

Voluntary Assisted Dying Bill

SUBMISSION

To: Ministerial Advisory Panel

Date: 10 April 2017



TABLE OF CONTENTS

TABLE OF CONTENTS	2
Introduction.....	3
Eligibility	4
The person	4
Access and eligibility	5
Assessment Process.....	7
Making a request.....	7
Properly Informed.....	9
Confirming a request.....	10
Conscientious Objections.....	10
Oversight.....	13
Administering a lethal dose of medication.....	13
Attendance	13
Monitoring the use of a lethal dose of medication.....	14
Lethal dose of medication not effective.....	14
After a person has died	15
Oversight	16

INTRODUCTION

The Law Institute of Victoria (LIV) is Victoria's peak body for lawyers and those who work with them in the legal sector, representing 19,000 members. We advocate on behalf of our profession and the wider community, lead the debate on law reform and policy, lobby and engage with government and provide informed and expert commentary.

The LIV welcomes the opportunity to participate in the Voluntary Assisted Dying Consultation and provide feedback to the Expert Ministerial Advisory Panel ("the Panel") on the Victorian Government's model framework. The LIV plays an essential role in the development of legal policy and legislation in Victoria to ensure laws are clear, consistent and predictable, and in line with the rule of law. The LIV acknowledges the disparate views on voluntary assisted dying within the legal profession, its member base and the broader community. The LIV does not have a position on the moral arguments for or against voluntary assisted dying. Rather, the LIV seeks to ensure the proposed legislation has the necessary legislative safeguards so that any such laws, regulations and guidelines are clear, accessible and adequately protect vulnerable patients, registered doctors, nurses and any health practitioners who are acting within the law, including those who do not wish to participate in voluntary assisted dying.

On 16 March 2017, the LIV formed a Voluntary Assisted Dying Consultation Taskforce ("the Taskforce") to respond to the Victorian Government's Discussion Paper and the Parliamentary Committee's recommendations. The Taskforce is made up of members from the Elder Law, Health Law, Human Rights and Charter of Rights, Medico-Legal and Young Lawyers Committees.

ELIGIBILITY

The person

Parliamentary Committee recommendation:

- An adult, 18 years and over, with decision-making capacity about their own medical treatment.
- People whose decision-making capacity is in question due to mental illness must be referred to a psychiatrist for assessment.
- Ordinary resident in Victoria and an Australian citizen or permanent resident.

The overarching narrative in this submission is the right a person has to exercise their personal choice and autonomy over their end of life choices, while balancing the safety of vulnerable patients, the community, medical practitioners and the wider health profession, including registered nurses and palliative care workers. It is crucial that the proposed legislation provides both the flexibility to ensure it is responsive to the individual needs and circumstances of a person requesting assistance to die, while having vigilant safeguards in place to prevent undue influence on the patient or the misuse of lethal medication.

Across the common law world there has long been recognised “a competent adult’s right of autonomy or self-determination: the right to control his or her own body.”¹ The respect for inherent dignity and individual autonomy, including the freedom to make one’s own choices is enshrined in the *International Convention on the Rights of Persons with Disabilities*, ratified by Australia in 2008; the *International Covenant on Economic, Social and Cultural Rights*; and the *International Covenant on Civil and Political Rights*.² The value that the Victorian community places on the right to autonomy and dignity is expressed in the *Charter of Human Rights and Responsibilities Act 2006*, which includes the rights to privacy, security, and protection from cruel, inhuman or degrading treatment.³

Is the existing decision-making capacity test in legislation such as the *Medical Treatment Planning and Decisions Act 2016* sufficient?

The importance of autonomy and self-determination is reflected in the proposed framework with the retention of a presumption of capacity. The LIV strongly supports the presumption of capacity and the proposed adoption of the decision-making capacity test in the *Medical Treatment Planning and Decisions Act 2016* (“MTPD Act”). Considerable work has been undertaken in recent years to address the fragmented legislative framework for end of life choices in Victoria. The LIV submits that the *Voluntary Assisted Dying Bill 2016* support, where possible and appropriate, consistency across other legislative frameworks. The LIV

¹ *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [5].

² *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) art 3(a); *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976); *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966.

³ See especially, *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 10, 13, 21.

notes that this is particularly important in areas such as this, where an individual is likely to engage with a number of legislative frameworks where decision-making capacity is assessed.

While the LIV supports the proposed framework and the adoption of section 4 of the MTPD Act, the LIV emphasises the crucial importance of education and training tools for the medical profession to ensure effective and adaptive communication techniques are employed which foster understanding. This is particularly critical in the context of patients that come from culturally and linguistically diverse (“CALD”) backgrounds and people with disabilities. The LIV is concerned that a lack of understanding of cultural differences in emotional responses could mean patients are misunderstood or that their requests to die are taken out of the cultural context with which they were intended. The LIV notes that cultural values can influence how individuals make decisions, for example, some cultures are more likely to engage in collective decision-making than individualistic communities. The medical profession should be aware of this diversity within Victoria and actively consider this when assessing the patient throughout the eligibility assessment process. The LIV recommends that existing professional development modules for the medical profession are reviewed to ensure there is adequate cultural awareness and unconscious bias training that is informed by diverse community perspectives and cultural knowledge. This training would benefit all members of the medical profession and should be compulsory for all those that are willing to participate in the voluntary assisted dying process.

Are there any other specialist referrals that would be appropriate for assessing decision-making capacity?

The LIV is supportive of the proposed framework that requires any of the doctors involved in the eligibility assessment process to refer the patient to a specialist if the patient making the request is suffering, or suspected to be suffering, from a mental health condition. LIV members that work in health and aged care sectors questioned whether a neuropsychologist may be better placed to conduct the assessment as they are specialists in assessing current cognitive functioning, while psychiatrists usually assess existing conditions. The LIV recommends that the Australian Medical Association (AMA) are consulted further on this matter.

Access and eligibility

Parliamentary Committee recommendation:

1. The person must be:
2. at the end of life (final weeks or months of life); and
3. suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable.
4. Suffering as a result of a mental illness only does not satisfy the eligibility criteria.

‘Serious and Incurable’

The definition of what is ‘serious and incurable’ could be difficult to establish. There are many illnesses and diseases that are captured by the phrase ‘serious and incurable’ but for which an assisted death would not be appropriate – for example, diabetes can be a serious and incurable disease. Similarly, the LIV finds the

word 'terminal' ambiguous, as someone can have terminal cancer and live for many years. As standalone criteria, the LIV finds both 'serious and incurable' and 'terminal' unhelpful. However, if the phrase is properly defined in the legislation, as the Canadian provision is, the LIV does not have any concerns about the phrase 'serious and incurable'.

The Canadian provision refers to 'grievous and irremediable condition':

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

'Reasonably Foreseeable'

The LIV does not have a specific opinion on whether the requirement is termed 'serious and incurable' or 'terminal' or 'a grievous and irremediable condition', rather the importance lies in how that requirement is determined. The Canadian example adopts the latter term, which is determined with reference to strict criteria, including the requirement a person's 'natural death to be reasonably foreseeable.' The LIV strongly favours this criterion and recommends that it is included in the Victorian legislation.

'Arbitrary Timelines'

The Canadian example further requires that 'death is reasonably foreseeable, taking into account all of the person's medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining'. The LIV does not support the inclusion of prescribed arbitrary timelines; rather, the LIV supports the Canadian approach, as it allows doctors to determine whether a patient is at the end of their life based on their professional expertise and knowledge of their client.

'Enduring and Unbearable Suffering'

The LIV strongly supports the Parliamentary Committee's recommendation that the person be experiencing 'enduring and unbearable suffering'. This is a subjective assessment made by the patient and is fundamental to patient-centered care. Provided the patient has been given information on their palliative care options, this assessment and decision must be made by the patient. The LIV supports the inclusion of this provision.

ASSESSMENT PROCESS

Making a request

Parliamentary Committee recommendation:

- The request must come from the person themselves. The request must be voluntary and free of coercion. The request cannot be made in an advance care directive.
- The request must be enduring.
- The person must be able to withdraw the request at any time.

What safeguards are necessary to ensure that a request is voluntary? How should this be assessed?

The LIV recognises that certain persons will be more vulnerable to coercion and undue influence than others. To address this serious concern, a number of safeguards need to be put in place to ensure the risk is minimised.

A significant challenge for the Panel is to decide how best to protect the rights of people with either cognitive or physical disabilities from coercion while ensuring they are able to access support aids to help them make a voluntary request. The LIV notes that the line between supported decision-making and substitute decision-making is a difficult boundary to navigate, which becomes even more difficult when there are language and cultural differences. For this reason, while the LIV strongly favours incorporating practicable and appropriate supports into the framework, it remains cautious about the types of practicable and appropriate supports permitted where a person seeks access to voluntary assisted dying.

For instance, the types of support provided as examples in section 4 of the MTPD Act and used in the proposed framework, which mirror the *Powers of Attorney Act 2014* ("POA Act"), include 'communicating or assisting a person to communicate the person's decision'. It will always be difficult in practice to delineate where the supportive role ends when a person is permitted to communicate on behalf of another person. It is paramount that where a decision to access voluntary assisted dying is made, is it done so by the person seeking to access it – freely and voluntarily – absent any undue influence or pressure and with fully informed consent, based on knowledge of the consequences and available alternatives.

Where a person seeking to access voluntary assisted dying comes from a CALD background and this impacts their ability to understand or communicate in English, there should be restrictions as to who should be permitted to communicate on their behalf as a practicable and appropriate support. In this situation, an independent third party, such as an accredited interpreter in the person's native or fluent language should be the only person able to communicate the request on behalf of the person. To safeguard against potential

abuse, the interpreter should be independent of the person or their family. Where the support required involves signing the written request at the direction of the person seeking to access voluntary assisted dying, doctors must be extra-vigilant to ensure the request is made freely and voluntarily. The framework should include provisions as to who is eligible to sign at the direction of the person seeking to access voluntary assisted dying. The LIV recommends such persons be over 18 years of age and not a person who is a witness or eligible to be a witness to the written request.

The LIV supports the Parliamentary Committee recommendation that the request is made in front of two witnesses. The LIV notes that the POA Act has a high standard for witnessing an enduring power of attorney, requiring two *independent* witnesses – one of whom must be someone authorised to witness affidavits or a medical practitioner, and neither of whom can be an attorney under the enduring power of attorney, or a relative of the principal, or a relative of an attorney, nor a care worker or accommodation provider for the principal. To ensure that there are sufficient safeguards in place to prevent involuntary requests because of undue influence, the LIV recommends that the witnessing requirements prescribed under the POA Act are adopted in respect of a written request for voluntary assisted dying, including the certification requirements in section 36. The LIV notes the risk of lingual and cultural miscommunication having unintended consequences. As noted above on page 5, the LIV recommends compulsory professional development for relevant medical professionals on cultural competency. The LIV strongly recommends the provision of information in plain English and where necessary, through accredited translators.

As a further safeguard, the LIV recommends doctors always communicate with their patient alone (but with the assistance of an accredited translator where necessary) at some stage during each step in the request process to ensure the decision is free from external pressures or undue influence.

Should there be a prescribed time period that must pass between the first and final request and, if so, what period?

In determining whether a prescribed time period should apply to the request process, the LIV considered that a concurrent request model would be the most appropriate model to adopt. The model would require both the primary and secondary doctors to begin their assessment of the patient at, or around, the same time. The LIV compared this model to a successive request model, where the primary doctor must complete and approve each stage in request process before the secondary doctor begins their assessment. The Taskforce considered both models, factoring in realistic time periods in circumstances where a person is at the end of their life.

The Taskforce concluded that a successive model would potentially result in delays which would significantly reduce access. The Taskforce concluded that the concurrent model is more compatible with the spirit and objects of the proposed legislation as it is not unduly onerous or burdensome on the patient making the request. The LIV notes that where people are choosing to take this pathway, they should be assisted to do it expeditiously. The LIV recommends the Bill expressly authorises a person seeking to access voluntary assisted dying to make the requests concurrently to the primary and secondary doctor. While this fosters an expeditious process, it creates a risk that the approval process could be completed within a matter of hours and people are left making a rushed decision. To balance the risk of a decision made in haste, the LIV recommends a legislated time period of at least three days between the first and final requests to provide the person making the request adequate time to weigh up all their options and make an informed decision. The LIV notes that even after the request is approved, it is still up to the patient to choose whether to self-administer the lethal dose of medication.

Should there be specific offences for those who fail to comply with the requirements in the Act or are the offences of homicide or aiding or abetting suicide appropriate and sufficient?

The LIV believes that there are sufficient criminal offences that would act as an additional safeguard. There are many and varied ways a breach of the proposed Act could occur that would attract criminal responsibility. The LIV believes that the offences of homicide and aiding and abetting suicide are appropriate and sufficient to prosecute people who fail to comply with the proposed Act. The offences of homicide and aiding and abetting suicide have been flexible enough in the past to tailor appropriate sentences to people who provide assistance to others to take their own lives.⁴ These sentences tend to be lower than the maximum sentence available and often do not include a prison sentence.⁵ However, where a breach of the proposed Act is caused by a person placing undue influence on another person or engaging in misleading and deceptive conduct, the relatively high maximum sentences for homicide and aiding and abetting suicide provide judges with ample discretion to impose a sentence appropriate to the circumstances of each case.

Properly Informed

Parliamentary Committee recommendation:

A person must be properly informed. The primary and secondary doctor must each properly inform the person:

1. of the diagnosis and prognosis of their condition, as well as the treatment options available to them, including any therapeutic options and their likely results;
2. of palliative care and its likely results;
3. that they are under no obligation to continue with a request for assisted dying and may rescind their request at any time; and
4. of the probable result and potential risks of taking the lethal drug.

Should the legislation include prescribed information that a medical practitioner must provide to a person requesting voluntary assisted dying and, if so, is the list recommended by the Parliamentary Committee in the box above sufficient?

The LIV agrees with the Parliamentary Committee's recommendation that a medical practitioner must provide a person requesting voluntary assisted dying with particular information. The LIV supports the proposed items and emphasises the importance of ensuring that a patient understands that just because they have obtained the lethal medicine, they are under no obligation to ingest it, and that if they do decide to ingest the medication, they may do so when they choose to.

What resources should be developed to support legislative obligations to provide information that would be useful in practice?

⁴ See e.g. *R v Hood* [2003] VSC 123; *R v Maxwell* [2003] VSC 278; *DPP v Karaca* [2007] VSC 190; *DPP v Rolfe* [2008] VSC 528; *R v Justins* [2011] NSWSC 568; *R v Mathers* [2011] NSWSC 339.

⁵ Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17 *Journal of Law and Medicine* 532.

The LIV recommends that any resources developed to support the legislative obligations on the health are available in a range of mediums and languages. Further, both doctors assessing eligibility, and the pharmacist or medical professional supplying the lethal medication, should inform the patient that they are able to withdraw their request at any time during the request process and at any later stage before the medication is ingested.

Confirming a request

Parliamentary Committee recommendation:

- The primary and secondary doctors must be independently satisfied that the patient's request is enduring and that a reasonable amount of time has passed between the patient's initial request and the provision of the lethal drug.
- In making this judgement the primary and secondary doctors must have regard to the patient's particular condition and its likely trajectory.
- The primary and secondary doctors must also assess the reasonableness of the request. This is to ensure that the patient truly understands and appreciates the nature and consequences of the decision to request assisted dying, as well as the alternatives to assisted dying, and that the patient's request is not ambivalent.
- Each doctor must be properly qualified to make a professional diagnosis and prognosis regarding the patient's specific condition. Each doctor must also assess the eligibility criteria.

It is vitally important for each doctor to be properly qualified to make a professional diagnosis and prognosis regarding the patient's specific condition. However, the LIV is cautious of including overly prescriptive requirements about qualifications of medical practitioners to participate in voluntary assisted dying in the legislation. Overly prescriptive requirements will significantly impact access to voluntary assisted dying where access to specialists is limited, especially in regional Victoria. Rather than prescribing qualifications in the legislation, the LIV recommends that the legislation require/provide that the first doctor must be satisfied that the patient understands their palliative care options. In meeting this requirement the doctor will consider their own expertise or whether the patient needs to be referred to a palliative care specialist before they can confirm the request for voluntary assisted dying.

Conscientious Objections

Parliamentary Committee recommendation:

- No doctor, other health practitioner or health service can be forced to participate in assisted dying.

The LIV supports the Parliamentary Committee's recommendation that no doctor, other health practitioner or health service, can be forced to participate in assisted dying. However, the LIV recommends that people or organisations that conscientiously object do not impede a patient's access to the health care of their choice,

including assisted dying. The LIV supports the proposed conscientious objection model under the *Abortion Law Reform Act 2008* ("Abortion Act"). The Abortion Act provides that where a registered health practitioner refuses to advise, or to perform, direct, authorise or supervise an abortion, and the practitioner has a conscientious objection, the practitioner must refer the woman seeking access to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion. The positive duty on the conscientious objector is crucial to ensure the patient, who is likely to be particularly vulnerable, has access to health practitioners that will assist with their request.

The LIV has some concern as to how the proposed legislation will operate for entities governed under the Commonwealth jurisdiction, for example, Aged Care facilities. In the Commonwealth jurisdiction, entities will not be able to conscientiously object, and potentially, patients will not have recourse to the protection of the positive duty to be referred to a known health provider that does not have a conscientious objection. However, the LIV notes that there are a number of provisions that may address this concern.

Pursuant to the *Aged Care Act 1997 (Cth)* ("Aged Care Act"), section 54.1 provides that approved providers have a responsibility to comply with the Accreditation Standards made under section 54.2 of the Aged Care Act. The Accreditation Standards provide:

Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a care recipient's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of State or Territory law [...]⁶

Further, section 56.1(m) prohibits an approved provider from acting in a way that is inconsistent with any rights and responsibilities of care recipients, as specified in the *User Rights Principles 2014 (Cth)* ("User Rights Principles"). The User Rights Principles contain a Charter of Care Recipients' Rights and Responsibilities, which include the following rights:

- to full and effective use of their personal, civil, legal and consumer rights;
- to quality care appropriate to their needs; to full information about their own state of health and about available treatments;
- to accept personal responsibility for their own actions and choices, even though these may involve an element of risk, because the care recipient has the right to accept the risk and not to have the risk used as a ground for preventing or restricting their actions and choices;
- to maintain control over, and to continue making decisions about, the personal aspects of their daily life, financial affairs and possessions;
- to have access to services and activities available generally in the community.⁷

The *Quality of Care Principles 2014 (Cth)* also provide that nursing services must be available to all care recipients who need them, including by a medical practitioner, specialist or qualified member of a palliative care team.⁸

The conscientious objection principle is codified in the *AMA Code of Ethics* and the *Code of Ethics for Nurses in Australia*.⁹ The *AMA Code of Ethics* provides that where 'a personal moral judgement or religious belief alone prevents a doctor from recommending some form of therapy, inform the patient so that they may

⁶ *Quality of Care Principles 2014 (Cth)* Pt 2, 2.4.

⁷ *Aged Care Act 1997 (Cth)* s 9; *Charter of Care Recipients' Rights and Responsibilities*, Sch 1.

⁸ *Quality of Care Principles 2014 (Cth)* Pt 3, 3.8.

seek care elsewhere.¹⁰ The obligation on the health professional is further recognised in the supplementary code of conduct, *Good medical practice: a code of conduct for doctors in Australia*, it provides:

Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal; not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.¹¹

The LIV believes that if health practitioners conscientiously object to voluntary assisted dying they be required to declare their objection to the care recipient as soon as possible. Where the conscientious objector is an entity, there should be an obligation on the entity to inform the potential patient or resident before such person is admitted to or contracted into a binding arrangement with the entity. The LIV recommends that the obligation on the entity extend to a positive duty to implement the referral of the patient to a provider that does not conscientiously object.

⁹ Nursing and Midwifery Board of Australia, *Code of Ethics for Nurses in Australia* (2008) 2.

¹⁰ (AMA Code of Ethics 2004, 1.1 (p). https://www.amaq.com.au/icms_docs/209098_ama-code-of-ethics-2004-editorially-revised-2006.pdf

¹¹ (2.4 (6, 7). <http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>

OVERSIGHT

Administering a lethal dose of medication

Parliamentary Committee recommendation:

A person should self-administer the lethal drug; the singular exception is where people are physically unable to take a lethal drug themselves. In this case, a doctor should be able to assist the person to die by administering the drug.

Where people are physically unable to take a lethal drug themselves, they should be permitted the assistance of a health care professional to administer the drug. In this situation, the doctor who assists in the administration of the drug should not be the primary or secondary doctor involved in the three-stage request process, any of the witnesses to the written request, or a family member or friend of the person. The LIV recommends that where a doctor is not reasonably available to administer the drug, a registered nurse or palliative care specialist may administer the drug at the direction of the person.

Attendance

The LIV supports the Parliamentary Committee's recommendation that, in all cases except where a person is physically unable to, a person must self-administer the medication.

The LIV understands that in many cases a person would feel comforted by having their health practitioner present while they self-administer the lethal dose of medication. The LIV has no objections to any person being present while a person self-administers the lethal dose of medication, so long as they do so freely. There should not be a professional obligation on the health practitioner if they do not wish to be present while the person self-administers the dose of lethal medication.

If a health practitioner is present when the person self-administers the dose of lethal medication, they should not be held liable if the medication is ineffective, nor any actions taken in good faith to assist the person. The LIV supports the legislation in Washington and California that provides that a medical practitioner should not face criminal or civil liability for being present when a person ingests the lethal dose of medication in accordance with the legislation. The LIV recommends extending this provision to all registered health practitioners.

Monitoring the use of a lethal dose of medication

How can a prescribed lethal dose of medication be effectively monitored without placing undue burdens or pressure on people accessing or using the medication?

The Parliamentary Committee recommended an accountability system for tracking assisted dying be established to effectively monitor the lethal dose of medication without placing undue burdens or pressure on people accessing the medication. The LIV supports this recommendation and acknowledges the difficulty in finding the appropriate balance between regulating and monitoring the use of the lethal medication once it is in the community while not placing undue burdens or pressure on people accessing the medication. The LIV further notes that there are already prescription medications, household items and illegal substances that cause death if they are ingested, and as individuals and as a community we are required to take some responsibility for how we manage this risk.

The LIV recommends further consideration be given to prescribing storage requirements of the drug pending ingestion and safe disposal of the drug where it is obtained, but not ingested, before the person dies, including considerations of who this responsibility should fall to. Further, the LIV recommends that the Panel consider how it can regulate where the medication can be used to avoid people self-administering the lethal dose of medication in public places.

The LIV notes that many of the key issues underlying the proposed legislation would involve determining key factors under the *Drugs Poisons and Controlled Substances Act 1981* (Vic) (“DPCS Act”), for example:

- Who may be authorised to administer, possess, prescribe, supply and use the drug;
- Where may the drug be administered and stored;
- How and when the drug may be prescribed, stored, administered and used.

Additionally, the LIV recommends that the DPCS Act is reviewed in light of the proposed legislation to ensure that it does not restrict access and availability of the medication.

The LIV further recognises that it is not appropriate for a health practitioner to ask a patient when they intend to take the medication, as this is likely to place pressure on the person. The Californian framework may place pressure on the patient, as they have to fill in a form within 48 hours prior to self-administering the lethal medication. The LIV has considered whether the patient could nominate a person to be responsible for informing the Assisted Dying Review (ADR) Board once the medication has been taken. This ‘nominated person’ could be someone the patient is close to, or a health practitioner.

Lethal dose of medication not effective

The reporting requirements to the ADR Board as outlined in the Discussion Paper will produce reliable data about the effectiveness of the medication. If the lethal dose proves to be ineffective over a number of users, this is something that the ADR Board should report to the Therapeutic Goods Administration (TGA). Individuals could also report ineffective medication to the TGA.

After a person has died

Once a person dies, any prescription medications can be returned to any pharmacy for safe disposal, however, there are currently no legislative requirements governing this process. The LIV identifies this as a serious gap in the regulation of poisons.

The LIV notes that the process for disposal should not be unduly burdensome, but given the high-risk nature of lethal medication and the vulnerability that family members and friends often find themselves in when they are grieving the loss of a loved one, it may be necessary to require a third party to return any unused medication to the issuing pharmacy or the prescribing doctor if a patient obtains the medication but dies of other causes before it is ingested.

The LIV has considered the concept of a 'nominated person' to fulfill this function, such as a family member or friend of the person. Another option would be for the doctor signing the death certificate to perform this role. When and where the medication was returned should be included as part of the information provided to the ADR Board.

The LIV does not recommend that death as a result of voluntary assisted dying is a reportable death. As recommended below on page 17, any suspicions or concerns surrounding voluntary assisted dying should be reported to the ADR Board and referred on to the appropriate authority.

The LIV recommends that the cause of death of a person who has ingested the lethal dose of medication is recorded on the death certificate as being the illness or disease that the patient would have died from but for the lethal dose of medication.

Oversight

Parliamentary Committee recommendation:

That an Assisted Dying Review Board be established to review each approved request for assisted dying. Membership of the Assisted Dying Review Board should include:

- a representative of End of Life Care Victoria
- a doctor
- a nurse
- a legal professional
- a community member.

The function of the Board will not be to approve or reject requests from patients to access assisted dying. That is the role of the primary doctor and independent secondary doctor in each case. Neither will the Board hear appeals from people whose requests to access assisted dying have been rejected.

The purpose of the Board is to ensure that doctors are complying with requirements of the assisted dying framework.

If the Board finds a breach of the assisted dying framework, it should forward its report to the appropriate authority. Depending on the nature of the breach, this may be Victoria Police, the Coroner or the Australian Health Practitioner Regulation Agency. Those bodies will then determine whether to investigate the case further.

The Board should report to Parliament on the operation of the assisted dying framework, including any trends it identifies and recommendations for improvement. For the purposes of increased transparency and accountability, during the first two years of operation these reports should be every six months. Following that the Board should report annually.

The LIV supports the Parliamentary Committee's recommendation that an ADR Board be established. The LIV recommends that the ADR Board is independent from the Department of Health and Human Services. The LIV agrees that the role of the ADR Board should not be to investigate complaints regarding the conduct of doctors or health professionals, as this is already covered by the Australian Health Practitioner Regulation Agency (AHPRA).

However, the LIV recommends that the proposed scope of the ADR Board is broadened to monitor cases where a request to access voluntary assisted dying is denied. If one of the roles of the ADR Board is to monitor and collate data on the implementation of the voluntary assisted dying framework, it is necessary to collate information on the requests that failed to ensure the full implementation of the framework is captured. Capturing cases where the request is denied may unveil patterns and assist to identify further training needs of professionals engaging with the legislation. The LIV submits that the extension of the ADR Board's scope to unsuccessful matters will lead to best practice and a safer voluntary assisted dying framework.

The LIV further envisages the ADR Board having some role in monitoring the use of the lethal medication once it has been prescribed to the patient. As noted above at page 14, the 'nominated person' or health practitioner or family member should be directed to contact the ADR Board once the lethal dose of medication has been taken, or once the patient dies, whichever occurs first.

The LIV supports the Parliamentary Committee's recommendation to review medical practitioners in each instance of voluntary assisted dying insofar that is necessary to monitor the implementation of the voluntary assisted dying framework. The LIV recognises the value of requiring the primary and secondary doctor to report to the ADR Board at certain stages of the process.

While the LIV does not recommend the ADR Board have the power to investigate and review medical practitioners conduct, the LIV supports the proposition that the ADR Board act as a first point of call for concerns by health practitioners, patients and their families regarding voluntary assisted dying. The ADR Board could refer matters to the relevant authority, for example AHPRA or Victoria Police, where there is a reasonable suspicion or a complaint is raised. The ADR Board could also have a support and educational role where health practitioners, the patient or their family could seek advice on a number of matters, for example, how to destroy remaining lethal medication. Having an ADR Board as the central reporting body for concerns regarding voluntary assisted dying will ensure that the data and information it collects can help inform future best practice.