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Voluntary Assisted Dying – International Update and new Victorian Legislation

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Mini-Review

Voluntary Assisted Dying – International Update and new Victorian Legislation

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Overview

In most countries, euthanasia and any form of assistance given to hasten the death of a person, even at their request, is illegal.

However, there has been a growing recognition of a person's right to choose to die when faced with unbearable suffering from a terminal, incurable and untreatable condition.

In June 2016, a Parliamentary Committee in Victoria Australia tabled a report in the Victoria Parliament entitled: Inquiry into End of Life Choices. The Committee recommended legislation for an Assisted Dying Framework, which would give some terminally ill patients the right to choose death.

The Committee made 49 recommendations, significantly 48 related to palliative care and advance care planning. The 49th recommendation outlined a proposal for legalising voluntary assisted dying in Victoria.

Following release of that Committee's very comprehensive report, an expert panel (The Voluntary Assisted Dying Ministerial Advisory Panel) (**Panel**) was appointed to conduct further consultation and inquiries. The Panel released its recommendations which dealt in detail with the implementation of legislation which was finally passed in the Victorian Parliament in November 2017. Before dealing with this legislation in some detail, I will give a brief overview of the situation internationally concerning legislated assisted dying.

Background

In developed nations, following significant advances in diagnostic medicine and health care generally, we are confronted with:

- An aging population; and
- Death following multiple complex pathologies and chronic and degenerative disease.

Indeed, in contrast to death even as recent as 100 years ago, dying has now been turned into a medical experience.

It is now well recognised that even with the best medicine and care available, severe physical and associated mental pain and suffering cannot always be relieved.

Consequently, some people are dying terribly at the end of a terminal illness. Furthermore, artificial life support, complex surgeries and drug

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therapies may sometimes be seen to be more directed toward prolonging life as distinct from pain relief and preserving a quality of life.

In the absence of a legal framework which accommodates voluntary euthanasia and physician assisted dying, the choices facing a patient who has an incurable terminal illness and suffering unbearable physical pain and/or mental anguish are limited and can be highly problematic:

- Patients can refuse treatment, if they are still capable of communication and mentally competent to do so;
- Medical treatment can be withdrawn or withheld;
- Continuous palliative sedation can be administered; or
- Patients can resort to suicide.

Generally, the expressions, 'Euthanasia' and 'Assisted Dying' are used in the following ways:
Euthanasia: Intentional termination of life by someone other than the person concerned, at his or her request.

Assisted Dying: Intentionally helping a patient to terminate his or her life at the patient's request.

Currently, specific legislation permitting a prescribed euthanasia and/or assisted dying only exists in the following countries:

Benelux countries

The Netherlands,[1] Belgium,[2] and Luxembourg,[3] each allow both euthanasia and assisted dying in circumstances of incurable conditions and unbearable suffering.

The Netherlands[4]

The main features in the regimes operating in the Benelux countries are largely reflected in the Dutch legislation: *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.*

This Act allows for both doctor administered and self-administered assisted dying, which will usually take place in the patient's home. Doctors typically administer a barbiturate intravenously, which puts the patient to sleep. This is followed by injection of a lethal neuromuscular blocker.

Eligibility and safeguards under the Netherlands regime

Eligibility and safeguards are based on a model requiring 'due care' on the part of the doctor assisting a patient to die. Assisted dying is legal only if the 'due care' criteria established in the Act are met. It is not a quick or easy process.

Patients have no absolute right to euthanasia and doctors no absolute duty to perform it.
The attending doctor must:

- be satisfied that the patient has made a voluntary and well-considered request;
- be satisfied that the patient's suffering was unbearable, with no prospect of improvement;
- have informed the patient about his or her situation and his or her prospects;
- have concluded, together with the patient, that there is no reasonable alternative, in light of the patient's situation;
- have consulted at least one other independent doctor who must have seen the patient and given a written opinion on the due care criteria referred to above; and
- have terminated the patient's life or provided assistance with suicide with due medical care and attention.

1 2002.
2 2002.
3 2009.
4 Refer Netherlands Government web site.

In addition to the 'due care' criteria described above, the framework under the Act includes the following elements:

1. generally accessible by adults aged 18 and over, but children aged 16–18 can also access assisted dying with parental consultation, as can children aged 12–16 with parental consent;
2. it applies not only to the terminally ill but also the chronically ill and people with mental suffering;
3. there is no need for mental competency at the time of a patient's death — a doctor may provide assisted dying to a patient 16 years or older, where they made the request in writing prior to losing competence (an Advance Euthanasia Directive);
4. there is no mandatory mental health assessment, but if a doctor determines that a patient's judgment may be impaired by poor mental health, theymay decide the request does not meet the 'well-considered' part of the due care criteria;
5. there is no residency requirement; and
6. there is no mention of a specified cooling-off period, but the doctor must be satisfied that a request is 'well-considered'.

1. Advance directives

Additionally, a patient can request doctor-administered assisted dying through an advance euthanasia directive. Some people feel that they would wish euthanasia to be performed if they ever find themselves in a situation which they would now regard as unbearable and offering no prospect of improvement. An advance directive may define the precise circumstances in which the patient would wish euthanasia to be performed. The document constitutes a request to the physician and must contain a clear and unambiguous expression of the patient's wishes.

2. Do not resuscitate medallion

A person may wear a DNR (do not resuscitate) medallion which indicates that the wearer does not want to be resuscitated in a medical emergency. The wearer's name, date of birth, signature and photograph are engraved on the medallion, so that it fulfils all the statutory requirements for an advance directive.

3. Euthanasia and minors

Minors may themselves request euthanasia from the age of 12, although the consent of the parents or guardian is mandatory until they reach the age of 16. Sixteen and seventeen-year-olds do not need parental consent in principle, but their parents must be involved in the decision-making process. From the age of 18, young people have the right to request euthanasia without parental involvement.

4. Euthanasia and patients with dementia

For some people, the prospect of ever suffering from dementia may be sufficient reason to make an advance directive (living will). This can either be drawn up independently or discussed first with the family doctor. A physician can perform euthanasia on a patient with dementia only if such a directive exists, if statutory care is taken and if, in his opinion, the patient is experiencing unbearable suffering with no prospect of improvement.

Reporting and Oversight in The Netherlands

Where assisted dying occurs, doctors are required to report the death to the municipal pathologist, who then notifies a Regional Euthanasia Review Committee. These committees, which consist of a medical doctor, an ethicist and a legal expert, assess whether the doctor has fulfilled the statutory due care criteria. If the committee finds that the doctor has not acted in accordance with the due care criteria, it reports its findings to the Public Prosecution Service and the Regional Health Inspector. These two agencies then consider what action, if any, should be taken against the doctor.

Penalties vary but may be as much as 12 years in prison for euthanasia and up to 3 years for assisting suicide.If the committee concludes that the criteria have been met, the doctor is exempt from criminal liability and no further action is taken.

Significantly, two thirds of euthanasia requests are declined and patients will be diverted to more

suitable treatment programs or palliative care.

Belgium became the second EU country to legalise euthanasia with the enactment of the *Belgium Act on Euthanasia* (28 May 2002). The Act allows adults who are in a 'futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated' to request voluntary euthanasia. Doctors who practise euthanasia commit no offence if prescribed conditions and procedures have been followed:

- the patient has legal capacity;
- the request is made voluntarily and repeatedly with no external pressure; and
- the patient's medical state is hopeless with constant, unbearable pain or mental suffering which cannot be relieved.

The Act does not cover assisted suicide (only doctor-administered assisted dying) although the Belgian Federal oversight body, *Commission Federale de Controle et Evaluation* acknowledges that some cases of self-administered assisted dying are covered by the law. Similar to the Netherlands, a patient can request doctor-administered assisted dying through an advance directive. Eligibility for euthanasia is not confined to those experiencing unbearable physical suffering; it extends to unbearable mental suffering as well.

In February 2014, Belgium made international headlines when it became the first country in the world to allow euthanasia for children of any age. Under the new law a child can request euthanasia if they are 'in a hopeless medical situation of constant and unbearable suffering that cannot be eased and which will cause death in the short term'.

Luxembourg became the third European country to legalise euthanasia with the passing in March 2009 of *Euthanasia and Assisted Suicide* (Lux). The law permits euthanasia and assisted suicide in relation to those with incurable conditions (requirements include repeated requests and the consent of two doctors and an expert panel). Doctors who provide euthanasia and assisted suicides do not face 'penal sanctions' or civil suits for damages and interest.

In **Switzerland**,[5] Article 115 of the Swiss *Criminal Code* (1994) states that inciting or assisting suicide is a punishable offence, however it is only a crime if it is undertaken out of self-interested motivations. This has the effect of 'legalising' assisted suicide in Switzerland without having a specific euthanasia law in place.

In Switzerland, assistance is provided almost exclusively by a range of not-for-profit right to die organisations (which can involve non-physicians). However, it is the patient who must self-administer the 'lethal dose'. All forms of active euthanasia (i.e. doctor-administered assisted dying) remain prohibited in Switzerland.

Doctors prescribe sodium pentobarbital but the assistance and counselling is given through one of three private voluntary right to die organizations, which each have their own criteria as to eligibility, but do not limit the option to the terminally ill.

Police are always informed. But only one group, DIGNITAS, in Zurich, will accept foreigners who are either terminal ill, or severely mentally ill, or clinically depressed beyond treatment.

American Continent

Active euthanasia remains illegal in most of the United States. There is no Federal legislation.

Assisted suicide is legal in the states of Oregon,[6] Washington State,[7] Vermont,[8] Colorado[9] and California.[10]

The State of Montana has no specific legislation but doctor assisted dying is permitted by court deci-

5 1940.
6 1997.
7 2009.
8 2013.
9 2016.
10 2015.

sion.[11]

In the relevant USA States, assisted dying is only available in cases of terminal illness and each State has largely adopted the Oregon model, which is in turn the basis of the Victorian model, which I will come to shortly.

In Oregon, approximately 30 per cent of people who are prescribed a lethal drug under the assisted dying framework do not take it. The evidence shows that simply knowing there is an option of assisted dying can be immensely beneficial to a person nearing the end of life, whether or not they choose to use it.

The terminal illness criterion in the regimes operating on the American continent effectively excludes people suffering from non-terminal illnesses, which may nevertheless be extremely debilitating, such as locked-in-syndrome, multiple sclerosis, muscular dystrophy, severe paralysis, severe degenerative nerve conditions and people with serious mental health problems. All of these types of conditions, may qualify in the Benelux countries if they otherwise satisfy the criteria for an unbearable and incurable condition.

The process of reporting applications and deaths varies by state. Only those states where physician-assisted suicide is mandated by law, have a reporting process.[12]

In **District of Colombia**;[13] physician assisted dying was legalised in February 2017.

The **Canadian Supreme Court** took a very interesting approach. In 2015, the Supreme Court of Canada[14] held that Canadians have a right to physician assisted suicide and that its criminalisation[15] was invalid on the basis that it was in breach of the right to life, liberty and security, of the person in article 7 of the *Charter of Rights and Freedoms* in the Canadian Constitution

The Supreme Court declared the infringing sections of the *Criminal Code* void:

> insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 'Irremediable', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.

The Court held that a prohibition on physician assisted suicide:

1) could deprive an individual of their life by forcing them to prematurely take their own life, fearing that they would later be incapable of doing so when their suffering was intolerable;
2) denied people the right to make decisions concerning their bodily integrity and medical care and thus infringes on their liberty; and
3) leaves people to endure intolerable suffering, which impinges on their security.

The Court further held that a permissive regime, with properly designed and administrative safeguards, was capable of protecting vulnerable people from abuse and error, making absolute prohibition unjustifiable.

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11 A Montana Supreme Court ruling in the case Baxter v. Montana asserts that the Rights of the Terminally Ill Act protects a physician, who prescribes an aid in dying drug, from liability.

12 **Oregon -** Since its enactment in 1997, there has been a steady increase in both prescription recipients and the number of deaths. According to the 2016 Data Summary, as of January 23, 2017, prescriptions have been written for 1,749 people, and 1,127 patients have died from ingesting the drugs that were legally prescribed to them under the law.
Washington - According to the 2015 annual report, since 2009 prescriptions have been written for 938 people, and there have been 917 reported deaths.
Vermont - As of June 8, 2017, physician reporting forms have been completed for 53 people, according to the Department of Health.

13 February 2017.

14 *Carter v Canada (Attorney General)* 2015 SCC5.

15 as set out in found that the prohibition on physician-assisted death in place in Canada (in ss 14 and 241(b) of the Canadian *Criminal Code*).

Since the Supreme Court's decision, the Canadian governments have been exploring options for legalising and regulating physician-assisted dying. A Special Joint Committee on Physician-Assisted Dying released its report in February 2016, recommending a legislative framework which would regulate 'medical assistance in dying' by imposing both substantive and procedural safeguards, namely:

Substantive Safeguards:

- A grievous and irremediable medical condition (including an illness, disease or disability) is required;
- Enduring suffering that is intolerable to the individual in the circumstances of his or her condition is required;
- Informed consent is required;
- Capacity to make the decision is required at the time of either the advance or contemporaneous request; and
- Eligible individuals must be insured persons eligible for publicly funded health care services in Canada.

Procedural Safeguards:

- Two independent doctors must conclude that a person is eligible;
- A request must be in writing and witnessed by two independent witnesses;
- A waiting period is required based, in part, on the rapidity of progression and nature of the patient's medical condition as determined by the patient's attending physician;
- Annual reports analyzing medical assistance in dying cases are to be tabled in Parliament; and
- Support and services, including culturally and spiritually appropriate end-of-life care services for Indigenous patients, should be improved to ensure that requests are based on free choice, particularly for vulnerable people.

It should be noted that in June 2014 the province of Québec legalised physician-assisted dying by *An Act Respecting End-of-Life Care*, with most of the Act coming into force on 10 December 2015. The Québec Act provides a 'framework for end-of-life care' which includes 'continuous palliative sedation' and 'medical aid in dying', defined as 'administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death.'

In order to access medical aid in dying under the Québec Act a patient must:

(1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
(2) be of full age and capable of giving consent to care;
(3) be at the end of life;
(4) suffer from a serious and incurable illness;
(5) be in an advanced state of irreversible decline in capability; and
(6) experience constant and unbearable physical or psychological suffering
(7) which cannot be relieved in a manner the patient deems tolerable.

The request for medical aid in dying must be signed off by two physicians. The Québec Act also established a Commission on end-of-life care to provide oversight and advice to the Minister of Health and Social Services on the implementation of the legislation regarding end-of-life care.

Asia

I could not find any legislation in any country in Asia which prescribed a regime for active voluntary euthanasia or assisted dying.[16]

UK

Euthanasia and assisted dying is illegal in the UK.[17]

Summary of Key Features of International Regimes

16 In India, euthanasia is banned and suicide is still a crime.
17 Various legislative proposals have been defeated most recently in 2015.

Legislative support for assisted suicide is limited to a small number of jurisdictions,[18] while voluntary euthanasia is permitted in even fewer jurisdictions.[19]

Eligibility criteria varies significantly. In particular, there is no consistency as to whether the patient must:

- be an adult;
- be mentally competent at the time death occurs;
- have a terminal illness;
- be afflicted with pain and/or mental suffering;
- be resident in the jurisdiction; or
- personally administer the lethal medication to themselves

Furthermore, there is variation in:

- the number and nature of health professionals required to be involved;
- the manner of assessing a patient's request;
- whether and how a patient is to be professionally informed;
- whether a cooling off period applies;
- the relevance of depression and other mental health issues; and
- reporting requirements and review.

The Victorian Model – Voluntary Assisted Dying Act 2017

The Victorian Parliament passed the **Voluntary Assisted Dying Act 2017** (**VAD Act**) in November 2017, although it will not commence until 19 June 2019. It is probably the most conservative and highly regulated voluntary assisted dying model in the world. The final legislation has substantially given effect to the original Parliamentary Committee report and the recommendations made by the expert Panel.

It is worth noting the four fundamental principles which the Committee recommended should underlie an assisted dying regime, namely:

- **First**, such regime cannot be implemented in isolation. It must be incorporated into existing end of life care processes in order to protect and support patients and ensure sound medical practice. Ensuring high standards of patient care requires that health practitioners and regulatory authorities work together in implementing an assisted dying framework;
- **Secondly**, there should be no unencumbered 'right' to assisted dying. Access will be determined by the careful assessment of a robust set of criteria by those best placed to do so: the person themselves, a primary doctor, and an independent secondary doctor;
- **Thirdly**, no doctor, other health practitioner or health service should be forced to participate in assisted dying; and
- **Fourthly**, an assisted dying framework must incorporate the culture and values of the people it serves. While some technical aspects of international frameworks may transfer well to Victoria, some may need refinement to align with the legal and medical values and culture that are essential to Victorians.

Having regard to these principles, the expert Panel made a series of recommendations, which are now essentially reflected in the legislation. I propose to set these out in detail as I believe they have uniquely articulated the starting point for any legislation of this kind and have then addressed, in extraordinary detail, a mechanism for its implementation.

Recommendation 1

That the following principles are included in the legislation to help guide interpretation:

- *Every human life has equal value.*

18 Certain USA States which have adopted the Oregan model; Netherlands; Belgium; Luxembourg; Canada; and Colombia.

19 Netherlands; Belgium; Luxembourg; and Canada.

- *A person's autonomy should be respected.*
- *A person has the right to be supported in making properly informed decisions about their medical treatment and should be given, in a manner that they understand, information about medical treatment options, including comfort and palliative care.*
- *Every person approaching the end of life has the right to quality care to minimise their suffering and maximise their quality of life.*
- *The therapeutic relationship between a person and their health practitioner should, wherever possible, be supported and maintained.*
- *Open discussions about death and dying and peoples' preferences and values should be encouraged and promoted.*
- *Conversations about treatment and care preferences between the health practitioner, a person and their family, carers and community should be supported.*
- *Providing people with genuine choices must be balanced with the need to safeguard people who might be subject to abuse.*

Eligibility Criteria

Recommendation 2

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- *be an adult, 18 years and over; and*
- *be ordinarily resident in Victoria and an Australian citizen or permanent resident; and have decision-making capacity in relation to voluntary assisted dying; and*
- *be diagnosed with an incurable disease, illness or medical condition, that:*
  - *is advanced, progressive and will cause death; and*
  - *is expected to cause death within weeks or months, but not longer than 12 months; and*
  - *is causing suffering that cannot be relieved in a manner the person deems tolerable.*

The legislation modified the above recommendation to the extent of limiting the adults who may access the voluntary assisted dying system to those determined to have 6 months or less to live or less than 12 months if suffering a neurodegenerative disease.

Recommendation 3

That the capacity test in the Medical Treatment Planning and Decisions Act 2016[20] *is used to assess a person's decision-making capacity in relation to voluntary assisted dying.*

In summary, existing relevant legislation in Victoria includes a four-part test for assessing decision-making capacity:

A person has decision-making capacity to make a decision if the person is able to do the following:

- a) understand the information relevant to the decision and the effect of the decision;
- b) retain that information to the extent necessary to make the decision;
- c) use or weigh that information as part of the process of making the decision;
- 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.

This assessment is undertaken to ensure that an adult is able to understand the nature and effect of the decision and is applied in a wide range of circumstances, including financial and medical decision making.

Recommendation 4

That when an assessing medical practitioner is in doubt about whether a person has decision-making ca-

20 This Act commenced on 12 March 2018.

pacity in relation to voluntary assisted dying, a referral must be made to an appropriate specialist for assessment.

Recommendation 5

That mental illness does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does mental illness exclude a person from eligibility to access voluntary assisted dying.

Recommendation 6

That disability does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does disability exclude a person from eligibility to access voluntary assisted dying.

The eligibility criteria ensures that voluntary assisted dying will allow a small number of people, at the end of their lives, to choose the timing and manner of their death.

There is no intention to give people who are not dying access, and the legislation will not give these people an option to choose between living and dying. This is a significant difference from the regimes operating in the Benelux countries.

A person must have decision-making capacity throughout the voluntary assisted dying process. This requirement is fundamental to ensuringa person's decision to access voluntary assisted dying is their own, is voluntary, andis not the product of undue influence or coercion.

This will mean some people who may want to request voluntary assisted dying will be excluded. People with dementia who do not have decision-making capacity, for example, will not be able to access voluntary assisted dying. People will also not be able to request voluntary assisted dying in an advance care directive. I will come to this shortly.

Only those whose disease, illness or conditionis expected to cause death within no longer than 6 months, or less than 12 months if suffering a neurodegenerative disease, will be eligible for voluntary assisted dying.

Mental illness alone will not satisfy the eligibility criteria. Disability alone will not satisfy the eligibility criteria. This is because the voluntary assisted dying framework is for people who are suffering at the end of their life.

However, if a person fulfils all the eligibility criteria, the fact that they have a mental illness or a disability should not exclude them from accessing voluntary assisted dying.

Suffering should always be judged by the person themselves. Research indicates that suffering has psychological, social and spiritual aspects as well as physical symptoms such as pain, breathlessness and nausea, and that loss of autonomy or control can also contribute to a person's suffering. Perceptions and judgements about suffering are inherently individual and subjective.

Request and assessment process

Initiating a request for voluntary assisted dying

Recommendation 7

That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

Recommendation 8

That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Recommendation 9

That a request for information about voluntary assisted dying does not constitute a first request.

Recommendation 10

That the person may withdraw from the voluntary assisted dying process at any time.

When the person withdraws from the voluntary assisted dying process, they must commence the process from the beginning if they decide to make a subsequent request for voluntary assisted dying.

Recommendation 11

That the legislation support access to voluntary assisted dying for people who are from culturally and linguistically diverse backgrounds and for

people who require alternative means of communication, by allowing appropriately accredited, independent interpreters to assist them to make verbal and written requests for voluntary assisted dying.

Receiving a request for voluntary assisted dying

Recommendation 12

That two medical practitioners must undertake independent assessments of a person's eligibility for voluntary assisted dying.

Recommendation 13

That the roles of the two assessing medical practitioners be clearly defined as:

- *the coordinating medical practitioner; and*
- *the consulting medical practitioner.*

Recommendation 14

That both the coordinating medical practitioner and the consulting medical practitioner must be qualified as Fellows of a College (or vocationally registered); and

- *at least one of the medical practitioners must have at least five years post fellowship experience; and*
- *at least one of the medical practitioners must have expertise in the person's disease, illness or medical condition.*

Recommendation 15

That both the coordinating medical practitioner and the consulting medical practitioner must complete specified training before undertaking an assessment of a person's eligibility for access to voluntary assisted dying.

Recommendation 16

That the specified training comprise of obligations and requirements under the legislation including:

- *assessing the eligibility criteria under the legislation;*
- *assessing decision-making capacity in relation to voluntary assisted dying and identifying when a referral may be required; and*
- *assessing the voluntariness of a person's decision to request voluntary assisted dying and identifying risk factors for abuse.*

Recommendation 17

That the coordinating medical practitioner or the person may request that the role of the coordinating medical practitioner for the voluntary assisted dying process be transferred to the consulting medical practitioner.

Recommendation 18

That a health practitioner may conscientiously object to participating in the provisionof information, assessment of a person's eligibility, prescription, supply or administration of the lethal dose of medication for voluntary assisted dying.

Making a request for voluntary assisted dying

Recommendation 19

That the person must make three separate requests to access voluntary assisted dying: a first request, followed by a written declaration of enduring request,and then a final request.

Recommendation 20

That the formal process for requesting voluntary assisted dying proceeds for the person as follows:

- *The person makes their first request to a medical practitioner.*
- *The person undergoes a first assessment by the coordinating medical practitioner.*
- *The person undergoes a second independent assessment by the consulting medical practitioner.*
- *The person makes a witnessed written declaration of enduring request to the coordinating medical practitioner.*
- *The person makes a final request to the coordinating medical practitioner.*

Recommendation 21

That the coordinating medical practitioner and the consulting medical practitioner must ensure that the person is properly informed of:

- *their diagnosis and prognosis;*
- *treatment options available to them and the likely outcomes of these treatments;*
- *palliative care and its likely outcomes;*
- *the expected outcome of taking the lethal dose of medication (that it will lead to death)*
- *the possible risks of taking the lethal dose of medication;*
- *that they are under no obligation to continue with their request for voluntary assisted dying, and that they may withdraw their request at any time; and*
- *any other information relevant to the person's needs.*

Recommendation 22

The coordinating medical practitioner and the consulting medical practitioner undertake independent assessments to form a view as to whether:

- *the person meets the eligibility criteria;*
- *the person understands the information provided;*
- *the person is acting voluntarily and without coercion; and*
- *the person's request is enduring.*

Recommendation 23

That the final request may only be made after a period of at least 10 days has passed since the first request.

Recommendation 24

That there is an exception to the 10 day requirement when the coordinating medical practitioner believes that the person's death is likely to occur within 10 days and this is consistent with the prognosis provided by the consulting medical practitioner.

Recommendation 25

That the final request cannot be made on the same day that the second independent assessment is completed.

Recommendation 26

That a person's written declaration of enduring request must be in writing, be signedby the person, and be witnessed by two persons in the presence of the coordinating medical practitioner. The two witnesses must

certify that the person appears to be voluntarily signing the declaration, to have decision-making capacity, and to understand the nature and effect of making the declaration.

Recommendation 27

That one of the witnesses to the written declaration of enduring request must not be a family member. The two witnesses must be 18 years and over and cannot be:

- *a person who knows or believes that they are a beneficiary under the will of the person making the written declaration of enduring request, or a recipient, in any other way, of a financial or other material bene t resulting from the person's death; or*
- *an owner or operator of any health care or accommodation facility at which the person making the written declaration of enduring request is being treated or any facility in which the person resides; or*
- *directly involved in providing health or professional care services to the person making the written declaration of enduring request.*

Recommendation 28

That the written declaration of enduring request allows the person to make a personal statement about their decision to access voluntary assisted dying.

Completing the voluntary assisted dying process

Recommendation 29

That the person appoint a contact person who will take responsibility for the return of any unused lethal medication to the dispensing pharmacist within 30 days after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board.

Recommendation 30

That, to conclude the assessment process, the coordinating medical practitioner complete a certification for authorisation to confirm in writing that they are satisfied that all of the procedural requirements have been met.

Recommendation 31

That the prescription of the lethal dose of medication requires an authorisation process.

Recommendation 32

That at the point of dispensing the lethal dose of medication, the dispensing pharmacist must:

- *attach labels clearly stating the use, safe handling, storage and return of the medication; and*
- *provide the person with information about the administration of the medication and the likely outcome.*

Recommendation 33

That the person be required to store the lethal dose of medication in a locked box.

Recommendation 34

That the legislation not preclude health practitioners from being present when a person self-administers the lethal dose of medication if this is the preference of the person.

Recommendation 35

That there be protection in the legislation for health practitioners who are present at the time a person self-administers the lethal dose of medication, including that the health practitioner is under no obligation to provide life-sustaining treatment.

Recommendation 36

That not being able to self-administer is defined as being physically unable to self- administer or digest the lethal dose of medication.

Recommendation 37

That if the person is not able to self-administer, the coordinating medical practitioner may administer the lethal dose of medication.

Recommendation 38

That, in the rare circumstance the person loses the capacity to self-administer the medication after it has been prescribed, they must return to their coordinating medical practitioner if they wish to proceed with voluntary assisted dying. After the previously prescribed medication has been returned to the pharmacist, the coordinating medical practitioner may undertake the process to administer the medication.

Recommendation 39

That, in the rare circumstance where both the coordinating and consulting medical practitioners conscientiously object to administering the lethal dose of medication, the coordinating medical practitioner can refer the person to a new consulting medical practitioner willing to administer the medication. The new consulting medical practitioner must conduct their own independent assessment, after which the coordinating medical practitioner may transfer the role of coordinating medical practitioner to them.

Recommendation 40

That, if the coordinating medical practitioner administers the lethal dose of medication, a witness who is independent of the coordinating medical practitioner must be present. The coordinating medical practitioner and the witness must certify that the person's request appears to be voluntary and enduring.

A prescriptive process will ensure requests are voluntary, well-considered and enduring, and that only those who meet all of the eligibility criteria will be able to access voluntary assisted dying.

In summary, the process requires the person to make three separate requests for voluntary assisted dying and undergo two independent medical assessments to ensure the eligibility criteria are met and the person is properly informed about their options.

There are a number of steps in the process to identify any coercion or undue influence. A person should be able to seek information about voluntary assisted dying with a medical practitioner they trust and with whom they feel comfortable before beginning a formal process to access voluntary assisted dying. This will allow a person to consider information without feeling pressured to commence the process.

To prevent coercion or inadvertent pressure, a health practitioner will not be able to raise or initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship. A person should be able to seek information from, and make a first verbal request to,a medical practitioner with whom they have a therapeutic relationship.

If a person requests voluntary assisted dying, a medical practitioner must determine whether they will accept the role of coordinating medical practitioner. This role will require them to coordinate the process and is designed to ensure the person is supported.

All health practitioners will have the option to conscientiously object to participating in the voluntary assisted dying process. Consistent with existing standards of care, this conscientious objection must not impede a person's access to what would be a legal medical treatment.

The coordinating medical practitioner will be required to conduct the first assessment of the eligibility criteria and to ensure the person is properly informed. If the person meets the eligibility criteria, the coordinating medical practitioner must refer the person to another medical practitioner.

The second medical practitioner will become the 'consulting medical practitioner' if they accept the role. They will be required to conduct a second, independent assessment.

Minimum qualifications and experience will be required for medical practitioners involved in voluntary assisted dying. The assessment of the eligibility criteria and conversations about voluntary assisted dying and end of life will require specific experience. The Panel recommends that both assessing medical practitioners must be qualified as Fellows of a College (or vocationally registered) and that at least one of the medical practitioners has at least five years of post-fellowship experience and at least one must have relevant expertise in the person's disease, illness or medical condition.[21]

Prior to conducting an assessment, both medical practitioners will be required to undertake specified training. This will ensure they understand the eligibility criteria and their legal obligations.

If a medical practitioner assesses a person as ineligible, the person may seek a second opinion. The Panel is of the view that this standard medical practice is part of person- centred care and allows people to ensure that the issues that concern them are addressed. Given the review of each assessment by the Voluntary Assisted Dying Review Board and potential for professional misconduct or criminal charges, the Panel is confident that medical practitioners will comply with the legislative framework and attempts to 'doctor shop' will be identified.

If both medical practitioners assess a person as eligible for voluntary assisted dying, the person will be required to complete a written declaration to proceed. This will clearly demonstrate the person understands their decision. The declaration will need to be signed by the person and witnessed by two independent witnesses in the presenceof the coordinating medical practitioner. The written declaration represents a lasting statement of the person's enduring request.

The person must then make a final verbal request for voluntary assisted dying to their coordinating medical practitioner and appoint a contact person. The final request must be at least 10 days after the first request.

The Panel also took into account those exceptional circumstances in which a person's death will occur within 10 days and that it would be unreasonable to preclude them from accessing voluntary assisted dying.

In these instances, the coordinating medical practitioner may waive the 10 day time period if their prognosis is consistent with the prognosis of the consulting medical practitioner. As a clear safeguard, under no circumstances will a person be able to make a final request on the same day as the second independent assessment.

As part of the request and assessment process, the person will also be required to appoint a contact person. The contact person will take responsibility for the return of any unused lethal dose of medication after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board. The coordinating medical practitioner must then complete a final check, which will require the practitioner to certify that each step in the process has been completed.

Before writing the prescription, the coordinating medical practitioner will be required to apply for a permit from the Department of Health and Human Services. This process will be similar to the current authorisation process for other restricted drugs and provides an opportunity for an independent check that the process has been complied with before the person accesses the lethal dose of medication.

The lethal dose of medication will be dispensed by a pharmacist, who will be required to appropriately label the medication and inform the person of their obligations to safely store the medication. The pharmacist will only dispense the medication if there is a valid permit issued by the Department of Health and Human Services. This provides another independent check to ensure compliance with the legal requirements.

The person will be required to store the medication in a locked box until they decide to self-administer the medication.

21 To obtain Fellowship of a College a medical practitioner must complete additional years of training in a specific field, whilst working as a medical practitioner, and must be accepted into the College after passing additional exams.

Furthermore, there are a series of provisions about how the lethal dose of medication is prescribed, dispensed and reported on, which create a numberof protections to ensure safety through constant monitoring of the lethal dose of medication, with a clear line of accountability.

The legislation provides protection for health practitioners who may be present when the person self-administers the medication.

The only circumstances in which a medical practitioner will be authorised to administer the lethal dose of medication will be if the person is physically unable to self- administer or digest the medication. In these circumstances, only the coordinating medical practitioner will be authorised to administer the medication.

While this option ensures voluntary assisted dying is not discriminatory, the Panel was of the view that it

- is important to limit the authorisation to administer the medication. The coordinating medical practitioner may only administer the lethal dose of medication at the request of the person and this must occur in the presence of an independent witness. If the coordinating medical practitioner is unwilling or unable to administer the medication, they may transfer the role to the consulting medical practitioner. This can only occur if the consulting medical practitioner accepts the role.
- The entire request and assessment process is designed to ensure voluntary and informed decisions, and to identify and prevent potential abuse. The Panel recognised the risk that vulnerable people may be pushed or coerced into requesting voluntary assisted dying but is confident the recommended framework will identify and address instances of abuse.

Oversight

Finally, there is a comprehensive framework for the operation and monitoring of voluntary assisted dying, including:

- protections and offences;
- the establishment of the Voluntary Assisted Dying Review Board;
- medication monitoring;
- monitoring after the person has died; and
- monitoring voluntary assisted dying activity.

Monitoring after death

Recommendation 41

That the death certificate of a person who has accessed voluntary assisted dying identifies the underlying disease, illness or medical condition as the cause of death.

Recommendation 42

That accessing voluntary assisted dying should not affect insurance payments or other annuities.

Recommendation 43

That the medical practitioner who certifies death must notify the Registrar of Births, Deaths and Marriages if they are aware that the person has been prescribed a lethal dose of medication or if they are aware that the person self-administered a lethal dose of medication under the voluntary assisted dying legislation.

Recommendation 44

That the Registrar of Births, Deaths and Marriages and the Voluntary Assisted Dying Review Board share information relating to voluntary assisted dying.

Recommendation 45

That a death by means of voluntary assisted dying in accordance with the legislative requirements will not be considered a reportable death for the purpose of the Coroners Act.

Voluntary Assisted Dying Review Board

Recommendation 46

That a Voluntary Assisted Dying Review Board be established under statute to review every case of voluntary assisted dying and report on the operation of voluntary assisted dying in Victoria.

Recommendation 47

That the role and functions of the Voluntary Assisted Dying Review Board be:

- *reviewing each case of voluntary assisted dying and each assessment for voluntary assisted dying to ensure the statutory requirements have been complied with;*
- *referring breaches of the statutory requirements to the appropriate authority to investigate the matter such as Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency;*
- *collecting information and data, setting out additional data to be reported and requesting additional information from medical practitioners or health services, for the purpose of performing its functions;*
- *monitoring, analysing, considering and reporting on matters relating to voluntary assisted dying,*
- *supporting improvement by facilitating and conducting research relating to voluntary assisted dying and maintaining and disseminating guidelines to support the operation of the legislation, in collaboration with other agencies and professional bodies and services; and*
- *any other functions necessary to promote good practice.*

Recommendation 48

That the membership of the Voluntary Assisted Dying Review Board be appointed by the Minister for Health, and that the appointments reflect the appropriate knowledge and experience required for the Board to perform its functions.

Monitoring of voluntary assisted dying

Recommendation 49

That there is mandatory reporting by medical practitioners to the Voluntary Assisted Dying Review Board within seven days of:

- *completing the first assessment (regardless of the outcome);*
- *completing the second independent assessment (regardless of the outcome);*
- *completing the certification for authorisation (which will incorporate the written declaration of enduring request and appointment of contact person forms); and*
- *when the lethal dose of medication is administered by a medical practitioner.*

Recommendation 50

That, in order to monitor the lethal dose of medication, there is mandatory reporting within seven days to the Voluntary Assisted Dying Review Board:

- *by the Department of Health and Human Services when the prescription is authorised;*
- *by the pharmacist when the prescription is dispensed; and*
- *by the pharmacist when unused lethal medication is returned by the contact person.*

Recommendation 51

Reporting forms are set out in the legislation to provide certainty and transparency about the information that is collected. These forms include a:

- *first assessment report (which includes record of first request);*
- *second assessment report;*
- *written declaration of enduring request;*
- *appointment of contact person;*
- *certification for authorisation;*
- *dispensing pharmacist report;*
- *administration by medical practitioner report; and*
- *return of medication notification.*

Recommendation 52

That the Voluntary Assisted Dying Review Board report to Parliament: every six months in the first two years after commencement, and thereafter annually.

Recommendation 53

That the voluntary assisted dying legislation be subject to review five years after commencement.

Protections and offences

Recommendation 54

That the legislation provides clear protection for health practitioners who act in good faith and without negligence to facilitate access to voluntary assisted dying under the legislation.

Recommendation 55

That a health practitioner must notify the Australian Health Practitioner Regulation Agency if they believe that another health practitioner is acting outside the legislative framework.

Recommendation 56

That any other person may notify the Australian Health Practitioner Regulation Agency if they believe that a health practitioner is acting outside the legislative framework.

Recommendation 57

That there be offences for:

- *inducing a person, through dishonesty or undue influence, to request voluntary assisted dying;*
- *inducing a person, through dishonesty or undue influence, to self-administer the lethal dose of medication;*
- *falsifying records related to voluntary assisted dying; and*
- *administering a lethal dose of medication to a person who does not have decision- making capacity*

The oversight process includes a series of checks involving a number of health practitioners, the Department of Health and Human Services, and independent witnesses; and provides an additional level of protection through the review of all voluntary assisted dying activity, not just those cases where voluntary assisted dying is completed.

The Voluntary Assisted Dying Review Board (the Board) will oversee the voluntary assisted dying framework and review every case and every assessment conducted by a medical practitioner to ensure compliance with the statutory requirements. Consistent with the recommendation of the Parliamentary Committee, the Board will not have the power to veto requests or arbitrate appeals.

The Board is established as a statutory entity to provide strong governance arrangements as part of the legislative framework under which an oversight body operates. The independence of a statutory body will ensure transparency with respect to its operations. Both the coordinating and consulting medical practitioners have mandatory requirements to report to the Board.

The dispensing pharmacist must report to the Board. The medical practitioner who certifies the person's must also report voluntary assisted dying to the Victorian Registrar of Births, Deaths and Marriages, who will report this to the Board. These independent reporting points will ensure the Board is able to accurately review what occurred in each case, and the Board will be able to seek further information if required.

If the Board identifies any improper conduct or potential criminal action, it will be required to refer

the matter to Victoria Police, the Australian Health Practitioner Regulation Agency, or the Coroner. The Panel is of the view that these existing bodies should be utilised to investigate wrongdoing, as they already have clearly understood roles and responsibilities. The Board will not only monitor completed cases, but also every assessment for voluntary assisted dying.

The Board will also monitor the lethal dose of medication to make sure it is returned if it is not self-administered. The person accessing voluntary assisted dying is required to appoint a contact person before they are prescribed the lethal dose of medication. The contact person must agree to return any unused medication to the dispensing pharmacist to be destroyed after the person has died.

The Board will receive a report from the pharmacist when the medication is dispensed and when any unused medication is returned. If the medication is not returned, or it is not known whether the person self-administered the medication, the Board will be able to follow up with the contact person. Information from the notification of death will be shared with the Board by the Registrar of Births, Deaths and Marriages. This will enable the Board to follow up a notification that the medication was not self-administered.

Although the Registrar of Births, Deaths and Marriages will obtain information about voluntary assisted dying, this will not be included on the person's death certificate. Instead, this information about voluntary assisted dying will be provided to the Board.

The VAD Act provides for a range of new offences that relate specifically to voluntary assisted dying, to ensure people are protected, including:

- inducing a person, through dishonesty or undue influence, to request voluntary assisted dying or to self-administer the lethal dose of medication;
- falsifying records related to voluntary assisted dying; and
- failing to report on voluntary assisted dying.

Implementation

There are also detailed implementation provisions concerning:

- voluntary assisted dying in the context of existing care options;
- implementation planning and governance;
- supporting health practitioners;
- supporting patient and health practitioner communication;
- informing the community;
- supporting the safe introduction of voluntary assisted dying;
- research;
- resourcing; and
- commencement.

Voluntary assisted dying in the context of existing care options

Recommendation 58

That the implementation of voluntary assisted dying should occur within the context of existing care available to people at the end of life, and ensure voluntary assisted dying activity is embedded into existing safety and quality processes.

Implementation planning and governance

Recommendation 59

That work to establish the Voluntary Assisted Dying Review Board begin at least 12 months before the commencement of the legislation and is supported to develop aclear work plan to meet its legislated obligations including collection requirementsand processes for receiving and recording data, procedural requirements related toits review, reporting and quality functions, and protocols for engaging and sharing informa-

tion with other partners (such as the Department of Health and Human Services, Safer Care Victoria, and services and providers) for quality improvement purposes.

Recommendation 60

That the Department of Health and Human Services establish and support an Implementation Taskforce to investigate and advise on the development of voluntary assisted dying. The Implementation Taskforce should have the coordinating role in overseeing and facilitating the work set out in these implementation recommendations.

Recommendation 61

That the functions proposed by the Parliamentary Committee for End of Life Care Victoria be subject to a gap analysis in relation to existing entities and their functions to determine a clear role for the proposed agency.

Implementation support

Recommendation 62

That appropriate workforce support, information, clinical and consumer guidelines, protocols, training, research and service delivery frameworks to support the operation of the legislative framework are developed in a partnership between Safer Care Victoria, the Voluntary Assisted Dying Review Board and the Department of Health and Human Services in consultation with key clinical, consumer and professional bodies and service delivery organisations.

Recommendation 63

That the Implementation Taskforce establishes a collaborative coordination process across responsible agencies to periodically review the resources and frameworks that support the operation of voluntary assisted dying.

The VAD Act seeks to ensure that voluntary assisted dying is incorporated into existing care processes to protect and support patients and to ensure sound medical practice. This will also ensure people get access to the range of treatment and care options based on their clinical needs and care goals.

Based on experience overseas, the Panel predicted very low rates of utilisation of voluntary assisted dying, initially and an expected gradual increase in use over a number of years.

An Implementation Taskforce is being established to provide the expertise, focus and leadership to develop the necessary resources, processes and systems over the next 18 months leading up to the commencement of the VAD Act.

The Implementation Taskforce will play a pivotal role in focusing and coordinating the work that will need to be completed to prepare for the commencement of the legislation. This should include reviewing the functions proposed in the Parliamentary Committee's report for the new agencies proposed to clarify roles and responsibilities of both the new and existing agencies. The Implementation Taskforce will also provide advice on the development of evidence-based resources, supports and guidelines to build a safe and compassionate voluntary assisted dying service system.

The Implementation Taskforce will engage with, and involve, key stakeholders prior to commencement, to develop effective implementation strategies and resources. Consistency in implementation and governance arrangements and staff support may best be facilitated in partnership with professional colleges and bodies such as the Australian Medical Association, Australian Nursing and Midwifery Federation, relevant professional colleges, pharmacy bodies, and consumer, carer and service representatives. Early planning and development of associated resources and training for the implementation of voluntary assisted dying will give health practitioners and services a sufficient period of time in which to

build capabilities, models of care and organisational responses.

In March 2018, the Victorian Government announced a partnership with experts in cancer and end of life care in Seattle USA to support the implementation process.

Victorian Model Compared to Other Legislated Regimes

The Panel considered in detail the existing legislative frameworks that support voluntary assisted dying in other jurisdictions to more fully inform its deliberations and recommendations. In consequence, the VAD Act incorporates detail not always reflected in legislation elsewhere. This ensures not only transparency about the framework but also that any changes can only be made through an Act of Parliament.

Passive voluntary euthanasia[22]

The Victorian model may be described as *Active voluntary euthanasia* – when medical intervention takes place, at the patient's request, in order to end the patient's life.

However, currently there is legislation in all Australian States and Territories which permit people, in one form or another, to formally communicate their wishes in end of life situations, an approach also reflected by practice in the UK, the USA and Canada.

Passive voluntary euthanasia, which may be described as the withdrawal or withholding of medical treatment from a patient, at the patient's request, in order to end the patient's life, thus appears to be largely accepted within current medical practice (and, in most jurisdictions, generally recognised and permitted by law), despite the refusal of medical practitioners and policy makers to describe these activities in such terms.

Examples include not resuscitating a person in cardiac arrest, turning off a life support machine or withholding or withdrawing other medical care that would prolong life.

In Australia, withholding or withdrawing medical treatment currently occurs under various circumstances and regulations.

5.

6. *Legislation*

Each State and Territory has enacted laws to regulate the act of withholding or withdrawing medical treatment with the effect of hastening death. These laws provide for instruments that allow, in a formal and binding manner, the previously expressed wishes of competent adults to continue to have influence over the kind of treatment they receive (or do not receive) when they lose competence.

No piece of legislation characterises such practices as euthanasia. Indeed, as with members of the medical profession, certain government departments have explicitly stated that such instruments do not permit euthanasia. However, again, such statements seem to be focused on active, rather than passive euthanasia.

There are two forms of instruments that exist to regulate the withholding or withdrawing of medical treatment:

1) advance directives; and
2) enduring powers of attorney or guardianship.

All States and Territories apart from Tasmania and New South Wales have legislation recognising types of 'advance directive' (variously described across jurisdictions).

All States and Territories have legislation recognising enduring powers of attorney or guardianship.

The following table below sets out which instruments are available in each Australian jurisdiction and the relevant Act.

Jurisdiction	Does legislation provide for advance directives?	Does legislation provide for enduring powers of attorney/guardianship?
South Australia	Yes – 'Advance care directives' (*Advance Care Directives*	Yes – 'Substitute decision makers' (*Advance Care Direct-*

22 Euthanasia, Human Rights and the Law Issues Paper May 2016, Australian Human Rights Commission.

	Act 2013)	*ives Act 2013)*
Northern Territory	Yes – 'Advance consent decisions' *(Advance Personal Planning Act* 2013)	Yes – 'Decision makers' *(Advance Personal Planning Act 2013)*
Victoria	Yes (*Medical Treatment Planning and Decisions Act 2016* replaced *Medical Treatment Act 1988)*	Yes (*Medical Treatment Planning and Decisions Act 2016* replaced *Powers of Attorney Act 2014)*
ACT	Yes – 'Health directions' (*Medical Treatment (Health Directions) Act 2006)*	Yes – 'Enduring powers of attorney' (*Powers of Attorney Act 2006)*
Western Australia	Yes – 'Advance health directives' (*Guardianship and Administration Act 1990)*	Yes – 'Enduring powers of guardianship' *(Guardianship and Administration Act 1990)*
Queensland	Yes – 'Advance health directives' (*Power of Attorney Act 1998)*	Yes – 'Enduring powers of attorney' (*Power of Attorney Act 1998)*
Tasmania	No (but an advance care plan can be registered as part of an enduring guardianship)	Yes – 'Enduring guardianship' *(Guardianship and Administration Act 1995)*
New South Wales	No	Yes – 'Enduring guardian' (*Guardianship Act 1987)*

The common key features and differences between these instruments are summarised below:

7.

8. Advance directives

Advance directives allow competent adults to execute formal directives in writing,[23] specifying their wishes concerning medical treatment, including the refusal of treatment.[24]

Directives will generally apply in situations where the person has impaired decision-making capacity, meaning they are unable to consent to or refuse medical treatment.[25]

For example:

In Queensland a directive specifying the withdrawal or withholding of treatment will only operate

23 Except for the ACT where they may be oral. *Medical Treatment (Health Directions) Act 2006* (ACT) ss 7 and 9.

24 *Advance Care Directives Act 2013* (SA) s 11 (requires use of particular form); *Advance Personal Planning Act 2013* (NT) ss 8(1)(a), 9, 10, and 38; *Medical Treatment Act 1988* (Vic) s 5; *Medical Treatment (Health Directions) Act 2006* (ACT) ss 7-9; *Guardianship and Administration Act 1990* (WA) ss 3 and 110P; *Powers of Attorney Act 1998* (Qld) s 35. Note though, for example, in Victoria and the ACT palliative care is expressly excluded from the definition of medical treatment which a person can refuse (see ss 3 and 4 of the *Medical Treatment Act 1988* (Vic) and s 6 of the *Medical Treatment (Health Directions) Act 2006* (ACT)).

25 *Advance Care Directives Act 2013* (SA) s 34(2); *Advance Personal Planning Act 2013* (NT) s 40; *Medical Treatment (Health Directions) Act 2006* (ACT) s 11; *Guardianship and Administration Act 1990* (WA) s 110S ('at any time the maker of the directive is unable to make reasonable judgments in respect of that treatment').

in certain circumstances (i.e. if the patient has a terminal illness, is in a persistent vegetative state, or is permanently unconscious).[26]

In Victoria, until recently, a directive to withhold or withdraw treatment could be made only in relation to a current condition.[27] This has now changed under the *Medical Treatment Planning and Decisions Act 2016* referred to below.

Directives in relation to refusal of treatment are generally legally binding on health professionals,[28] although there are circumstances in which a health provider will be protected for non-compliance (for example, if there are reasonable grounds to believe that the directive does not reflect the current wishes of the person, or where a directive is uncertain or inconsistent with good medical practice).[29]

Health practitioners who act in good faith and/or reasonably refuse to provide or continue medical treatment in reliance on an advance directive are generally taken to be acting with the consent of the patient.[30]

In relation to liability, the Victorian, South Australian and Australian Capital Territory Acts specify that practitioners, acting reasonably and/or in good faith, that act in accordance with an advance directive are generally protected from criminal liability.[31]

In Queensland, a person acting in accordance with an advance health directive is 'not liable for an act or omission to any greater extent than if the act of omission had happened with the principal's consent.'[32] However, the Queensland Act also specifies that reliance on an advance directive does not prevent criminal liability under section 296 of the Queensland *Criminal Code* which criminalises the acceleration of death.[33]

New South Wales has not legislated to provide for advance directives. However, it has developed 'Using Advance Care Directives' guidelines on the management of end-of-life decisions, and advance care directives that comply with the requirements of these guidelines are legally binding in NSW, functioning as an 'extension of the common law right to determine one's own medical treatment'.[34]

9.

10. Enduring powers of attorney or guardianship.

Enduring powers of attorney or guardianship allow a person to appoint one or more agents to make

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26 *Powers of Attorney Act 1998* (Qld) s 36. Also, s 66A of the *Guardianship and Administration Act 2000* (Qld) provides that whether contained in an advance directive or given by an enduring power of attorney, 'consent to the withholding or withdrawal of a life-sustaining measure for the adult cannot operate unless the adult's health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.'

27 *Medical Treatment Act 1988* (Vic) s 5.

28 *Advance Care Directives Act 2013* (SA) ss 19 and 36 and *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s 17(2)(b); *Advance Personal Planning Act 2013* (NT) ss 41, 45, 52 and 53(1) and (4); *Medical Treatment Act 1988* (Vic) s 6; *Guardianship and Administration Act 1990* (WA) s 110ZJ (note however that there is an exception in this Act for urgent treatment following an attempted suicide, in which case a directive may be overridden – see s 110ZIA); *Powers of Attorney Act 1998* (Qld) s 36 (1)(b) (but see s 103, which protects health providers for non-compliance with an advance health directive in certain circumstances, including if the health provider believes that the directive is 'inconsistent with good medical practice').

29 See, e.g. *Powers of Attorney Act 1998* (Qld) s 103; *Advance Care Directives Act 2013* (SA) s 36(2).

30 See, for e.g., *Advance Care Directives Act 2013 (SA)* s 38; *Advance Personal Planning Act 2013* (NT) s 45; *Guardianship and Administration Act 1990* (WA) s 110ZK. In Western Australia and the Northern Territory, legislation states that a health practitioner is deemed to be acting with valid consent when relying on an advance directive, even where this may hasten death: See *Advance Personal Planning Act 2013* (NT) ss 45 and 46 and *Guardianship and Administration Act 1990* (WA) s 110ZL.

31 *Medical Treatment Act 1988* (Vic) s 9; *Advance Care Directives Act 2013 (SA)*, s 41; *Medical Treatment (Health Directions) Act 2006* (ACT) s 16.

32 *Powers of Attorney Act 1998* (Qld) s 101.

33 *Powers of Attorney Act 1998* (Qld) s 37. Section 296 of the *Criminal Code 1899* (Qld) provides that 'A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person.'

34 NSW Government, NSW Health, *Guideline: Advance Care Directives (NSW) – Using* (2005) 5. At http://www0.health.nsw.gov.au/policies/gl/2005/GL2005_056.html(viewed 8 April 2016).

decisions about the provision or refusal of medical treatment if and when that person has impaired decision-making capacity.[35]

The attorney or guardian is generally required to make treatment decisions that are consistent with directions given by the person when competent, including those specified within the enduring power of attorney/guardianship itself, or in an advance directive.[36]

In some jurisdictions, there are limitations on the ability of attorneys and guardians to refuse treatment in certain situations.

In Victoria, prior to the recent commencement of the *Medical Treatment Planning and Decisions Act 2016* (dealt with below), an agent or guardian could only refuse medical treatment on behalf of a patient if the medical treatment would cause unreasonable distress to the patient, or there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.[37]

In Queensland, an enduring power of attorney cannot consent to the withholding or withdrawal of a life-sustaining measure unless this would be consistent with good medical practice.[38]

With regards to advance directives, health practitioners who reasonably/in good faith rely on the decision of an attorney or guardian are generally protected from criminal and civil liability (in the Northern Territory, Western Australia, Tasmania, New South Wales and Queensland because they are deemed to have acted with the patient's consent) if the agent makes refusal of treatment decisions in compliance with a valid instrument.[39]

11.

12.<u>*Common law*</u>

Common law rules govern the doctor-patient relationship and the provision of medical treatment more generally.[40] Advance directives legislation in every Australian jurisdiction except for South Australia explicitly states that common law rights are not displaced by the legislation.[41]

With regard to passive voluntary euthanasia, the common law allows a competent adult to refuse medical treatment, even where that refusal will lead to death.[42] Where a patient's refusal is both voluntary and informed, the decision must be respected and practitioners acting in accordance with such decisions are shielded from liability.[43]

Two cases considering the common law position concerning the right to refuse medical treatment help to clarify this position.

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35 *Advance Care Directives Act 2013* (SA) ss 21, 23(1) and 34(1); *Advance Personal Planning Act 2013* (NT), ss 15, 16, 17, 20; *Powers of Attorney Act 2014 (Vic)* ss 22, 23; *Powers of Attorney Act 2006* (ACT) ss 8, 13(2), 32; *Guardianship and Administration Act 1990* (WA) ss 3, 110B 110F and 110G(1); *Powers of Attorney Act 1998* (Qld) ss 32 and 33(4); *Guardianship and Administration Act 1995* (Tas) ss 25(2)(e) and 32; *Guardianship Act 1987* (NSW) ss 3, 6 and 6A.

36 *Advance Care Directives Act 2013* (SA) s 35; *Advance Personal Planning Act 2013* (NT) ss 18 and 21; *Medical Treatment (Health Directions) Act 2006* (ACT) ss 44, 46 and sch 1, cl 1.11(2); *Guardianship and Administration Act 1990* (WA) ss 110G(1) and 110ZJ(2); *Guardianship and Administration Act 1995* (Tas) s 32(6); *Guardianship Act 1987* (NSW) s 6E (1)(d), (2) and (3); *Powers of Attorney Act 2014* (Vic) ss 21 and 24.

37 *Medical Treatment Act 1988* (Vic) s 5B(2).

38 *Guardianship and Administration Act 2000* (Qld) s 66A and *Powers of Attorney Act 1998* (Qld) sch 2 cl 5(2).

39 Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), 1.

40 Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), 1.

41 *Advance Personal Planning Act 2013* (NT) s 55; *Medical Treatment Act 1988* (Vic) s 4; *Medical Treatment (Health Directions) Act 2006* (ACT) s 6; *Guardianship and Administration Act 1990* (WA) s 110ZB; *Powers of Attorney Act 1998* (Qld) s 39.

42 Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), 1.

43 Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), i-ii.

In ***Hunter and the New England Area Health Authority v A***[44] the Supreme Court of New South Wales considered the validity of a common law advance directive (there being no legislative provisions for such directives in NSW) given by Mr A, refusing kidney dialysis. One year after making the directive Mr A was admitted to a hospital emergency department in a critical state with a decreased level of consciousness. His condition deteriorated to the point that he was being kept alive by mechanical ventilation and kidney dialysis. The hospital sought a judicial declaration to determine the validity of his advance directive.

McDougall J confirmed that the directive was valid and held that the hospital must respect this decision. His Honour stated and applied the common law principle that:

> A person may make an 'advance care directive': a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and it is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive.[45]

In ***Brightwater Care Group v Rossiter***,[46] also dubbed the 'right to starve' case, concerned a contemporaneous rather than anticipatory refusal of treatment by Mr Rossiter, a man with quadriplegia who was 'unable to undertake any basic human functions', including taking nutrition or hydration orally. Mr Rossiter was not terminally ill, dying or in a vegetative state and had full mental capacity. He had 'clearly and unequivocally' indicated that he did not wish to continue to receive medical treatment which, if discontinued, would inevitably lead to his death. The Care facility refused his request.

The matter came before the WA Supreme Court where Martin CJ considered the position at common law and concluded:

> [A]t common law, the answers to the questions posed by this case are clear and straightforward. They are to the effect that Mr Rossiter has the right to determine whether or not he will continue to receive the services and treatment provided by Brightwater and, at common law, Brightwater would be acting unlawfully by continuing to provide treatment [namely the administration of nutrition and hydration via a tube inserted into his stomach] contrary to Mr Rossiter's wishes.[47]

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44 (2009) 74 NSWLR 88.

45 *Hunter and the New England Area Health Authority v A* (2009) 74 NSWLR 88, [40].

46 (2009) WASC 229.

47 *Brightwater Care Group v Rossiter* (2009) WASC 229, [32].

Six key themes have developed from Supreme Court jurisprudence of "best interests" for decisions about life-sustaining treatment for adults who lack capacity:[48]

- Futile medical treatment is not in a patient's best interests.
- Treatment that is overly burdensome is not in a patient's best interests, even if the patient is unconscious or unaware of treatment burdens.
- Courts have generally not engaged expressly in quality-of-life assessments, but they remain relevant for determining best interests when considering the patient's medical condition and prognosis.
- A patient's wishes and values (gleaned when the patient was competent) are relevant to, but do not determine, his or her best interests. Family members' views may also be relevant where they are reflecting a patient's wishes, and perhaps also when reflecting their own wishes, but these views are not conclusive in determining a patient's best interests.
- The interests of other people and organisations (including the wider health system) are generally not relevant when determining a patient's best interests.
- Courts have generally deferred to medical practitioners' opinions about treatment decisions, even when the patient's family has strongly opposed them.

Finally, it is appropriate to make brief reference to the ***Medical Treatment Planning and Decisions Act 2016*** (Victoria) which commenced on 12 March 2018. This Act introduced major reforms to the law relating to medical treatment decisions, advance care planning and decision making at the end of life and warrants a separate paper.

The new Act creates clear obligations for health practitioners caring for people who do not have decision making capacity.

The Act establishes a single framework for medical treatment decision making for people without decision making capacity that ensures that people receive medical treatment that is consistent with their preferences and values.

These arrangements replace medical powers of attorney and medical decisions made under enduring powers of attorney.

Victorians are now able to create a legally binding advance care directive that will allow them to:

- Make an instructional directive (which will provide specific directives about treatment a person consents to or refuses).
- Make a values directive (which will describe a person's views and values. A medical treatment decision maker and health practitioners will be required to give effect to a values directive).
- Appoint a medical treatment decision maker (who will make decisions on behalf of a person when they no longer have decision making capacity).
- Appoint a support person (who will assist a person to make decisions for themselves, by collecting and interpreting information or assisting the person to communicate their decisions).

The Act does not authorise physician assisted dying which is wholly provided for in the VAD Act.

If there is dispute or uncertainty, people can apply to the Victorian Civil and Administrative Tribunal (**VCAT**) for a decision or advice on behalf of the person needing treatment. There is no cost to apply. The Public Advocate also has a decision making role for health practitioners in certain circumstances.

VCAT can make decisions about:

- medical treatment decisions
- whether a person needing treatment has decision making capacity
- advance care directives
- medical treatment decision makers

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48 Prof Lindy Willmott and Dr Ben White, Withholding and withdrawing life sustaining treatment in a patient's best interests: Australian judicial deliberations Ethics and Law 3 November 2014, Article is based on research undertaken for a paper presented at the annual Queensland Supreme Court Judges' Seminar in August 2011. These cases concern the common law position regarding the doctor-patient relationship and provision of medical treatment in general, rather than the issue of passive voluntary euthanasia specifically.

- support persons
- medical research procedures.

Acknowledgments

This paper is based upon part of a presentation prepared for the International Association on the Quality of Life Conference in Penang, August 2017.

I wish to emphasize that I have not conducted any original research. The material has been derived principally from published Parliamentary reports and research of published scientific and legal papers.