Australian College of Nursing

LEGAL FRAMEWORK FOR VOLUNTARY ASSISTED DYING

AUSTRALIAN COLLEGE OF NURSING RESPONSE TO THE QUEENSLAND LAW REFORM COMMISSION (November 2020)

General comments

The Australian College of Nursing (ACN) would like to thank the Queensland (QLD) Law Reform Commission for the opportunity to provide feedback on the **Framework for Voluntary Assisted Dying (November 2020)**. The Australian College of Nursing is the pre-eminent and national leader of the nursing profession and a strong collective voice for nurses in all health care settings. ACN is committed to ensuring those at the end of their lives are treated with the utmost dignity and respect; and are supported in their autonomous choices to explore all available end of life options. Nurses are best placed to provide compassionate, safe and professionally competent care for individuals as they face the end of their lives.

ACN has been actively involved in efforts to enhance end-of-life (EOL) care, regardless of whether individuals opt for advanced care planning or voluntary assisted dying (VAD). ACN represents thousands of nurses working in all health care settings including aged and palliative care and has strongly advocated for nurse leadership in designing and implementing appropriate and carefully considered VAD frameworks. In a 2019 **submission to the QLD Department of Health's Committee on Health, Communities, Disability Services and Domestic and Family Violence Prevention**, ACN argued all health professionals, care workers and volunteers should be supported to work according to their ethical values, while providing safe, quality and compassionate care to people living with a life limiting illness.[1] In a 2019 submission to the **Western Australia (WA) Voluntary Assisted Dying Public Consultation,** ACN argued an individual's dignity and choice are vital to ensuring a person's quality of life, comfort and dignity during this vulnerable time.[2] In a 2018 **submission to the Australian Capital Territory (ACT) Legislative Assembly Inquiry into End of Life Choices,** ACN highlighted the challenges many nurses face in responding to increasing requests for assisted dying in jurisdictions with ill-defined scope of practice or lack of support around EOL care decisions.[3] ACN is pleased to see specific reference to the roles, responsibilities and expectations of nurses – particularly nurse practitioners (NPs) – not only in the provision of palliative care, but in conversations about VAD with patients facing the end of their lives. ACN welcomes the inclusion of the Nursing and Midwifery Board of Australia (NMBA) Code of Conduct principle 3.6[4] in section 7.6, 9.11 and footnote 5 (page 122) in establishing an ethical framework for nurses in providing EOL care. As outlined in sections 7.27-7.30, NPs in some jurisdictions with VAD legislation can participate in discussions with patients considering VAD, and even administer the VAD substance. ACN supports this, and believes NPs are uniquely placed to provide trusted, compassionate and professionally competent care to patients making EOL decisions.

In a 2018 Position Statement, ACN argued legislation around **voluntary assisted dying in Victoria** should be based on the assumption that all people with a life-limiting diagnosis deserve to receive high quality, evidence-based health care, and access to appropriate services such as specialist

[1] Australian College of Nursing 2019. ACN submission to the Queensland Department of Health's Committee on Health, Communities, Disability Services and Domestic and Family Violence Prevention. https://www.acn.edu.au/wp-content/uploads/20190418-ACN-response-QLD-VAD-parliamentary-inquiry.pdf

[2] Australian College of Nursing 2019. ACN submission to the Western Australia voluntary assisted dying public consultation. https://www.acn.edu.au/wp-content/uploads/20190524-ACN-response-WA-voluntary-assisted-dying.pdf

[3] Australian College of Nursing 2018. ACN submission to the ACT legislative assembly inquiry into end of life choices in the ACT. https://www.acn.edu.au/wp-content/uploads/2018/03/20180323_ACN-response_ACT-Leg-Assem-End-of-Life-Inq_FINAL.pdf

[4] Nursing and Midwifery Board of Australia 2018. Code of conduct for nurses. https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx

palliative care.[5] ACN notes references in sections 6.85 and 6.86 and footnote 113 to the challenges many face in accessing quality palliative or even basic nursing care in rural, remote and very remote settings. ACN has strongly urged greater investment in palliative care nursing in these areas, to ensure equity of access to high-quality care provision.[6] In the case of discussing and administering VAD care in rural and remote areas, ACN agrees NPs can play a crucial role in ensuring those with life-limiting conditions have the same access and autonomy to make EOL decisions. ACN also welcomes specific mention to respecting the needs, preferences and beliefs of culturally and linguistically diverse (CALD) people, including the protection of families, children and cultural rights of Aboriginal and Torres Strait Islander peoples in 1.43 and 3.5. It is likely some members of the Aboriginal and Torres Strait Islander community with life-limiting illnesses will choose to pursue voluntary assisted dying on country, and this should be honoured. Special care should also be taken to support those with a disability to understand and access their different EOL care options, including VAD, as outlined in 3.32 and 3.49.

ACN acknowledges nurses and members of the community more broadly will have different views on VAD, but stresses that high-quality nursing care for all individuals at the end of their lives should be responsive to the needs, preferences and values of people, their families and carers. ACN promotes patient-centred communication that ensures a person's wishes are understood and acknowledged and that autonomy is respected and acted upon. Importantly, ACN believes palliative care and VAD are not the same, and nor are they mutually exclusive. If an individual with a life-limiting illness chooses VAD, this does not and should not preclude them from receiving specialist palliative care services.

No matter what decision an individual makes, ACN believes nurses are best placed to provide the compassionate, competent, safe and person-centred care all individuals at the end of their lives deserve. In a 2019 White Paper on **achieving quality palliative care for all: the essential role of nurses**, ACN argued nurses are uniquely qualified to address the range of physical, emotional, social and spiritual needs of people with a life-limiting illness and promote continuity of care across the care trajectory.[7] In a 2020 White Paper, ACN made the case for **establishing a nurse-led palliative care service in Australia: implementation toolkit,** including how to effectively plan, engage stakeholders, develop a business case, implementation and evaluation of nurse-led palliative care.[8] More broadly, ACN believes **nurses are essential in health and aged care reform**.[9]

[5] Australian College of Nursing 2018. Position Statement: Voluntary assisted dying in Victoria. https://www.acn.edu.au/wp-content/uploads/2018/10/Voluntary-Assisted-Dying-in-Victoria.pdf.

[6] Australian College of Nursing 2019. White Paper: Achieving quality palliative care for all: The essential role of nurses. https://www.acn.edu.au/wp-content/uploads/white-paper-end-of-life-care-achieving-quality-palliative-care-for-all.pdf

[7] Australian College of Nursing 2019. White Paper: Achieving quality palliative care for all: The essential role of nurses. https://www.acn.edu.au/wp-content/uploads/white-paper-end-of-life-care-achieving-quality-palliative-care-for-all.pdf

[8] Australian College of Nursing 2020. White Paper: Establishing a nurse-led palliative care service in Australia: An implementation toolkit. https://www.acn.edu.au/wp-content/uploads/white-paper-establishing-nurse-led-palliative-care-service-in-australia-implementation-toolkit.pdf

[9] Australian College of Nursing 2016. White Paper: Nurses are essential in health and aged care reform. https://www.acn.edu.au/wp-content/uploads/white-paper-nurses-essential-health-aged-care-reform.pdf

ACN responses to consultation questions

SPECIFIC CONSULTATION QUESTIONS

CHAPTER 3: PRINCIPLES

Q-1 What principles should guide the Commission's approach to developing voluntary assisted dying legislation?

ACN supports the principles as outlined in Chapter 3, page 25-6.

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)?

ACN favours option a), for the principles to aid interpretation of the legislation.

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?

Not applicable

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?

ACN supports option b) from section 4(1) of the Voluntary Assisted Dying Act (WA), particularly specific reference to the needs of those in rural and remote areas and those from culturally and linguistically diverse backgrounds.

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)?

ACN supports option b) that the medical condition is advanced, progressive and will cause death (as in Western Australia) There may be some conditions that are curable but depending on the circumstances will lead to death.

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?

ACN supports both a) and b); that a person should not be eligible to access voluntary assisted dying only if they have a disability or diagnosed mental illness. However, if the person has one or both conditions and satisfy all other criteria, they should not be excluded from accessing VAD.

This is a really important point to make and it relates to Q5 above in that a disability may be the cause of seeking VAD and legislation should not dictate or preclude a persons' choice. To do so counteracts autonomy and respect for an autonomous choice.

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?

ACN members believe the eligibility criteria for a person to access voluntary assisted dying should require the person to be diagnosed with a disease, illness or medical condition expected to cause death within a specific timeframe. ACN acknowledges this may impose limits on some individuals seeking VAD such as those with neurodegenerative disease.

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? 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)?

ACN members believe imposing any timeframe would be arbitrary and may cause a person suffering intolerably to be ineligible.

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)?

Yes.

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 or more.

ACN agrees. The aged of consent for medical treatment is 18 years of age. However, there are circumstances in which patients under the age of 18 can consent to their own medical treatment.[10] This may need to be considered in the legislation for VAD.

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?

[10] Legal Aid Queensland. Medical Consent: http://www.legalaid.qld.gov.au/Find-legal-information/Personal-rights-and-safety/Health-and-medical/Medical-consent

ACN believes to be eligible for assisted dying, the person must be a citizen or permanent resident and ordinarily a resident in Queensland. Otherwise the eligibility criteria would be too complex and require changes Australia wide.

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?

ACN believes case law must define a 'reasonable' minimum period of time. It is important to set a minimum period to prevent people from other states/territories flooding into Queensland to access VAD as was seen with the NT legislation.

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.

ACN agrees.

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.

ACN agrees.

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?

ACN largely supports the definitions of 'capacity' provided in the Guardianship and Administration Act 2000 and the Powers of Attorney Act 1998, though supports specific inclusion of 'decision-making capacity' in relation to voluntary assisted dying, as stated in 4.137. A hybrid model based on the Guardianship and Power of Attorney Acts, and the WA and VIC conditions in 4.103 and 4.104 would be ideal. The overarching principle is for the person concerned to be legally competent to make a decision for themselves.

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?

ACN members do not believe such a person should be ineligible, provided they had capacity when requesting VAD. Noting that capacity can fluctuate from having decision making capacity to not having that capacity.

(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?

ACN members support reducing waiting times when a person is at-risk of losing their decision-making capacity. Capacity can vary and be inconsistent over periods of time.

(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?

ACN supports the use of advance care directives in specifying in circumstances in which VAD should be provided in situations where the person has lost capacity following their initial VAD request. The choices expressed in an advanced directive should be respected.

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?

Yes, requests should be enduring as this would allow the legal carer to ensure the patient's wishes were carried out.

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?

Nurses in EOL care settings commonly receive requests for assisted dying (up to 18%), placing them in difficult professional, ethical and legal positions.[11] However, legally they need to be receptive to requests as per the Code of Conduct and Ethics for Nurses,[12] [13] which indicates nurses must provide safe, person-centred care whilst working within their scope of practice.

Ordinarily, ACN would not recommend health practitioners initiating discussions about VAD as an EOL option, but rather be a source of validation for personal choices. People who are dying are at the most vulnerable time in their lives and for this reason it is important to protect them from being coerced into EOL care choices that do not reflect their own. However, there would likely be patients unaware of this option, particularly those presenting from culturally and linguistically diverse (CALD) backgrounds. To be truly given autonomous choice, patients must be aware of all end of life options. If clinically indicated because of the therapeutic relationship developed, health practitioners should be able to appropriately present this option, alongside all other end of life care pathways available to the patient, as specified in section 10 of the WA legislation outlined in 5.18. ACN would welcome specific inclusion of nurse practitioners in this provision.

ACN believes that whatever decision is made for legislation must be accompanied by community education and background on VAD.

[11] Health Times, 2017. 'Dignity and choice vital for end-of-life care'. Accessed 1st September 2020 at: https://healthtimes.com.au/hub/palliative-care/69/news/nc1/dignity-and-choice-vital-for-endoflife-care/3067/

[12] International Council of Nurses, The ICN Code of Ethics for Nurses, International Council of Nurses, Geneva, Switzerland, 2012.

[13] Nursing and Midwifery Board of Australia, Code of Conduct for Nurses, Nursing and Midwifery Board of Australia, Canberra, 2018.

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)?

Nurses providing care frequently establish relationships of trust such that discussions on sensitive and delicate topics, like end of life, can be conducted in an atmosphere of safety and respect. As mentioned above, there would likely be patients unaware of VAD as an EOL option. In these instances, there needs to be guidance on how discussions around VAD can be initiated or how awareness about VAD can reach people from different communities or backgrounds, who may not necessarily find this information easily.

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 must sign the written declaration in the presence of:

(a) two witnesses (as in Western Australia); or

(b) two witnesses and the coordinating practitioner (as in Victoria)?

ACN supports option (a). From a practical standpoint, as noted in 6.14, there are likely to be instances where the requirement for the coordinating practitioner to be present is likely to pose a significant burden, particularly in rural and remote areas.

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);**
- **(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);

(d) are directly involved in providing health services or professional care services to the person making the declaration (as in Victoria);

(e) are the coordinating practitioner or consulting practitioner for the person making the declaration (as in Western Australia);

(f) are a family member of the person making the declaration (as in Western Australia)?

ACN believes options (a) to (f) should render a witness ineligible. In the case of (f), family and/or carers must allow their dying loved one to make AHD decisions voluntarily and not influence this for financial gain for example.

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)?

In principle, ACN agrees with the Victoria legislation. In practice however, particularly in rural and remote areas, it may be difficult to locate a witness who is not a family member. Some clearly articulated and precise exceptions in very limited circumstances may be necessary, particularly for those in rural and remote areas, including for Aboriginal and Torres Strait Islander people living on country.

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?

ACN members support the nine day period (as per legislation in Victoria and Western Australia), except in cases where the person's death is imminent, or they can reasonably be expected to lose decision-making capacity, particularly where they may experience greater suffering out of fear VAD will no longer be available should they lose capacity in the intervening period, as outlined in 6.20 and 6.21.

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?

ACN members support option (b).

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?

ACN members support option (a). Particularly in rural and remote areas, option (b) is likely to be prohibitively impractical.

Requirements for referral of certain matters to a specialist or another person

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)?

ACN supports options (a), (b)-(ii) and (c).

Other requirements

Q-24 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 administering 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?

ACN believes both conditions should render the consulting practitioner ineligible from determining whether the person meets eligibility requirements or administering the VAD substance.

Review of certain decisions by Tribunal

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)?

ACN supports all four conditions of any QCAT review.

Q-26 If yes 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?

ACN supports all three options.

Reporting requirements for health practitioners

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:

(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)?

ACN supports options (a) and (c).

Additional approval process

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)?

ACN members do not support this requirement. It adds an unnecessary procedural layer, with no evidence to date that it makes the process any safer. The co-ordinating practitioner may not be available or relevant (as per above response in relation to rural and remote areas).

Administration of the voluntary assisted dying substance

Self-administration or practitioner administration

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)?

ACN believes this should be decided by the person in consultation with or on the advice of the coordinating health practitioner, as in Western Australia.

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?**

ACN supports option (a). While the options listed in (b) are reasonable, it should ultimately be the person's decision whether or not they wish to self-administer the substance.

Requirements for self-administration

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?

ACN does not support this requirement, as this would likely impinge on the person's autonomy. Once the decision has been made to administer the VAD substance, carrying out administration should not be dependent on the schedule or availability of health practitioners. If the person wishes to have a health practitioner present, they can request this at their discretion.

Requirements for practitioner administration

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?

Yes. An independent witness will ensure that there is no collusion between the 'practitioner' and the witness in administering the VAD substance.

Community, cultural and linguistic considerations

Requirements for interpreters to be accredited and impartial

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?

Yes, though ACN recognises this may pose a significant burden in some very remote areas. Some very limited exceptions may be necessary.

Procedural requirements

Q-34 Are there any other issues relating to these or other procedural matters that you wish to comment on?

No

CHAPTER 7: QUALIFICATIONS AND TRAINING OF HEALTH PRACTITIONERS

Minimum qualification and experience requirements of coordinating and consulting 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?

No. ACN strongly advocates for nurse practitioners to act as a coordinating or consulting practitioner and assess eligibility requirements. This is particularly important in rural and remote parts of Queensland. In very remote areas, it may be necessary to extend this to an appropriately trained remote area nurse.

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?

As above, it should not be accessible to only medical practitioners. Any heath practitioner with minimum qualifications and five years practice experience should be eligible. In the case of remote and very remote areas, that practice experience needs to be in remote and/or very remote areas specifically.

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)?

ACN believes that while these conditions are ideal, this is likely to pose an undue burden in rural, remote and very remote areas and may result in unnecessary suffering. Some clearly articulated and precise exceptions may need to be made in very limited circumstances.

Role of other health practitioners

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)

ACN supports all three options, and particularly applauds the QLD Law Reform Commission for their inclusion of nurse practitioners.

Mandatory assessment training

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. For nurses this could be added to existing palliative care training.

CHAPTER 8: CONSCIENTIOUS OBJECTION

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)?

ACN believes registered health practitioners with a conscientious objection to voluntary assisted dying have the right to refuse participation in options (b)-(e). While ACN strongly respects the rights of health practitioners to act according to their own values and beliefs, and in accordance with that profession's code of ethics and of conduct, exemption from providing information about VAD in an appropriate manner alongside all other end of life options may impinge on the person's ability to make an autonomous decision.

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?

Yes. If the person expresses a wish to discuss or pursue VAD, the objecting health practitioner should refer the person to another appropriately qualified health practitioner. The person should not deliberately be discouraged or dissuaded at any stage of this discussion or subsequent referral.

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:
(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?

Yes. Entities should not be able to conscientiously object without being required to refer the person and facilitate the transfer in a professional, appropriate and timely manner.

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?

ACN supports this requirement and suggests that a nurse practitioner with expertise in VAD and palliative care be appointed to such a body.

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 (WA)?

ACN believes a hybrid system with the function and powers of the VIC, WA and proposed W&W legislation would be ideal, with particular reference to the inclusions of nurses and nurse ethicists in 9.11, community engagement in 9.20 and educational initiatives in 9.22.

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?

ACN favours option (b).

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, criminal offences should be included in the legislation, as outlined in 9.47.

Q-47 Should the draft legislation include protections for health practitioners and others who act in good faith and without negligence in accordance with the legislation, in similar terms to those in the Voluntary Assisted Dying Act 2017 (Vic)?

Yes, as in Victoria.

Q-48 Should there be a statutory requirement for review of the operation and effectiveness of the legislation?

ACN supports an initial review within three years of implementation, and every five years subsequently.

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?

ACN supports the VIC and WA legislation in listing the underlying condition as the cause of death, while requiring the health practitioner to inform the Voluntary Assisted Dying Board, and the Board to inform the Registrar, as outlined in 10.4.

Q-50 What key issues or considerations should be taken into account in the implementation of voluntary assisted dying legislation in Queensland?

Must be in accordance with Queensland Law, including the Enduring Powers of Attorney and the Advance Health Directive and Capacity guideline which become law on 30 November 2020 (the Powers of Attorney Act 1998). ACN notes particular reference to whether power of attorney is given to someone who represents the service provider in which person with an AHD resides. This must all be in accordance with professional practice standards, as promulgated by the Nursing and Midwifery Board of Australia.