Appendix A - The White and Willmott Voluntary Assisted Dying Bill 2019

Voluntary Assisted Dying Bill 2019

This Bill was drafted by Professors Ben White and Lindy Willmott of the Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology in April 2019.

The purpose of drafting this Bill is to convey in practical terms our proposed policy framework for permitting and regulating voluntary assisted dying. The Bill is accompanied by a short Explanatory Notes document which provides some context for how the Bill was drafted and further background about some of the policy decisions made.

We gratefully acknowledge the critical review and feedback on earlier drafts of the Bill and/or the Explanatory Notes, including by Rebecca Meehan, Katrine del Villar, Dr Jayne Hewitt, Eliana Close, Dr Laura Ley Greaves, Emeritus Professor Malcolm Parker, Jodhi Rutherford, Dr Rachel Feeney, Dr Mark Thomas and interested members of the Queensland Law Society. The Bill represents our views and should not be taken to represent the views of those who provided feedback on it, the Australian Centre for Health Law Research or the Faculty of Law.

Voluntary Assisted Dying Bill 2019

Contents

2019

A Bill

for

An Act to provide for voluntary assisted dying, in specific and restricted circumstances and subject to safeguards, for persons with an incurable, advanced and progressive medical condition that will cause death, to protect registered medical practitioners who wish to provide voluntary assisted dying and registered health practitioners who do not wish to participate in voluntary assisted dying, and for related purposes.

The Parliament of [State] enacts—

Part 1 Preliminary

1 Short title

This Act may be cited as the *Voluntary Assisted Dying Act 2019*.

2 Commencement

(1) Subject to subsection (2), this Act comes into operation on a day or days to be proclaimed.

(2) If a provision of this Act does not come into operation before [insert day 18 months after Parliament passing this Act], it comes into operation on that day.

3 Act binds all persons

This Act binds all persons, including the State.

4 Main objects of the Act

The main objects of this Act are to—

(a) provide access to voluntary assisted dying for persons with an incurable, advanced and progressive medical condition that will cause death;

(b) establish safeguards to ensure that voluntary assisted dying is accessed only by persons who meet this Act's eligibility criteria;

(c) establish the Voluntary Assisted Dying Review Board to provide oversight of voluntary assisted dying under this Act;

(d) provide protections from liability for registered health practitioners and other persons who facilitate voluntary assisted dying in accordance with this Act; and

(e) enable registered health practitioners and entities who provide a health service, residential service or professional care service to refuse to participate in voluntary assisted dying without incurring liability.

5 Principles

A person exercising a power or performing a function or duty under this Act must have regard to the following principles—

(a) human life is of fundamental importance and should be valued;
(b) a person's autonomy should be respected;
(c) freedom of conscience should be respected, including choosing to—
  (i) participate in voluntary assisted dying; and
  (ii) not participate in voluntary assisted dying;
(d) a person's equality should be respected and they should be free from discriminatory treatment;
(e) persons who are vulnerable should be protected from coercion and abuse;
(f) human suffering should be reduced; and
(g) the provision of voluntary assisted dying should reflect the established standards of safe and high-quality care.

6 Meaning of voluntary assisted dying

(1) ***Voluntary assisted dying*** means the administration of voluntary assisted dying medication to a person and includes steps reasonably related to such administration.

(2) To remove any doubt, ***voluntary assisted dying*** may occur through—
  (a) a registered medical practitioner administering voluntary assisted dying medication to a person to bring about their death (***practitioner administration***); or
  (b) a person taking voluntary assisted dying medication themselves to bring about their death under the supervision of a registered medical practitioner (***self-administration***).

(3) For the purposes of subsection (2)(b), being under the supervision of a registered medical practitioner means that the registered medical practitioner is present while the person self-administers the voluntary assisted dying medication.

7 Meaning of decision-making capacity

(1) A person has ***decision-making capacity*** in relation to voluntary assisted dying if the person is able to—
  (a) understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision; and
  (b) retain that information to the extent necessary to make the decision; and

(c) use or weigh that information as part of the process of making the decision; and

(d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

(2) For the purposes of subsection (1), a person is presumed to have decision-making capacity unless there is evidence to the contrary.

8 Definitions

The dictionary in Schedule 1 defines particular words used in this Act.

Part 2 Eligibility and requests for access to voluntary assisted dying

Division 1 Eligibility for access to voluntary assisted dying

9 Eligibility criteria

For a person to be eligible for access to voluntary assisted dying—

(a) the person must be aged 18 years or more; and

(b) the person must—

(i) be an Australian citizen or permanent resident; and

(ii) be ordinarily resident in [State]; and

(c) the person must have decision-making capacity in relation to voluntary assisted dying; and

(d) the person's decision to access voluntary assisted dying must be—

(i) enduring;

(ii) made voluntarily and without coercion; and

(e) the person must be diagnosed with a medical condition that—

(i) is incurable; and

(ii) is advanced, progressive and will cause death; and

(iii) is causing intolerable and enduring suffering.

10 Clarification of eligibility criteria

(1) Whether a person's medical condition will cause the person's death is to be determined by reference to available medical treatment that is acceptable to the person.

(2) For the purposes of subsection 9(e)(iii)—

(a) whether suffering is intolerable is to be determined by the person requesting access to voluntary assisted dying;

(b) suffering caused by a person's medical condition includes suffering caused by treatment provided for that medical condition; and

(c) suffering includes physical, psychological and existential suffering.

Division 2 Requests for access to voluntary assisted dying

11 A person may make a first request

(1) A person may make a request to a registered medical practitioner for access to voluntary assisted dying (a ***first request***).

(2) A person's first request for access to voluntary assisted dying must be—

(a) clear and unambiguous; and

(b) made by the person personally.

(3) The person may make the first request verbally or by gestures or other means of communication available to the person.

Part 3 Assessment of eligibility for access to voluntary assisted dying

Division 1 Two registered medical practitioners to assess eligibility

12 Two registered medical practitioners to assess eligibility

(1) A person may access voluntary assisted dying only if two registered medical practitioners (a ***first medical practitioner*** and a ***second medical practitioner***) assess the person as eligible for access to voluntary assisted dying.

(2) The first medical practitioner and a second medical practitioner must be independent of each other.

(3) For the purposes of subsection (2), the first medical practitioner and a second medical practitioner will not be independent of each other if—

(a) they are family members; or

(b) one medical practitioner is employed by or working under the supervision of the other medical practitioner.

13 Qualifications and experience of first and second medical practitioners

(1) Each of the first medical practitioner and second medical practitioner must—

(a) hold a fellowship with a specialist medical college; or

(b) be a vocationally registered general practitioner.

(2) Either the first medical practitioner or each second medical practitioner must have practised as a registered medical practitioner for at least 5 years after completing a fellowship with a specialist medical college or vocational registration (as the case requires).

(3) Either the first medical practitioner or each second medical practitioner must have relevant experience in treating or managing the medical condition expected to cause the death of the person being assessed.

14 Approved training

The first medical practitioner and a second medical practitioner must not commence their assessment for eligibility for access to voluntary assisted dying unless that practitioner has completed approved assessment training.

Division 2 Assessment by first medical practitioner

15 First medical practitioner may undertake first assessment

(1) A registered medical practitioner (the ***first medical practitioner***) who receives a first request from a person may undertake a ***first assessment***.

(2) The first assessment requires an examination of the person and a review of their relevant medical records.

16 First assessment

When undertaking a first assessment, the first medical practitioner must assess whether the person requesting access to voluntary assisted dying meets the eligibility criteria.

17 Further expertise required for assessment

(1) If the first medical practitioner is unable to determine whether a person requesting access to voluntary assisted dying meets one or more of the eligibility criteria, they must refer the person to a registered health practitioner or health practitioners with appropriate skills and training.

Example—

A first medical practitioner who is unable to determine whether a person has capacity in relation to voluntary assisted dying must refer the person to a registered health practitioner with expertise to undertake that assessment. This could be, for example, a psychiatrist or geriatrician.

(2) If the first medical practitioner refers the person to a registered health practitioner under subsection (1), the first medical practitioner may adopt the determination of the registered health practitioner in relation to the matter in respect of which the person was referred.

18 Information to be provided if first medical practitioner assesses person as meeting eligibility criteria

(1) If the first medical practitioner is satisfied that the person requesting access to voluntary assisted dying meets all the eligibility criteria, the first medical practitioner must inform the person about the following matters—

(a) the person's diagnosis and prognosis;

(b) the treatment options available to the person and the likely outcomes of that treatment;

(c) palliative care options available to the person and the likely outcomes of that care;

(d) the potential risks of taking voluntary assisted dying medication or having it administered;

(e) that the expected outcome of taking voluntary assisted dying medication or having it administered referred to in paragraph (d) is death; and

(f) that the person may decide at any time not to continue with their request for access to voluntary assisted dying.

(2) The first medical practitioner must also encourage the person to inform their family and other treating registered medical practitioners of the person's request for access to voluntary assisted dying.

(3) Nothing in this section affects any duty a registered medical practitioner has at common law or under any other enactment.

19 Referral to second medical practitioner

If the first medical practitioner is satisfied that the person—

(a) meets the eligibility criteria; and

(b) understands the information required to be provided under section 18,

the first medical practitioner must refer the person to a second medical practitioner for a second assessment.

Division 3 Assessment by second medical practitioner

20 Second medical practitioner may undertake second assessment

(1) A registered medical practitioner (a ***second medical practitioner***) who receives a referral from the first medical practitioner may undertake a ***second assessment***.

(2) A second assessment requires an examination of the person and a review of their relevant medical records.

21 Second assessment

When undertaking a second assessment, a second medical practitioner must assess whether the person requesting access to voluntary assisted dying meets the eligibility criteria.

22 Further expertise required for assessment

(1) If a second medical practitioner is unable to determine whether a person requesting access to voluntary assisted dying meets one or more of the eligibility criteria, they must refer the person to a registered health practitioner or health practitioners with appropriate skills and training.

Example—

A second medical practitioner who is unable to determine whether a person has capacity in relation to voluntary assisted dying must refer the person to a registered health practitioner with expertise to undertake that assessment. This could be, for example, a psychiatrist or geriatrician.

(2) If a second medical practitioner refers the person to a registered health practitioner under subsection (1), the second medical practitioner may adopt the determination of the registered health practitioner in relation to the matter in respect of which the person was referred.

23 Information to be provided if second medical practitioner assesses person as meeting eligibility criteria

(1) If a second medical practitioner is satisfied that the person requesting access to voluntary assisted dying meets all the eligibility criteria, the second medical practitioner must inform the person about the following matters—

(a) the person's diagnosis and prognosis;

(b) the treatment options available to the person and the likely outcomes of that treatment;

(c) palliative care options available to the person and the likely outcomes of that care;

(d) the potential risks of taking voluntary assisted dying medication or having it administered;

(e) that the expected outcome of taking voluntary assisted dying medication or having it administered referred to in paragraph (d) is death; and

(f) that the person may decide at any time not to continue with their request for access to voluntary assisted dying.

(2) Nothing in this section affects any duty a registered medical practitioner has at common law or under any other enactment.

24 Outcome of first and second assessments

(1) If the first medical practitioner and a second medical practitioner are satisfied that the person—

(a) meets the eligibility criteria; and

(b) understands the information required to be provided under sections 18 and 23,

the person is eligible for access to voluntary assisted dying.

(2) If the first medical practitioner assesses a person as eligible for access to voluntary assisted dying but a second medical practitioner assesses that person

as not eligible for access to voluntary assisted dying, the first medical practitioner may refer the person to another registered medical practitioner for a further second assessment.

25 First medical practitioner report to Board about eligibility determination

(1) The first medical practitioner must, within 14 days of an ***eligibility determination*** being made in relation to a person, give the Board a report about a person's eligibility determination in the approved form.

(2) The report must include a copy of the following—

(a) a record of the first request;

(b) the first assessment report;

(c) any second assessment report; and

(d) any other information required by regulation.

(3) For the purposes of this section, an eligibility determination means a determination by the first medical practitioner that—

(a) a person is eligible for access to voluntary assisted dying in accordance with subsection 24(1); or

(b) a person is not eligible for access to voluntary assisted dying in accordance with subsection 24(1).

Division 4 Transfer of first medical practitioner's role

26 Transfer of first medical practitioner's role

(1) The first medical practitioner for a person may transfer the role of first medical practitioner to another registered medical practitioner at—

(a) the request of the person; or

(b) the first medical practitioner's own initiative.

(2) The first medical practitioner for a person may transfer the role of the first medical practitioner to a second medical practitioner for the person if the second medical practitioner has assessed the person as eligible for access to voluntary assisted dying

Note—

The first and second medical practitioners' assessments that the person is eligible for access to voluntary assisted dying remain valid despite this referral and so the person will have the two assessments as required under this Act. A second medical practitioner, who has already conducted their assessment, will become the first medical practitioner who will supervise the person's voluntary assisted dying.

(3) The first medical practitioner for a person may also transfer the role of the first medical practitioner to a registered medical practitioner other than a second medical practitioner.

(4) A transfer of the role of the first medical practitioner under subsection (3) can take effect only if the new first medical practitioner has assessed the person as eligible for access to voluntary assisted dying, having conducted their own assessment in accordance with sections 15 to 18.

Note—

The purpose of this subsection is to ensure that the first medical practitioner has always undertaken their own eligibility assessment given that practitioner is supervising the person's voluntary assisted dying.

(5) The person requesting access to voluntary assisted dying must agree to the role of the first medical practitioner being transferred to the other registered medical practitioner before that transfer can take effect.

Part 4 Access to voluntary assisted dying

Division 1 Second request for access to voluntary assisted dying

27 Person assessed as eligible for access to voluntary assisted dying may make second request

(1) A person assessed as eligible for access to voluntary assisted dying in accordance with subsection 24(1) may make a written request (a ***second request***) requesting access to voluntary assisted dying.

(2) The second request must—

(a) specify that the person—

(i) makes the declaration voluntarily and without coercion; and

(ii) understands the nature and the effect of the request the person is making; and

(b) be in writing and in the approved form;

(c) be signed by the person making the request in the presence of two witnesses and the first medical practitioner.

(3) Despite subsection (2)(c), a person may sign a second request at the direction of the person making the request if—

(a) the person making the request is unable to sign the declaration; and

(b) the person signing—

(i) is aged 18 years or more; and

(ii) is not a witness to the signing of the request.

(4) A person who signs a written request on behalf of the person making the request must do so in that person's presence.

(5) If a person makes a second request with the assistance of an interpreter, the interpreter must certify on the request that the interpreter provided a true and correct translation of any material translated.

28 Witness to making of second request

(1) A person is eligible to witness the making of a second request if the person is—

(a) aged 18 years or more; and

(b) not an ineligible witness.

(2) A person is an ineligible witness for the purposes of a second request if the person—

(a) knows or believes that the person—

(i) is a beneficiary under a will of the person making the second request; or

(ii) may otherwise benefit financially or in any other material way from the death of the person making the second request; or

(b) is an owner of, or is responsible for the day-to-day operation of, any facility at which the person making the second request is receiving a health service, residential service or professional care service; or

(c) is directly involved in providing a health service, residential service or professional care service to the person making the second request.

(3) Not more than one witness may be a family member of the person making the second request.

29 Certification of witness to signing of second request

(1) A witness who witnesses a person signing a second request must—

(a) certify in writing in the second request that—

(i) in the presence of the witness, the person making the second request appeared to voluntarily and without coercion sign the second request; and;

(ii) at the time the person signed the second request, the person appeared

to have decision-making capacity in relation to voluntary assisted dying; and

(iii) at the time the person signed the second request, the person appeared to understand the nature and effect of making the second request; and

(b) state that the witness is not knowingly an ineligible witness.

(2) A witness who witnesses another person signing a second request on behalf of the person making it must—

(a) certify in writing in the second request that—

(i) in the presence of the witness, the person making the second request appeared to voluntarily and without coercion direct the other person to sign the second request; and

(ii) the other person signed the second request in the presence of the person making the second request and the witness; and

(iii) at the time the other person signed the second request, the person making it appeared to have decision-making capacity in relation to voluntary assisted dying; and

(iv) at the time the other person signed the second request, the person making it appeared to understand the nature and effect of making the second request; and

(b) state that the witness is not knowingly an ineligible witness.

(3) A certification and statement under subsection (1) or (2) must be signed by the witness making it in the presence of the first medical practitioner.

Division 2 Final request for access to voluntary assisted dying

30 Person may make final request for access to voluntary assisted dying

(1) A person may make a ***final request*** to the first medical practitioner for the person that the first medical practitioner provide access to voluntary assisted dying to the person if—

(a) the person has made a second request in accordance with section 27;

(b) the person has decision-making capacity in relation to voluntary assisted dying;

(c) the person's request for access to voluntary assisted dying is made voluntarily and without coercion;

(d) the person's request for access to voluntary assisted dying is enduring; and

(e) the person understands that access to voluntary assisted dying will be provided immediately after the making of the final request.

(2) The person's final request for access to voluntary assisted dying must be—
  (a) clear and unambiguous; and
  (b) made by the person personally.

(3) The person may make the request verbally or by gestures or other means of communication available to the person.

(4) A final request must be made in the presence of a witness.

(5) The first medical practitioner must refuse to accept the person's final request if the first medical practitioner is not satisfied of any matter under subsection (1).

31 Nature of voluntary assisted dying in final request

The person's final request must specify the nature of the voluntary assisted dying requested from the first medical practitioner, namely—

(a) practitioner administration of voluntary assisted dying medication to the person; or

(b) supervised self-administration by the person of voluntary assisted dying medication.

32 Witness to making of final request

(1) A person is eligible to witness the making of a final request if the person is—
  (a) aged 18 years or more;
  (b) not employed by or working under the supervision of the first medical practitioner; and
  (c) not a family member of the first medical practitioner.

(2) The witness who witnesses a person making a final request must certify in writing in the approved form that—
  (a) the person at the time of making the final request appeared to have decision-making capacity in relation to voluntary assisted dying;
  (b) the person in requesting access to voluntary assisted dying appeared to be acting voluntarily and without coercion; and
  (c) the person's request to access voluntary assisted dying appeared to be enduring.

33 Timing of final request

(1) A person's final request must be made—

(a) subject to subsection (2), at least nine days after the day on which the person made the first request; and

(b) in any case, at least one day after the day on which the second assessment that assessed the person as eligible for access to voluntary assisted dying was completed.

(2) Subsection (1)(a) does not apply if the first medical practitioner for the person considers that the person's death is likely to occur before the expiry of the time period specified in that subsection, and this is consistent with the prognosis of a second medical practitioner who conducted a second assessment for the person.

(3) A person's final request must also be made immediately before the first medical practitioner provides access to voluntary assisted dying.

Division 3 First medical practitioner may provide access to voluntary assisted dying

34 First medical practitioner may provide access to voluntary assisted dying

Upon receiving the final request from a person, the first medical practitioner for that person may provide access to voluntary assisted dying to that person in accordance with the final request.

Division 4 Management of voluntary assisted dying medication

35 Collection, storage and disposal of voluntary assisted dying medication

The collection, storage and disposal of the voluntary assisted dying medication by the first medical practitioner must occur in accordance with the requirements set out in the regulations.

Division 5 Person may decide at any time not to take any further step in relation to access to voluntary assisted dying

36 Person may decide at any time not to take any further step in relation to access to voluntary assisted dying

(1) A person requesting access to voluntary assisted dying may decide at any time not to take any further step in relation to access to voluntary assisted dying.

(2) The person may express their decision verbally or by gestures or other means of communication available to the person.

Division 6 Reporting of voluntary assisted dying

37 First medical practitioner report to Board about voluntary assisted dying

(1) The first medical practitioner must, within 14 days of providing access to voluntary assisted dying to a person, give the Board a report about the voluntary assisted dying in the approved form.

(2) The report must include a copy of the following—

(a) a record of the first request;

(b) the first assessment report;

(c) any second assessment report;

(d) the second request;

(e) a record of the final request;

(f) the witness's certification of the final request; and

(g) any other information required by regulation.

Part 5 Participation in voluntary assisted dying is voluntary

38 Registered health practitioners with conscientious objection

(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—

(a) provide information about voluntary assisted dying;
(b) participate in any part of the request and assessment process for voluntary assisted dying;
(c) supply, prescribe or administer voluntary assisted dying medication;
(d) be present during voluntary assisted dying.

(2) A registered medical practitioner exercising a conscientious objection in accordance with subsection (1) must disclose the practitioner's conscientious objection to the person and offer to refer the person to another practitioner or entity in accordance with subsection (3).

(3) If requested, the registered medical practitioner must refer the person, or transfer their care, to—
(a) another registered medical practitioner who, in the referring registered medical practitioner's belief, does not have a conscientious objection to voluntary assisted dying; or
(b) an entity at or through which, in the referring registered medical practitioner's belief, the person will have access to another registered medical practitioner who does not have a conscientious objection to voluntary assisted dying.

Note—

Subsection (3)(b) provides for referral of a person requesting access to voluntary assisted dying to be to an entity through which the person will have access to another registered medical practitioner who does not have a conscientious objection to voluntary assisted dying. This would permit a registered medical practitioner to provide the person requesting access to voluntary assisted dying with contact details of an entity which can provide information that will facilitate access to voluntary assisted dying.

39 Entity may refuse access to voluntary assisted dying within its facility

(1) This section applies to an entity, other than a natural person, who provides a health service, residential service or professional care service.

(2) An entity may refuse access to voluntary assisted dying, including assessments in relation to voluntary assisted dying, within its facility.

(3) Where a person who requests access to voluntary assisted dying is being cared for or resides in a facility of an entity that refuses access to voluntary assisted dying within the facility, the entity must—
(a) inform the person of the entity's decision to refuse access to voluntary assisted dying within its facility;
(b) offer to arrange a transfer of the care or residence of the person to an entity at which, in the entity's belief, access to voluntary assisted dying can be

provided by a registered medical practitioner who does not have a conscientious objection to voluntary assisted dying; and

(c) take reasonable steps to facilitate that transfer.

Part 6 Voluntary Assisted Dying Review Board

This Part of the Bill is not outlined in detail because legislative provisions for statutory boards vary by jurisdiction. However, the model outlined in the Voluntary Assisted Dying Act 2017 *(Vic) is generally supported. Specific matters that the Bill should address include:*

- *establishing the Voluntary Assisted Dying Review Board and its functions, along with the powers needed to undertake those functions;*
- *determining the composition of the Board and its procedures and staffing; and*
- *the Board's monitoring role.*

In relation to the Board's monitoring role, this would need to be both for individual cases and the system as a whole. In terms of individual cases, the Board should conduct a post-hoc review of each case of voluntary assisted dying to ensure that it complied with the requirements of the Act and this duty should be specified in the Act. The Board's powers should include the ability to request further information beyond that provided by the first medical practitioner if it considers this necessary. If there are concerns about compliance, the Board should be empowered to refer that case to entities such as the police, the Coroner and the Australian Health Practitioner Regulation Agency.

The Board's monitoring role also requires oversight of the system as a whole to ensure that it is functioning as intended and to make recommendations for improvement where needed. To support this, the Board would collect and analyse data provided to it by registered medical practitioners in their reporting. It may also need to collect further information to undertake this overall monitoring role. This data (in de-identified form) should also be made publicly available for community scrutiny in the form of annual reports tabled in Parliament. The Board should also have power to undertake educational initiatives for registered health practitioners and the wider community to promote understanding of, and compliance with, the requirements of the Act.

Part 7 Protections from liability for acting in accordance with Act

40 Protection from criminal liability of person who assists or facilitates request for or access to voluntary assisted dying

A person who in good faith does something or fails to do something—

(a) that assists or facilitates any other person who the person believes on reasonable grounds is requesting access to or is accessing voluntary assisted dying in accordance with this Act; and

(b) that apart from this section, would constitute an offence at common law or under any other enactment—

does not commit the offence.

41 No liability for registered health practitioner who acts in accordance with Act

(1) A registered health practitioner who, in good faith and without negligence, acts under this Act believing on reasonable grounds that the act is in accordance with this Act is not in respect of that act—

(a) guilty of an offence; or

(b) liable for unprofessional conduct or professional misconduct; or

(c) liable in any civil proceeding; or

(d) liable for contravention of any code of conduct.

(2) To remove any doubt, subsection (1) includes when a registered health practitioner exercises a conscientious objection to voluntary assisted dying provided that occurs in accordance with this Act.

42 No liability for registered health practitioner present after voluntary assisted dying medication administered

(1) A registered health practitioner who, in good faith, does not administer life saving or life sustaining medical treatment to a person who has not requested it, and believes on reasonable grounds that the person is dying after being administered or self-administering voluntary assisted dying medication in accordance with this Act, is not, in respect of that omission to act—

(a) guilty of an offence; or

(b) liable for unprofessional conduct or professional misconduct; or

(c) liable in any civil proceeding; or

(d) liable for contravention of any code of conduct.

(2) This section does not prevent a registered health practitioner from providing medical treatment for the purpose of ensuring the person's comfort.

43 Section [insert number] of the [insert relevant criminal law Act or Code] does not apply

Section [insert number] of the [insert relevant criminal law Act or Code] does not apply to a person who knows or believes on reasonable grounds that a person is accessing voluntary assisted dying in accordance with this Act.

This provision is based on section 82 of the Voluntary Assisted Dying Act 2017 *(Vic) which states that section 463B of the* Crimes Act 1958 *(Vic) does not apply. Section 463B justifies the use of force to prevent a suicide. This means that the proposed provision in this Bill will only be needed in jurisdictions where a provision like section 463B exists authorising the prevention of a suicide.*

Part 8 Offences

The approach to and wording of offence provisions varies by jurisdiction so the below are illustrative of the standard type of offences included in Voluntary Assisted Dying Bills. Other offences may be added or the below proposed offences modified depending on how the criminal law is regulated by jurisdiction.

44 Inducing another person to request access to voluntary assisted dying

A person who, by dishonesty or undue influence, induces another to make a request for access to voluntary assisted dying is guilty of a crime.

Maximum penalty— [insert]

45 Inducing another person to access voluntary assisted dying

A person who, by dishonesty or undue influence, induces another to self-administer voluntary assisted dying medication or induces another to request

that a registered medical practitioner administer that medication is guilty of a crime.

Maximum penalty— [insert]

46 False or misleading statements

A person who knowingly makes a false or misleading statement in, or in relation to, a request for access to voluntary assisted dying is guilty of a crime.

Maximum penalty— [insert]

47 Failing to report to Board

A registered medical practitioner who fails to report to the Board as required by this Act is guilty of a crime.

Maximum penalty— [insert]

Part 9 Miscellaneous

The approach to the Miscellaneous Part of the Bill will also vary by jurisdiction. Specific matters that the Bill could or should address include:

- *a requirement to review the Act's operation after 5 years;*
- *provisions regulating the use of interpreters;*
- *approval of training for registered medical practitioners by the relevant government department;*
- *confidentiality duties for those with access to personal information in the course of administering the Act;*
- *the recording of the death on the Register of Births, Deaths and Marriages;*
- *that the death is not a 'reportable death' for coronial investigation;*
- *the effect that the Act has on wills, insurance policies, contracts and other statutes;*
- *forfeiture provisions in relation to a person's estate where another person is found guilty of an offence under this Act; and*
- *the making of regulations under the Act.*

Consequential or transitional provisions will also vary by jurisdiction and so have not been included in the Bill

Schedule 1 Dictionary

Only a limited number of important terms used in this Bill are defined below as jurisdictions vary in their approaches to definitions sections. Variability also arises because jurisdictions have:

- *different acts interpretation legislation which can define commonly used legislative terms in different ways; and*
- *different local health legislation from which definitions for Voluntary Assisted Dying Bills are sometimes taken.*

approved assessment training means training approved by the [insert relevant government department official] under section 14.

Board means the Voluntary Assisted Dying Review Board.

decision-making capacity has the meaning set out in section 7.

eligibility criteria means the criteria set out in section 9 and clarified in section 10.

eligibility determination has the meaning set out in section 25(3).

family member of a person means the person's spouse or domestic partner, parent, grandparent, sibling, child or grandchild.

final request means a request from a person for access to voluntary assisted dying to a registered medical practitioner in accordance with section 30.

first assessment means an assessment undertaken in accordance with Part 3 Division 2.

first medical practitioner means the registered medical practitioner—

(a) who receives a first request from a person and undertakes a first assessment; or

(b) to whom the role is transferred in accordance with section 26.

first request means a request from a person for access to voluntary assisted dying to a registered medical practitioner in accordance with section 11.

ineligible witness has the meaning set out in section 28(2).

medical condition means a medical condition whether caused by disease, illness or injury.

practitioner administration has the meaning set out in section 6.

professional care services means any of the following provided to another person under a contract of employment or a contract for services—

(a) support or assistance;

(b) special or personal care;

(c) a disability service within the meaning of [the Disability Act].

registered health practitioner means a person registered under the *Health Practitioner Regulation National Law* to practise a health profession other than as a student.

registered medical practitioner means a person registered under the *Health Practitioner Regulation National Law* to practise in the medical profession other than as a student.

request and assessment process means, in respect of a person, the making or the conducting of the following—

(a) a first request;

(b) a first assessment;

(c) a second assessment;

(d) a second request;

(e) a final request.

second assessment means an assessment undertaken in accordance with Part 3 Division 3.

second medical practitioner means a registered medical practitioner who receives a referral from the first medical practitioner under section 19 and undertakes a second assessment.

second request means a request from a person for access to voluntary assisted dying to a registered medical practitioner in accordance with section 27.

self-administration has the meaning set out in section 6.

special or personal care means—

(a) assistance with one or more of the following—

(i) bathing, showering or personal hygiene;

(ii) toileting;

(iii) dressing or undressing;

(iv) meals; or

(b) assistance for persons with mobility problems; or

(c) assistance for persons who are mobile but require some form supervision or assistance; or

(d) assistance or supervision in administering medicine; or

(e) the provision of substantial emotional support.

voluntary assisted dying has the meaning set out in section 6.

voluntary assisted dying medication means a poison or controlled substance or a drug of dependence prescribed by the first medical practitioner for the purpose of causing a person's death.

Explanatory Notes for Voluntary Assisted Dying Bill 2019

These Explanatory Notes explain the approach taken to drafting the Voluntary Assisted Dying Bill 2019. This includes identifying the values and principles that underpin the Bill, the major policy positions taken, and the approach adopted in relation to drafting style. These Notes are different from the traditional Explanatory Notes which usually explain each provision sequentially. While some specific provisions are explained further below, this document is primarily aimed at explaining the Bill at a more global level. A diagram providing an overview of the process proposed by the Bill for accessing voluntary assisted dying is included in the Appendix.

Values underpinning the Bill

The values underpinning the design of this Bill are those outlined and explained in the book chapter 'Assisted Dying in Australia: A Values-based Model for Reform' in the book *Tensions and Traumas in Health Law*.[1] Those values are:

- Life;
- Autonomy;
- Freedom of conscience;
- Equality;
- Rule of law;
- Protecting the vulnerable; and
- Reducing human suffering.

Added to this list which underpinned the design of the Bill is the concept of safe and high-quality care.[2] The proposed model situates voluntary assisted dying as part of health care and as being provided within the health system. Accordingly, voluntary assisted dying must be provided in a way that is safe and of high-quality like all other health care.

[1] Lindy Willmott and Ben White, 'Assisted Dying in Australia: A Values-based Model for Reform' in Ian Freckelton and Kerry Peterson, *Tensions and Traumas in Health Law* (Federation Press, 2017).

[2] For a discussion of the elements of safe and high-quality end of life care, see Australian Commission on Safety and Quality in Health Care, *National consensus statement: Essential elements for safe and high-quality end-of-life care*, available at: https://www.safetyandquality.gov.au/wp-content/uploads/2015/05/National-Consensus-Statement-Essential-Elements-forsafe-high-quality-end-of-life-care.pdf.

Position on key overarching policy issues

Many of the key policy decisions are explained in the book chapter 'A Values-based Model for Reform',[3] and so will not be repeated at length below. However, drafting a Bill necessarily requires more detailed decisions to be made about how a voluntary assisted dying system should operate and some of these other overarching positions will be briefly explained.

- Clause 6 outlines that voluntary assisted dying includes both of what has historically been called voluntary euthanasia (called practitioner administration in the Bill) and physician assisted suicide (called self-administration in the Bill). We do not endorse the Victorian approach of having self-administration as the default and primary method of voluntary assisted dying. Providing a choice of practitioner administration and self-administration for a person requesting access to voluntary assisted dying promotes the value of autonomy. Where both options are available internationally, people overwhelmingly choose practitioner administration.[4] Also, while the evidence base is limited, that which exists suggests that practitioner administration is safer than self-administration with fewer complications.[5]

- Clause 6 also explains that voluntary assisted dying must occur under medical supervision. This will clearly occur with practitioner administration when the registered medical practitioner administers the voluntary assisted dying medication. In relation to self-administration, being under the supervision of a registered medical practitioner means that the registered medical practitioner will be present while the person self-administers the voluntary assisted dying medication. We anticipate this could be done unobtrusively by the medical practitioner so as to respect the person's wishes about how their death occurs.

  We acknowledge that such an approach has disadvantages, including: access implications for persons living in rural and remote areas;[6] burdens on medical practitioners to supervise voluntary assisted dying; and some limits on a person's autonomy in terms of timing of their death and who is present. In addition to there

[3] Lindy Willmott and Ben White, 'Assisted Dying in Australia: A Values-based Model for Reform' in Ian Freckelton and Kerry Peterson, *Tensions and Traumas in Health Law* (Federation Press, 2017).
[4] For example, in the Netherlands in 2017, of 6585 cases reported to Euthanasia Review Committees, 6306 were of euthanasia, 250 were of assisted suicide, and 29 cases involved a combination of both: Regional Euthanasia Review Committees, *Annual Report 2017* (March 2018) 10. In Canada, drawing on the last two federal government reports covering the period from 1 January 2017 to 31 October 2018, of the 4575 medically assisted deaths reported, only 2 were self-administered: Health Canada, *Fourth Interim Report on Medical Assistance in Dying Canada* (April 2019) 5 (note: this does not include data from some provinces as outlined in the report).
[5] Ezekiel Emanuel, Bregje Onwuteaka-Philipsen, John Urwin and Joachim Cohen, 'Attitudes and practices of euthanasia and physician assisted suicide in the United States, Canada and Europe' (2016) 316(1) *Journal of American Medical Association* 79, 86.
[6] While we have not proposed this in the Bill, permitting nurse practitioners to provide voluntary assisted dying has been one response to address access issues in Canada.

being ways to address these concerns, our view is that the policy benefits of the proposed approach outweigh these disadvantages for three main reasons:

1. These disadvantages only arise in relation to self-administration as by definition practitioner administration is always medically supervised. Given that where choice is available, practitioner administration is overwhelmingly chosen, these disadvantages are only likely to arise in the small number of voluntary assisted dying cases where a person specifically wants to self-administer.
2. The safety and quality of voluntary assisted dying for the person should be prioritised. This is enhanced by medical supervision.
3. The voluntary assisted dying medication will be safely managed as it will always be in the possession or under the direct supervision of a registered medical practitioner. This also means that complex provisions relating to the medication's collection, storage and disposal, such as those in the *Voluntary Assisted Dying Act 2017* (Vic), are not required. Registered medical practitioners are subject to existing regulations in relation to the dangerous medications and the Bill provides scope for regulations to address this further if needed.

- The starting point for drafting the eligibility criteria in clause 9 was broadly the approach in the *Voluntary Assisted Dying Act 2017* (Vic). While there may be cases that many regard as appropriate to allow access to voluntary assisted dying which may fall outside that legislation, eligibility criteria necessarily involve a basis for determining access and the Victorian model is a defensible approach. We have, however, departed from this model in three important respects.

  The first is that although the Bill requires a person to have a medical condition that will cause their death, it does not impose a time limit within which a person is expected to die. We adopt this approach because a time limit is arbitrary. While a secondary consideration, not imposing a time limit avoids a registered medical practitioner from having to engage in the difficult task of determining prognosis and timing of death. The Western Australian Joint Select Committee on End of Life Choices has also expressed reservations about requiring a specified time period until expected death.[7]

  The second difference is that we have not required that a person be *both* (a) ordinarily resident in a State *and* (b) ordinarily resident in a State for a period of at least 12 months prior to a first request. The Bill only requires (a) as this is sufficient to achieve the policy goal of preventing non-residents having access to voluntary assisted dying in another State. The additional time-based requirement of (b) creates a further hurdle to access voluntary assisted dying for otherwise eligible persons and is unnecessary to prevent cross-border requests.

[7] Joint Select Committee on End of Life Choices, 40th Parliament of Western Australia, *My Life, My Choice* (Report 1, August 2018) 199, 213.

The third difference is in relation to the suffering requirement. To be eligible under the Bill, the medical condition must be causing the person 'intolerable and enduring' suffering. This is a higher threshold than under the Victorian Act but is consistent with some international approaches.

- Clauses 38 and 39 protect conscientious objection by registered health practitioners in relation to voluntary assisted dying and the ability of entities providing care and residential services to refuse access to voluntary assisted dying within their facilities. However, both provisions also create mechanisms that reflect the balance normally struck in medicine that respects conscience but values autonomy and equality in ensuring a person still has effective access to a lawful health service. As outlined in the Note at the end of Clause 38, subclause (3) is drafted sufficiently broadly to allow the person requesting access to voluntary assisted dying to be provided with contact details of an entity which can provide information that will facilitate that access to voluntary assisted dying. This provides an option that some registered medical practitioners might regard as morally preferable. This would, however, be dependent on the existence of an entity to provide such information enabling access to voluntary assisted dying.

Approach to drafting

Other legislation and Bills consulted

We adopted or adapted the drafting of the *Voluntary Assisted Dying Act 2017* (Vic) where our policy position was the same or similar, recognising that this Act had been passed already by an Australian Parliament. This includes retaining some wording that may otherwise be regarded as complex.

We also consulted a range of other sources in drafting this Bill. They include other recent Australian Bills[8] that were close to passing through the relevant Chamber in which they were introduced such as the Voluntary Assisted Dying Bill 2013 (Tas), the Death with Dignity Bill 2016 (SA) and the Voluntary Assisted Dying Bill 2017 (NSW) as well as the *Rights of the Terminally Ill Act 1995* (NT) which was in force for a 9 month period in the mid-1990s. Legislation regulating voluntary assisted dying overseas was also consulted but we note that drafting styles are quite different in some of these countries, especially in European civil law jurisdictions.

[8] See also the account of Australian Bills in Lindy Willmott, Ben White, Christopher Stackpoole, Kelly Purser and Andrew McGee, '(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics' (2016) 39(1) *University of New South Wales Law Journal* 1, and updated in Ben White and Lindy Willmott, 'Future of assisted dying reform in Australia' (2018) 42 *Australian Health Review* 616.

Acknowledging jurisdictional drafting styles and different laws

We recognise that legislative drafting is a specific skill and that different jurisdictions have different drafting conventions. Accordingly, our approach in drafting this Bill was to make the policy position clear, being aware that it would be revised in line with local drafting guidelines. We also acknowledge that there are alternative drafting techniques to present the policy framework proposed in this Bill.

Preference for brevity

Our view is that the Bill should be as short and simple as practicable. A decision was made therefore that the Bill should focus on establishing the wider legal framework for voluntary assisted dying, but not be the source of detailed procedural steps about how it is provided. In part, this is because unnecessary length and complexity can impede a clear explanation on the proposed policy position.

However, we favour this approach predominantly because of our view about the appropriate role of legislation within a regulatory framework. Voluntary assisted dying should be governed by a suite of regulatory tools including legislation, regulations, policies and guidelines. We consider the appropriate function for legislation is to establish the legal framework for these decisions, but that the detailed procedural guidance is better addressed in regulations, policies and guidelines.

This is one way in which we have departed from the *Voluntary Assisted Dying Act 2017* (Vic), which is very prescriptive in its approach. We also note this means that omitting a provision in the Victorian Act from our Bill does not mean we consider that the relevant issue should not be regulated. It may simply reflect that such a matter is more appropriately dealt with in regulations or policies and guidelines. It may also be that some matters are already adequately dealt with either by existing legislation or established protocols in the health system within which voluntary assisted dying will occur.

Specific policy issues explained

Earlier in these Explanatory Notes, some key overarching policy issues were explained. Here we address a series of smaller and specific policy decisions that have been made in the course of drafting the Bill.

Some of the below discussion explains why certain safeguards in the *Voluntary Assisted Dying Act 2017* (Vic) have not been adopted. A global point to make here is that the Victorian Act is very unusual in its detail and complexity when compared with international models, the *Rights of the Terminally Ill Act 1997* (NT) and the other Australian Bills consulted. As mentioned above, some of this detailed procedural guidance in the Victorian Act is better placed in regulations, policies or guidelines.

Further, some of the Victorian Act's safeguards do not add substantive value to safeguarding vulnerable persons, may impose undue burden on persons requesting

access to voluntary assisted dying and the registered health practitioners assisting them, and are inconsistent with the overarching values that we consider should guide the law in this area. For these reasons, we concluded that their inclusion in the Bill was not justified. Instead, we have focused on safeguards that we consider are needed to ensure the voluntary assisted dying system operates as intended, and have drawn on approaches in other Australian Bills and international models.

- The Bill does not contain a prohibition on registered health practitioners initiating discussions about voluntary assisted dying with their patients as imposed by section 8 of the *Voluntary Assisted Dying Act 2017* (Vic). For reasons expanded on elsewhere,[9] this impedes the frank discussions needed for safe and high-quality end-of-life care. This also reflects the approach taken by the Western Australian Joint Select Committee on End of Life Choices.[10]

- The Bill does not contain a requirement to obtain a permit from the relevant government department prior to providing access to voluntary assisted dying as required by Part 4 of the *Voluntary Assisted Dying Act 2017* (Vic). This requirement is unnecessarily bureaucratic, delays access to voluntary assisted dying, and is of limited utility as a safeguard as it is only likely to be a review of the relevant documentation. The Western Australian Joint Select Committee on End of Life Choices has also recommended against requiring a permit.[11]

- The wording of clause 13(3) of the Bill prescribing the required qualifications and experience of one of the registered medical practitioners is intentionally different from section 10(3) of the *Voluntary Assisted Dying Act 2017* (Vic). Under the Victorian Act, one of the registered medical practitioners must be a *medical specialist in the person's disease, illness or medical condition* (emphasis added). The interpretation of this provision is that General Practitioners and Palliative Care Physicians would not qualify as having this 'expertise and experience'. The proposed wording in this Bill is instead that either of the registered medical practitioners 'must have relevant experience in treating or managing the medical condition expected to cause the death of the person being assessed'. While retaining the same policy goal that at least one of the registered medical practitioners has particular experience with the person's medical condition, this wider wording is intended to reflect that General Practitioners and Palliative Care Physicians may have such experience.

[9] See for example, Carolyn Johnston and James Cameron, 'Discussing Voluntary Assisted Dying' (2018) 26 *Journal of Law and Medicine* 454.
[10] Joint Select Committee on End of Life Choices, 40th Parliament of Western Australia, *My Life, My Choice* (Report 1, August 2018) 199-200. Note also that the Ministerial Expert Panel on Voluntary Assisted Dying raises this as an issue for consideration in its discussion paper: Ministerial Expert Panel on Voluntary Assisted Dying, *Discussion Paper*, Government of Western Australia (2019) 23.
[11] Joint Select Committee on End of Life Choices, 40th Parliament of Western Australia, *My Life, My Choice* (Report 1, August 2018) 201. Note also that the Ministerial Expert Panel on Voluntary Assisted Dying raises this as an issue for consideration in its discussion paper: Ministerial Expert Panel on Voluntary Assisted Dying, *Discussion Paper*, Government of Western Australia (2019) 35.

- This Bill does not contain additional provisions in relation to notifications to the Australian Health Practitioner Regulation Agency as the existing law requiring mandatory notifications and permitting voluntary notifications is considered to be adequate.[12]

- This Bill does not include specific provisions about intervention in voluntary assisted dying decisions by the courts or tribunals. This is because these are primarily clinical matters for the first and second medical practitioner to assess. An exception is in relation to decision-making capacity. Depending on local legislation, guardianship or civil and administrative tribunals may have jurisdiction to adjudicate a person's decision-making capacity, and if not, it may be appropriate to specifically grant such jurisdiction to a tribunal in relation to capacity. Finally, should exceptional circumstances warrant wider judicial scrutiny, Supreme Courts have been willing to consider end-of-life issues in appropriate circumstances when approached for guidance.[13]

- Clause 2 of the Bill requires an 18-month delay before the Act comes into force to permit time for implementation as has occurred in Victoria.

- Clause 5 sets out the Bill's principles, which are based on the values outlined above. We note for completeness, however, that the value of respecting the rule of law does not appear in this list of principles. While it remains an appropriate value to inform the design and implementation of voluntary assisted dying laws, it is not as relevant in guiding a person or other entity who is exercising a power or performing a function or duty under the Act.

- Definitions of capacity or decision-making capacity (defined in clause 7 of the Bill) vary by jurisdiction and so the Bill's approach may need to be adjusted to reflect this. For example, Queensland includes the requirement for the person to have 'freely and voluntarily' made the decision as part of the capacity test in its guardianship legislation.[14] In the proposed model, this requirement is addressed as part of the eligibility criteria.

- Clause 33(3) contains the safeguard that a person's final request for voluntary assisted dying must occur immediately prior to access. This ensures it is a contemporaneous request by a person with capacity who is acting freely and voluntarily in requesting access to voluntary assisted dying.

[12] See for example part 8, divisions 2 and 3 of the *Health Practitioner Regulation National Law* (Qld). Note that the provisions in part 7, division 1 of the *Voluntary Assisted Dying Act 2017* (Vic) closely resemble those in part 8, divisions 2 and 3 in the *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic).
[13] See for example, *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84; *H Ltd v J* (2010) 107 SASR 352.
[14] See *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of 'capacity') and *Powers of Attorney Act 1998* (Qld) sch 3 (definition of 'capacity').

- As noted in the Bill, the criminal law of each jurisdiction varies and accordingly, Parts 7 and 8 will need to be considered in light of local laws. This would include determining the appropriate reach of existing criminal law offences, such as those relating to assisting suicide, and how they would interact with the Bill including its proposed protections from criminal liability.