chronic obstructive pulmonary disease, or in palliative care. They may be nurse practitioners with years of experience as registered nurses in similar fields before they became nurse practitioners. These doctors and nurses will have developed the clinical skills and the experience to deal compassionately and professionally with individuals who are suffering and dying.

They will have the clinical skills and experience to conduct assessments or administer substances (as the case may be). These doctors and nurses will have a professional interest in end of life care. They will also have to undertake specific training about voluntary assisted dying.

**PARTICIPATION BY INDIVIDUALS AND CONSCIENTIOUS OBJECTION**

Access to voluntary assisted dying depends on access to information and to suitably qualified persons to provide advice, conduct assessments and administer substances.

For various reasons, individuals may be unable or unwilling to participate in one or more of these ways. For example, a health practitioner will not be able to be an assessing practitioner if they do not hold the required qualifications or if they have not completed the required voluntary assisted dying training. Some health practitioners will be qualified and willing to participate, but at times be unavailable or not have the time to deal with a request for advice or services related to voluntary assisted dying.

The unwillingness of a health practitioner to participate may be for personal reasons and be a conscientious objection. Generally, a conscientious objection is constituted by a refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner’s personal beliefs, values or moral concerns.¹⁰ A variety of concerns may found a conscientious objection by a practitioner to voluntary assisted dying. They include secular or professional reasons.¹¹

Chapter 14 of the Commission’s report discusses:

- whether the law should provide for conscientious objection by a health practitioner or other individual to voluntary assisted dying;
- the scope of any conscientious objection provision;
- whether any right of a health practitioner to conscientiously object should be coupled with a requirement:


to inform the person of their objection; and
− to refer the person elsewhere, or to transfer the person’s care.

We proposed that the law address those issues as follows.

Subject to a requirement to inform a patient of certain things, a registered health practitioner who has a conscientious objection to voluntary assisted dying should have the right to refuse to do any of the following:

• provide information about voluntary assisted dying;
• participate in the request and assessment process;
• participate in an administration decision;
• prescribe, supply, or administer a voluntary assisted dying substance; or
• be present at the time of the administration of a voluntary assisted dying substance.

A practitioner who refuses to do one of those things should be required:

• to inform the person that other health practitioners, health service providers or services may be able to assist them; and
• to provide the person with:
  − information about a health practitioner, health service provider or service who, in the practitioner’s belief, is likely to be able to provide the requested assistance; or
  − the details of an official voluntary assisted dying care navigator service which is able to provide the person with information, including the name and contact details of a health practitioner, health service provider or service who may be able to assist.

This does not necessarily require the health practitioner who has a conscientious objection to give the person information about another health practitioner, health service provider or service, or to refer the person to another practitioner. In some circumstances, the health practitioner who has a conscientious objection will find it convenient to give the person information about another practitioner, perhaps one who practises in the same or a nearby clinic. In other circumstances, the requirement will be satisfied by giving the person the details of an official voluntary assisted dying care navigator service.

Similar rights to refuse to participate and similar requirements to provide information exist for speech pathologists, who are not registered health practitioners. Those provisions recognise the role speech pathologists typically play in facilitating communication between a
health practitioner and a patient, and the fact that they are likely to be employed or engaged by a health service, rather than the patient.

PARTICIPATION BY ENTITIES

Access to voluntary assisted dying depends on the extent to which entities allow access to information and services. For a variety of reasons, entities may choose not to provide access to voluntary assisted dying. Their reasons may be pragmatic, based on the non-availability of qualified staff who are prepared to provide assessments or administer substances. The decision may be based on an objection in principle to providing or promoting voluntary assisted dying. This kind of objection is sometimes styled ‘institutional conscientious objection’.

This gives rise to a potential conflict between, and a need to reconcile, competing rights and interests. On the one hand, there are the rights of individuals to access information about voluntary assisted dying, request it if they choose, then engage in the assessment process and, finally, if eligible, to administer the substance. On the other hand, there are the rights and interests of entities to not provide services they do not wish to provide and to not facilitate their provision by others.

One approach to the conflict, which prioritises individual autonomy and the public interest in practical access to voluntary assisted dying as an end of life option, is to prevent an entity from banning entry to its facility of any health practitioner for the purpose of discussing voluntary assisted dying with a person, assessing eligibility or administering the substance, or to prevent an entity from prohibiting a person from self-administering the substance on its premises.

Another approach, which places pre-eminence on the rights of entities to not provide or otherwise promote voluntary assisted dying, would be to permit institutional objections without qualification. This would extend to not even requiring such entities to refer an individual to a service, entity or practitioner where they might obtain information about voluntary assisted dying.

Between these extremes are forms of regulation that seek to accommodate the competing rights and interests. The most appropriate form of regulation depends on consideration of the competing interests, and the context in which the issue arises.

In Chapter 15 we discussed certain issues of principle in general terms. However, the circumstances of individuals and entities differ widely. For example, some individuals will reside at a place and be in a physical condition where they are free to choose between entities that provide voluntary assisted dying and those which do not. They will be able to move to a facility that offers access to voluntary assisted dying and do so without any great detriment or
inconvenience. Other individuals, however, may be close to death and in great pain, and be at a certain facility out of necessity. In such circumstances, being required to transfer to a different hospital, hospice or other institution, if a place is available there, may subject them to pain and distress, and deny them, in a practical sense, access to voluntary assisted dying.

The circumstances of entities also differ. They range from public hospitals, private hospitals and hospices operated by private entities, to long-term care facilities such as nursing homes and residential aged care facilities. For some individuals, these places will be their home. Statutory regulation or contract may provide these individuals with security of tenure. An insistence by the entity which operates such a facility that the individual go elsewhere to access advice and assistance would require that individual to leave their home and to attempt to find a new home when they may be in an extremely vulnerable state. Depending on the circumstances, insisting that the person go elsewhere in the final stages of life may be inconsistent with the person’s legal right of residence at the facility.

The term ‘entity’ is used to refer to a non-natural person, typically a corporation or a body given legal status. The entity may provide a health service, residential aged care or personal care service for reward (such as assistance with mobility or taking medicine), or own a facility at which such services are provided. The position of such a ‘non-natural person’ is different to a natural person, for example, a doctor who owes professional and ethical duties.

Chapter 15 of the report addresses the rights and interests of a patient or resident, and the rights and interests of such an entity.

Our approach was to create processes by which certain rights and interests are assumed and reasonably accommodated. The legislation seeks to accommodate the rights and interests of individuals to access a scheme that is lawful and the rights and interests of an entity to not provide voluntary assisted dying at its facility.

In devising processes, it is appropriate to have different rules for different stages. For example, different considerations apply to receiving information (which the patient or resident requests but which the entity does not provide) to being assessed (assuming the entity does not provide access to the request and assessment process at the facility). Different considerations apply if the person is requesting access to a coordinating practitioner when the person is in a private hospital to when they are in their own home, such as an aged care facility in which they have security of tenure.

In general terms, the processes to accommodate a patient’s or a resident’s right to access a lawful end of life option and the entity’s right to not provide that option at its facility involves either the entity taking reasonable steps to facilitate a transfer to a place outside the facility or allowing reasonable access to a qualified registered health practitioner who is willing to attend if a transfer would not be reasonable in the circumstances.
For example, if a person is not a permanent resident at the facility and the entity does not provide access to the request and assessment process at its facility, it should:

- take reasonable steps to facilitate the transfer of the person to a place outside the entity's facility for the purpose of undergoing an eligibility assessment and, if requested, facilitate the return of the person to the facility after the assessment is completed; or
- allow access to the facility by the coordinating practitioner to conduct the assessment when transfer to a place outside the facility for the purpose of assessment would not be reasonable.

In determining whether it is reasonable for the person to be transferred to a place outside the entity's facility for an eligibility assessment, regard may be had to whether or not:

- the transfer would be likely to cause serious harm to the person, for example, significant pain or a significant deterioration in the person’s condition;
- the person’s access to voluntary assisted dying might be adversely affected by the transfer, for example, because the transfer would be likely to result in a loss of capacity, or because the transfer would require pain relief or other medication that would affect the person’s decision-making capacity for voluntary assisted dying;
- the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
- no alternative place is reasonably available, for example, because another facility within a reasonable distance does not have a suitable place to which to admit the person or cannot provide the level of care required by the person for the relevant period;
- the person would incur financial loss or costs because of the proposed transfer.

We favoured a legislative approach to clarifying the rights of individuals and entities when an entity chooses not to provide or facilitate voluntary assisted dying. The benefit of legislation, supported by more detailed regulations and policy statements, is that it informs individuals and entities of the basic ground rules by which their respective rights and interests are reconciled and the process which applies.

**REVIEW OF CERTAIN DECISIONS BY QCAT**

We addressed whether there should be a right of review to the Queensland Civil and Administrative Tribunal ("QCAT") for certain decisions about a person’s eligibility.

Any review mechanism has to be timely and accessible, with appropriate limits to minimise unnecessary distress and delay.
The legislation permits QCAT review for certain non-clinical decisions made by a coordinating practitioner or consulting practitioner in the request and assessment process. To leave every decision of an assessing practitioner open to review by the tribunal would add an unnecessary layer of complexity to the process and cause uncertainty and delay. Tribunal review of a practitioner’s non-clinical decisions should not be a routine part of the request and assessment process.

**Decisions that should be reviewable**

The eligibility criteria that are assessed by the practitioner involve varying degrees of judgment and questions of fact. Some are more appropriate for review than others. We addressed each and concluded that the law should enable an eligible person to apply to QCAT for review of a decision of the coordinating practitioner (in a first assessment or in a final review) or of a consulting practitioner (in a consulting assessment) that the person:

- was—or was not—**ordinarily resident in Australia** for at least three years immediately before making the first request;
- was—or was not—**ordinarily resident in Queensland** for at least 12 months immediately before the person makes the first request;
- has—or does not have—**decision-making capacity** in relation to voluntary assisted dying; or
- is—or is not—**acting voluntarily and without coercion**.

We considered whether a decision of an administering practitioner about whether the requesting person meets the requirements for practitioner administration should also fall within the scope of the review mechanism. The purpose and character of the administration stage of the process differs from the request and assessment stage. The administering practitioner must be satisfied of the relevant matters at the point in time immediately before administering the substance. A person’s capacity may fluctuate or diminish. Therefore, substituting a decision of the tribunal for that of an administering practitioner would be problematic.

Neither the Victorian nor Western Australian legislation extends tribunal review to decisions of the administering practitioner. Those Acts similarly require the administering practitioner to be satisfied of the relevant matters at the time of administration. For reasons given in Chapter 16, it is neither necessary nor desirable for the QCAT review mechanism to apply to decisions of an administering practitioner.
Who may apply for review

The review mechanism should not become a means of unjustified interference or delay. The range of potential applicants should be kept small. The Act provides that an application for review may be made by the person who is the subject of the decision; an agent of the person; or ‘any other person who has a sufficient and genuine interest in the rights and interests of the person in relation to voluntary assisted dying’. In addition to the person making the request, there may also be a small number of other persons who have a direct, relevant and genuine interest in upholding the requesting person’s rights and interests. The third category of applicant should be confined to those persons who have a special interest. They might include, for example, another member of the person’s health care team, a spouse or other close family member, or carer.

As in other jurisdictions, simply being a member of the person’s family will not, by itself, entitle a person to bring an application. Whether a family member, health practitioner or other person has a sufficient and genuine interest that meets the test will depend on the individual circumstances and the decision of the tribunal.

Other matters

The law also addresses many procedural aspects, such as the short time within which a review application must be made, the effect of an application, what the tribunal may decide and the effect of its decisions. Because of the seriousness of the subject matter, the tribunal should be constituted by at least one legally qualified member, and one would expect the President of QCAT to constitute a tribunal hearing a challenge to a decision about decision-making capacity with a tribunal member with experience in that field. Hearings should be in private.

The Commission recommended that QCAT be given the additional resources that are needed to ensure the effective operation of its new review jurisdiction.

COMPLIANCE AND PROTECTION FROM LIABILITY

We had regard to compliance monitoring and ‘appropriate safeguards and protections, including for treating health practitioners’. Chapter 17 addresses criminal offences for specified conduct, protections from liability, and notifications of concerns to the Health Ombudsman.

Our general approach to compliance and enforcement was to recognise that health practitioners are subject to a comprehensive legal, regulatory and ethical framework and that there are existing mechanisms to deal with concerns about health practitioners’ conduct. The recommended Voluntary Assisted Dying Review Board would refer identified issues to
appropriate agencies for investigation or follow up. The Board is not intended to have a dispute resolution or enforcement role.

We also recognised that voluntary assisted dying legislation requires significant changes to the current law. This includes adjustments to the criminal law to deal with conduct that is authorised by the voluntary assisted dying law. It also requires protections from liability for certain persons who act in good faith and without negligence under the new legislative framework.

The creation of specific offences in the draft legislation does not affect the operation of existing criminal laws for conduct that is not protected. Therefore, individuals who act outside the legal framework for voluntary assisted dying will still be subject to homicide and other laws.

AN OVERSIGHT BODY: THE VOLUNTARY ASSISTED DYING REVIEW BOARD

We were asked to consider ‘appropriate safeguards’ and ‘ways in which compliance with the Act can be monitored’. An oversight body is essential to support the safe, practical and transparent operation of the voluntary assisted dying scheme.

We proposed a Voluntary Assisted Dying Review Board as an independent statutory board. This has the advantage of flexibility, independence, and delivering a robust oversight mechanism as part of an integrated legislative framework. We recommend that the Board be constituted by at least five but no more than nine members (including the chairperson) with an appropriate mix of expertise and experience. The Board’s functions will likely be wide-ranging, but should focus on monitoring, reporting, and advising on voluntary assisted dying. We recommend that the Board’s functions should include:

- **monitoring** the Act’s operation;
- **reviewing** completed cases retrospectively;
- **referring** relevant matters to entities such as the Commissioner of Police, the State Coroner, and the Health Ombudsman;
- **recording** and **keeping** information about requests for, and provision of, voluntary assisted dying; **analysing** this information; and **researching** matters related to the Act;
- **providing information, reports and advice** to the Minister or chief executive of the Department about the operation of the Act, the Board’s functions, or the improvement of the processes and safeguards;
annual reporting obligations; and

promoting compliance with the Act; promoting continuous improvements of the Act; and consulting and engaging with the community and other entities.

The Board should have all the powers necessary to perform its functions.

A FUTURE REVIEW

We also proposed that the effectiveness of any legislation that is enacted be reviewed after it operates for three years.

COMMONWEALTH LAWS THAT IMPEDE ACCESS

Access to information and advice about voluntary assisted dying is critical to the operation of any scheme.

Chapter 20 of the Commission’s report addresses in detail the uncertain possible application of Commonwealth ‘carriage service’ offences to conduct that is authorised by state voluntary assisted dying laws. This uncertainty is unsatisfactory. It led to the then Victorian Health Minister instructing doctors and other practitioners involved in voluntary assisted dying services to conduct all discussions, consultations and assessment face-to-face, so as to avoid potentially breaching the Commonwealth law.

The Victorian Board has made repeated calls for the Commonwealth to make an exemption to allow Victorians, especially those in regional Victoria, to be able to have ‘important conversations about voluntary assisted dying over the phone or via teleconference’.

In general, it is preferable for all requests for, and provision of, information and advice about voluntary assisted dying to occur in face-to-face personal communications between the health practitioner and their patient. However, this may not be possible because of the location of the person and their inability to travel possibly long distances to consult a health practitioner or the inability of the health practitioner to travel to speak to them in person. In such cases, information may need to be given by telephone, video link, email or some other form of electronic communication.

The need to use those forms of communication to request, and provide, information and advice will be greatest when the patient lives in a remote location. Without access to those forms of communication, persons living in remote and regional parts of the state may have greatly impaired access to voluntary assisted dying.

The uncertain application of the Commonwealth law particularly affects individuals who are suffering and dying in remote and regional areas.
The Commonwealth law was enacted before voluntary assisted dying laws were introduced in different states. Therefore it is doubtful that a death that is authorised by such a state law is ‘suicide’ within the meaning of the Commonwealth law. The Commonwealth Parliament cannot be said to have intended that because the state laws did not exist at the time.

The report recommended that Queensland and other states with voluntary assisted dying laws raise the issue of legal uncertainty at forums with senior members of the Commonwealth Government with a view to the Criminal Code (Cth) being amended and clarified. The effect of the amendments would be that the term ‘suicide’ in the relevant Commonwealth provisions does not apply to a death that is assisted in accordance with state or territory voluntary assisted dying laws.

We also recommended, as an interim measure, that the Commonwealth Director of Public Prosecutions be asked to consider issuing prosecutorial charging guidelines. The risk of prosecution would be removed by a guideline that the Commonwealth offences will not be prosecuted where a health practitioner or other person is acting in accordance with a procedure that is authorised under state voluntary assisted dying laws.

**IMPLEMENTATION**

Effective implementation is essential for a compassionate, safe and practical voluntary assisted dying legal framework. For example, the Voluntary Assisted Dying Review Board in Victoria noted the work involved in translating:  

> the complex Voluntary Assisted Dying Act into forms that are easy to understand and processes that are easy to follow for both patients and doctors, but still rigorous enough to reassure the wider community.

The Parliamentary Committee observed that Queensland is well placed to learn from the implementation experiences of Victoria and Western Australia, including ‘the extent and types of material needed to guide both community members and medical practitioners’. 

However, as noted by the Western Australian Panel: 

> the uniqueness of Western Australia in its geography and great diversity of cultures and languages will present its own challenges for implementation and as such the Victorian process cannot be followed indiscriminately.

Any implementation process must be fit for purpose for Queensland’s geographic, cultural and health care environment.

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13 Qld Parliamentary Committee Report No 34 (2020) 149.
Queensland is the second largest state in Australia after Western Australia, covering over 1.7 million square kilometres. More than half of Queensland’s population lives outside the greater metropolitan area of Brisbane—a large proportion compared with the rest of highly urbanised Australia.

In the 2016 Census, Aboriginal and Torres Strait Islander people made up four per cent of the population. As at 2016, 21.6 per cent of Queensland’s population was born overseas and 11.2 per cent of Queenslanders spoke a language other than English at home.

To facilitate the efficient and effective implementation of voluntary assisted dying legislation, new bodies are to be created. They should be established well before the commencement of provisions that permit access to voluntary assisted dying. They include:

- the Voluntary Assisted Dying Review Board;
- a Statewide Care Navigator Service; and
- a Statewide Pharmacy Service.

As noted, the Voluntary Assisted Dying Review Board will have functions of monitoring, review and referral, data collection and research, reporting and advice, and community engagement.

The Care Navigator Service is essential. The inherent complexities of any voluntary assisted dying framework require a dedicated body to help people who are at the end of life to navigate the process. The body will also support practitioners and service providers (such as interpreters) to meet the challenges of participating in the process.

The care navigator service should be established under the umbrella of Queensland Health as early as possible as part of the implementation process to ensure the timely engagement and training of skilled and culturally competent navigators and the development of information and other resources. Its staff will include compassionate and skilled nurses and social workers.

The service should be properly resourced to provide services in rural and regional areas. That will help ensure access to the scheme by all Queenslanders.

Without a well-resourced care navigator service, any scheme of voluntary assisted dying in Queensland is unlikely to work as envisaged.

A Statewide Pharmacy Service will facilitate the supply of the voluntary assisted dying substance across Queensland. It also will provide a central source of information about those substances for people accessing voluntary assisted dying, as well as for their loved ones and
medical practitioners. Queensland’s size and population distribution will need to be considered in establishing the service.

In addition to these crucial bodies, policies, training, guidelines and educational materials are to be developed to ensure health practitioners are suitably trained, and information about the scheme, eligibility and how to access it is readily available across Queensland.

A critical element for the practical operation of any scheme is Information and Communications Technology (“ICT”).

A dedicated, well-designed and tested ICT system that supports the voluntary assisted dying scheme is essential to its operation in Queensland. It should work efficiently from the time the scheme begins to operate and busy health practitioners are required to access it, with the need for only minor refinements as the scheme continues. The primary purpose of the ICT system is to enable the submission of relevant forms to the Board at the various stages of the voluntary assisted dying process.

A dedicated ICT system is needed that can be used easily by practitioners to comply with time-sensitive processes that require relevant documentation to be submitted to the Board. The system will enable the coordinating practitioner, the Board and other relevant entities to track a person’s progress through the voluntary assisted dying process.

A robust, user-friendly ICT system, with ongoing technical support to address issues with the system as they arise, should be developed to ensure the submission of forms required by the legislation and that the scheme operates efficiently from its inception.

If not, the process will become unworkable, and practitioners who might otherwise have been willing to participate in it will not do so. The process will be delayed and protracted. In some cases, unnecessary delay in being able to submit forms through a dedicated portal and to proceed further through the process will result in persons dying or losing capacity before they can access voluntary assisted dying.

The experience of other States demonstrates the importance of allowing enough time to establish effective bodies, an ICT system and processes, to train people to understand the inherent complexities of the system, and to then make the system work safely, compassionately and efficiently in practice. It is possible to learn from Victoria and Western Australia about the many things that need to be completed during the implementation period. Those lessons are useful but do not significantly reduce the time needed to implement a new system in Queensland.

We were conscious of concerns about delay in implementation—that individuals will miss out on accessing voluntary assisted dying because, for them, it comes too late.
Based on all that needs to be done, its complexity, and the experience of other States, an implementation period of at least 18 months was thought to be appropriate.

THE COMMISSION’S REPORT AND THE DEMOCRATIC PROCESS

The Commission’s report and draft Bill were delivered on 10 May 2021. The government had already established an implementation unit within Queensland Health in anticipation of legislation being passed.

The Commission’s draft Bill was referred to a Parliamentary Committee. The draft Bill introduced into the Parliament reflected the Commission’s draft. The Bill was the subject of extensive Parliamentary debate and many proposed amendments. The Commission did not advocate any position. Its work was effectively completed when its report was delivered. Others debated the substance and detail of the proposed new laws. Professors White and Willmott, whose contribution to informed debate about voluntary assisted dying cannot be overstated, explained why proposed amendments were considered by them to lack merit.\(^\text{15}\)

The Commission has appreciated the praise which its report has received from commentators like Professors White and Willmott. However, had its draft Bill been rejected or heavily amended, rather than being passed in the form it was, then the Commission would have accepted that democratic outcome.

Our task was to design a legal framework. Our work built upon the extensive work of a Parliamentary Committee which recommended that there be such legislation.

As the detailed contents of our report show, there were issues about which views differed, for example, whether there should be a timeframe until death. Advocates for voluntary assisted dying laws took different positions on many issues. The Commission tried to frame legislation that was correct in principle and workable in practice.

The goal was not uniformity or conformity with voluntary assisted dying laws in other States. We tried to draw what was good in them and not adopt provisions which were simply the result of political compromise in other States.

I was personally attracted to the notion that in a federation like ours States are ‘laboratories of democracy’.\(^\text{16}\) The expression was used by the great jurist Justice Louis Brandeis. The idea is that different policies can be enacted and tested in a State, as in a scientific experiment. If the policy is a failure, it does not affect any other State. If, however, the policy

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is a success, it might be expanded to another State. If improvements are made in that next State, they might be adopted in another.

The result is not necessarily uniform legislation across the States that adopt the policy. A State can identify the strengths and weaknesses of laws that were enacted in another.

The Commission’s task was to create the best legal framework for Queensland, based on experiences in other States particularly in Victoria and Western Australia’s process of implementation.

A legal framework is simply that. The dedication of people and resources will be required to overcome the challenges of implementing a scheme for voluntary assisted dying in Queensland’s unique conditions.