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The Ministerial Expert Panel on
Voluntary Assisted Dying
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Perth Business Centre
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By email: VADconsultations@health.wa.gov.au

Ministerial Expert Panel on Voluntary Assisted Dying

Thank you for the opportunity to provide feedback on the issues in the Ministerial Expert Panel's Discussion Paper on Voluntary Assisted Dying.

Our submission is attached.

Please contact me on the details below if you require any further information or clarification of the matters raised in this submission.

We would appreciate the opportunity to provide further submissions once the proposed legislation has been drafted.

Yours sincerely

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Avant submission to the Ministerial Expert Panel on Voluntary Assisted Dying

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 78,000 medical practitioners and students around Australia, including Western Australia.

In addition to assisting members in civil litigation, professional conduct matters and coronial matters, Avant has a medico-legal advisory service (MLAS) that provides support and advice to members when they encounter medico-legal issues. Our members have contacted us for advice about issues relating to end-of-life care and voluntary assisted dying. We provide our submission from this perspective.

In this submission we have answered select questions where we believe our experience could assist in creating a legislative framework which incorporates sufficient protections for those doctors who choose to participate, and those who choose not to participate in voluntary assisted dying.

Key points

1. Any legislative framework must incorporate sufficient protections for those medical practitioners who choose to participate, and those who choose not to participate.

2. Legislation should clearly outline the processes to be followed and medical practitioners' obligations at a high level with further detail contained in guidelines.

3. The following protections should be included in the legislation:

    a. That a medical practitioner is not required or compelled to comply with a person's request, or to be involved in voluntary assisted dying at all.
    b. That a medical practitioner should not face any criminal, civil, administrative or disciplinary action for refusing to participate, or for choosing to participate.
    c. That a medical practitioner is immune from criminal and civil liability, and disciplinary action for providing treatment that causes death if they have acted in accordance with the requirements of the legislation in good faith and without negligence.
    d. That this immunity be extended to a medical practitioner being present when the person takes the medication.

4. The legislation should not include a prescriptive requirement for referral in the case of conscientious objection. Issues relating to referral where there is a conscientious objection should be dealt with under current ethical guidelines.

5. The oversight body should not have a role in determining whether or not there has been a breach of the legislative regime and should not have any investigative powers. These functions should remain with the authorities currently in existence, including the Australian Health Practitioner Regulation Agency, the Coroner and the police.

6. Avant supports national consistency of approach in legislation and national consistency of terminology in all areas of health law. As this type of legislation has only been passed

in Victoria, there is a unique opportunity for other state and territory governments to develop legislation that is consistent with one another where appropriate.

As a national organisation, we see the pitfalls of having multiple and inconsistent laws governing the same subject matter across Australia's many jurisdictions. It affects medical practitioners and patients. Medical practitioners need to understand the nuances of each law of each Australian jurisdiction if they are to practise in that area. This could be particularly burdensome for practitioners who have cross-border practices. Patients can also become dissatisfied if health laws in Australia are not consistent because Australians have varying levels of access to healthcare depending on the state they reside.

The Person

- ***Should there be a specified period during which someone has to be continuously living in Western Australia in order to be considered 'ordinarily resident'? If so, what period?***

Whatever period is determined, the criteria surrounding that period should be clear and specific so that medical practitioners can apply them easily.

We support provisions, similar to that in the *Voluntary Assisted Dying Act 2017* (Vic), that allow the State Administrative Tribunal to determine issues of usual residency where it is unclear.

The decision

- ***What safeguards should there be to ensure that a request is voluntary?***
- ***Should the assessing medical practitioner be able to refer to other health practitioners with relevant competency to assess that the decision is voluntary?***

We agree that it is fundamental to this legislative scheme that the person's decision to access voluntary assisted dying is voluntary. We understand that ensuring that a person's decision is voluntary is an important safeguard, to ensure that the request is free from coercion or duress.

The issue of referral to another health practitioner to assess voluntariness was not raised in the Joint Select Committee's report. Rather, the Joint Select Committee noted the evidence of the president of the RACGP that was to the effect that he did not have concerns that vulnerable people were being influenced or coerced into refusing medical treatment and that if it was happening, most GPs would be able to detect it.[1]

While referral to another health practitioner appears on its face to be a reasonable suggestion, we are concerned about how this would work in practice.

[1] Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices* (2018) 218 [7.57].

While medical practitioners are competent to assess decision-making capacity, unlike capacity, voluntariness is not a clinical issue and there are no clear criteria on which to judge voluntariness from a clinical perspective.

The presence or absence of coercion (undue influence) or duress is more of a legal question. It arises in various contexts, including wills and succession, contract law, equity and financial decision-making. We refer the panel to an article in the Melbourne University Law Review which contains an examination of some of the complex, legal issues involved in determining undue influence in the context of the elderly.[2]

However, it may be appropriate to include a mechanism for medical practitioners to be able to refer cases to the State Administrative Tribunal if the practitioner had a reason to suspect that the decision was not being made voluntarily. This would be a more effective way to protect vulnerable people who may be being coerced.

An informed decision

- ***Should health practitioners be able to discuss voluntary assisted dying with their patients in the same way they raise and discuss other health or medical decisions and care options?***

Yes. Avant supports medical practitioners being allowed to discuss voluntary assisted dying with their patients in the same way they initiate and discuss other medical decisions and care options. While we generally favour national consistency in health law across all Australian jurisdictions, we do not believe that the Western Australian model should follow the Victorian model on this point.

If the legislation is passed, voluntary assisted dying will be a legal, medical option, and it should form part of a medical practitioner's general discussion with their patients about end-of-life care. Without the medical practitioner raising it as an option, they cannot fulfil their obligation to their patient to provide them with all the relevant information, including treatment options, to make an informed decision and to provide valid consent. This will allow medical practitioners to provide patients with information about all relevant, appropriate and legal treatment options.

[2] Burns, Fiona "Undue Influence Inter Vivos And The Elderly" [2002] MelbULawRw 27; (2002) 26(3) Melbourne University Law Review 499.

Decision-making capacity

- ***How should capacity be determined? Is the way in which this is done in existing WA law sufficient? (Refer to Appendix 4 for more detail)***

Doctors play an important legal role in determining capacity.[3] Capacity is decision-specific, so we agree that a patient wishing to request assisted dying must have decision-making capacity in relation to voluntary assisted dying in particular. We agree that general practitioners can usually determine capacity in this context, but that if a medical practitioner is unable to assess capacity, they must refer the person to a specialist.

Ideally, to ensure legal consistency and to avoid confusion, the same legal test for capacity should apply whatever medical decision is being made by a patient.

The test for capacity in the voluntary assisted dying legislation should be consistent with the test for capacity in other legislation and the common law to the greatest extent possible.

The way capacity is determined in current WA law is sufficient. We believe that the test in the *Mental Health Act 2014* (WA) would be appropriate to adopt in this legislation.

- ***Should the assessing medical practitioner be able to refer to other health practitioners with relevant competency in capacity assessment (e.g. a neuropsychologist) instead of a consultant psychiatrist or consultant geriatrician?***

Yes, Avant supports medical practitioners being able to refer to other practitioners with relevant competency in capacity assessment. The important consideration here is that the other health practitioner is competent in assessing capacity related to the specific decision and treatment option, rather than being from a specific specialty.

Eligible conditions

- ***If voluntary assisted dying only applies to an illness or disease that is terminal, is specification of a timeframe either desirable or necessary?***

- ***Would a timeframe help or hinder access to voluntary assisted dying? From the perspective of the person? Or medical practitioner?***

- ***If a timeframe is to be specified should it be defined as:***
    - ***reasonably foreseeable outcome of the eligible condition?***
    - ***reasonably foreseeable outcome for this person?***
    - ***6 months? (with 12 months for neurodegenerative disorders)***
    - ***12 months?***
    - ***other?***

[3] See for example Wilmot L, White B, Parker M, Cartwright C "The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)" (2011) 18 JLM 773.

Whether a patient has an eligible condition will depend on the precise condition the patient has, as well as on the doctor's clinical judgement.

Making an accurate prognosis at the end of life can be difficult. The timeframe for being at the "end of life" will depend on the type of condition the patient has and may be difficult to predict. Some patients will go on to live for longer than anticipated. Others may die more quickly than anticipated.

We are concerned about the use of the term "reasonably foreseeable". As one of our members said recently "death is a reasonably foreseeable outcome of life".

"Reasonable foreseeability" is a technical, legal term and one that is not well understood by medical practitioners and other people. The difficulties noted in the discussion paper with the use of the term "reasonably foreseeable" in Canada suggest that it may not be advisable to use this term as it is open to interpretation and difficult to apply in practice.

We appreciate that having a set timeframe such six or 12 months can be arbitrary and clinically problematic, given that prognosis can be difficult to predict. Nevertheless, it will require doctors and patients to turn their minds to the patient's prognosis with some precision. It sets some boundaries around eligibility and will be easier to implement in practice.

On balance, we believe that the WA legislation should follow the timeframes outlined in the Victorian legislation.[4]

- ***Must a person's suffering be 'grievous and irremediable' to be eligible?***

We believe that the term 'grievous and irremediable' is problematic as it is not a term used by medical practitioners.

We agree that the person's suffering should be subjectively assessed. However, we believe that the phrase used in the Victorian legislation, 'cannot be relieved in a manner that the person considers tolerable',[5] is easier to understand for the person and the medical practitioners involved, compared with, 'grievous and irremediable'.

Also, adopting the same words as the Victorian legislation will promote consistent legislation across jurisdictions so that Australians can expect the same level of care across the country.

[4] *Voluntary Assisted Dying Act 2017* (Vic) ss 9(1)(d)(iii), 9(4).
[5] *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iv).

The process

Assessment

- ***Should a medical practitioner or health service that conscientiously objects have an obligation to refer the patient to a practitioner or service that has no objection? If so, how should the medical practitioner find out which doctors are willing to provide voluntary assisted dying?***

We support the inclusion of a provision that allows a medical practitioner to conscientiously object to participating in voluntary assisted dying, but we consider that the legislation should not include a positive obligation to refer a patient to a practitioner who has no objection. Referral should be dealt with under current ethical guidelines.

For some practitioners, their conscientious objection extends to steps taken to *refer* a patient for a procedure to which they conscientiously object, as well as objecting to the procedure itself. We have had experience assisting practitioners with the *Abortion Law Reform Act 2008* (Vic) which contains a positive obligation to refer. In our experience, this provision has caused difficulty for doctors who have a conscientious objection, both in terms of their own conscience and also in the way they provide care to patients.

The Medical Board of Australia's Code of Conduct outlines the expected standard of practice where doctors' religious or moral views have the potential to impact on patient access to care.[6] In our view, the guidance included in the Code of Conduct is sufficient to guide practitioners about their ethical obligations where they hold a conscientious objection.

Therefore, we recommend that issues relating to referral not be included in the legislation. We recommend that issues relating to referral continue to be dealt with within the ethical framework of the Code of Conduct.

- ***What should the purpose and timing of the written statement be?***
  - to formalise the initial request (and thus occur before the assessments)? or
  - to formalise the request once the person has been informed of all of their options, including palliative care, and is approved as eligible (and thus occur after the assessments)?

The purpose and timing of the written statement should be to formalise the request once the person has been informed of all their options and is approved as 'eligible'. It should demonstrate the person's enduring request to access assisted dying. In the flowchart, we understand this to be the '3rd Request'.

At present, it is difficult to distinguish the difference between the '1st Request' and the '2nd Request' in the flowchart. These could be discrete requests; however, in practice it seems likely that the first four steps of the process could be a series of events that take place in a single discussion/consultation between the person and the co-ordinating practitioner.

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[6] Medical Board of Australia (March 2014), Good Medical Practice: A Code of Conduct for Doctors in Australia, clauses 2.4.6 and 2.4.7.

An initial verbal request should be sufficient to commence the assessment process. After the person has been informed of their options, the assessments have taken place and the person has been approved as 'eligible', a written request to access assisted dying should be required.

- ***Should the assessing medical practitioners have practised for at least five years after completing their fellowship or registering as a GP?***
  Should this be required for both medical practitioners or at least one (as in Victoria)?

We support having at least one of the assessing medical practitioners having practised for at least five years after completing their fellowship or registering as a GP, as is the case in Victoria.[7]

- ***What should be included in the training for health practitioners involved in voluntary assisted dying?***
- ***Should the completion of approved training be mandatory before a medical practitioner is able to undertake the process for voluntary assisted dying?***

Yes. All medical practitioners should be required to complete mandatory approved training before they are able to undertake the process for voluntary assisted dying. We believe that practitioners should be required to meet minimum competencies, to be determined by a group of appropriately qualified practitioners. This could include competency in palliative care, end of life care generally, determining capacity and other relevant skills to undertake the assessment of the patient and provide treatment under this regime.

This will act as a safeguard for everybody involved. It will help ensure that the person is receiving the treatment they are eligible for and that the medical practitioner understands their legal obligations to their patient.

Medication

- ***Should a medical practitioner only be permitted to administer the medication if the person is physically incapable of self-administration?***

We make no comment on whether or not a medical practitioner should only be permitted to administer the medication if the person is physically incapable of self-administration. If a medical practitioner is permitted under the legislation to administer medication to a patient (whether or not the patient is physically capable of doing so), then there should be a requirement in the legislation that another person be present and witness the administration and that the process be documented. This is an important safeguard for both patients and medical practitioners.

[7] *Voluntary Assisted Dying Act 2017* (Vic) s 10(2).

Death certification

- ***Should it be required that voluntary assisted dying is listed as a contributing cause of death on:***
  - the Medical Certificate Cause of Death?

Yes. Voluntary assisted dying should be listed on the Medical Certificate Cause of Death as a contributing cause.

- the publicly available Death Certificate?

No. To preserve the privacy of the person and the medical practitioners involved, this information should not be listed on such a public document. The disease, illness or medical condition that was the basis for the person accessing voluntary assisted should be listed on the Death Certificate.

Oversight

- ***How should community information and education be provided?***
- ***How should health practitioner training and education be provided?***

We know from our experience in assisting practitioners with medico-legal issues at the end of life is that there is a lack of understanding among doctors about their legal obligations. We are also aware from our experience that medical practitioners often have difficulty dealing with situations where there is disagreement among or between family members, the patient and the treatment team about treatment options. Disagreement could be heightened in the context of assisted dying.

We strongly support comprehensive training and education for medical practitioners and the community on voluntary assisted dying, on the legislative requirements, and the practical implementation of the legislation. This will help to prepare practitioners to have informative conversations with patients faced with terminal conditions who may wish to access voluntary assisted dying.

- ***How should complaints about voluntary assisted dying be handled?***

We believe that the oversight body should not be involved in complaints handling or any other investigative process.

There are several bodies currently in existence that have jurisdiction to investigate an incident or complaint if necessary, including Australian Health Practitioner Regulation Agency, the Health and Disability Services Complaints Office, the Coroner and the police

Any complaints or concerns about voluntary assisted dying should be handled by the bodies that already exist.

Conclusion

- ***Are there any further issues related to the Joint Select Committee's recommended framework that require the Ministerial Expert Panel's consideration?***

General comments on the legislative framework

The legislation needs to provide a clear framework within which patients and doctors can operate.

As a matter of general principle, the legislation should balance the need for clear and unambiguous wording with the need to leave sufficient scope for the exercise of clinical judgement, consideration of the patient's individual circumstances and changing standards of medical practice. We have pointed out above where the wording proposed in the discussion paper may be difficult for practitioners to understand and apply in practice.

If the legislation is too prescriptive, compliance will be difficult and may leave limited room for clinical judgement and increase medico-legal risk. Legislation that is too flexible may be open to interpretation and retrospective criticism.

Protections from liability

We **strongly recommend** that the legislation incorporate sufficient protections for those medical practitioners who choose to participate (as outlined in the Joint Select Committee's report[8]), and those who choose not to participate.

The legislation should clearly state that:

1. a medical practitioner should not face any criminal, civil, administrative or disciplinary action for refusing to participate, or for choosing to participate.
2. a medical practitioner is immune from criminal and civil liability, and disciplinary action for providing treatment that causes death if they have acted in accordance with the requirements of the legislation in good faith and without negligence.

For the avoidance of doubt, we **recommend** that the legislation make it clear that the immunity extends to a doctor (or other person) being present when the patient takes the medication.

These provisions will ensure doctors are protected if they make decisions based on their clinical judgement, for example, a patient lives longer than anticipated when a doctor originally assessed a patient as being at the end of life.

Avant Mutual
24 May 2019

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[8] Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices* (2018) 221 [7.71].