Submission
No 34

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: St Thomas More Society

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Submission to Legislative Council Law and Justice Committee

Voluntary Assisted Dying Bill 2021

The approach I have adopted to the Voluntary Assisted Dying Bill 2021 is to ask a series of questions.[1] I then set out particular significant provisions of the Bill, together with portions of the Second Reading speech, and make certain observations. Finally, I refer to the views of the Australian and New Zealand Society of Palliative Medicine, and the Royal Australian College of Physicians. These views, together with the views of Dr Eugene Moylan, oncologist, Director of the Liverpool Cancer Therapy Centre, and Dr John Obeid, geriatrician, (both of whom have made submissions), suggest that the Voluntary Assisted Dying Bill 2021 is inconsistent with the best of contemporary medicine. The aim is to engage in a dialogue with the sponsors of the Bill. Of the twelve Parts of the Bill, the following are most significant:

- Part 1 – insofar as it establishes a **presumption** of decision-making capacity.
- Part 2 – insofar as it establishes **eligibility** for voluntary assisted dying.
- Part 5 – insofar as it imposes significant obligations on faith-based hospitals and residential aged care to **cooperate** with voluntary assisted dying, even contrary to the conscientious objection of these faith-based institutions.

Questions

The *Voluntary Assisted Dying Bill 2021* (hereafter referred to as the Greenwich Bill) raises the following questions:

1 Voluntary Assisted Dying Board

1. Is there appropriate provision for **membership** of the Voluntary Assisted Dying Board by experts qualified in geriatrics, palliative care, oncology, neurology, psychiatry?
2. Is there adequate provision for **independent review** of the operation of the Voluntary Assisted Dying Board?

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3. Are the **principles** in s 4 mere platitudes or are there administrative provisions in the remainder of the Greenwich Bill which provide those principles with real effect?

2 Assessment

4. Is the **presumption of decision-making capacity** in s 6 of the Greenwich Bill appropriate?

5. Does the Greenwich Bill adequately take into account the **fluctuating capacity** of many elderly and sick persons?

6. Does the Greenwich Bill take into account in the **assessment of decision-making capacity** contemporary tools used by geriatricians, neuropsychologists, and psychiatrists to determine capacity?

7. Does the Greenwich Bill undermine a **professional approach** to patient care, replacing that professional approach with a bureaucratic and form-filling approach?

8. Is it possible to **predict when a person will die**?

9. Are there **mistakes**, on occasion made, as to diagnosis of a patient's condition?

10. Given the large number of **adverse events** in hospitals, does the Greenwich Bill sufficiently guard against adverse events in the procedures which it establishes?

11. Does the Greenwich Bill make sufficient provision for involvement of **treating doctors**, including specialists (where the treating doctor does not have a conscientious objection) to voluntary assisted dying?

12. Does the Greenwich Bill make adequate provision to ensure that doctors involved in the voluntary assisted dying process have regard to the patient's **medical, and hospital records**, particularly where there is a history of **psychiatric illness**?

13. Will the Greenwich Bill operate in such a fashion that professional colleagues (the coordinating practitioner, and the consulting practitioner) will **simply**

agree with each other in what will become a **form filling exercise** (tick and flick) without adequate examination of whether the eligibility criteria are truly met, and without detailed written explanation of the reasons justifying voluntary assisted dying?

14. Is the assessment of the probability of death appropriately, on the balance of probabilities: s 16(1)(d)(ii)? Is the "balance of probabilities" appropriate in medical practice (as opposed to law)?

15. Is it appropriate to make voluntary assisted dying available to persons suffering significant mental illness: s 16(2)(b)?

16. Should coordinating and consulting practitioners for the purpose of voluntary assisted dying have specialist accreditation: s 18?

17. Is the provision for **audio-visual communication** likely to give rise to abuse with the result that, in many cases, there will be inadequate consideration of the patient's condition, and inadequate communication with the patient and the patient's family: s 19(2), s 48(2)(b), s 182?

18. Should a person be able to request voluntary assisted dying using gestures that are not specified: s 19(3)(b), s 48(3)(b), s 57(3)(b)?

19. Should referral to a psychologist/psychiatrist be mandatory if a person is suffering from mental illness: s 27?

20. Should it be mandatory to notify the treating doctor: s 28(1)(j)?

21. Should the Voluntary Assisted Dying Board be notified of the existence of a mental illness: s 30(4)?

22. Is the mechanism established for voluntary assisted dying likely to attract zealots who will form an opinion in favour of voluntary assisted dying without having adequate regard to **other options**, including palliative care?

3 Conscientious Objection

23. Is the recognition of **conscientious objection** in s 9 of the Greenwich Bill undermined by other provisions (ss 21(5), 22, 23, 28(1)(j), 28(3), 32(5), 33, 34, together with Part 5 Participation).

24. Should conscientious objection be required to be immediately announced: s 21(5)(a)?

25. Should conscientious objectors be obliged to advise the Voluntary Assisted Dying Board of their conscientious objection: s 23(2)(h), s 34(2)(e)?

26. Should faith-based residential aged care facilities be required to allow all stages of voluntary assisted dying for permanent residents: ss 91-97?

27. Should faith-based hospitals be required to allow Voluntary Assisted Dying Navigators into the hospital to provide information: s 99(2)?

28. Will Part 5 of the proposed legislation drive faith-based institutions out of healthcare, and residential homes for the aged?

4 Administration

29. Does the **bureaucratic system** established by s 10(2) and s 10(3) of the Act create a scheme surrounding dying which will be offensive to many patients in the final part of their lives?

30. Does the Greenwich Bill undermine the **culture of care** which is a feature of medical, age and disability care in New South Wales derived from, inter alia, the Hippocratic Oath?

31. Should nurses be permitted to administer lethal drugs: s 55(a)?

32. Should the Supreme Court be able to review prognosis: s 109?

33. Should the process of voluntary assisted dying be shrouded in secrecy: ss 131-132, 149?

34. Should the limitation period for prosecutions be two years: s 135? Should there be any limitation period?

35. Should breaches of the law be protected: s 139?

36. Is the information recorded by the Voluntary Assisted Dying Board sufficient: s 176?

37. Should authority to determine matters (**Access Standard**) be delegated to the Health Secretary or should such be determined by Parliament?

38. Should the time between first and final requests be as short as five days, or even shorter if the patient is expected to die or lose mental capacity within five days: s 49?

39. Is the definition of ‘family member’ appropriate to First Nation communities: Schedule 1?

40. Given widespread abuse of patients in residential care, is voluntary assisted dying appropriate?

41. Should there be provision for payment of interpreters?

5 Culture

42. Will the Voluntary Assisted Dying Care Navigator Service, together with the Voluntary Assisted Dying Board become advocates for voluntary assisted dying in circumstances where their activities are not adequately scrutinised?

43. Will the Greenwich Bill, if enacted, give rise to **further campaigns** intended to “liberalise” eligibility for voluntary assisted dying, whether on a voluntary or non-voluntary basis?

Below is an outline of certain significant provisions of the Greenwich Bill with reference to the Second Reading Speech, together with various, far from comprehensive observations:

Part 10 Voluntary Assisted Dying Board

Division 1 Establishment (ss 140 – 141)

Division 2 Functions and powers (ss 142 – 144)

142 Functions of Board

(1) The Board has the following functions—

- *(a) to* ***monitor*** *the operation of this Act,*
- *(b) to* ***keep a list of registered health practitioners who are willing to assist with voluntary assisted dying****, including by—*
  - *(i) participating in the request and assessment process, and*
  - *(ii) prescribing, supplying or administering a voluntary assisted dying substance, and*
  - *(iii) being present at the time of the administration of a voluntary assisted dying substance,*
- *(c)* ***to make decisions about applications*** *made to the Board under section 17(1),*
- *(d)* ***to make decisions about voluntary assisted dying substance authorities****,*
- *(e) to provide to the Minister or the Health Secretary, on its own initiative or on request,* ***advice****, information and reports on matters* relating to the operation of this Act*, including* ***recommendations for the improvement of voluntary assisted dying****,*
- *(f) …*

Division 3 Staff and assistance (ss 145 – 146)

Part 10 Voluntary Assisted Dying Board

Division 4 Accountability (s 147 – 148)

147 Minister may give directions

*(1) The Minister may give **written directions** to the Board about the performance of its functions.*

(2) The Board must comply with a direction given by the Minister under subsection (1).

(3) …

148 Minister to have access to information

(1) The Minister is entitled—

- *(a) to have **information** in the Board's possession, and*
- *(b) if the information is in or on a document—to have, and make and keep **copies of**, the document.*

(2) …

(3) For the purposes of subsection (1), the Minister may—

- *(a) ask the Board to give information to the Minister, and*
- *(b) ask the Board to give the Minister access to information, and*
- *(c) for the purposes of paragraph (b), make use of staff provided to the Board under section 145 and the Board's facilities to obtain and give the information to the Minister.*

(4) The Board must—

- *(a) comply with a request under subsection (3), and*
- *(b) make staff and facilities available to the Minister as required under subsection (3)(c).*

(5) …

Division 5 Membership (s 149 – 163)

149 Membership of Board

*(1) The Board consists of **5 members** jointly appointed by the Minister and the Attorney General by Gazette notice.*

*(2) A person may be appointed as a member of the Board if the Minister and Attorney General are satisfied the person has **knowledge, skills or experience relevant to the Board's functions**.*

(3) …

(4) …

150 Chairperson and deputy chairperson

(1) The Minister and the Attorney General must appoint—

  *(a) one member of the Board to be the **chairperson** of the Board, and*

  *(b) another member of the Board to be the **deputy chairperson** of the Board.*

(2) A member of the Board is not eligible to be appointed as the chairperson or deputy chairperson unless the person is—

  *(a) an **Australian legal practitioner** with at least 7 years' legal practice experience, and*

  (b) either—

  *(i) a **Judge** or other judicial officer, or a former Judge or other judicial officer, of a superior court of record of the State or of another State or Territory or of Australia, or*

  (ii) qualified to be appointed as a Judge or other judicial officer of a court referred to in subparagraph (i).

(3) …

(4) …

Division 6 Board meetings (s 156 – 163)

Part 10 Voluntary Assisted Dying Board

Division 7 Disclosure of interests (s 164 – 168)

Division 8 Committees (s 169 – 172)

Division 9 Information (s 173 – 176)

176 Board to record and keep statistical information

*(1) The Board **must record and keep statistical information** about the following matters relating to voluntary assisted dying—*

*(a) the **disease**, illness or medical condition of a patient that met the requirements of section 16(1)(d), whether or not the patient made a final request,*

*(b) if a patient has died after self-administering or being administered a voluntary assisted dying substance in accordance with this Act—the **age** of the patient on the day the patient died,*

*(c) participation in the request and assessment process, and access to voluntary assisted dying, by patients who are **regional residents**,*

(d) a matter specified in a direction under subsection (2).

*(2) The Minister **may give a written direction** to the Board requiring the Board —*

*(a) to **record and keep statistical information** about a matter relating to voluntary assisted dying specified in the direction, and*

*(b) to **include the statistical information in its annual report**.*

(3) The Board must give effect to a direction under subsection (2).

Division 10 Miscellaneous (s 177 – 179)

179 Annual report

*(1) The Board must, **within 6 months** after the end of each financial year, prepare and give to the Minister a report on the operation of this Act during the financial year.*

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(2) The report must include—

- *(a) any* ***recommendations*** *the Board considers appropriate in relation to voluntary assisted dying, and*
- *(b) any* ***information the Board considers relevant to the performance of its functions****, and*
- *(c) the* ***number of referrals*** *made by the Board under section 142(1)(f), and*
- *(d) the text of any direction given to the Board under section 147(1) or 176(2), and*
- *(e) details of any disclosure under section 164(1) that relates to a matter dealt with in the report and of any resolution under section 166 about the disclosure, and*
- *(f)* ***statistical information*** *the Board is directed under section 176(2) to include in the report, and*
- *(g) information about the extent to which* ***regional residents*** *had access to voluntary assisted dying, including statistical information recorded and kept under section 176(1)(c), and having regard to the access standard under section 180.*

(3) The report must not include—

- *(a) personal information about a patient, medical practitioner or other person who has participated in the request and assessment process or the process for accessing voluntary assisted dying under Part 4, or*
- *(b) information that would prejudice—*
  - *(i) a criminal investigation or criminal proceeding, or*
  - *(ii) a civil proceeding, or*
  - *(iii) a proceeding in the Coroner's Court of New South Wales.*

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(4) The Minister must ensure a copy of the report is laid before each House of Parliament within 6 sitting days of the House after the day on which the Minister receives the report.

Second Reading Speech

- The Voluntary Assisted Dying Board will play an important **oversight role**. The board will **collect and publish data**; provide advice, information and reports to the minister and the Health Secretary; and refer matters, for example to the police, the Coroner or the Health Care Complaints Commission.
- The board will be responsible for **determining applications** to prescribe a voluntary assisted dying substance and for sending information to the patient's Contact Person to ensure that they know how to comply with obligations.
- The board will be made up of five members jointly appointed by the Minister for Health and the Attorney General. The chairperson and the deputy chairperson will be required to have minimum specified practical **legal experience**.

Comment

1. The Voluntary Assisted Dying Board is responsible for administering the Act. The Board is to consist of five members: s 149. The Board has a global view of the operation of the Scheme. The Board also has a role in suggesting changes to the legislation. The Board has a role with respect to delegated legislation.

Membership

2. Section 150 provides that the Chairperson and the Deputy Chairperson must be lawyers. While there is provision for the Board to have two persons who are legally trained, there should be provision for membership from among the following fields of medicine:
    - geriatrics
    - palliative care

Part 10 Voluntary Assisted Dying Board

- oncology
- neurology
- psychiatry

3. The limit on the number of members on the Board to five does not allow for adequate representation of medical specialists. It is best practice for a **multidisciplinary** team to provide medical input.

4. All applications for voluntary assisted dying must go to the Board. All such applications ultimately have to be approved to ensure that the relevant criteria have been satisfied. The Board is the authority which provides the medication.

5. The Board is required to publish an annual report.

6. In effect, the Voluntary Assisted Dying Board will promote voluntary assisted dying.

7. Assuming that the proposed NSW legislation operates similarly to the Victorian, the majority of persons who seek voluntary assisted dying will have some form of **cancer**, or suffer from a **neurodegenerative disease.** The term ‘neurodegenerative disease’ is problematic as it is a vague term.

Continuing Independent Assessment

8. While there are provisions to enable the Minister to give directions, for an Annual Report, for review of the Act, for provision of information to the Minister, there are not there provisions which are to be found in some other legislation which enable **continuing independent assessment** of the work of the Voluntary Assisted Dying Board.

ICAC Inspector

9. For instance, Part 5A of *the Independent Commission Against Corruption Act 1988* provides for appointment of an Inspector of ICAC, whose role includes:

    9.1. auditing the operations of the Commission for the purpose of **monitoring compliance** with the law of the State, and

9.2. dealing with **complaints** of abuse of power, impropriety and other forms of misconduct on the part of the Commission or officers of the Commission, and

9.3. dealing with conduct amounting to **maladministration** (including, without limitation, delay in the conduct of investigations and unreasonable invasions of privacy) by the Commission or officers of the Commission, and

9.4. Assessment of the **effectiveness and appropriateness of the procedures** of the Commission relating to the legality or propriety of its activities.

10. The functions of the ICAC Inspector may be exercised on the Inspector's initiative at the request of the Minister, in response to a complaint made to the Inspector or in response to a reference by the Joint Committee or any public authority or public official. The Inspector is not subject to the Commission in any respect.

Maladministration

11. For the purposes of Part 5A conduct is of a kind that amounts to maladministration if it involves action or inaction of a serious nature that is:

- contrary to law, or
- unreasonable, unjust, oppressive or improperly discriminatory, or
- based wholly or partly on improper motives.

12. The ICAC Inspector has extensive powers to investigate matters and make recommendations, as well as the powers and authorities, protections and immunities conferred on a commissioner by Division 1 of Part 2 of the *Royal Commissions Act 1923*.

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Parliamentary Joint Committee

13. Similarly, **the Greenwich Bill has no provision equivalent to Part 7 of the *Independent Commission Against Corruption Act 1988* which provides for a Parliamentary Joint Committee** to:

    13.1. to **monitor** and to **review** the exercise by the Commission and the Inspector of the Commission's and Inspector's functions,

    13.2. to **report** to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or the Inspector or connected with the exercise of its functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,

    13.3. to **examine each annual and other report** of the Commission and of the Inspector and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,

    13.4. to examine **trends** and **changes** in corrupt conduct, and practices and methods relating to corrupt conduct, and report to both Houses of Parliament any change which the Joint Committee thinks desirable to the functions, structures and procedures of the Commission and the Inspector,

    13.5. to **inquire into any question** in connection with its functions which is referred to it by both Houses of Parliament, and report to both Houses on that question.

14. Part 8 of *the Independent Commission Against Corruption Act 1988* provides for references by and reports to Parliament.

Modern Slavery Act 2018

15. Division 4 of Part 2 of the *Modern Slavery Act* provides for a **Modern Slavery Committee** being a Joint Committee of Members of Parliament:

    15.1. to inquire into and report on relevant matters; and

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15.2. report to both Houses on relevant matters.

15.3. given the novel nature of the Voluntary Assisted Dying Bill, there should be an effective method available by an **independent person**, as well as by the **Parliament** itself, to **constantly monitor** the activities of the Voluntary Assisted Dying Board.

Part 1 – Preliminary

Part 1 Preliminary

Preliminary Part 1

Division 1 Preliminary (ss 1-3)

Division 2 Principles (s 4)

4 Principles

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

- *(a) **every human life has equal value**,*
- *(b) a person's **autonomy**, including autonomy in relation to end of life choices, should be respected,*
- *(c) a person has the **right to be supported** in making **informed decisions** about the person's medical treatment and should be given, in a way the person understands, information about medical treatment **options**, including **comfort** and **palliative care** and **treatment**,*
- *(d) a person approaching the end of life should be provided with high quality care and treatment, including **palliative care and treatment**, to **minimise the person's suffering** and maximise the person's **quality of life**,*
- *(e) a **therapeutic relationship** between a person and the person's health practitioner should, wherever possible, be supported and maintained,*
- *(f) a person should be encouraged to **openly discuss death and dying**, and the person's preferences and values regarding the person's care, treatment and end of life should be encouraged and promoted,*

Part 1 Preliminary

(g) *a person should be supported in conversations with the person's health practitioners,* ***family****, carers and community about care and treatment preferences,*

(h) *a person is entitled to* ***genuine choices*** *about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,*

(i) *a person who is a* ***regional resident*** *is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region,*

(j) *there is a need to protect persons who may be subject to* ***pressure or duress****.*

(k) *all persons, including health practitioners, have the* ***right to be shown respect for their culture, religion, beliefs, values and personal characteristics****.*

(2) …

Division 3 Interpretation (s 5-8)

6 Decision-making capacity

(1) For the purposes of this Act, a patient has ***decision-making capacity*** *in relation to voluntary assisted dying if the patient has the capacity to—*

(a) ***understand*** *information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient, and*

(b) ***remember*** *the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and*

(c) *understand the* ***matters involved*** *in a voluntary assisted dying decision, and*

(d) *understand the* ***effect*** *of a voluntary assisted dying decision, and* *(e) **weigh up** the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and*

*(f) **communicate** a voluntary assisted dying decision in some way.*

*(2) For the purposes of this Act, a patient is— (a) **presumed** to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision, and (b) **presumed** to have decision-making capacity in relation to voluntary assisted dying **unless the patient is shown not to have the capacity.***

(3) In this section— voluntary assisted dying decision means— (a) a request for access to voluntary assisted dying, or (b) a decision to access voluntary assisted dying.

Division 4 Other provisions (ss 9 – 14)

9 Registered health practitioner may refuse to participate in voluntary assisted dying

*(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) participate in the **request and assessment process**,*

*(b) **prescribe, supply or administer** a voluntary assisted dying substance,*

*(c) **be present** at the time of the administration of a voluntary assisted dying substance.*

*(2) Subsection (1) **does not limit** the circumstances in which a registered health practitioner may refuse to do any of the things referred to in the subsection.*

21 Medical practitioner to accept or refuse first request

(1) …

(2) …

Part 1 Preliminary

(3) The medical practitioner must immediately decide to refuse the first request if the practitioner is not eligible to act as a coordinating practitioner at the time the first request is made.

(4) Unless subsection (5) applies, the medical practitioner must, within 2 business days after the first request is made—

(a) inform the patient that the practitioner has decided to accept or refuse the request, and

(b) give the patient the information approved by the Health Secretary, by Gazette notice, for the purposes of this section.

(5) If the medical practitioner decides to refuse the first request because the practitioner has a **conscientious objection** *to voluntary assisted dying, the practitioner must,* ***immediately*** *after the first request is made—*

(a) inform the patient that the practitioner has decided to refuse the request, and

(b) ***give the patient the information approved by the Health Secretary****, by Gazette notice, for the purposes of this section.*

22 Medical practitioner to record first request and acceptance or refusal

The medical practitioner must record the following in the patient's medical record

(a) the first request,

(b) the practitioner's decision to accept or refuse the first request,

Note— See section 21(2), which provides the only reasons for which a medical practitioner may refuse a first request.

(c) ***if the practitioner's decision is to refuse the first request—the reason for the refusal****,*

(d) ***whether the practitioner has given the patient the information referred to in section 21(4)(b) and (5)(b).***

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23 Medical practitioner to notify Board of first request

(1) Within 5 business days after deciding to accept or refuse the first request, the medical practitioner must—

(a) complete the approved form (the first request form), and

(b) ***give a copy of the first request form to the Board****.*

(2) The first request form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the medical practitioner's name and contact details,

(c) the date the first request was made,

(d) whether the first request was made in person or using audiovisual communication,

(e) whether the first request was made verbally or in another way,

(f) if the patient was assisted by an interpreter to make the first request—the interpreter's name, contact details and accreditation details,

(g) the medical practitioner's decision to accept or refuse the first request, (h) if the medical practitioner's decision is to refuse the first request—the reason for the refusal,

(h) ***if the medical practitioner's decision is to refuse the first request—the reason for the refusal,***

(i) the date the medical practitioner informed the patient of the practitioner's decision and gave the patient the information referred to in section 21(4)(b) or (5)(b), (j) the medical practitioner's signature and the date the form was signed.

28 Information to be provided if patient assessed as meeting eligibility criteria

Part 1 Preliminary

(1) If the coordinating practitioner is satisfied the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters—

(a) …

(b) …

(c) …

(d) …

(e) …

(f) …

(g) …

(h) …

(i) …

(j) that if the patient is receiving ongoing health services from a medical practitioner (the treating practitioner) other than the coordinating practitioner—

(i) the patient is ***encouraged*** *to inform the treating practitioner about the patient's request for access to voluntary assisted dying, and*

(ii) it is ***unlawful for the treating practitioner to withdraw other services the practitioner would usually provide to the patient*** *or the patient's family and other close contacts* ***because of the patient's request for access to voluntary assisted dying****, and*

(iii) ***if the treating practitioner withdraws services mentioned in subparagraph (ii)—the matter should be the subject of a complaint to the Health Care Complaints Commission under the Health Care Complaints Act 1993***

(k) …

*(3) The withdrawal of services by a medical practitioner in circumstances mentioned in subsection (1)(j)(ii) may be **unsatisfactory professional conduct** for the purposes of the Health Practitioner Regulation National Law*

10 Health care worker not to initiate discussion about voluntary assisted dying

*10 Health care worker **not to initiate discussion about voluntary assisted dying***

*(1) A health care worker who provides health services or professional care services to a person **must not**, while providing the services to the person—*

- *(a) **initiate a discussion with the person that is in substance about voluntary assisted dying**, or*
- *(b) in substance, **suggest voluntary assisted dying** to the person. Note—A contravention of this Act is capable of constituting **unsatisfactory professional conduct or professional misconduct** for the purposes of the Health Practitioner Regulation National Law, whether or not the contravention constitutes an offence.*

*(2) Subsection (1) does not apply to a medical practitioner who initiates a discussion or makes a suggestion referred to in subsection (1)(a) or (b) if, **at the time the discussion is initiated or the suggestion is made, the medical practitioner also informs the person about the following**—*

- *(a) the **treatment options** available to the person that would be considered standard care for the disease, illness or medical condition with which the person has been diagnosed,*
- *(b) the **likely outcomes** of the treatment options available to the person,*
- *(c) the **palliative care and treatment options** available to the person,*
- *(d) the **likely outcomes** of the palliative care and treatment options.*

(3) Also, subsection (1) does not apply to a health care worker, other than a medical practitioner, who initiates a discussion or makes a suggestion referred

to in subsection (1)(a) or (b) if, at the time the discussion is initiated or the suggestion is made, the health care worker also informs the person that the person—

*(a) has **palliative care and treatment options** available, and*

*(b) should discuss the **palliative care and treatment options** with the person's medical practitioner.*

(4) …

(5) ….

11 Contravention of Act by registered health practitioner

*(1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting **unsatisfactory professional conduct** or **professional misconduct** for the purposes of the Health Practitioner Regulation National Law.*

(2) Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

12 Voluntary assisted dying not suicide

*(1) For the purposes of the law of the State, **a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.***

(2) Voluntary assisted dying action does not—

(a) constitute an attempt by the person to cause serious physical harm to the person for the purposes of the Mental Health Act 2007, section 22, or

(b) otherwise provide a ground for a police officer to take action under that section.

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(3) In this section— voluntary assisted dying action means any of the following done in accordance with this Act—

(a) a request for access to voluntary assisted dying,

(b) a self-administration decision or a practitioner administration decision,

(c) self-administration by a person of a prescribed substance,

(d) asking an administering practitioner to administer a prescribed substance

Second Reading Speech

- The Greenwich Bill provides for, and **regulates access to, voluntary assisted dying** for persons with a terminal illness; and **establishes the Voluntary Assisted Dying Board to administer the legislation.**
- The bill sets out in detail:
    - the **principles** that underpin the legislation;
    - the **eligibility** criteria to access voluntary assisted dying;
    - the steps that a person must take before they can get access;
    - the protections for health care workers including to ensure they can **conscientiously object**;
    - the rights and responsibilities of **institutions and facilities that refuse to provide voluntary assisted dying services**;
    - the **eligibility criteria** of other persons involved in the process such as doctors, nurses and witnesses;
    - the makeup and role of the **Voluntary Assisted Dying Board**;
    - the options to request a review through the **Supreme Court**;
    - **offences**; and
    - requirements to **review** the legislation.

Part 1 Preliminary

- The process is **entirely voluntary**, there is no obligation on a patient to continue, and the patient is told multiple times throughout the process that they can withdraw at any time.
- A doctor can refuse because they have a **conscientious objection** to voluntary assisted dying, or because they are unwilling or unable to perform the duties of a Coordinating Practitioner.

Comment

Part 1 – Preliminary

Principles

1. The principles which are set out here are not unreasonable. However, they are, in effect, platitudes**. If there is no machinery to give effect to such 'principles', they are largely useless**. There is no provision in the Greenwich Bill which gives effect to s 4(1)(e) requiring that a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained. Indeed, quite the contrary. There is no provision in the Greenwich Bill which gives effect to s 4(1)(g) that a patient be supported in conversation with the patient's health practitioner's **family**, carers and community about care and treatment preferences. Indeed, quite the contrary.

Therapeutic Relationship

2. The therapeutic relationship between a patient and their doctor is diminished by the Greenwich Bill. The presumption of capacity is at odds with other areas of medicine. For example, an orthopaedic surgeon would not perform surgery on a patient presuming that the patient had capacity to give consent. In no other area of medicine is a presumption made that a person has capacity.
3. Doctors are accustomed to making decisions for the good of the patient which, on occasion, involves **refusing to provide suggested treatment**, various

procedures, therapy and medication. The proposed legislation significantly diminishes the entitlement of medical practitioners to refuse to provide suggested “treatment”. By way of example, if a surgeon disagrees that surgery is necessary, the surgeon is **not** required to refer the patient to another surgeon to perform the surgery. Medical practitioners are under an obligation to continue to treat a patient even if the patient is in the process of accessing voluntary assisted dying. Arguably, this involves diminution of the therapeutic relationship which may, in some circumstances, involve the doctor refusing to provide certain forms of suggested “treatment”, not for the doctor’s personal reasons, but for the good of the patient.

Section 6 – Decision making-capacity

4. With respect to s 6(2), it is **presumed** that a patient has **capacity** to understand information, and it is **presumed** that the patient has decision-making capacity. This subsection is problematic. The onus should be reversed, such that the **patient is presumed not to have capacity until the patient is shown to, in fact, have capacity**.

5. See ‘Seven Deaths in Darwin: Case Studies under the Rights of the Terminally Ill Act, Northern Territory, Australia’, *The Lancet*, Vol 352, pp1097-1102. During the nine months between July 1996, and March 1997, the provision of euthanasia for the terminally ill was legal in the Northern Territory. Seven patients made use of the legislation. Four died. The authors taped in-depth interviews with the general practitioner who provided euthanasia. Further information was available from public texts created by patients, the media, and the Coroner. All seven patients had cancer, most at advanced stages. Three were **socially isolated**. Symptoms of **depression** were common. Having met the criteria of the Act, some patients deferred their decision for a time before proceeding with euthanasia. **Medical opinions about the terminal nature of illness differed.** Provision of opinions about the terminal nature of illness and

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the mental health of the patient as required by the legislation, created **problematic gatekeeping** roles for the doctors involved.

Fluctuating Capacity

6. Capacity can be **fluctuating**, particularly when dealing with the elderly. By way of example, **elderly persons can present, very often in a state where their capacity is compromised, as a result of suffering from a relatively common illness**, such as a urinary tract infection. Often when an elderly person presents at hospital with a urinary tract infection the person is delirious and does not have capacity. With treatment, the urinary tract infection resolves, and the patient's capacity to make decisions returns.

Assessment of Capacity

7. With respect to the elderly, geriatricians are expert in evaluating whether or not an elderly person has capacity. Geriatricians use various tools, such as a mental mini score, to assess a person's capacity. Geriatricians employ various measures to assess a person's cognition at a given point in time.

Neuropsychologist

8. Given that access to voluntary assisted dying is not considered a medical emergency, it is appropriate for a patient contemplating such, to be referred to a neuropsychologist for an assessment of the patient's capacity. Neuropsychologists specialise in assessing capacity. Neuropsychologists often deal with patients who are coming to a point in their life where their capacity is in doubt. By way of example, a neuropsychologist often will assess a patient prior to entering a nursing home or where an application is made with respect go guardianship.

Psychiatric or Psychological Assessment

9. Another issue here is that no mandatory consideration is given to a patient's situation from a psychiatric or psychological perspective.

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Forms

10. Assuming that a series of forms (possibly computerised forms) are developed for the consulting practitioner to fill in, and a 'yes' or 'no' box provided for the question – Is the patient presumed to have capacity? – there does not seem to be any requirement for medical practitioners to provide or be required to provide a **considered and detailed written opinion**, as opposed to simply **ticking a box**. There is no requirement that the medical practitioners have access to a patient's medical records. If this is simply a tick and flick system with respect to presumed capacity, the decision cannot be effectively challenged. The reasoning of the medical practitioners will be opaque rather than transparent.

Section 9 Conscientious Objections

11. There is an obligation placed upon a medical practitioner such that if he or she objects to voluntary assisted dying, and it is raised by a patient - the medical practitioner **must** provide information to the patient so that the patient can access another health practitioner who will assist. This raises issues for medical practitioners who regard compliance with such mandatory obligations as 'immediate material cooperation'. The conscientious objection provision must be read subject to s 21(5), 22, 23, 28(1)(j), 28(3), 32(5), 33, 34 and Part 5 (which relates to hospitals and residential facilities, mainly aged care institutions). Those provisions must also be read subject to s 11(1) which relates to unsatisfactory professional conduct, and professional misconduct.

Section 10 - Health care worker not to initiate discussion about voluntary assisted dying

12. Section 10 provides, in effect, a direction that a doctor **must not initiate a discussion about voluntary assisted dying.** However, subsection (2) almost obviates subsection (1), because it says that it does not apply if **at the time of the discussion is initiated** or a suggestion is made the medical practitioner

also informs the patient about treatment options, likely outcomes, palliative care and likely outcomes.

13. Subsection (2) may give rise to a situation where doctors in discussing standard treatment options **may feel compelled to raise the option of voluntary assisted dying where they may not otherwise do so**.

14. Whist the proposed legislation proposes that doctors go through all treatment options for a patient, this does not happen in practice. A medical practitioner may make a decision that a certain treatment option is not appropriate for a given patient and will therefore not offer the treatment option to the patient, even though technically it is a treatment option. By way of example, if a patient presents with cancer, such as a lesion on his/her lung, at the age of 90, most oncologists would not consider aggressive chemotherapy appropriate, and therefore would not suggest chemotherapy as a treatment option. Doctors limit the range of treatment options to the treatment options that they consider are in the best interest of the patient. Patients are not taken through theoretical options.

15. The Greenwich Bill **establishes a legalistic process whereby patients may be given more options than necessary**, including options such as voluntary assisted dying which are offensive to the patient. Patients are entitled to die in peace without being badgered about “options” which are deeply offensive to them. Medical practitioners who are pro voluntary assisted dying may zealously push their agenda.

Varying Opinions as to Diagnosis and Treatment

16. Doctors do not always get diagnosis correct, and opinions between doctors as to diagnosis and treatment vary. By way of example, one surgeon may examine a patient and consider that, given the evidence, spinal surgery is necessary. Another doctor, looking at the same evidence, may decide that a conservative approach is appropriate. Doctors, looking at the same set of

facts and evidence, can vary with respect their diagnosis and suggested treatment plan.

17. Most people tend to take the advice of their doctor. There is the risk that a doctor who is pro voluntary assisted dying may be of the view that the patient will experience immeasurable suffering if the patient pursues palliative care, and thus lead the patient to seek access to voluntary assisted dying, without the patient trying palliative care first. Voluntary assisted dying should not be considered a treatment option in a broad suite of treatment options.

Family

18. The procedure proposed in the Greenwich Bill ignores the reality that in many cases, doctors do not just discuss issues with a patient, but also with the patient’s family. There should be a provision in subsection 10(1) that the medical practitioner must initiate any discussion with the patient, **and, with the patient’s consent, with the family of the patient.** The Greenwich Bill operates on a very individualistic basis, effectively excluding the patient’s family. The Greenwich Bill does not see the patient as part of a family, with members of the family intimately involved in the patient’s care at a time when the patient is particularly vulnerable.

19. The Greenwich Bill does not see the patient as likely to be discussing issues with family members. Where the patient does not understand what the doctor tells them, when technical words are used, if a family member is present, the family member may question the doctor further. When a person dies in hospital unexpectedly, family members are usually very distressed, particularly when the family members have not been forewarned of the impending death.

20. This is where professionalism, as opposed to bureaucracy, arises because, at the end of the day, the doctor needs to consider who the discussion should be with or who should be at the discussion. It is very difficult to set out a set of rules about this. The role of the family needs to be recognised. Even in

situations where a person has capacity, it is common for the patient not to make decisions by themselves. It is not unusual for a patient to ask his or her medical practitioner to speak to their son or daughter about their condition and treatment options.

21. All medical decisions, particularly of this nature, ultimately rely on the good will of the medical professional, not only with respect to their knowledge, but also on their judgment, and their willingness to communicate, both with the patient and the patient's family.

Bureaucratic as Opposed to Professional Model

22. The proposed voluntary assisted dying model, is both individualistic and bureaucratic. The proposed model is inconsistent with the current professional model. The professional model recognises that circumstances are infinitely various and require an element of discretion, often where the doctor is operating on the basis of limited information, and, maybe, inconsistent information.

Section 12 - *Voluntary assisted dying not suicide*

23. The proposed legislation uses various euphemisms, including 'voluntary assisted dying.' There has been research which demonstrates that patients and their families are more satisfied with discussions with their doctor when the doctor is direct, does not 'beat around the bush', and does not use euphemisms. A doctor who says plainly, but kindly, to a patient that they have a terminal illness, may be more appreciated than a doctor who beats around the bush.

Culture

24. The culture of the medical and nursing profession, of hospitals, aged person and disability facilities in Australia is directed to preserving life, not destroying it. The Hippocratic objection to killing - *And I shall give to no-one a deadly medicine if asked to do so, neither shall I give advice to that effect* - is a

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powerful reminder of the traditional culture of doctors, hospitals and other institutions. The proposed legislation will alter the culture of doctors and nurses, the culture of medical, aged and disability care.

Part 2 Requirements for access to voluntary assisted dying

Part 2 Requirements for access to voluntary assisted dying

15 When person may access voluntary assisted dying

A person may access voluntary assisted dying if—

(a) the person has made a ***first request****, and*

(b) the person has been ***assessed as eligible*** *for access to voluntary assisted dying by—*

(i) the person's ***coordinating practitioner****, and*

(ii) the person's ***consulting practitioner****, and*

(c) the person has made a ***written declaration****, and*

(d) the person has made a ***final request*** *to the person's coordinating practitioner, and*

(e) the person's coordinating practitioner has certified in a ***final review*** *form that—*

(i) the request and assessment process has been completed in accordance with this Act, and

(ii) the practitioner is satisfied of each of the matters referred to in section 52(3)(f), and

(f) the person has made an ***administration decision****, and*

(g) ***if the person has made a self-administration decision—the person has appointed a contact person****, and*

(h) a ***voluntary assisted dying substance authority*** *has been issued by the Board in relation to the person.*

Part 2 Requirements for access to voluntary assisted dying

16 Eligibility criteria

(1) The following criteria must be met for a person to be eligible for access to voluntary assisted dying—

(a) the person is an adult,

(b) the person—

*(i) is an **Australian citizen**, or*

*(ii) is a **permanent resident** of Australia, or*

*(iii) at the time of making a first request, has been **resident in Australia for at least 3 continuous years**,*

*(c) at the time of making a first request, the person has been **ordinarily resident in New South Wales** for a period of at least **12** months,*

(d) the person is diagnosed with at least one disease, illness or medical condition that—

*(i) is **advanced, progressive and will cause death**, and*

*(ii) **will, on the balance of probabilities, cause death**—*

*(A) **for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months**, or*

*(B) **otherwise—within a period of 6 months**, and*

*(iii) is **causing suffering to the person that cannot be relieved in a way the person considers tolerable**,*

*(e) the person has **decision-making capacity** in relation to voluntary assisted dying,*

*(f) the person is acting **voluntarily**,*

*(g) the person is **not acting because of pressure or duress**.*

(h) the person’s request for access to voluntary assisted dying is enduring.

Part 2 Requirements for access to voluntary assisted dying

(2) A person is not eligible for access to voluntary assisted dying merely because the person has— (a) a ***disability****, or (b) a* ***mental health impairment*** *within the meaning of the Mental Health and Cognitive Impairment Forensic Provisions Act 2020*

17 Residency exemptions

Second Reading Speech

- The Voluntary Assisted Dying Bill 2021 will provide a safe framework for a patient whose **death is imminent**, and whose **pain and suffering** has become **unbearable** to get help to end that suffering at a time of their choosing. It follows the same eligibility, process and safeguards as bills passed in all other states.
- To be eligible to receive voluntary assisted dying, a patient must be at least 18 years of age, an Australian citizen, permanent resident or have been living in Australia for at least three continuous years; and ordinarily reside in New South Wales.
- A patient must be diagnosed with at least one disease, illness or medical condition that is **advanced, progressive and which, on the balance of probabilities, will cause death within six months, or in the case of a neurodegenerative disease, within 12 months**.
- The disease, illness or medical condition must cause **suffering** to the patient in a way that **cannot be tolerably relieved**.
- Importantly, the patient must have **decision-making capacity** to make a voluntary assisted dying decision.
- In seeking assistance, the patient must be acting **voluntarily** and without any pressure or duress. Pressure or duress includes coercion, intimidation, threats and undue influence.
- The bill also requires a patient's request for voluntary assisted dying to be **enduring**.
- The bill sets out in detail **each step** that a patient must take before they can access voluntary assisted dying from the First Request to disposing of any

unused substance. Each step must be recorded in specific forms that are sent to the Voluntary Assisted Dying Board.

- The process is **entirely voluntary**, there is no obligation on a patient to continue, and the patient is told multiple times throughout the process that they can withdraw at any time.

Comment

Section 15 – When person may access voluntary assisted dying

1. This section is, in effect, a summary of the process. It is to be noted that **neither** the coordinating practitioner nor the consulting practitioner **need be treating doctors**. This involves a recognition by the framers of the Bill that many doctors will wish to have no part of voluntary assisted dying.

Section 16 - Eligibility criteria

2. With respect to s 16(1)(d) (**advanced, progressive and will cause death**) it can be difficult to predict if a condition will cause a patient to die within a period of 12 months. A doctor may not be able to predict when a person who suffers from such a condition is likely to die.

3. A **neurodegenerative condition** means a condition of a neurological basis that progresses with time. This is a very broad term. Examples of neurodegenerative disorders include Alzheimer's Disease and dementia.

Victoria

4. It is interesting to note the experience of other States which have instituted voluntary assisted dying schemes. Only Victoria has had significant experience of voluntary assisted dying, albeit that all States, other than New South Wales, have enacted voluntary assisted dying schemes. In Victoria, registered practitioners are mainly general practitioners. There are 137 general practitioners, 41 medical oncologists, 11 neurologists, 8 general

medicine and 6 respiratory physicians.[2] It would seem that there are relatively few number medical practitioners accredited to participate in the scheme – which raises the issue as to whether it is only doctors who are zealots have signed up to it. In Victoria, in the six months up to June 2021, 7.6% of the people who took up voluntary assisted dying were aged 18 – 54, 18.4% were aged 54 – 64, 30.9% were aged 65 – 74, and 28.4% were aged 75-84 etc.[3] So, there were quite a number of young people who took up voluntary assisted dying. Over the six months to 30 June 2021, in Victoria, about 900 persons took advantage of voluntary assisted dying.[4] Of the 900 who took up voluntary assisted dying, 37% were said to be suffering from malignancy. 46% were said to be suffering from neurodegenerative disease. 21.7% were said to be suffering respiratory failure.[5]

Palliative Care

5. The other ‘condition’ of eligibility is - ‘**causing suffering to the person that cannot be relieved in the way a person considers tolerable**.’ Arguably, patients should be required to try an alternative first, because a patient, by way of example, cannot say that palliative care treatment will not work if they have not tried such. Similarly, a doctor cannot say that palliative care will not work if there has not been a trial. **Palliative care has, for the most part, allowed people to manage their pain levels**. **Medication** is available that will, for the majority of cases, control a patient’s pain so that their condition is tolerable. However, in situations where the pain is not controllable, there is the option for the patient to be **sedated** so that pain is not an issue, and nature can takes it course.

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[2] Voluntary Assisted Dying Review Board. Report of Operations: January – June 2021, p 5

[3] Op cit p 9

[4] Op cit p 10

[5] Op cit p 14

Part 2 Requirements for access to voluntary assisted dying

Subjective

6. The phrase '…in a way the person considers tolerable' is subjective. The person will not know what is tolerable until they experience it.

Adverse Incidents

7. Approximately 10% of all hospitalisations in Australia involve some adverse incident in a hospital setting, with the patient experiencing a hospital acquired condition. The high incidence of adverse incidents in Australia is of concern in the context of voluntary assisted dying. The proposed legislation takes little account of such high rates of adverse incidents. The Australian Institute of Health and Welfare, *Australia's Health 2016* stated that in 2013/2014 9.9% of hospitalisations in public hospitals, and 6% in private hospitals involved a substantial acquired condition. Things in hospitals go wrong for many reasons. If hospitals and other institutions are to become institutions of deliberate killing, things will, on occasion, go wrong in a fashion which cannot be remedied. The Gratton Institute's report, *All Complications Should Count: Using Our Data to Make Hospitals Safer*, February 2018, says that one in nine patients who go into hospital in Australia suffers a complication – about 900,000 patients each year. A patient's risk of developing a complication varies dramatically, depending on which hospital they go to. In some cases, the additional risk of a complication at the worst performing hospital can be four times higher than the best performers. Introducing a system of intentional killing of vulnerable patients into a hospital system where there are large numbers of adverse events, and inadequate data as to those events, will have unpredictable, and unfortunate consequences for the overall quality of patient care.

Aged Care

Part 2 Requirements for access to voluntary assisted dying

8. The danger associated with voluntary assisted dying is highlighted by the findings of the Royal Commission into **Aged Care, Quality and Safety: Final Report** where Commissioner Briggs said:

> *It is likely that at least 1 in 3, or over **30%**, of people in aged care have experienced **substandard care**.*
>
> - *In some areas of care, the data is clearer about the extent of substandard care, including:*
>   - *the incidence of **assaults** may be as high as **13–18%** in residential aged care*
>   - *there is a clear overuse of **physical restraint** in residential aged care*
>   - *in **residential aged care**, some **47%** of people have concerns about staff, including understaffing, unanswered call bells, high rates of staff turnover, and agency staff not knowing the residents and their needs*
>   - *in **home care**, one-third of people have concerns about staff, including continuity of staff and staff not being adequately trained*
>   - *similarly, in residential **respite care** and the Commonwealth Home Support Program respite care, about 30% of people have concerns about staff, including understaffing, continuity, unanswered call bells, training and communication.*
> - ***Substandard care has become normalised in some parts of the aged care system**, such that people have low expectations of the quality of their care.*

Amendment

9. The proposed legislation contains a variety of provisions which are likely to be the subject of **subsequent campaigns for amendment** to enable increasing numbers of persons to be subject to voluntary assisted dying eligibility, possibly with a drift from voluntary to nonvoluntary. Once the prohibition of intentional killing is crossed, there will be no turning back. Advocates for

voluntary assisted dying may see an initial restrictive law as a first step to amendments authorising increasingly broad killing. In this regard, reference should be made to the comments of Lord Wilson in *Nicklinson v Ministry of Justice* [2014] UKSC 38 at [228]:

> *228. The **vulnerability to pressure of the old or terminally ill** is a more formidable problem. The problem is not that people may decide to kill themselves who are not fully competent mentally. I am prepared to accept that mental competence is capable of objective assessment by health professionals. The real difficulty is that **even the mentally competent may have reasons for deciding to kill themselves which reflect either overt pressure upon them by others or their own assumptions about what others may think or expect**. The difficulty is particularly acute in the case of what the Commission on Assisted Dying called "**indirect social pressure".** This refers to the problems arising from the low self-esteem of many old or severely ill and dependent people, combined with the spontaneous and negative perceptions of patients about the views of those around them. The great majority of people contemplating suicide for health-related reasons, are **likely to be acutely conscious that their disabilities make them dependent on others**. These disabilities may arise from illness or injury, or indeed (a much larger category) from the advancing infirmity of old age. People in this position are vulnerable. **They are often afraid that their lives have become a burden to those around them**. The fear may be the result of **overt pressure**, but may equally arise from a **spontaneous tendency to place a low value on their own lives and assume that others do so too**. Their **feelings of uselessness** are likely to be accentuated in those who were once highly active and engaged with those around them, for whom the contrast between now and then must be particularly painful. These assumptions may be mistaken but are none the less powerful*

*for that. The legalisation of assisted suicide would be followed by its **progressive normalisation**, at any rate among the very old or very ill. In a world where suicide was regarded as just another optional end-of-life choice, the pressures which I have described are likely to become more powerful. It is one thing to assess some one's mental ability to form a judgment, but another to **discover their true reasons for the decision which they have made and to assess the quality of those reasons**. I very much doubt whether it is possible in the generality of cases to distinguish between those who have spontaneously formed the desire to kill themselves and those who have done so in response to real or imagined pressure arising from the impact of their disabilities on other people. There is a good deal of evidence that this problem exists, that it is significant, and that it is aggravated by **negative modern attitudes to old age and sickness-related disability**. Those who are vulnerable in this sense are not always easy to identify (there seems to be a consensus that the factors that make them vulnerable are variable and personal, and not susceptible to simple categorisation). It may be, as Lord Neuberger suggests, that these problems can be to some extent be alleviated by applying to cases in which patients wish to be assisted in killing themselves a procedure for obtaining the **sanction of a court**, such as is currently available for the withdrawal of treatment from patients in a persistent vegetative state. But as he acknowledges, there has been no investigation of that possibility in these proceedings. It seems equally possible that a proper investigation of this possibility would show that the intervention of a court would simply interpose an expensive and time-consuming forensic procedure without addressing the fundamental difficulty, namely that the wishes expressed by a patient in the course of legal proceedings may be as much influenced by covert social pressures as the same wishes*

> *expressed to health professionals or family members. These are significant issues affecting many people who are not as intelligent, articulate or determined as Diane Pretty or Tony Nicklinson.*

Vulnerable

10. Most persons are vulnerable when they are sick and dying. It is essential that the proposed legislation ensures that death is truly sought. **Depression** and **anxiety**, which are often an accompaniment of sickness, must be addressed. The safeguards must be administered by doctors who are not tired of the demands of a particular patient, or worse, voluntary assisted dying zealots assisted by a colleague who, in reality, exercises no independent judgement, unchallenged by family, who are provided with no real information, deferential to the "authority" of doctors, exhausted by the demands on their time made by the sick or dying person. Privacy must not be used as a means of ensuring no real scrutiny of what may be a failure of care. Euphemistic language must not oil the process. The process cannot be a system of ticking and flicking forms. The Bill should be amended to ensure that both coordinating and consulting medical practitioners provide a **detailed written report** explaining:

    - **Why** voluntary assisted dying is appropriate, taking into account the patient's medical history, including evaluation for mental illness, the patient's diagnosis.
    - The basis on which that **diagnosis** is arrived at.
    - The patient's **prognosis** and how that prognosis is arrived at.
    - The **options for treatment** of the patient including palliative care.
    - Why **palliative care** (including pain relief and/or sedation) is not appropriate.

11. The bureaucracy created to administer legislation must not be staffed by voluntary assisted dying enthusiasts. Doctors and institutions who conscientiously object to killing patients should not be shunted aside, or

forced to leave for areas of medicine or care where they are not required to do what they abhor. Voluntary assisted dying, in some circumstances, can be an assault on the most vulnerable at their most vulnerable.

12. The Greenwich Bill makes no distinction between **chronic illness and terminal illness**. Yet that distinction is important in everyday medical practice. There is some evidence that **depression is strongly associated with a desire to hasten death**, and that **once depression is effectively treated, almost all patients change their mind about wanting to die. Many doctors do not recognise depression or know how to assess the presence of depression in the terminally ill**. Even when depression is recognised, doctors wrongly may take the view that understandable depression cannot be treated, does not count or in some way is not real depression.[6]

Trust

13. It is important that unexpressed distrust not alter the relationship with the patient. Patients ought not be reluctant to see a doctor, go into hospital, go into care. The euphemisms which are the accompaniment of voluntary assisted dying, should not be allowed to drive out confidence and sew scepticism.

Narrowing of Lens

14. Much of the argument for the proposed legislation depends on hard cases, catastrophic situations, with a selected ‘assembly’ of facts, narrowing of the lens, a restricted view which leads important considerations out. Left out of consideration may be the danger of creating a culture hostile to life; emphasising the individual, disregarding the person’s role as a member of a family; allowing no room for practical compassion, no room for solidarity with

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[6] John Keown, “Voluntary Euthanasia and Physician-Assisted Suicide: The Two ‘Slippery Slope’ Arguments”, The Anscombe Bioethics Centre.

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the aged, the sick and disabled; seeing little value in the lives of persons who are regarded as not contributing, motivated only by utilitarian considerations.

Plasticity of Medical Opinion

15. The Greenwich Bill fails to address the reality that, given the plasticity of medical opinion, **anything is possible as regards medical certification**. Apparently complex procedures become perfunctory in the hands of those who have an interest in ridding themselves of challenging patients and in the hands of zealots.

Family

16. The Greenwich Bill **shuts the sick person's family largely out of decision making** – or even consultation. The Greenwich Bill fails to recognise that persons who are seriously ill are particularly vulnerable, that patients are usually members of a family, who value the patient for his or herself, and that the involvement of the patient's family may enhance the decision-making process for a patient who is old, or sick, or disabled – and hence vulnerable.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

Division 1 Eligibility requirements for medical practitioners (s 18)

18 Eligibility to act as coordinating practitioner or consulting practitioner

A medical practitioner is eligible to act as a ***coordinating practitioner*** *or* ***consulting practitioner*** *for a patient if—*

(a) the medical practitioner—

  (i) holds ***specialist*** *registration, or*

  (ii) holds ***general registration*** *and has practised the medical profession for at least* ***10 years*** *as the holder of general registration, or*

  (iii) is an ***overseas-trained specialist*** *who holds limited registration or provisional registration, and*

(b) the medical practitioner has completed the ***approved training****, and*

(c) the medical practitioner meets ***other requirements prescribed*** *by the regulations for the purposes of this section, and*

(d) the medical practitioner is not a family member of the patient, and

(e) the medical practitioner does not know or believe that the practitioner—

  (i) is a beneficiary under a will of the patient, or

  (ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

Division 2 First request (ss 19 – 24)

19 Person may make first request to medical practitioner

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

(2) The request must be—

- *(a) clear and unambiguous, and*
- *(b) made during a medical consultation, and*
- *(c) made in person or, if that is not practicable, in accordance with section 182(1)(a).*

(3) The person may make the request—

- *(a) verbally, or*
- *(b) in another way. Example for paragraph (b)— by use of gestures*

(4) The person may make the request with the assistance of an interpreter

Division 3 First assessment (ss 25 – 31)

28 Information to be provided if patient assessed as meeting eligibility criteria

(1) If the coordinating practitioner is satisfied the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters—

(a)...
(b)…
(c)…
(d)…
(e)…
(f)…

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

(g)…

(h)…

(i)…

(j) that if the patient is receiving ongoing health services from a medical practitioner (the treating practitioner) other than the coordinating practitioner—

  (i) the patient is encouraged to inform the treating practitioner about the patient's request for access to voluntary assisted dying, and

  (ii) it is unlawful for the treating practitioner to withdraw other services the practitioner would usually provide to the patient or the patient's family and other close contacts because of the patient's request for access to voluntary assisted dying, and

  (iii) if the treating practitioner withdraws services mentioned in subparagraph (ii)—the matter should be the subject of a complaint to the Health Care Complaints Commission under the Health Care Complaints Act 1993,

(k) …

30 Recording and notification of outcome of first assessment

(1) …

(2) …

(3) …

(4) The first assessment report form must include the following—

  (a) the patient's name, date of birth and contact details,

  (b) the following information about the patient—

    (i) gender,

(ii) nationality,

(iii) ethnicity,

(iv) whether the patient has a disability and, if so, details of the disability,

(v) whether the patient's first language is a language other than English,

(vi) whether the coordinating practitioner engaged an interpreter in accordance with section 182(2) to communicate the information in section 28(1) and (4) to the patient,

(c) the coordinating practitioner's name and contact details,

(d) a statement confirming the coordinating practitioner meets the requirements of section 18,

(e) the date the first request was made,

(f) the date the first assessment was completed,

(g) the outcome of the first assessment, including the coordinating practitioner's decision about each of the eligibility criteria,

(h) the date the patient was informed of the outcome of the first assessment,

(i) if the patient was referred under section 26(2) or 27(2)—the outcome of the referral, including a copy of a report given by the registered health practitioner or other person to whom the patient was referred,

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

(j) if the patient was assisted by an interpreter when having the first assessment— the interpreter's name, contact details and accreditation details,

(k) the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(l) a statement confirming the patient has been advised of the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(m) the coordinating practitioner's signature and the date the form was signed.

Division 5 Written declaration (ss 43 – 47)

Division 6 Final request and final review (ss 48 – 54)

Second Reading Speech

- The first step is for a patient to make a **First Request** to a doctor.
- The doctor must either accept or refuse the request.
- If the doctor accepts the First Request, the doctor becomes the **Coordinating Practitioner**.
- The Coordinating Practitioner must conduct a **First Assessment** of the patient against each eligibility criteria. This covers residency, diagnosis, prognosis, decision-making capacity, whether the request is voluntary and without pressure or duress, and whether the request is enduring.
- The bill makes it absolutely clear, that if a Coordinating Practitioner is uncertain about whether a patient has a **disease, illness or medical condition that complies with the requirements**, they must refer the patient to a medical practitioner who is qualified to make that decision such as an oncologist or a neurologist.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

- Similarly, if a Coordinating Practitioner is uncertain about whether the patient has **decision-making capacity** for a voluntary assisted dying decision, or whether the person could be subject to pressure or duress, they must refer the person to a psychiatrist or another registered health practitioner who is qualified to make that decision, such as a geriatrician.
- In the case of **pressure or duress**, if appropriate, a patient can be referred to a person who is not a registered health practitioner provided they have the skills and training to make an assessment. An example could be a social worker.
- If the Coordinating Practitioner determines after the First Assessment that the patient meets the eligibility criteria, they must provide the patient extensive **information** about their diagnosis, prognosis, treatment and palliative care options, and the process going forward if the patient chooses to continue. The Coordinating Practitioner must tell the patient that they may decide at any time not to continue further.
- If the Coordinating Practitioner is not satisfied that the patient meets any criterion, then they must assess the patient as ineligible, and the process ends.
- The Coordinating Practitioner must then refer the patient to another doctor for an **independent assessment**.
- The doctor who receives the Referral can accept or refuse it.
- A doctor can refuse a Referral because they have a conscientious objection to voluntary assisted dying, or because they are unwilling or unable to perform the duties of a Consulting Practitioner. They must refuse the Referral if they are not eligible to act as a Consulting Practitioner.
- The eligibility criteria for a Consulting Practitioner is the same as that for the Coordinating Practitioner.
- If the doctor accepts the Referral, they become the **Consulting Practitioner** and must independently assess the patient against each eligibility criterion.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

- The mandatory obligations on the Consulting Practitioner to refer a patient if they are uncertain about particular eligibility criteria reflect those on the Coordinating Practitioner in the First Assessment.
- If the Consulting Practitioner is not satisfied that the patient meets any criterion, then they must assess the patient as ineligible.
- If the Consulting Practitioner assesses the patient as eligible, they must provide the patient with the same information required of the Coordinating Practitioner after the First Assessment to ensure that the patient is kept informed about their medical situation and the outcomes of their decisions throughout the process. Importantly, the patient is told again that they are under no obligation to proceed with the process.
- Patients assessed as eligible in this rigorous process who choose to proceed with their application, must then make a **Written Declaration**.
- The Written Declaration involves making a request for access to voluntary assisted dying in writing, that declares that the request is voluntary and without pressure or duress, and that the patient understands the nature and effect of voluntary assisted dying.
- The patient is required to sign their Written Declaration in front of two witnesses. Each witness must certify in the declaration that in their presence, the patient appeared to freely and voluntarily sign the declaration.
- After the patient has given the Written Declaration to their Coordinating Practitioner, they must make a **Final Request** to the Coordinating Practitioner.
- This Final Request cannot be made earlier than five days after the First Request was made. However, if both the Coordinating Practitioner and the Consulting Practitioner agree that the patient is likely to die or lose decision-making capacity within that period, the Final Request can be made earlier.
- The Coordinating Practitioner must then conduct a **Final Review** of all assessment forms and certify that the assessment process has been complete and that the patient has decision-making capacity, is acting voluntarily and not

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

because of pressure or duress, and that their request for voluntary assisted dying is enduring.

Comment

Section 18 – Eligibility to act as coordinating practitioner

1. With respect to overseas trained specialists, it is very common for such practitioners to work in areas, usually rural areas, where there is a doctor shortage. Such doctors have to work in such areas for a number of years, after which time their qualifications are fully recognised and they are free to work anywhere in Australia.

Treating Doctors

2. The main area of concern with respect to this section is that a **patient's treating doctor/s are effectively not involved.** However, there is a concern that by legislating that a treating doctor have an obligation to be involved in such a process, may raise ethical issues for a doctor who has a conscientious objection to voluntary assisted dying legislation.

Medical Records

3. There is no provision for the coordinating or consulting doctor to have even looked at the **patient's medical records**. Such provision is necessary to ascertain whether the patient has a **long history of chronic depression**, **abuse of prescribed medication**, or **a long history of an exaggerated response to a medical condition, or whether the patient suffers from other psychiatric illness.**

4. The provision with respect to a coordinating practitioner who is uncertain as to whether or not a patient has decision making capacity and must refer to a psychiatrist (s 27), seems to be in contrast with the provision whereby it is presumed that a person has capacity (s 6).

Part 4 Accessing voluntary assisted dying and death

Part 4 Accessing voluntary assisted dying and death

Division 1 Eligibility requirements for administering practitioners (s 55)

55 Eligibility to act as administering practitioner

A person is eligible to act as an administering practitioner for a patient if—

(a) the person is—

- *(i) a medical practitioner who holds **specialist registration**, or*
- *(ii) a medical practitioner who holds **general registration** and has practised the medical profession for at least **5 years**, or*
- *(iii) a medical practitioner who is an **overseas-trained specialist who holds limited registration or provisional registration**, or*
- *(iv) a **nurse** practitioner, or*
- *(v) a **registered nurse** who has practised the nursing profession for at least **5** years, and Note— Under the Interpretation Act 1987, section 21D, a reference to a registered nurse does not include an enrolled nurse.*

(b) the person has completed **approved training***, and*

*(c) the person meets **other requirements prescribed** by the regulations for the purposes of this section, and*

(d) the person is not a family member of the patient, and

(e) the person does not know or believe that the person—

- *(i) is a beneficiary under a will of the patient, or*

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the administering practitioner for the patient.

Part 4 Accessing voluntary assisted dying and death

Division 2 Administration of voluntary assisted dying substance (ss 56 – 64)

Division 3 Contact person (ss 65 – 69)

Division 4 Authorisation in relation to voluntary assisted dying substances (ss 70 – 72)

Division 5 Prescribing, supplying and disposing of voluntary assisted dying substance (ss 73 – 83)

Division 6 Other matters (ss 84 – 87)

Second Reading Speech

- The Coordinating Practitioner must then request an authorisation to prescribe a substance from the Voluntary Assisted Dying Board. The board can refuse the authorisation if it suspects that the eligibility requirements have not been met.
- Before issuing a prescription, the Coordinating Practitioner must provide the patient **information on the substance**, including how the substance is to be administered, stored and prepared; the expected effects and risks of taking the substance; and the period after taking the substance when the patient is expected to die. The patient must be told at this time that they are under no obligation to proceed.
- The Coordinating Practitioner can then **prescribe a substance to assist the patient to die**. The prescription is sent directly to an Authorised Supplier.
- The patient will need to make an **Administration Decision** to decide whether they would like to **self-administer** the voluntary assisted dying substance or **have a health practitioner administer the substance to them**.
- A patient who chooses to self-administer must appoint a **Contact Person** to be responsible for returning any unused substance to an Authorised Disposer and informing the Coordinating Practitioner if the patient dies.
- Where a patient has chosen to self-administer the substance, the substance can be supplied to the patient, their agent or the Contact Person, and it must be stored in a locked box at all times.

Part 4 Accessing voluntary assisted dying and death
• Where a patient has chosen to have the substance administered by a health practitioner, the substance is supplied directly to the Administering Practitioner. • The **Administering Practitioner is likely to be the Coordinating Practitioner**, however they can also be a specialist, an overseas trained specialist, a general practitioner who has practised for at least five years, a nurse practitioner or a registered nurse who has practised for at least five years. They must have completed the Health Secretary's training. • The Administering Practitioner must administer the substance in front of an independent witness. The witness will need to certify to the board that the patient's request for access appeared to be free, voluntary and enduring.
Comment 1. As discussed elsewhere, the Bill assumes that voluntary assisted dying will commonly not be the province of treating doctors with consequent diminution of the assessment of the 'need' for voluntary assisted dying.

Part 5 Participation

Part 5 Participation

Division 1 Preliminary *(ss 88 – 89)*

88 Definitions

In this Part—

deciding practitioner*, for a decision about a person, means—*

(a) the person's coordinating practitioner, or

(b) if the person's coordinating practitioner is not available—another medical practitioner nominated by the person.

health care *means medical, surgical or nursing care.*

health care establishment *means—*

(a) a ***private health facility*** *within the meaning of the Private Health Facilities Act 2007, or*

(b) a ***public hospital*** *within the meaning of the Health Services Act 1997.*

health entity *means an entity that owns or operates a health care establishment.* ***relevant entity*** *means an entity, other than an individual, that provides a relevant service. relevant service means—*

(a) a personal care service, or

(b) a ***residential aged care service****.*

residential aged care means nursing care or personal care provided to a person in a residential facility in which the person is also provided with accommodation that includes—

(a) staffing to meet the nursing care and personal care needs of the person, and (b) meals and cleaning services, and

(c) furnishings, furniture and equipment for the provision of the person's nursing care or personal care and accommodation.

89 Participation in providing voluntary assisted dying services

(1) A residential facility or health care establishment ***may decide that it will not provide services relating to voluntary assisted dying*** *at the facility or establishment.*

(2) For the purposes of subsection (1), the residential facility or health care establishment may refuse to do any of the following or refuse to have persons employed by or at the facility or establishment do any of the following at the facility or establishment—

- *(a) participate in the request and assessment process,*
- *(b) participate in an administration decision,*
- *(c) prescribe, supply or administer a voluntary assisted dying substance,*
- *(d) store a voluntary assisted dying substance,*
- *(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.*

(3) Subsections (1) and (2) are ***subject to the requirements of Divisions 2 and 3****.*

Division 2 Residential facilities (i.e. aged care)

Subdivision 1 Information about voluntary assisted dying

90 Access to information about voluntary assisted dying

(1) This section applies if—

- *(a) a person is receiving relevant services from a relevant entity at a residential facility, and*
- *(b) the person asks the relevant entity for information about voluntary assisted dying, and*

Part 5 Participation

(c) the relevant entity does not provide at the residential facility, to persons to whom relevant services are provided, the information that has been requested.

(2) The relevant entity and any other entity that owns or occupies the residential facility—

(a) ***must not hinder the person's access at the residential facility to information about voluntary assisted dying****, and*

(b) ***must, if asked, allow reasonable access to the person at the residential facility*** *by—*

(i) a registered health practitioner or another person to enable the practitioner or other person to ***personally provide the requested information*** *about voluntary assisted dying to the person, or*

(ii) a member of an ***official voluntary assisted dying care navigator service*** *to provide support, assistance and information to persons relating to voluntary assisted dying*

Subdivision 2 Access to voluntary assisted dying *(ss 91- 96)*

92 First and final requests

(1) This section applies if—

(a) the person or the person's agent advises the relevant entity that the person wishes to make a first request or final request (each a relevant request), and

(b) the relevant entity does not provide, to persons to whom relevant services are provided at the residential facility, access to the request and assessment process at the facility.

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(2) The relevant entity and any other entity that owns or occupies the facility ***must allow reasonable access*** *to the person at the residential facility by a medical practitioner—* *(a) whose presence is requested by the person, and* *(b) who—* *(i) for a first request—is eligible to act as a coordinating practitioner, or* *(ii) for a final request—is the coordinating practitioner for the person.* *(3) If the requested medical practitioner is not available to attend, the relevant entity* ***must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made*** *to—* *(a) the requested medical practitioner, or* *(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner* ***93 First assessments*** *(1) This section applies if—* *(a) the person has made a first request, and* *(b) the person, or the person's agent, advises the relevant entity that the person wishes to undergo a first assessment, and* *(c) the relevant entity does not provide, to persons to whom relevant services are provided at the residential facility, access to the request and assessment process at the facility.* *(2) If the person is a permanent resident at the residential facility—* *(a) the relevant entity and any other entity that owns or occupies the residential facility* ***must allow reasonable access to the person at the***

facility *by a relevant practitioner for the practitioner to assess the person, and*

*(b) if a relevant practitioner is not available to attend—**the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by**—*

(i) the relevant practitioner, or

(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the residential facility—

*(a) the relevant entity **must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment may be carried out** by a relevant practitioner for the person, or*

*(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the residential facility **must allow reasonable access to the person at the facility by a relevant practitioner** for the person.*

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section— relevant practitioner, for a person, means—

(a) the person's coordinating practitioner, or

(b) a medical practitioner to whom the person's coordinating practitioner has referred a matter under section 26.

94 Consulting assessments

(1) This section applies if—

(a) the person has undergone a first assessment, and

(b) the person, or the person's agent, advises the relevant entity that the person wishes to undergo a consulting assessment, and

(c) the entity does not provide, to persons to whom the relevant services are provided at the residential facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the residential facility—

(a) the relevant entity and any other entity that owns or occupies the residential facility ***must allow reasonable access to the person at the facility*** *by a relevant practitioner for the practitioner to assess the person, and*

(b) if a relevant practitioner is not available to attend—the relevant entity ***must take reasonable steps to facilitate the transfer of the person to and from a place*** *where the person's assessment may be carried out by—*

(i) the relevant practitioner, or

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(ii) *another medical practitioner who is eligible and willing to act as a relevant practitioner.*

(3) *If the person is not a permanent resident at the residential facility—*

(a) *the relevant entity* ***must take reasonable steps to facilitate the transfer of the person*** *to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person, or*

(b) *if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the residential facility* ***must allow reasonable access to the person*** *at the facility by a relevant practitioner for the person.*

(4) *In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—*

(a) *whether the transfer would be likely to cause serious harm to the person,*

(b) *whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,*

(c) *whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,*

(d) *whether the place to which the person is proposed to be transferred is available to receive the person,*

(e) *whether the person would incur financial loss or costs because of the transfer.*

(5) *In this section— relevant practitioner, for a person, means—*

(a) *the person's consulting practitioner, or*

(b) *a medical practitioner to whom the person's consulting practitioner has referred a matter under section 37.*

95 Written declarations

(1) This section applies if—

(a) *the person has been assessed as eligible for access to voluntary assisted dying, and*

(b) *the person or the person's agent advises the relevant entity that the person wishes to make a written declaration, and*

(c) *the entity does not provide, to persons to whom relevant services are provided at the residential premises, access to the request and assessment process at the facility.*

(2) If the person is a permanent resident at the residential facility—

(a) *the relevant entity and any other entity that owns or occupies the residential facility* ***must allow reasonable access to the person*** *at the facility by—*

  (i) *the person's coordinating practitioner, and*

  (ii) *another person lawfully participating in the person's request for access to voluntary assisted dying to enable the person to make a written declaration, and*

(b) *if the coordinating practitioner is not available to attend—the relevant entity* ***must take reasonable steps to facilitate the transfer of the person*** *to and from the place where the person may make a written declaration.*

(3) If the person is not a permanent resident at the residential facility—

(a) *the relevant entity **must take reasonable steps to facilitate the transfer** of the person to and from a place where the person may make a written declaration, or*

(b) *if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the entity and any other entity that owns or occupies the residential facility **must allow reasonable access to the person** at the facility by—*

(i) *the person's coordinating practitioner, and*

(ii) *any other person lawfully participating in the person's request for access to voluntary assisted dying.*

(4) *In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—*

(a) *whether the transfer would be likely to cause serious harm to the person,*

(b) *whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,*

(c) *whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,*

(d) *whether the place to which the person is proposed to be transferred is available to receive the person,*

(e) *whether the person would incur financial loss or costs because of the transfer.*

96 Application for administration decision

(1) *This section applies if—*

(a) *the person has made a final request, and* *(b) the person or the person's agent advises the relevant entity that the person wishes to make an application for an administration decision, and (c) the entity does not provide, to persons to whom relevant services are provided at the residential facility, access to a person's coordinating practitioner to enable the application to be made.*

(2) If the person is a permanent resident at the residential facility—

(a) the relevant entity and any other entity that owns or occupies the facility ***must allow reasonable access to the person*** *at the facility by the person's coordinating practitioner for the practitioner to consult with and assess the person in relation to the application, and*

(b) if the coordinating practitioner is not available to attend—the relevant entity ***must take reasonable steps to facilitate the transfer*** *of the person to and from a place where consultation and assessment of the person can occur in relation to the application in consultation with, and on the advice of—*

(i) the coordinating practitioner, or

(ii) another medical practitioner who is eligible and willing to act as the person's coordinating practitioner.

(3) If the person is not a permanent resident at the residential facility—

(a) the relevant entity ***must take reasonable steps to facilitate the transfer*** *of the person to and from the place where the person's coordinating practitioner can consult with and assess the person in relation to the application, or*

(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the residential facility ***must allow reasonable access*** *to the*

person at the facility by the person's coordinating practitioner to consult with and assess the person in relation to the application.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

Subdivision 3 Administration of voluntary dying substance *(s 97)*

97 Administration of voluntary assisted dying substance

(1) This section applies if—

(a) the person has made an administration decision, and

(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have the person's administering practitioner administer a voluntary assisted dying substance to the person, and

(c) the relevant entity does not provide, to persons to whom relevant services are provided at the residential facility, access to the administration of a voluntary assisted dying substance at the facility.

(2) If the person is a permanent resident at the residential facility, the relevant entity and any other entity that owns or occupies the facility must—

(a) *if the person has made a practitioner administration decision—**allow reasonable access** to the person at the facility by the following persons—*

  (i) *the person's administering practitioner, for the practitioner to administer a voluntary assisted dying substance to the person,*

  (ii) *any other person lawfully participating in the person's request for access to voluntary assisted dying, including an eligible witness to the administration of the voluntary assisted dying substance by the person's administering practitioner, or*

(b) *if the person has made a self-administration decision—*

  (i) ***allow reasonable access** to the person at the facility by a person lawfully delivering a voluntary assisted dying substance to the person, and*

  (ii) ***allow reasonable access** to the person at the facility by another person lawfully participating in the person's request for voluntary assisted dying, and*

  (iii) ***not otherwise hinder access** by the person to a voluntary assisted dying substance.*

(3) *If the person is not a permanent resident at the residential facility—*

(a) *the relevant entity **must take reasonable steps to facilitate the transfer** of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance, or*

(b) *if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—subsection (2) applies in relation to the person as if the person were a permanent resident at the residential facility.*

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

***Subdivision 4 Information about non-availability of voluntary assisted dying** (s 98)*

98 Relevant entities to inform public about non-availability of voluntary assisted dying

(1) This section applies to a relevant entity that does not provide, at a residential facility at which the entity provides relevant services, services associated with voluntary assisted dying, including access to the request and assessment process or access to the administration of a voluntary assisted dying substance.

*(2) The **relevant entity must publish information about the fact the entity does not provide any services, or services of a specified type, associated with voluntary assisted dying** at the residential facility.*

*(3) **The relevant entity must publish the information in a way in which it is likely that persons who receive the services of the entity at the residential facility become aware of the information.***

Part 5 Participation

Division 3 Health care establishments (hospitals etc)

Subdivision 1 Information about voluntary assisted dying (s 99)

99 Access to information about voluntary assisted dying

(1) This section applies if—

(a) a person is receiving health care from a health entity at a health establishment, and

(b) the person asks the health entity for information about voluntary assisted dying, and

(c) the health entity does not provide at the health establishment, to persons to whom health care is provided, the information that has been requested.

(2) The health entity—

(a) ***must not hinder the person's access at the health establishment to information about voluntary assisted dying****, and*

(b) ***must, if asked, allow reasonable access to the person at the health establishment by a member of an official voluntary assisted dying care navigator service to provide support, assistance and information to persons relating to voluntary assisted dying****.*

Subdivision 2 Access to voluntary assisted dying (ss 100 – 105)

100 Application of Subdivision

This Subdivision applies if a person is receiving health care from a health entity at a health establishment.

101 First and final requests

(1) This section applies if—

(a) the person or the person's agent advises the health entity that the person wishes to make a first request or final request (each a relevant request), and

(b) the health entity does not provide, to persons to whom health care is provided at the health care establishment, access to the request and assessment process at the establishment.

(2) The health entity ***must take reasonable steps to facilitate the transfer of the person to and from a place*** *where the person's relevant request may be made to—*

(a) a medical practitioner requested by the person who—

(i) for a first request—is eligible to act as a coordinating practitioner, or

(ii) for a final request—is the person's coordinating practitioner, or (b) if the requested medical practitioner is not available—another medical practitioner who is eligible and willing to act as a coordinating practitioner for the person.

102 First assessments

(1) This section applies if—

(a) the person has made a first request, and

(b) the person, or the person's agent, advises the health entity that the person wishes to undergo a first assessment, and

(c) the health entity does not provide, to persons to whom health care is provided at the health establishment, access to the request and assessment process at the facility.

(2) The health entity ***must take reasonable steps to facilitate the transfer of the person*** *to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person.*

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

(4) In this section— relevant practitioner, for a person, means—

(a) the person's coordinating practitioner, or

(b) a medical practitioner to whom the person's coordinating practitioner has referred a matter under section 26.

103 Consulting assessments

(1) This section applies if—

(a) the person has undergone a first assessment, and

(b) the person, or the person's agent, advises the health entity that the person wishes to undergo a consulting assessment, and

(c) the entity does not provide, to persons to whom health care is provided at the health establishment, access to the request and assessment process at the establishment.

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*(2) The health entity **must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment** may be carried out by a relevant practitioner for the person.*

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

- *(a) whether the transfer would be likely to cause serious harm to the person,*
- *(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,*
- *(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,*
- *(d) whether the place to which the person is proposed to be transferred is available to receive the person,*
- *(e) whether the person would incur financial loss or costs because of the transfer.*

(4) In this section— relevant practitioner, for a person, means—

- *(a) the person's consulting practitioner, or*
- *(b) a medical practitioner to whom the person's consulting practitioner has referred a matter under section 37.*

104 Written declarations

(1) This section applies if—

- *(a) the person has been assessed as eligible for access to voluntary assisted dying, and*
- *(b) the person or the person's agent advises the health entity that the person wishes to make a written declaration, and*

(c) the entity does not provide, to persons to whom health care is provided at the residential premises, access to the request and assessment process at the facility.

*(2) **The health entity must take reasonable steps to facilitate the transfer** of the person to and from a place where the person may make a written declaration.*

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

105 Application for administration decision

(1) This section applies if—

(a) the person has made a final request, and

(b) the person or the person's agent advises the health entity that the person wishes to make an application for an administration decision, and

(c) the entity does not provide, to persons to whom relevant services are provided at the health establishment, access to a person's coordinating practitioner to enable the application to be made.

*(2) The health entity **must take reasonable steps to facilitate the transfer of the person** to and from the place where the person's coordinating practitioner can consult with and assess the person in relation to the application.*

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

- *(a) whether the transfer would be likely to cause serious harm to the person,*
- *(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,*
- *(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,*
- *(d) whether the place to which the person is proposed to be transferred is available to receive the person,*
- *(e) whether the person would incur financial loss or costs because of the transfer*

Subdivision 3 Administration of voluntary assisted dying substance *(s 106)*

106 Administration of voluntary assisted dying substance

(1) This section applies if—

- *(a) the person has made an administration decision, and*
- *(b) the person or the person's agent advises the health entity that the person wishes to self-administer a voluntary assisted dying substance or have the person's administering practitioner administer a voluntary assisted dying substance to the person, and*
- *(c) the health entity does not provide, to persons to whom health care is provided at the health establishment, access to the administration of a voluntary assisted dying substance at the establishment.*

(2) The health entity ***must take reasonable steps to facilitate the transfer of the person*** *to a place where the person may be administered, or may self-administer, a voluntary assisted dying substance.*

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

- *(a) whether the transfer would be likely to cause serious harm to the person,*
- *(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,*
- *(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,*
- *(d) whether the place to which the person is proposed to be transferred is available to receive the person, (e) whether the person would incur financial loss or costs because of the transfer.*

Subdivision 4 Information about non-availability of voluntary assisted dying *(s 107)*

107 Relevant entities to inform public about non-availability of voluntary assisted dying

(1) This section applies to a health entity that does not provide, at a health establishment at which the entity provides health care, services associated with voluntary assisted dying, including access to the request and assessment process or access to the administration of a voluntary assisted dying substance.

(2) The health entity ***must publish information about the fact the entity does not provide any services, or services of a specified type, associated with voluntary assisted dying at the health establishment****.*

Part 5 Participation

(3) The health entity must publish the information in a way in which it is likely that persons who receive health care at the health establishment will become aware of the information

Second Reading Speech

- The bill enshrines the power for facilities – which are referred to as entities in the bill – not to provide voluntary assisted dying services, while setting out responsibilities towards patients and residents, depending on whether the entity is a **residential facility** or a **hospital.**
- **Residential facilities** will have greater responsibilities towards residents because they are people's homes and nobody should be denied a legal medical option in their home because of the views held by management, especially given choice in residential care is often limited.
- Residential facilities that do not provide voluntary assisted dying services will be required to let doctors and other participants attend the premises to provide voluntary assisted dying services.
- Those in residential facilities seeking voluntary assisted dying will be told to inform their residential facility. I thank Uniting and Catholic Health Care Australia for this recommendation.
- **Hospitals** – which are referred to as health care establishments in the bill – will only be required to help transfer patients to and from the hospital to access voluntary assisted dying services elsewhere. There is no obligation on a hospital to allow external doctors onsite.

Comment

1. Part 5 of the Greenwich Bill derogates from s 9 of the Bill which relates to conscientious objection. It may be thought that what the Greenwich Bill gives with one hand, it takes with the other.[7]

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[7] For an academic discussion of some of the issues here, see Ben P White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' in UNSW Law Journal Forum [2021] No 3, pp 1-19

Part 5 Participation
2. **Residential facilities** (Part 5 Division 2) and healthcare establishments (i.e. **hospitals**) (Part 5 Division 3) in NSW are commonly conducted by religious and charitable institutions. The overwhelming response of religious institutions is against the Greenwich Bill. The perspective of most religious institutions to the Greenwich Bill is exemplified in a letter from Anglicare dated 8 October 2021 sent to all Parliamentarians: ***In-principle opposition*** *Anglican Community Services (**Anglicare**) is opposed in-principle to the Bill.* *As an organisation, Anglicare exists to serve the needy and vulnerable in our society. We do so motivated by our Christian identity.* *Anglicare opposes physician assisted suicide in all its forms. In short, this opposition is driven by our commitment to life through all its stages, and our desire to help people live well until they die well naturally.* *Our opposition is driven by our deep concern (validated by the experience in multiple jurisdictions) that legislation providing for physician assisted suicide and other forms of euthanasia can never truly protect the most vulnerable from abuse as they approach their death. Further, our opposition is founded in the vulnerability of the exceptions and limitations in scope envisaged in this initial Bill to erosion through legislative amendment (again, validated by the consistent widening in the scope of such legislation in other jurisdictions).* *The Bill would force a **fundamental change in the societal understanding of suicide** – and would corrode the elemental sacred prohibition on one private citizen actively engaging in the ending of another person's life. Moreover, the Bill would **change the relationship between medical professionals** (who take an oath to provide life-affirming treatment and care) **and patients, by introducing uncertainty and fear into these relationships**.* *Anglicare is deeply committed to excellence in the delivery of end-of-life, palliative care services that holistically support a person's physical, emotional and*

Part 5 Participation

spiritual wellbeing through the last months of life. Anglicare has a nurse-led, palliative care team who assist our residential and community based aged care staff, to provide exceptional end-of-life care to our residents and clients. Anglicare considers physician assisted suicide to be the antithesis of this approach, inconsistent with Biblical teachings and a ***significant shift in the social ecology that exists around matters of life and death*** *for all.*

3. Further:

8 *Anglicare strongly advocates that facilities and organisations should have the* ***right to choose whether they support physician assisted suicide and whether any or all of the activities contained in Division 2 will be permitted to be undertaken at their facilities****. This approach is consistent with the position in Western Australia and Victoria.*

9 ***Anglicare presses that, at an absolute minimum, the protections in section 89 of the Bill that permit facilities to decide not to provide physician assisted suicide should be maintained.***

10 ***Anglicare further asserts that, as an absolute minimum, the following amendments should be made to the Bill****:*

(a) *an amendment to section 89(3), so that the right to decide not to provide physician assisted suicide is not subject to Part 5, Division 2, subdivision 3, which outlines the process for the administration of a 'voluntary assisted dying substance';*

(b) *an amendment to Part 5, Division 2, Subdivision 3 to make it clear that there is* ***no obligation on approved providers of residential aged care to allow physician assisted suicide*** *(i.e., the administration of a 'voluntary assisted dying substance')* ***to be administered at their facility****; and*

(c) *amendments to section 97 to expressly provide that, in the event that a permanent or non-permanent resident of a residential facility*

Part 5 Participation

is preparing for the administration of a 'voluntary assisted dying substance' and they reside at a facility which does not provide physician assisted suicide, the facility will engage with the resident to transfer them to an alternative location where the resident can receive the 'voluntary assisted dying substance'.

11 Although Anglicare maintains its in-principle opposition to the Bill, the amendments proposed ***would assure Christian residential aged care providers of legislative protection for refusing to engage in physician assisted suicide****. These amendments would enable residents in Anglicare facilities to engage in the administrative process that underpins physician assisted suicide while at an Anglicare facility, but would permit Anglicare to require the resident to be transferred to another facility in order to access the 'voluntary assisted dying substance'. This ensures that the act of physician assisted suicide does not take place at an Anglicare facility.*

12 Anglicare endorses the advertising requirements contained in section 98 of the Bill, and intends to clearly communicate to all existing and potential residents that Anglicare does not provide voluntary assisted dying.

Dementia

4. Further, Anglicare comments on voluntary assisted dying for **dementia** residents:

Physician assisted suicide for dementia residents

14 As a provider of residential aged care, Anglicare provides care to a significant number of residents who suffer from dementia. Elderly Australians suffering from dementia are particularly susceptible to elder abuse.

15 Anglicare asserts that there are ***insufficient safeguards contained in the Bill to protect vulnerable, older Australians suffering from dementia or other forms of cognitive impairment, particularly in the period***

Part 5 Participation
between the final assessment and the provision of voluntary assisted dying substances*.* 16 *Anglicare acknowledges that the Bill requires a person seeking access to physician assisted suicide to have decision-making capacity. However, the Bill is silent on how it applies to a person who subsequently loses decision-making capacity (noting that* ***decision-making capacity for people with dementia is changeable****).* 17 *Further,* ***the Bill is silent on whether dementia would satisfy the criteria of a 'disease, illness or medical condition' that is 'neurodegenerative' and will cause death within 12 months****.* 18 *Anglicare asserts that this provides a '****grey area'*** *through which the Bill* ***may be exploited****. It may also create* ***uncertainty*** *for workers in residential aged care, who do not know how to manage a resident with dementia, or their family member, who may seek to initiate a physician assisted suicide conversation.* 19 *Anglicare notes that although there are obligations on medical practitioners throughout the physician assisted suicide process in the Bill to confirm that a person has decision-making capacity,* ***it should be made clear that eligibility to access the scheme may be negated where decision-making capacity is lost****.* 20 *Anglicare submits that it would additionally be appropriate for Parliament to amend section 16 of the Bill to:* (d) *make it clear that* ***if a person loses decision-making capacity at any stage of the physician assisted suicide process, they will no longer be eligible to access physician assisted suicide****; and* (e) ***dementia is not a 'neurodegenerative disease' to which the Bill is intended to apply****, and that a person with dementia will not be*

Part 5 Participation
eligible to access physician assisted suicide on the basis of their dementia diagnosis, or the progression of that illness alone.

Part 6 Review by Supreme Court

Part 6 Review by Supreme Court

Sections 108-122 108, 109, 110, 113, 118

108 Definitions

*In this Part— **eligible applicant** means—*

*(a) a **patient** who is the subject of a decision referred to in section 109(1)(a)–(d), or*

*(b) a person who has been **appointed by a patient** mentioned in paragraph (a) as the patient's agent—*

  (i) in writing, or

  (ii) by other means the Supreme Court considers satisfactory in the circumstances, or

*(c) **another person who has a sufficient and genuine interest in the rights and interests of a patient** referred to in paragraph (a) in relation to voluntary assisted dying. party to the proceeding, in relation to a review application, means a party to the proceeding before the Supreme Court relating to the application. review application, in relation to a patient, means an application under section 109(1) for a review of a decision made in relation to the patient. reviewed decision, in relation to a review application, means the decision the subject of the application.*

109 Application for review of certain decisions by Supreme Court

(1) An eligible applicant may apply to the Supreme Court for a review of any of the following decisions—

  *(a) a **decision of a patient's coordinating practitioner** in a first assessment that the patient—*

(i) at the time of making the first request, has or has not been ordinarily resident in New South Wales for a period of at least 12 months, or

(ii) has or does not have decision-making capacity in relation to voluntary assisted dying, or

(iii) is or is not acting voluntarily, or

(iv) is or is not acting because of pressure or duress, Note— See the definition of pressure or duress in the Dictionary in Schedule 1.

(b) a ***decision of a patient's consulting practitioner*** *in a consulting assessment that the patient—*

(i) at the time of making the first request, has or has not been ordinarily resident in New South Wales for a period of at least 12 months, or

(ii) has or does not have decision-making capacity in relation to voluntary assisted dying, or

(iii) is or is not acting voluntarily, or

(iv) is or is not acting because of pressure or duress,

(c) a decision of a patient's coordinating practitioner to make a statement in a final review form certifying that the coordinating practitioner is satisfied the patient—

(i) has or does not have decision-making capacity in relation to voluntary assisted dying, or

(ii) in requesting access to voluntary assisted dying—

(A) is or is not acting voluntarily, or

(B) is or is not acting because of pressure or duress, and

(d) a decision of the Board to refuse an application for a voluntary assisted dying substance authority in relation to a patient.

*(2) A **review of a reviewed decision**—*

(a) is to be dealt with as a new hearing, and

(b) evidence or information may be given in addition to, or in substitution for, the information given in relation to the reviewed decision

110 Patient party to proceedings

*If a review application is made in relation to a patient, the **patient is a party** to the proceeding whether or not the patient is the applicant for the review*

113 Decision of Supreme Court

In deciding a review application made in relation to a patient, the Supreme Court may decide that—

(a) at the time of making the first request, the patient had been ordinarily resident in New South Wales for a period of at least 12 months, or

(b) at the time of making the first request, the patient had not been ordinarily resident in New South Wales for a period of at least 12 months, or

(c) the patient has decision-making capacity in relation to voluntary assisted dying, or

(d) the patient does not have decision-making capacity in relation to voluntary assisted dying, or

(e) the patient is acting voluntarily, or

(f) the patient is not acting because of pressure or duress, or Note— See the definition of pressure or duress in the Dictionary in Schedule 1.

(g) the patient is not acting voluntarily, or

(h) the patient is acting because of pressure or duress, or (i) a ground to refuse to issue a voluntary assisted dying substance authority exists, or (j) a ground

to refuse to issue a voluntary assisted dying substance authority does not exist

118 Notice requirements

(1) If a review application is made in relation to a patient, the Principal Registrar of the Supreme Court ***must give notice*** *of the application and any decision or order, however described, of the Court in relation to the application to the following—*

  (a) if the coordinating practitioner is not a party to the proceeding—the ***patient's coordinating practitioner****,*

  (b) if the consulting practitioner is not a party to the proceeding—the ***patient's consulting practitioner****,*

  (c) if the role of administering practitioner for the patient has been transferred under section 64(2)—the ***patient's administering practitioner****,*

  (d) the ***Health Secretary****, (e) the Board.*

(2) The Board must, as soon as practicable after receiving notice of a review application under subsection (1), give notice of the effect of section 111(2) and

(3) to—

  (a) each party to the proceeding, and

  (b) if the coordinating practitioner is not a party to the proceeding—the patient's coordinating practitioner, and

  (c) if the role of administering practitioner for the patient has been transferred under section 64(2)—the patient's administering practitioner

Comment

1. Section 108(c) makes inadequate provision to enable a family member to make an application to the Supreme Court.

Part 7 Offences

Part 7 Offences
Sections 123 – 131
Second Reading Speech • The bill creates a comprehensive set of offences to protect against any misuse of voluntary assisted dying. These will act in addition to the safeguards that are built into the very robust statutory process. • A new offence for administering a prescribed substance to another person outside of the provisions of the bill will incur a maximum penalty of life imprisonment, as does a new offence for inducing someone to take a prescribed substance. Inducing someone to apply for voluntary assisted dying, attracts a maximum of seven years imprisonment. • Advertising a Schedule 4 or Schedule 8 poison as a voluntary assisted dying substance attracts a maximum penalty of three years imprisonment. A Contact Person who fails to return any unused substance that remains after a person dies, will be subject to a maximum penalty of 12 months in prison. There are also offences to protect people's privacy.

Part 8 Enforcement

Part 8 Enforcement

Sections 132- 135

134 Who may commence proceedings for simple offence

A prosecution for an offence under this Act may only be commenced by—

(a) the Health Secretary, or

(b) a person authorised, in writing, by the Health Secretary.

135 Time limit for prosecution of offence

*(1) A prosecution for an offence under this Act must be commenced within **2** years after the day on which the offence is alleged to have been committed.*

(2) However, if a prosecution notice alleging an offence specifies the day on which evidence of the alleged offence first came to the attention of a person authorised under section 134 to commence the prosecution—

*(a) the prosecution may be commenced within **2** years after that day, and*

(b) the prosecution notice need not contain particulars of the day on which the offence is alleged to have been committed.

(3) The day on which evidence first came to the attention of a person authorised under section 134 to commence a prosecution is, in the absence of evidence to the contrary, the day specified in the prosecution notice.

Comment

1. The time limit for prosecutions which may involve the death of a human person is inappropriate. By contrast, there is no limitation period for the prosecution of murder or manslaughter. Given the lack of independent overview of the operations of the Voluntary Assisted Dying Board, there will be no prosecution of offences. The Bill provides an opaque system in which,

on occasion, persons will be inappropriately assessed, but in which the true facts will not come to light because it is nobody’s interest that inconvenient facts become known. Serious offences (s 123 – Unauthorised administration of prescribed substance – and s 125 – Inducing self-administration of a prescribed substance) should be prosecuted by the Director of Public Prosecutions on indictment.

Part 9 Protection from Liability

Part 9 Protection from Liability
Sections 136 – 139
Comment 1. Whilst a practitioner who participates in the scheme is protected from criminal and civil liability, there should be an express mechanism whereby if a family member has a concern as to the manner in which the practitioner has engaged in the voluntary assisted dying process, the family member can raise the issue with an independent regulatory body (such as the HCCC), or an Inspector, whose function it is to audit from an independent perspective, the operation of voluntary assisted dying, so that the issue can be investigated. The Greenwich Bill lacks a mechanism for ongoing, independent scrutiny of the legislation similar to that found in Part 5A of the *Independent Commission Against Corruption Act 1988*. At the very least, a person, a family member, or friend, dissatisfied with the circumstances leading to a patient's death, should have the explicit entitlement to lodge a complaint with the Healthcare Complaints Commission and, if appropriate, with the Coroner. Otherwise, the adage about doctors burying their mistakes, applies here.

Part 11 Access standard

Part 11 Access standard

Section 180 provides:

180 Standard about access to voluntary assisted dying

(1) The Health Secretary must issue a standard (the access standard) setting out ***how the Ministry of Health intends to facilitate access to voluntary assisted dying*** *for persons ordinarily resident in New South Wales, including* ***how the Ministry intends to facilitate access to****—*

(a) ***the services of medical practitioners and other persons who carry out functions under this Act****, and*

(b) ***prescribed substances****, and*

(c) ***information about accessing voluntary assisted dying.***

(2) The access standard must specifically set out how the Ministry intends to facilitate access to voluntary assisted dying for regional residents.

(3) The access standard may also include ***information about the potential risks of self-administering or being administered a voluntary assisted dying substance*** *likely to be prescribed under this Act.*

(4) The Health Secretary may modify or replace the access standard.

(5) The Health Secretary must publish the access standard on the Ministry of Health's website

Comment

1. The delegation by Parliament of this crucial document to the Health Secretary diminishes **the power which Parliament might otherwise exercise** in relation to the administration of the legislation. The issue of delegated legislation, and effective parliamentary scrutiny, is, of course, not peculiar to

voluntary assisted dying, but is a concern for anyone who wishes to uphold parliamentary democracy, and both individual and collective ministerial responsibility. The Access Standard should be brought to Parliament's attention, and Parliament should have the power to disallow the Standard or any part thereof – and replace the Standard appropriately.

Part 12 General

Part 12 General

Sections 181 – 191

182 Communication between patient and practitioner

*(1) **If it is not practicable** for a patient to make a first request, final request or administration decision in person—*

*(a) the patient may make the request or decision **using audiovisual communication**, and*

*(b) the medical practitioner who receives the request or is being informed of the decision may give the patient advice or information in relation to the request or decision **using audiovisual communication.***

*(2) Subject to subsection (1)(b), a medical practitioner or other registered health practitioner may give advice or information to, or otherwise communicate with, a person for the purposes of this Act **using any method of communication, including electronic communication or the use of an interpreter, the practitioner considers appropriate.***

(3) However, subsections (1) and (2) do not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.

(4) In this section— audiovisual communication means a method of electronic communication designed to allow people to see and hear each other simultaneously.

184 Information about voluntary assisted dying

*(1) An authorised official **may make information about voluntary assisted dying publicly available**.*

(2) *Information may be made available under this section using any method of communication, including electronic communication, that the authorised official considers appropriate.*

(3) *However, subsection (2) does not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.*

(4) *The Health Secretary may, by Gazette notice, designate persons, or persons in a class, as authorised officials for the purposes of this section.*

(5) *In this section— authorised official means—*

- (a) *the Health Secretary, or*
- (b) *a public service officer employed in the Ministry of Health, or*
- (c) *a person designated as an authorised official under subsection (4).*

185 Official voluntary assisted dying care navigator service

(1) *The Health Secretary may, by Gazette notice, approve an entity to be an* ***official voluntary assisted dying care navigator service*** *for this Act*

190 Review of Act

(1) *The* ***Minister*** *must review the operation and effectiveness of this Act, and prepare a report based on the review—*

- (a) ***as soon as practicable after the second anniversary of the day on which this section comes into operation****, and*
- (b) *after that, at intervals of* ***not more than 5 years****.*

(2) *Without limiting subsection (1), a review of the operation and effectiveness of this Act must include consideration of the principles set out in section 4 including, in particular, the following principles—*

Part 12 General

(a) *a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,*

(b) *a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region. (3) The Minister must cause the report to be laid before each House of Parliament as soon as practicable after the report is prepared, but not later than—*

  (a) *for the first review—12 months after the second anniversary, or*

  (b) *for a subsequent review—12 months after the expiry of the period of 5 years*

Second Reading Speech

- The bill provides for the introduction of a care navigator service. Both Victoria and Western Australia have established care navigator services which provide a point of contact for patients, the community, health practitioners, health services and residential facilities. Care navigators can provide general information, connect people with medical practitioners who provide services, and provide holistic advice on appropriate end-of-life services. The feedback on the care navigator service in Victoria is very positive.
- The legislation will be subject to regular review every five years after an initial review that must commence two years after the provisions come into force. Reviews will look at the operations and effectiveness of the laws, as well as access issues in regional areas or that are associated with language and culture.

Comment

Audio-Visual Communication

1. Except in extraordinary circumstances, medical practitioners should communicate **personally** with the patient, **not by audio-visual means.** The

proposed legislation provides that a patient who wishes to access voluntary assisted dying may be assessed by audio-visual means. Whilst this may be acceptable in circumstances where a patient lives in a very remote location, it is not ideal. When it comes to assessing decision-making capacity, a conference by audio-visual means, as opposed to an in-person conference, is not appropriate. When conducting a conference by audio-visual means, typically, one can only view the other person from the head up. One is not able to see bodily movements, and there is a great deal of information that cannot be picked up, which would be picked up if the conference was conducted in person.

Interpreters

2 Conferences by audio-visual link are suboptimal at best. Hence the desirability of medical examinations involving interpreters being conducted in person rather than by audio-visual link. The competence of interpreters differs greatly. Even when there is an excellent interpreter, often cultural cues are missed.

3 There is no adequate provision for payment of interpreters. This has been pointed out by the Legislation Review Committee:

> *Payment for work performed - interpreters*
>
> *18 Section 18 of the Bill sets out requirements for the interpreter of a patient. One of these requirements is that the interpreter must not know or believe that that they are a beneficiary under a will of the patient or that they may otherwise benefit financially or in any other material way from the death of the patient. The interpreter must also be accredited.*
>
> *19 However, the corresponding eligibility requirement for a coordinating practitioner, consulting practitioner, administrating practitioner and a medical practitioner, psychiatrist, registered health practitioner or other person to whom the patient is referred carves out the right for the*

person to receive reasonable fees for the provision of their services or acting in the role.

The Bill requires that people who provide professional services to the patient regarding voluntary assisted dying must not know or believe that they are a beneficiary under a will of the patient or otherwise benefit financially or in any other material way from the death of the patient.

In relation to a coordinating practitioner, consulting practitioner, administrating practitioner and a medical practitioner, psychiatrist, registered health practitioner or other person to whom the patient is referred, this requirement makes clear that those persons are able to receive reasonable fees for the provision of services or acting in the role. However, ***this is not made clear in relation to the provision of services by accredited interpreters****.*

It is therefore unclear if interpreters are able to receive reasonable fees for provision of services under the Bill*. This may impact the right to payment for services performed of interpreters. The Committee notes the provision is an important safeguard as it ensures that interpreters involved do not gain financially by the patient's request and assessment for voluntary assisted dying. However the Committee also recognises that the role of an interpreter may require the engagement of professional interpreting services for a reasonable fee.* ***Such fees do not appear to be provided for under the Bill.*** *The Committee refers this issue to parliament for its consideration.*

Schedule 1A Consequential amendment of other Acts

1A.3 Ombudsman Act 1974 No 68

[1] Schedule 1 Excluded conduct of public authorities Insert "(1)" before "Conduct" in item 3.

[2] Schedule 1, item 3 Insert at the end of the item— (2) However, sub-item (1) does not apply to the conduct of the Voluntary Assisted Dying Board established under the Voluntary Assisted Dying Act 2021

Comment

1 The Ombudsman should have unfettered power to scrutinise any aspect of the administration of the Voluntary Assisted Dying Board, including individual cases. The conduct of the Board, including dealings with individual cases, should be open to independent scrutiny.

Schedule 1 – Dictionary

designated period, *in relation to a patient's final request, means the period— (a) starting on the day on which the patient made the first request, and (b) ending on the day that is 5 days after that day.*

family member, *of a person, means any of the following—*

(a) the person's spouse or de facto partner

(b) the person's parent or step parent, or a sibling of the person's parent or step parent,

(c) the person's grandparent or step grandparent,

(d) the person's sibling or step sibling, or a child of the person's sibling or step sibling,

(e) the person's child or step child,

(f) the person's grandchild or step grandchild

palliative care and treatment *means care and treatment that—*

(a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting, and

(b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering to improve their comfort and quality of life.

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

(a) assistance or support, including the following—

  (i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals,

  (ii) assistance for persons with mobility problems,

(iii) assistance for persons who are mobile but require some form of assistance or supervision,

(iv) assistance or supervision in administering medicine,

(v) the provision of substantial emotional support,

(b) providing support or services to persons with a disability

***request and assessment process** means the process that consists of the following steps—*

(a) a first request,

(b) a first assessment,

(c) a consulting assessment,

(d) a written declaration, (e) a final request, (f) a final review

***residential facility** means—*

(a) a nursing home, hostel or other facility at which accommodation, nursing or personal care is provided to persons on a residential basis who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care, or

(b) a residential aged care facility.

***voluntary assisted dying** means the administration of a voluntary assisted dying substance and includes steps reasonably related to the administration.*

The *Voluntary Assisted Dying Bill 2021* is fundamentally flawed and should not be enacted.

Australian and New Zealand Society of Palliative Medicine

The reasons the Bill should not be enacted are set out in a statement of the Australian and New Zealand Society of Palliative Medicine on The Practice of Euthanasia and Physician Assisted Suicide, last updated November 2021:

> ***Statement***
>
> *1. Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. In accordance with best practice guidelines internationally, the discipline of Palliative Medicine* ***does not include the practices of euthanasia and physician-assisted suicide.*** *ANZSPM activities are limited to the Palliative Medicine discipline.*
>
> *2.* ***ANZSPM does not support the legalisation of euthanasia and physician-assisted suicide****, but recognises that ultimately these are matters for government to decide having regard to the will of the community and, critically, informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.*
>
> *3. With the legalisation of euthanasia and physician-assisted suicide practices in Victoria, Western Australia, Tasmania, South Australia, and New Zealand, and recognising that other jurisdictions in Australia are considering the introduction of similar legislation, ANZSPM endorses international guidelines reaffirming that these practices are* ***not part of palliative care****. ANZSPM will continue to advocate for and, through its*

members, deliver good quality care for the dying, and this does not include the practice of euthanasia or physician-assisted suicide.

4. *Patients have the **right to refuse life-sustaining treatments** including the provision of medically assisted nutrition and/or hydration. Refusing such treatment **does not constitute euthanasia or physician-assisted suicide.***

5 *Good medical practice mandates that the ethical principles of **beneficence and non-maleficence** should be followed at all times. The benefits and harms of any treatments (including the provision of medically assisted nutrition and/or hydration) should be considered before instituting such treatments. The benefits and harms of continuing treatments previously commenced should be regularly reviewed. Withholding or withdrawing treatments that are not benefitting the patient, is not euthanasia or physician-assisted suicide.*

6. ***Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia or physician-assisted suicide.***

7. ***Palliative sedation for the management of refractory symptoms is not euthanasia.***

8. ***Requests for euthanasia or physician-assisted suicide should be acknowledged with respect and be extensively explored in order to understand, appropriately address and if possible, remedy the underlying difficulties that gave rise to the request.** Appropriate ongoing care consistent with the goals of Palliative Medicine should continue to be offered.*

9. *When requests for euthanasia or physician-assisted suicide arise, particular attention should be given to gaining **good symptom control**, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. **depressive disorders** and **poorly controlled pain**). In such*

> *situations, early referral to an appropriate specialist should be considered.*
>
> *10. Despite the best that palliative care can offer to support patients in their suffering, appropriate specialist palliative care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.*
>
> *11. ANZSPM acknowledges the **significant deficits in the provision of palliative care in Australia** and New Zealand, especially for patients with non-malignant life-limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations and those from culturally and linguistically diverse backgrounds.*
>
> *12. ANZSPM advocates for health reform programs in Australia and New Zealand to strengthen end of life care by remedying **shortages in the palliative care workforce** (including in the specialist medical, nursing, and allied health fields), ensuring improved access to appropriate facilities and emphasising the role of advance care plans and directives.*

Royal Australian College of Physicians

The Royal Australian College of Physicians in July 2021 made a Submission to the Queensland Parliament's Health and Environment Committee's Enquiry into the *Voluntary Assisted Dying Bill 2021*:

> *The RACP takes the following positions if and where voluntary assisted dying is legalised:*
>
> - *Every patient should have access to timely, equitable, good quality end-of-life care, with access to specialist palliative care where appropriate. These services must not be devalued.*
> - *On the specific issue of a competent adult in the last stages of incurable illness requesting voluntary assistance to die, the RACP supports a clinical approach of critical neutrality to encourage **reflective dialogue**.*

- *Although physicians should not be forced to act outside their values and beliefs, they also should not disengage from patients holding different values and beliefs without ensuring that arrangements for ongoing care are in place.*
- ***Patients seeking voluntary assisted dying should be made aware of the benefits of palliative care**. Referral to specialist palliative care should be strongly recommended but cannot be made mandatory. **Voluntary assisted dying must not be seen as part of palliative care**.*
- *Legitimate concerns exist around protection of traditionally under-serviced individuals or groups. Government, society and physicians must ensure that specific groups have **equitable access** to palliative and end-of-life care and that relationships of trust are not jeopardised. Specific regard must be given to cultural and **Indigenous** experience.*
- *All physicians must affirm the **value of all patients' lives**, exploring reasons for requests for voluntary assisted dying while remaining alert to any signs of coercion and reduced capacity.*
- *Assessments **must not follow a 'tick box' approach. They must be underpinned by adequate physician-patient relationships**, including appropriate training, skill and experience.*
- *Support, counselling and conflict mediation services must be available for individuals, families and health professionals involved.*
- *There must be **rigorous documentation and data collection** to enable review of any scheme and to assess changes in practice and the impacts on health professionals, patients and families.*

Additionally, the Royal Australian College of Physicians commented:

- *Any legislative provisions on conscientious objections to participating in VAD must ensure practitioners are **not forced to refer** and must extend beyond medical practitioners to multidisciplinary teams and institutions.*

- ***Safeguards against coercion*** *must be central to any VAD legislation and supported by appropriate policies and procedures.*
- *VAD training must be adequately funded and support practitioners to undertake VAD assessments underpinned by a* ***genuine and enduring relationship with the person****.*
- ***Comprehensive monitoring and reporting*** *must be part of VAD legislation to support evidence-based practice.*
- *Structures and institutions implementing any VAD legislation must provide* ***conflict and bereavement support services*** *for individuals, families and health professionals involved.*

The Greenwich Bill should be rejected as an attack on some of the most vulnerable persons in society. If, to the contrary, it is to be enacted, it needs to be considered section by section, clause by clause, to address its many problematic features.