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SUBMISSION TO QUEENSLAND LAW REFORM COMMISSION

A Legal Framework for Voluntary Assisted Dying: Response to WP NO79

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A LEGAL FRAMEWORK FOR VOLUNTARY ASSISTED DYING: RESPONSE TO WP NO79

Palliative Care Social Work Australia

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Legislation provides guidance about what is a legal activity or process, and when and how it should occur. However, despite the advantages, the law can struggle to account for the complexities of life and for individuals within their context. Legislation has significant implications for those whom it affects. This submission will focus on potential unintended socio-legal consequences that may arise from the practical application of some of the proposed VAD sections - both for the individual and those who support them in the process. Our professional colleagues in Victoria and their experiences of what works and does not work in practice have also informed this submission.

This submission is submitted by Palliative Care Social Work Australia (PCSWA), a newly formed association which represents social workers who provide palliative and end of life care and bereavement support in Australia, regardless of the setting in which they work. PCSWA aims to strengthen the voice of social work and to promote excellence in social work practice in the provision of psychological, social, cultural, emotional, spiritual, and practical support in palliative care contexts. To improve access to quality of care and outcomes for people who receive palliative and end of life care, social work assessments and interventions take into account the social determinants of health in the context of political and power structures and work to address issues of inequity that impact a person’s structural vulnerability and disadvantage. Requests for VAD do not occur in a social vacuum and advanced practice and social work clinicians play a key role in supporting patients and families through in-depth assessments and effective interventions. As well as providing high quality and safe patient care, social workers focus on advocacy and contributing to change at a macro level on important issues, such as voluntary assisted dying (VAD).

PCSWA has chosen to answer a majority, but not all the consultation questions. Our submissions to the consultation questions are noted in the right-hand panel of the table below:

CHAPTER 3: PRINCIPLES		
	Q-1 What principles should guide the Commission’s approach to developing voluntary assisted dying legislation?	It is important to highlight the human rights values that underpin the intent of the legislation. Human rights including principles of autonomy, choice, freedom of conscience and right to protection from torture and cruel, inhumane, or degrading treatment are of utmost importance. Relying upon concepts such as beneficence alone would be inappropriate as this works on the concept of preventing harm or doing the best for the patient but this is sometimes interpreted in a protectionist manner rather than a human rights autonomy framework. Compassion and non-abandonment are essential principles that should also be incorporated. Additionally, another principle to guide the Commission’s approach should be ‘the legislation should be considered through the lens of application in practice and how to ensure the reduction of unintended socio-legal consequences of the use of the legislation’. Using this principle will ensure quality but also safer outcomes for the person, their family/friends but also professionals involved in exercise of the legislation.
	Q-2 Should the draft legislation include a statement of principles: (a) that aids in the interpretation of the legislation. (b) to which a person must have regard when exercising a power or performing a function under the legislation (as in Victoria and Western Australia)?	A statement of principles to guide interpretation of the legislation and how it should be used in practice is essential. Principles also remind people how the power with the legislation should be exercised. If there are no principles, then dominant viewpoints can overshadow the process, leading to potential harm. The principles used in the WA legislation are comprehensive and remind us of the important of quality care; irrespective of where you live. Other legislation that contains Principles e.g. Guardianship and Administration Act QLD 2000 also contain a section about the aim and purpose of the Act. A stipulated purpose outlining the intent of the VAD Act would be helpful.
	Q-3 If yes to Q-2(b), what would be the practical, and possibly unintended, consequences of requiring such persons to have regard to each of the principles?	Legislation cannot provide direction for every situation; however, a well-considered set of principles can inform decision making and provide guidance. Furthermore, principles can serve as a benchmark to question a process if a VAD related activity is being queried.

	Q-4 If yes to Q-2(a) or (b) or both, what should the principles be? For example, should the statement of principles include some or all of the principles contained in: (a) section 5(1) of the Voluntary Assisted Dying Act 2017 (Vic); (b) section 4(1) of the Voluntary Assisted Dying Act 2019 (WA); or (c) clause 5 of the W&W Model?	Western Australian Principles present as appropriate and relevant, however, with the inclusion of the following amended phrase as follows: *"A person is entitled to genuine choices about the person's care, treatment and end of life; irrespective of where the person lives in Queensland and having regard for the person's culture and language and identity e.g. LGBTIQ+"*
CHAPTER 4: ELIGIBILITY CRITERIA FOR ACCESS TO VOLUNTARY ASSISTED DYING		
	Q-5 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness, or medical condition that: (a) is incurable, advanced, progressive and will cause death (as in Victoria); or (b) is advanced, progressive and will cause death (as in Western Australia)?	"Incurable" is an appropriate criterion for inclusion, as it clarifies that there is an end to the person's life as opposed to having an advanced disease. An advanced disease may be chronic and last for many years. "Incurable" as a term reminds all medical practitioners to consider whether the criteria is being fulfilled e.g. is the disease process incurable?
	Q-6 Should the eligibility criteria for a person to access voluntary assisted dying expressly state that a person is not eligible only because they: (a) have a disability; or (b) are diagnosed with a mental illness?	Yes. Social workers strongly value 'equity' and a human rights approach to access and submit that a person should not be excluded based on having a mental illness or a disability if they meet the criteria.
	Q-7 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that is expected to cause death within a specific timeframe?	Whilst there are challenges relating to time frames (e.g. requires a physician to be definitive in their prognosis), time frames are commonly understood and used in clinical practice and provide some level of clarity regarding eligibility.
	Q-8 If yes to Q-7, what should the timeframe be? Should there be a specific timeframe that applies if a person is diagnosed with a disease, illness or medical condition that is neurodegenerative?	The QLD VAD legislation should remain consistent with Victoria and Western Australia – i.e. six months, or within 12 months in the case of a disease, illness or medical condition that is neurodegenerative. Health professionals regularly consider the clinical "surprise" question (e.g

	For example, should the relevant timeframe be within six months, or within 12 months in the case of a disease, illness or medical condition that is neurodegenerative (as in Victoria and Western Australia)?	"Would it surprise you if this person died within 1 year?") so keeping with 12 months is suggested
	Q-9 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable (as in Victoria and Western Australia)?	This should be part of the criteria as diagnosis alone is not sufficient as a threshold criterion. Additionally, it should also be reliant on how the disease is impacting on functioning and the suffering incurred. However, "suffering" seems not to be defined in the legislation? It is submitted that a definition of suffering is required. Currently, the onus is upon the personal experience of the person seeking VAD to decide upon the intolerable suffering. This reflects a trauma-informed approach to suffering which is commendable. However, a trauma-informed approach also reminds us that people often have significant and debilitating suffering emotionally, physically and psychologically from matters that are caused by the disease, but which can be addressed by other non-clinical interventions. Sometimes diseases or medical conditions impact upon people and their lives in ways that are not related to clinical pain. 'Suffering' invites a broad interpretation. The issue is whether the intent of the law means to invite <u>any</u> suffering by the individual, which will trigger access to VAD e.g. if the person is 'suffering' because they cannot work due to the illness and feel significant grief and loss and depression as a result of losing their identity as the main 'breadwinner'. It is submitted that this type of suffering (which can be intense) should be distinguished in a definition from a person who has terrible physical pain that cannot be ameliorated.
	P-1 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be aged 18 years	Adulthood is 18 years in most legislation, so consistency regarding this should remain.
	Q-10 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be: (a) an Australian citizen or permanent resident; and (b) ordinarily resident in Queensland?	It is understood that opening access to non-Australian citizens or permanent residents; and those who do not ordinarily reside in Queensland would have funding and resource implications. However, if a person is eligible for Medicare or from a country with a reciprocal Medicare arrangement, could this be considered? It is suggested the

		issue of residency be approached through a social justice lens (underpinned by principles of access and equity). Applications could be considered from other states/territories where VAD is not legalised on the provision a person provides evidence they are going to live with family members with whom they share a significant relationship with. Case study: Robert is a widowed man who lives in rural South Australia and has end-stage liver cancer. He has one daughter who resides in Queensland. The only consistent health care specialist Robert has been seeing is his oncologist when she outreaches to Robert's community on a monthly basis. The GP's come and go in the local medical centre, so consistency has been a challenge to date. On his last oncology review, Robert was referred for palliative care services, which are also scant in his community. He was informed at his last medical appointment, he has only months left to live. He would like to travel to Queensland and seek VAD so he can die by his daughter's side. However, this is prohibited as he is not ordinarily a Queensland resident.
	Q-11 If yes to Q-10(b), should that requirement also specify that, at the time of making the first request to access voluntary assisted dying, the person must have been ordinarily resident in Queensland for a minimum period? If so, what period should that be?	No comment
	P-2 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be acting voluntarily and without coercion.	Yes – this is of utmost importance.
	P-3 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must have decision-making capacity in relation to voluntary assisted dying.	Yes – the person must have decision making capacity to request VAD Additionally, refining the focus to the capacity for decision-making in relation to VAD is strongly supported as in practice, a person may lack capacity for decision-making in other domains or aspects of their life (e.g. financial matters) but still retain the ability to seek VAD.
		Yes, use the same definition of capacity as per the other QLD legislation currently in use as this is the definition that most health practitioners

	Q-12 Should 'decision-making capacity' be defined in the same terms as the definition of 'capacity' in the Guardianship and Administration Act 2000 and the Powers of Attorney Act 1998, or in similar terms to the definitions of 'decision-making capacity' in the voluntary assisted dying legislation in Victoria and Western Australia? Why or why not?	recognize, and it will also interface well with any review by the Human Rights Division, QCAT. Furthermore, there is already an embedded limb in this definition that requires the decision to be made 'freely and voluntarily"- and this is important as it covers the issue in P-2 about coercion.
	Q-13 What should be the position if a person who has started the process of accessing voluntary assisted dying loses, or is at risk of losing, their decision-making capacity in relation to voluntary assisted dying before they complete the process? For example: (a) Should a person who loses their decision-making capacity become ineligible to access voluntary assisted dying? (b) Should there be any provisions to deal with the circumstance where a person is at risk of losing their decision-making capacity, other than allowing for a reduction of any waiting periods? If so, what should they be? (c) Should a person be able, at the time of their first request, to give an advance directive as to specific circumstances in which their request should be acted on by a practitioner administering a voluntary assisted dying substance, despite the person having lost capacity in the meantime?	A) This question highlights the vital importance of a sound and clear consent and communication processes in all areas relating to VAD. Losing decision-making capacity should not be an impediment to an enduring VAD request if there has been a robust informed consent process undertaken by the health practitioner and the person as well as their family/close others are aware that the process cannot be stopped once they lose capacity to consent or change their mind in relation to VAD. B + C) Given that AHDs may be established years ahead of any illness, it would not usually be appropriate for an AHD preference to cover a VAD request. Statistics in the USA indicate that many people change their mind or even receive the substance but do not use it. In practice, people can and often do change their mind when faced with the ultimate decision and if decision making capacity has been lost and a robust and well-documented and communicated VAD process has not been undertaken, it may give rise to a residual "what if ?" question. This is a matter that practitioners and family members would need to thoroughly explore, with an awareness of possible impacts after the death.
	Q-14 Should the eligibility criteria for a person to access voluntary assisted dying require that the person's request for voluntary assisted dying be enduring?	See above

CHAPTER 5: INITIATING A DISCUSSION ABOUT VOLUNTARY ASSISTED DYING		
	Q-15 Should the draft legislation provide that a health practitioner is prohibited from initiating a discussion about voluntary assisted dying as an end of life option?	This requires weighted consideration. Although VAD should be included in discussions regarding options for the provision of end of life care, there are some factors to consider. The issue of the power dynamic between patient and health practitioner needs to be acknowledged. By the very nature of being health professionals, we are in a position of power and are seen to have some authority due to our training. Health professionals could thus unwittingly be coercive by emphasising VAD as the main option for end of life care. VAD should be included in the range of options presented for end of life care, which should include palliative care. Even with training, many health professionals are not comfortable talking about end of life care wishes. Potential scenarios that portray the above concerns could be reflected in the following example: PATIENT: "I've been worried that this pain might continue to get really bad." HEALTH PROFESSIONAL: "There's always VAD as an option if the pain gets too much to bear." Although not intentional, this could potentially be coercive as the only 'go to' option. If VAD is presented in a way that conveys this is the favoured or more optimal option, the person may think VAD is the only option. A more **experienced and skilled clinician** might respond with: HEALTH PROFESSIONAL: "You have raised concerns a number of times that you're worried your pain will continue to get worse – have you thought about what options there might be available to you." However, If the Victorian approach was adopted, where practitioners are not allowed to raise the VAD as an option but only after initiation by the consumer, uncertainty may arise. It is not simple to determine if a

		consumer is asking about VAD options (if a frank conversation is prohibited) and an unsolicited but well-intentioned discussion may expose health practitioners inadvertently to breaching the intent of the law. E.g. if a patient says that they want to die as they are in pain and have no quality of life, is this sufficient to meet the criteria for discussing VAD? Health practitioners should be allowed to provide VAD information in the context of the exploration of all options for end of life care; unless of course, an option is futile. VAD should be open for discussion but presented and reviewed only in an unbiased way.
	Q-16 If yes to Q-15, should there be an exception to the prohibition if, at the same time, the practitioner informs the person about the treatment options available to the person and the likely outcomes of that treatment, and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment (as in Western Australia)?	-
CHAPTER 6: THE VOLUNTARY ASSISTED DYING PROCESS **Requesting access to voluntary assisted dying** **Witnessing requirements for the written declaration**		
	Q-17 Should the draft legislation provide that the person who makes a written declaration in the presence of: (a) two witnesses (as in Western Australia); or (b) two witnesses and the coordinating practitioner (as in Victoria)?	The Victorian VAD option is preferred to ensure that the coordinating practitioner is satisfied that the witnesses were impartial and that the consent from the person was real and not coerced. It may be sufficient if the co-ordinating practitioner is present via telehealth e.g. rural and remote.
	Q-18 Should the draft legislation provide that a person is not eligible to witness a written declaration if they: (a) are under 18 years (as in Victoria and Western Australia); (b) know or believe that they: (i) are a beneficiary under a will of the person making the declaration (as in Victoria and Western Australia);	Yes, this is preferred. No witness should benefit from the death of the person who is seeking VAD and independence in the witness will allay any concerns of coercion or bias. It will also alleviate any potential feelings of guilt from family or others who may feel obliged to sign for the person. However, it is acknowledged that this could raise problems of access for people who are socially isolated or live remotely. However, provisions for use of telehealth options may be useful here.

	(ii) may otherwise benefit financially or in any other material way from the death of the person making the declaration (as in Victoria and Western Australia); (c) are an owner of, or are responsible for the day-to-day operation of, any health facility at which the person making the declaration is being treated or resides (as in Victoria); (c) are directly involved in providing health services or professional care services to the person making the declaration (as in Victoria); (d) are the coordinating practitioner or consulting practitioner for the (e) person making the declaration (as in Western Australia); (f) (f) are a family member of the person making the declaration (as in Western Australia)?	
	Q-19 Alternatively to Q-18(f), should the draft legislation provide that not more than one witness may be a family member of the person making the declaration (as in Victoria)?	No
	Waiting periods	
	Q-20 Should the draft legislation include provisions about the prescribed period that must elapse between a person's first request and final request for access to voluntary assisted dying, in similar terms to the legislation in Victoria and Western Australia?	Yes
	Q-21 If yes to Q-20, should the draft legislation provide that the final request can be made before the end of the prescribed period if: (a) the person is likely to die within that period; or (b) the person is likely to lose decision-making capacity for voluntary assisted dying within that period?	Yes on the proviso that the final request can only be made early if medical palliative options are insufficient to resolve the acute symptoms or pain of the patient; otherwise palliative care would be sufficient. For the request to be enduring, there is a supposition that the person will not change their mind, but it is important to acknowledge that this is not always the reality. This comes back to the issues re enduring decisions raised and answered in Q13.
Eligibility assessments **Requirement for the eligibility assessments to be independent**		

	Q-22 Should the draft legislation provide that the coordinating practitioner and the consulting practitioner must each assess whether the person is eligible for access to voluntary assisted dying and that: (a) the consulting assessment must be independent from the coordinating assessment (as in Victoria and Western Australia); and (b) the coordinating practitioner and the consulting practitioner who conduct the assessments must be independent of each other?	Assessments should be undertaken independently. None of the involved practitioners should be junior to the other (e.g. registrar and consultant) as this creates a power dynamic that will reduce the independence requirement. It may be difficult to consider how independence is maintained in small rural communities. However, Queensland Health is currently building more linkages around palliative care from metropolitan to rural areas via telehealth, which could assist with this concern.

	Q-23 Should the draft legislation provide that, if the coordinating practitioner or consulting practitioner: (a) is not able to determine if the person has decision-making capacity in relation to voluntary assisted dying—they must refer the person to a health practitioner with appropriate skills and training to make a determination in relation to the matter (as in Victoria and Western Australia); (b) is not able to determine if the person has a disease, illness or medical condition that meets the eligibility criteria—they must refer the person to: (i) a specialist medical practitioner with appropriate skills and training in that disease, illness or medical condition (as in Victoria); or (ii) a health practitioner with appropriate skills and training (as in Western Australia); (c) is not able to determine if the person is acting voluntarily and without coercion—they must refer the person to another person who has appropriate skills and training to make a determination in relation to the matter (as in Western Australia)?	This question assumes that coordinating or consulting practitioners will know their own limitations or referral pathways. Unfortunately, this is not always the case. Referrals may not occur to other health practitioners if the coordinating or consulting practitioners are not current with the latest medical innovations or options regarding palliative care or other forms of care e.g. trauma-informed approaches. A practice example may assist here: ***Case example 1:*** *Sue has acute, chronic back pain and spinal stenosis that is affecting her ability to sit and walk. Her spine is essentially crumbling due to bone disease. Pain medications are increasingly ineffective, and she is placed on a palliative pathway by a practitioner. VAD is an option. However, what the health practitioner does not know is that there is a new type of spinal intervention that can reduce the pain significantly and thereby reduce the need for pain medications and resume her ability to walk and sit and participate in life again.* It is suggested that a full psychosocial assessment should be required as part of a VAD suitability assessment to review a) what other matters may be underlying the person's wish to seek VAD; b) what other information and bio-psycho-social interventions may be required by the family/friends of the person seeking VAD. A holistic approach would question whether some of concerns lay beyond a disease process and could be addressed by further exploration and assessment. If a person is not being considered holistically in the terms of care needs, it is queried whether all their options have been thoroughly investigated. It is important to note that although VAD is about the person's human rights, others will be impacted by the process and it is important to assess early to ensure a compassionate response to all involved. There are therapeutic interventions that relieve the risk of bereavement complexities. Follow-up bereavement care, including pre and post death matters is also required or at least assessed.

		A thorough psychosocial assessment can identify these key issues and ensure quality support is established for all concerned. Advanced social work practitioners such as specialist palliative care social workers have the requisite skills to undertake psychosocial assessments within the context of VAD as they have specialist knowledge in psychological emotional, social, cultural and spiritual domains of end of life care. The following highlight the importance of a holistic assessment process rather than just a clinical one: ***Case example 2:*** *Due to the lack of a psycho-social assessment being undertaken as part of the VAD assessment, the medical practitioner is unaware that Myrtle, John's mother, is afraid of being present when John dies but as this is John's wish and she is his only remaining social support, she thinks she should be there for his death. Myrtle is suffering emotionally, awaiting the death of her son and she feels spiritually compromised as VAD is against her value stance. VAD affects more than the person seeking it but there is nothing in the legislation that acknowledges the needs of the support people.* ***Case example 3:*** *John has a progressive cancer of the bowel – late stage. He is seeking VAD as he has significant suffering. What is not known because a full assessment has not been undertaken is that John's wife of 16 years has recently left him and taken the 4-year-old child. John now faces financial losses e.g. separation of assets and legal concerns. His depression is linked to these potentially remediable issues. Is this the right circumstance to seek VAD?*

	Q24 Should the draft legislation provide (as in Western Australia) that the coordinating practitioner, the consulting practitioner, any health practitioner (or other person) to whom the person is referred for a determination of whether the person meets particular eligibility requirements, or the administrating practitioner must not: a) Be a family member of the person; or b) know or believe that they are a beneficiary under a will of the person or may otherwise benefit financially or in any other material way from the person's death?	The practitioner involved in the VAD process should not be a family member or benefit in any way. This also aligns with current ethical responsibilities of medical practitioners.
	Q-25 Should the draft legislation provide for an eligible applicant to apply to the Queensland Civil and Administrative Tribunal for review of a decision of a coordinating practitioner or a consulting practitioner that the person who is the subject of the decision: (a) is or is not ordinarily resident in the State (as in Victoria); (b) at the time of making the first request, was or was not ordinarily resident in the State for a specified minimum period (as in Victoria and Western Australia); (c) has or does not have decision-making capacity in relation to voluntary assisted dying (as in Victoria and Western Australia); (d) is or is not acting voluntarily and without coercion (as in Western Australia)?	Yes. It is essential to have a tribunal review cases so concerns/conflicts can be scrutinized in an independent thorough manner
	Q. 26 If yest to Q-25, should an application for review be able to be made by: a) the person who is the subject of the decision b) an agent of the person who is the subject of the decision; or c) another person who the tribunal is satisfied has a special interest in the medical care and treatment of the person	Any of a) b) or c)
	Q. 27 At what points during the request and assessment process should the coordinating practitioner or consulting practitioner be required to report to an independent oversight body? For example, should it be required to report to an independent oversight body:	Points of reporting should be a) after each eligibility assessment is completed, b) after the person has made a written declaration and c) after the person has made their final request.

	a) after each eligibility assessment is completed (as in Victoria and Western Australia b) after the person has made a written declaration (as in Western Australia c) after the person has made their final request (as in Victoria and Western Australia) d) at some other time (and, if so, when?)	The documentation should be thorough and include information on how the assessment met the VAD criteria and how any other concerns were addressed.
	Q-28 Is it necessary or desirable for the draft legislation to require the coordinating practitioner to apply for a voluntary assisted dying permit before the voluntary assisted dying substance can be prescribed and administered (as in Victoria)?	Whenever restricted medication is released, it should be recorded and notified. In most cases of release of restricted substances, there is a process of two people recording release etc. It is important for information to be recorded via a VAD permit so that there is continuity of process and if a review is required, clarity of documentation.
Administration of the substance		
	Q-29 Should the draft legislation provide that practitioner administration is only permitted if the person is physically incapable of self-administering or digesting the voluntary assisted dying substance (as in Victoria)?	No – how the substance is administered should be decided consensually between the person and the practitioner.
	Q-30 Alternatively to Q-29, should the draft legislation provide (as in Western Australia) that: (a) the person can decide, in consultation with and on the advice of the coordinating practitioner, whether the voluntary assisted dying substance will be self-administered, or practitioner administered; and (b) practitioner administration is only permitted if the coordinating practitioner advises the person that self-administration is inappropriate, having regard to one or more of the following: (i) the ability of the person to self-administer the substance (ii) the person's concerns about self-administering the substance; or (iii) the method for administering the substance that is suitable for the person. Requirements for self-administration	No administration of a sedative is risk-free. There have been adverse outcomes e.g. seizures, from administration of substances in the past in international jurisdiction and so medical supervision should be required. The aim should be a pain-free uncomplicated death, not one that causes trauma.

	Q-31 Should the draft legislation provide that the coordinating practitioner or another health practitioner must be present when the person self-administers the voluntary assisted dying substance? Requirements for practitioner administration	It is preferable that some health practitioner is present so that in case of emergency or reaction, there is help available. It will also ensure that there is someone independent present to document or testify that the substance was used as intended and by the person whom it was intended for – this seems to be missing in the current proposed legislation? Concerns arise though in how this will be managed in rural or remote sectors. Furthermore, support for family/friends is essential and may also help to mitigate any adverse outcomes in bereavement
	Q-32 Should the draft legislation provide that a witness, who is independent of the administering practitioner, must be present when the practitioner administers the voluntary assisted dying substance?	This may be difficult to arrange across Queensland.
	Q-33 Should the draft legislation provide that an interpreter who assists a person in requesting or accessing voluntary assisted dying must be accredited and impartial, in similar terms to the legislation in Victoria and Western Australia?	An impartial and accredited interpreter is always preferred to ensure that there is clarity not only in communication but also intent. However, some communities are so small that interpreters are known and even live within the community and in some of these cases, it may be culturally inappropriate for the person seeking the VAD to be seen to do so. Sensitivity around culture is therefore necessary when considering use of interpreters. It should be recognised also that given the complexity of the nature of VAD that translating these concepts can prove difficult in some languages. For instance, in some languages finding an equivalent word to convey the meaning of a concept such as "palliative care" can be difficult. Certainly, using family should be avoided for emotional, independence but also coercion reasons. Also, it is important to note that in some First Nations groups, the dialects are so specific that there are no interpreters. It may also be inappropriate for some people to die 'in country' if their death is undertaken via a VAD process.
	Q-34 Are there any other issues relating to these or other procedural matters that you wish to comment on?	We note that a person may attain the substance but decide not to administer. Research highlights that 30-40% of persons do not use the substance after receiving it. Upon review, it has been noted there is no requirement posed on what should happen to the substance or follow-

		up in these instances. This would be a community safety issue as well as a restricted substances concern.
Chapter 7: Qualifications and training of health practitioners		
	Q-35 Should the draft legislation provide that only a medical practitioner can act as a coordinating practitioner or a consulting practitioner and assess the person's eligibility for access to voluntary assisted dying? Q-36 Should the draft legislation set out minimum qualification and experience requirements that a medical practitioner must meet in order to act as a coordinating practitioner or a consulting practitioner?	It is preferable that a medical practitioner can assess the medical and symptom components for the purposes of VAD but a full psychosocial assessment should be required as well to guide and complement the medical assessment. This will also allay and hopefully reduce any unintended consequences of inappropriate VAD. Yes. VAD is an ethically as well as emotionally complex matter and so someone who has not only a higher level of experience but also received robust and sound education in VAD should be a requirement.
	Q-37 If yes to Q-36, what should the minimum qualification and experience requirements be? For example, should it be a requirement that either the coordinating practitioner or the consulting practitioner must: (a) have practised as a medical specialist for at least five years (as in Victoria); and (b) have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed (as in Victoria)? Role of other health practitioners	The Victorian model is appropriate Problems will occur with access in remote and rural communities so funding will be needed to support this, if it is legislated. However, it is important that people in remote and rural communities have equal access to expertise for safety as well as quality outcome purposes. In Victoria, the practice experience has meant that many practitioners who have had to have discussions around VAD have not been specialists in this area or with the requisite skill sets. It is suggested that all people involved indirectly with VAD should have a base-line of training but also clear pathways around who should be involved and when. For those administering the VAD process including psycho-social and functional or clinical assessments, their level of education and expertise should be specialist. It should certainly involve more than an on-line education course on how to complete the VAD process.
	Q-38 Should the draft legislation provide that the voluntary assisted dying substance can be administered by: (a) the coordinating practitioner (as in Victoria and Western Australia); (b) a medical practitioner who is eligible to act as a coordinating practitioner for the person (as in Western Australia); or (c) a suitably qualified nurse practitioner (as in Western Australia)?	A medical practitioner should be the coordinating practitioner rather than a nurse as medical knowledge is necessary to understand differential diagnoses for more complex illnesses. It is noted that a social work psychosocial assessment of the person and their environment and any social or other pressures that may be influencing their seeking VAD be completed as part of any VAD assessment.

	Q-39 Should the draft legislation require health practitioners to complete approved training before they can assess a person's eligibility for access to voluntary assisted dying?	Yes. **All** practitioners should have robust education about the process and requirements of VAD prior to the implementation commencement. Practice Implications: Healthcare professionals should also have regular professional supervision with an understanding around any emotional, psychological, social, ethical and spiritual concerns that may arise. The possibility of moral distress should be openly acknowledged and safely addressed. Additionally, a multi-faceted understanding of the experience of loss and grief beyond death is an important aspect of care that needs specific training and expertise. A trauma-informed approach to care is also vital. VAD processes raise a different set of concerns to the needs of those seeking palliative care or of those working with them.
Chapter 8: Conscientious objection		
	40 +41 +42 Q-40 Should the draft legislation provide that a registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following: (a) provide information about voluntary assisted dying; (b) participate in the request and assessment process; (c) if applicable, apply for a voluntary assisted dying permit; (d) prescribe, supply, dispense or administer a voluntary assisted dying substance; (e) be present at the time of the administration of a voluntary assisted dying substance; or (f) some other thing (and, if so, what)? Q-41 Should a registered medical practitioner who has a conscientious objection to voluntary assisted dying be required to refer a person elsewhere or to transfer their care? Q-42 Should the draft legislation make provision for an entity (other than a natural person) to refuse access to voluntary assisted dying within its facility? If so, should the entity be required to:	Every person has human rights. No person should feel obligated against their will, to engage in an activity that conflicts with their values. It is a person's right to refuse and not provide VAD due to conscientious objection However, no one should prevent someone from doing something that is legally permissible and referring someone in a time-sensitive manner - e.g. if a patient is seeking VAD, then they have a right to be referred elsewhere or their care transferred immediately. A key challenge arises if a medical practitioner objects to participation, but they are the sole medical practitioner in a rural or remote community. There may not be another practitioner in the community for the referral. This should be addressed with specific guidance in the legislation.

	(a) refer the person to another entity or a medical practitioner who may be expected to provide information and advice about voluntary assisted dying; and (b) facilitate any subsequent transfer of care?	
Chapter 9: Oversight, reporting and compliance		
	Q-43 Should the draft legislation provide for an independent oversight body with responsibility for monitoring compliance with the legislation?	Yes
	Q-44 If yes to Q-43, should the oversight body have some or all of the functions and powers conferred on: (a) the Voluntary Assisted Dying Review Board under the Voluntary Assisted Dying Act 2017 (Vic); or b) the Voluntary Assisted Dying Board under the Voluntary Assisted Dying Act 2019 (Western Australia)?	-
	Q-45 Should notifications to the Health Ombudsman of concerns about health practitioners' professional conduct relating to voluntary assisted dying: (a) be dealt with by specific provisions in the draft legislation, as in Victoria, which provide for mandatory and voluntary notification in particular circumstances; or (b) as in Western Australia, be governed by existing law under the Health Practitioner Regulation National Law (Queensland) which states when mandatory notification is required, and voluntary notification is permitted?	Having specific provisions in the legislation will clarify requirements but also ensure that concerns are addressed and brought to attention rather than relying only upon voluntary notification.
	Q-46 Should the draft legislation include specific criminal offences related to non-compliance with the legislation, similar to those in the Voluntary Assisted Dying Act 2017 (Vic) or the Voluntary Assisted Dying Act 2019 (WA)?	Yes
	Q-47 Should the draft legislation include protections for health practitioners and others who act in good faith and without negligence	Yes

	in accordance with the legislation, in similar terms to those in the Voluntary Assisted Dying Act 2017 (Vic)?	
	Q-48 Should there be a statutory requirement for review of the operation and effectiveness of the legislation?	Yes
Chapter 10: Other matters:		
	Q-49 How should the death of a person who has accessed voluntary assisted dying be treated for the purposes of the Births, Deaths and Marriages Registration Act 2003 and the Coroners Act 2003?	-
	Q-50 What key issues or considerations should be taken into account in the implementation of voluntary assisted dying legislation in Queensland?	• Training and education on implementing VAD should be available to all healthcare practitioners that administer care to persons with an incurable, advanced and progressive illness • A thorough psychosocial assessment should accompany a request for VAD. This will identify other possible psychosocial stressors that could be underpinning the VAD request. Additionally, the possibility of coercion could be detected and addressed. Understandably, there is no requirement to inform the family of the patient's request, however, there is significant emphasis placed upon detecting and addressing elder abuse. • Poor literacy skills, vision or hearing difficulties are important factors that can influence decisions regarding VAD. This requires specific consideration when undertaking a comprehensive psychosocial assessment • Unconscious bias is also another factor to be considered – e.g. If a healthcare practitioner strongly believes in VAD, and is also a coordinating doctor, this may affect the degree to which they unpack the reasons behind a person's request or similarly if the practitioner is against VAD. • Additionally, what about those people who request VAD but are not eligible? How are they supported? They have expressed a wish for

		suicide, so presumably this risk may be elevated if they are not eligible for the VAD pathway. There has been no discussion about this within the legislation and it should at least provide an exit point for them to receive some level of assessment and compassionate follow-up. If the legislation cannot address this, then the QLRC could make comment about the importance of development of this differential pathway? • Coordinating practitioners and consulting practitioners need to have a robust level of communication skills training as well as about the specificities of VAD • Follow-up should also occur for family members of those who have died after taking the substance. Quality bereavement support is crucial, with necessary risk assessments being undertaken to assess for potential bereavement complexities. Pending on risk assessment reviews, continued follow-up or referrals to a bereavement specialist service may be necessary