




Government of **Western Australia**
Department of **Health**

Ministerial Expert Panel on Voluntary Assisted Dying Discussion Paper

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LifeLine WA 13 11 14 (available 24/7) or online chat www.lifelinewa.org.au

The Suicide Call Back Service 1300 659 467(available 24/7) or
online chat www.suicidecallbackservice.org.au



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Introduction from the Minister for Health

The McGowan Government is committed to improving and strengthening end of life and palliative care for all Western Australians. This is important because end of life care will affect all of us. In recognition of the importance of this, in May 2018 the Government released the WA End of Life and Palliative Care Strategy 2018 – 2028. This Strategy provides a 10-year vision for improving the lives of all Western Australians through the provision of quality end of life and palliative care.

However, the reality is that even with the best palliative care some people continue to experience profound suffering at the end of their life.

In November 2018 I announced that the Government will introduce legislation into Parliament to enable voluntary assisted dying in Western Australia. This discussion paper is a vital step in the progress of the legislation – put simply it is your chance to be heard and help ensure the legislation we introduce has appropriate safeguards for all involved and is world's best practice.

The decision to introduce legislation was made following the recommendations of the Joint Select Committee on End of Life Choices (**Joint Select Committee**). The Joint Select Committee was made up of cross-party membership from both Houses of Parliament and released its report *My Life, My Choice* in August 2018.

The Joint Select Committee made 18 recommendations aimed at strengthening and adapting the way the health system delivers end of life and palliative care. The McGowan Government has accepted each of those recommendations and recognises that with an ever-growing and ageing population, a renewed focus on the provision of palliative care is vital.

The Joint Select Committee also found that the nature of dying under WA's existing legal framework can sometimes be extraordinarily difficult for individuals and harrowing for family, friends, communities and first responders.

Unnecessary suffering and broad community support for the principle of autonomy underpinned the Joint Select Committee's recommendation that the WA Government introduce a bill for voluntary assisted dying. The principle of autonomy means that individuals with terminal suffering have a say in their own end of life.

In accordance with the Joint Select Committee's recommendations I established a Ministerial Expert Panel (**Panel**) to advise on key issues for the legislation. The Panel is chaired by Malcolm McCusker AC QC and includes expertise from clinical, legal, consumer, disability and culturally and linguistically diverse groups¹. We are fortunate to have panel members with a range of skills that will ensure comprehensive consideration of key issues for a legislative framework for voluntary assisted dying. The role of the Panel is not to review the 'for' and 'against' arguments but to develop recommendations on specific elements, including safeguards, for voluntary assisted dying legislation.

The Panel has identified key questions and issues and is seeking input from experts and across the community. This discussion paper is part of the consultation process.

I am confident that the recommendations made by the Joint Select Committee, together with the comprehensive consultation undertaken by the Panel, in collaboration with the community, will result in legislation that is well informed, workable and includes strong safeguards for those people who wish to access voluntary assisted dying.

¹ Members details are listed in Appendix 1.

This discussion is not just about the healthcare profession. This is a discussion for all of us within the WA community. Voluntary assisted dying is not a choice between life or death. It is a choice regarding the manner and timing of an expected and unavoidable death. It will not be a choice which is either appropriate or achievable for everyone at the end of their life but for those people with terminal suffering who wish to access voluntary assisted dying – it is a choice that should be respected. I encourage all Western Australians to consider taking part in the Panel’s consultations over the next few months to help ensure that the voluntary assisted dying legislation developed for Western Australia is based on the best available evidence and reflects the needs of our diverse State and its people.

A handwritten signature in blue ink, appearing to read 'Roger Cook', with a stylized flourish extending to the right.

Hon. Roger Cook, MLA
Deputy Premier; Minister for Health; Mental Health

Chairman's message

It is my honour to chair the Voluntary Assisted Dying Ministerial Expert Panel (the Panel) appointed by the Minister for Health to provide expert advice on the development of voluntary assisted dying legislation.

Details of the 13 Panel members are in Appendix 1. They cover a range of relevant disciplines and experience, and it is my great pleasure to be working with such a distinguished and committed group of people.

The Panel's brief is to take the findings and recommendations of the Report by a Parliamentary Joint Select Committee, *My Life, My Choice*, tabled in August last year, and develop a policy position that will inform the development of legislation for compassionate and safe voluntary assisted dying.

The Joint Select Committee Report provides a framework for legislation to enable voluntary assisted dying in Western Australia but further consideration is required to determine how the framework should be implemented and work in practice.

From March until May this year the Panel will consult widely. It will discuss and consider the Key Issues with a number of relevant questions. These questions are not intended to limit discussion, but to guide and prompt discussion.

The Panel will be guided by, and adhere to, the Principles stated later in this discussion paper, the essence of which is respect for human life and human rights.

Throughout the consultation period, the Panel will listen carefully, and always respectfully, to differing views, comments and suggestions. Submissions that are considered by the Panel will be published on our website unless the submitter requests confidentiality. All feedback provided will help to inform the Panel's final report and recommendations to the Minister for Health.

If the Western Australian Parliament enacts the proposed legislation, it will do so in the knowledge that such a law has strong community support (as the Joint Select Committee Report *My Life, My Choice* noted), and that the content and detail will have been very carefully considered by the Ministerial Expert Panel, following extensive consultation with the community and experts.

Death comes, soon or late, to all of us. It is not death that most fear, but the manner of our dying. This proposed law aims to give some people a greater choice than is, under present law, available.

I believe that the Panel will, assisted by the consultations I have mentioned, provide advice and recommendations which will enable that aim to be met.



Malcolm McCusker AC QC
Chairman
Ministerial Expert Panel

Voluntary Assisted Dying Discussion Paper Fact Sheet

Key Messages

- Everyone has the right to make choices about their own life
- The Western Australian government wants to make laws that allow some adults to ask for medical help to end their lives sooner if they are already dying and are suffering badly
- These laws would be very strict
- A group of experts is helping the government to decide how the laws might work
- You are now being asked for your thoughts and ideas about that

What is voluntary assisted dying?

Voluntary assisted dying means that some adults could ask for medical help to end their life if they have a disease or illness that is so severe it is going to cause their death and they are suffering badly.

Who could it help?

If laws are made in Western Australia it is expected that this could help Western Australians who are at least 18 years old and able to make their own decisions. They would have to be making the decision without pressure from anyone else. They would have to have a disease or illness that is going to cause their death and is causing them to suffer badly.

What about someone with a mental illness or disability?

It is expected that a person that only has a mental illness or a disability could not access voluntary assisted dying. They must also have a disease or illness that is going to cause their death and is causing them to suffer badly.

How would the decision be made? Can we make sure it is safe?

It is expected that the person would need to see two doctors and the doctors must agree that the person's situation fits the law. The doctors must make sure that no one is pressuring the person to make the choice. Sometimes another doctor would be asked their opinion too.

The person would always have the right to say "No".

What else do I need to know?

This is a plain language fact sheet and does not have all the information on voluntary assisted dying.

Where can I find out more information?

The full discussion paper has much more detail about the possible law and how it might work. It also has questions for people to consider.

This paper is also on the website. Parts of it can be listened to or watched on the website.

How can I tell the Government my opinion?

The group of experts will hold meetings in Perth and in country WA. They will explain the ideas and listen to what people have to say.

Please attend these meetings. Details of the meetings are on the website.

You are also welcome to answer the questions on the website, send in an email or write to the group of experts. Information that you provide will be put up on the website unless you ask us not to.

Website: health.wa.gov.au/voluntaryassisteddying

Email: VADconsultations@health.wa.gov.au

Mail: *The Ministerial Expert Panel on Voluntary Assisted Dying*
PO Box 8172
Perth Business Centre
Perth WA 6849

Introduction

In August 2017 a cross-party Joint Select Committee comprising four members of the Legislative Council of Western Australia and four members of the Legislative Assembly was appointed to conduct an inquiry into End of Life Choices.

In the course of its year-long inquiry the Joint Select Committee considered more than 700 submissions and supplementary submissions, held 81 hearings and took evidence from more than 130 witnesses. It visited metropolitan and country regions (Great Southern and Kimberley) to meet with hospital and community palliative care providers, residential care facilities, Aboriginal health services, hold hearings and meet with local communities.

The Joint Select Committee also reviewed international jurisdictions that have already legislated for some form of voluntary assisted dying (the state of Oregon in the United States of America has had such a law for over 20 years) and conducted international conferences by video with persons having acknowledged experience in this subject. A summary of voluntary assisted dying in other jurisdictions is provided in Appendix 2.

On 23 August 2018 the Joint Select Committee tabled its report, *My Life, My Choice*, in both Houses of Parliament (the Report). The Report is available at www.parliament.wa.gov.au. The Report made 52 findings and 24 recommendations relating to advance health care planning, palliative care and lawful options available to persons experiencing grievous and irremediable suffering at end of life.

In her Foreword to the Report, the Joint Select Committee Chair, Ms A Sanderson MLA, observed:

Modern medicine has given us greater longevity; but it has also delivered longer periods of dying. People now survive a lot longer than they did, but often with debilitating symptoms. The prevalence of chronic disease means that many of us may face a protracted death at an advanced age.

Over the course of its inquiry, the Committee found that too many Western Australians are experiencing profound suffering as they die. This is, in part, due to inequitable access to palliative care. Palliative care aims to provide treatment to alleviate symptoms from diseases and illnesses that cannot be cured. However, it is clear from the evidence that even with access to the best quality palliative care, not all suffering can be alleviated. Palliative care physicians themselves acknowledge this.

There are many life-limiting conditions that cause profound suffering that cannot be completely palliated. The committee heard from individuals and health professionals about the terrible effects of some of those illnesses, such as Motor Neurone Disease, Huntington's disease, Dementia, Parkinson's and some cancers. The report explores what it is like to die from these illnesses. It makes for difficult reading².

Ms Sanderson noted that after its extensive inquiry the Joint Select Committee had concluded that the lawful options currently available to people experiencing grievous and irremediable suffering at end of life are inadequate, and that this can be exceptionally difficult and emotionally draining for the dying person and for that person's family and friends³.

Based on its finding that some people experience unnecessary suffering at the end of life, and that there is broad community agreement regarding the importance of individual autonomy and choice, the Report recommended that the Western Australian Government draft and introduce a Bill for voluntary assisted dying.

² "My Life, My Choice" report of the Joint Select Committee on End of Life Choices, Parliament of Western Australia (August 2018).

³ Ibid.

Recommendation 21 in the Report was that the Minister for Health establish an expert panel including health and legal practitioners and health consumers, to undertake consultation and develop legislation for voluntary assisted dying in Western Australia, in consideration of the Report and the Framework (refer Appendix 3).

The Panel was appointed by the Minister in December 2018 and includes health practitioner, legal practitioner, health consumer, multicultural and disability advocate representation.

While the Joint Select Committee was still conducting its inquiry, the Victorian Parliament passed the *Voluntary Assisted Dying Act 2017*. That legislation presents Western Australia with the opportunity to examine the approach taken in Victoria and use this as a basis for the design of legislation suitable for the needs of Western Australians. However, when considering the Victorian legislation it is important that the special circumstances of Western Australia are kept in mind. What suits Victoria may not necessarily suit Western Australia in every respect. Apart from its geographical size and location, Western Australia is the most culturally diverse state in Australia with Aboriginal people, migrants and refugees accounting for nearly 30% of its population⁴.

Purpose of the discussion paper

The Western Australian Government has undertaken to introduce legislation in the second half of 2019 to provide for voluntary assisted dying. This will be based on the framework provided in the Joint Select Committee report, recognising that further work is required to develop this legislation.

The purpose of this discussion paper is to assist the metropolitan and regional consultations being conducted by the Panel. It aims to promote discussion and generate suggestions. These will help inform the Panel's recommendations to the Western Australian Government. It is believed that the experience, knowledge and insights of the community and of experts on particular issues, will help in the development of fully informed and workable legislation, to ensure safe and compassionate processes for voluntary assisted dying.

It is not the purpose of this paper, nor of the Panel, to review or debate the arguments for or against voluntary assisted dying which were the subject of the Joint Select Committee's inquiry and its recommendations.

Responding to the discussion paper

The Ministerial Expert Panel invites comment, critical or otherwise, on the key issues set out in this discussion paper. Please do not, however, offer opinions or comment either for or against voluntary assisted dying. This is outside the Panel's Terms of Reference and cannot be considered.

Key issues are raised along with a series of questions for you to consider. Your responses will assist in the development of a Voluntary Assisted Dying Bill.

Submissions that are considered by the Panel will be published on our website unless the submitter requests confidentiality.

The closing date for response to this discussion paper is 24 May 2019.

Please submit your response via the website health.wa.gov.au/voluntaryassisteddying, via email to VADconsultations@health.wa.gov.au, or via post addressed to: *The Ministerial Expert Panel on Voluntary Assisted Dying*, PO Box 8172, Perth Business Centre, Perth WA 6849.

⁴ WA Health System Language Services Policy Guidelines.

Language

There are many important conversations that Western Australians need to have in relation to voluntary assisted dying.

It will be critical that these conversations take place respectfully and with clarity about what is being said. Having a common, easy-to-understand approach to the meanings of key words and phrases will help with clarity and to avoid the misunderstandings that can sometimes derail helpful discussion.

Various different terms and definitions have been used in Australia and around the world in relation to voluntary assisted dying. The approach taken by the Panel is to use words and definitions that are consistent with the key principles of choice and keeping the person who is at the end of their life at the centre of all considerations.

Voluntary assisted dying

The term ‘voluntary assisted dying’ is used by the Joint Select Committee and the Panel. It emphasises the voluntary nature of the choice of the person who has capacity to make this decision⁵. It reflects a person-centred approach focussed on those who are eligible to access assisted dying. Voluntary assisted dying involves a process to access medication and to enable a person to legally choose the manner and timing of their death.

Person

Throughout this discussion paper the Panel uses the word ‘person’ to refer to *the person who is approaching the end of their life*. ‘Person’ is preferred over the terms ‘patient’ or ‘client’. This emphasises the key principles of autonomy and choice in voluntary assisted dying.

Person-centred

Like the Joint Select Committee, the Panel recognises that end-of-life care needs to be person-centred. Person-centred care is a philosophical approach to clinical care and service delivery that sees services provided in a way that is respectful of, and responsive to, the preferences, needs and values of people and those who care for them⁶.

Terms not used

The following terms are not used by the Panel because they are not an accurate description of the process, who is in control of the process, or because of the value judgements implicit in these terms. These have been well described in the *Ministerial Advisory Panel on Voluntary Assisted Dying Final Report* (Department of Health and Human Services, State of Victoria, July 2017) and are reproduced with amendment following.

⁵ Ministerial Advisory Panel on Voluntary Assisted Dying Final Report, Department of Health and Human Services, State of Victoria (July 2017).

⁶ Valuing people, What is person-centred care?, Alzheimer’s Australia, <<http://valuingpeople.org.au/the-resource/what-is-person-centred-care/>>; cited in Ministerial Advisory Panel on Voluntary Assisted Dying Final Report, Department of Health and Human Services, State of Victoria (July 2017).

Euthanasia

“Euthanasia refers to the situation when death is induced to relieve suffering. The term derives from the Greek for ‘good death’. The term, however, can carry connotations of something bad as well as something good, because of its historic abuse in involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value. Many people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. [...] When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient.”⁷

Assisted suicide

Suicide involves the tragic loss of life of a person who is otherwise not dying, whereas voluntary assisted dying involves a person’s choice about their mode of death when they are already dying. Suicide is usually undertaken alone as an act of desperation, whereas voluntary assisted dying is a pathway involving medical and family support. Suicides are potentially avoidable; “every effort should be made to prevent these deaths”⁸ and there is a “range of critical work being undertaken to prevent suicide”⁹. By contrast, the people “who are the focus of voluntary assisted dying face an inevitable death as a result of an incurable disease, illness or medical condition. It would not be appropriate to use the same terminology to describe”¹⁰ their choice about the circumstances of their impending death. For these reasons, the Panel believes the word ‘suicide’ should not be used in relation to voluntary assisted dying. It is wrong to confuse these two very different kinds of deaths.

Other terms

Voluntary assisted dying is one element of a broader range of end of life choices. It sits within the context of a person exercising a number of choices as they approach the end of their life from a terminal disease or terminal illness. Some of the other terms associated with end of life are outlined below. These definitions have been chosen by the Panel for their use of simple, person-centred language.

End-of-life care¹¹

End-of-life care is care needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness. During this period, people may experience rapid changes and fluctuations in their condition and require support from a range of people, including health services, as well as family and carers.

Palliative care¹²

Palliative care helps people with any life-limiting or terminal condition to live their lives as fully and as comfortably as possible. It is not just for people with cancer. Palliative care identifies and treats symptoms which may be physical, emotional, spiritual or social. It also provides practical and emotional support to family and carers.

⁷ Ministerial Advisory Panel on Voluntary Assisted Dying Final Report, Department of Health and Human Services, State of Victoria (July 2017).

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ WA End-of-life and Palliative Care Strategy 2018-2028.

¹² Palliative Care WA (Source: palliativecarewa.asn.au/palliative-care accessed on 29/01/2019).

Glossary

A more detailed glossary of other terms used in this discussion paper is provided below.

Advance Health Directive

An Advance Health Directive (AHD) is a legal document that enables you to make decisions now about the treatment you would want - or not want - to receive if you ever became sick or injured and were incapable of communicating your wishes. In such circumstances, your AHD would effectively become your voice¹³.

Capacity

Also known as decision-making capacity, this refers to the ability of a person to make a decision. Capacity is decision specific – a person can have the ability to make one type of decision but not another. A person may have a disease, illness, brain injury or disability that impacts the ability to make some decisions but not all decisions – it can't be assumed that someone does not have capacity just because they have one of these conditions. Capacity can fluctuate or vary depending on other factors such as stress, medication or infection¹⁴.

Chronic disease / illness

Chronic disease is defined on the basis of the biomedical disease classification, and includes diabetes, asthma, organ failure and depression.

Chronic illness is the personal experience of living with chronic disease¹⁵.

Controlled drugs

These are substances which require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence¹⁶. Also known as Schedule 8 (S8) drugs.

Departmental approval

This means approval by a government department or someone acting on behalf of a government department.

End of life

End of life is the timeframe during which a person lives with, and is impaired by, a life-limiting/fatal condition, even if the prognosis is ambiguous or unknown. Those approaching end of life will be considered likely to die during the next 12 months¹⁷.

Grievous

(Of something bad) very severe or serious¹⁸.

¹³ https://www.publicadvocate.wa.gov.au/A/advance_health_directives.aspx

¹⁴ <http://capacityaustralia.org.au/about-decision-making-capacity/>

¹⁵ Martin, C M 2007, 'Chronic disease and illness care: Adding principles of family medicine to address ongoing health system redesign', *Canadian Family Physician*, vol. 53, no. 12, pp. 2086-2091.

¹⁶ Medicines and Poisons Act 2014.

¹⁷ WA End-of-life and Palliative Care Strategy 2018-2028.

¹⁸ Oxford Dictionary (accessed online <https://en.oxforddictionaries.com>).

Irremediable

Impossible to cure or put right¹⁹.

Joint Select Committee

The Joint Select Committee refers to a parliamentary committee that was established on 23 August 2017 to look into End of Life Choices in Western Australia. The Joint Select Committee was chaired by Ms Amber-Jade Sanderson MLA and consisted of four members of the Legislative Council and four members of the Legislative Assembly. The Joint Select Committee tabled its report, *My Life, My Choice*, on 23 August 2018.

Medical practitioner

Medical practitioner refers to a medical doctor who is registered with the Australian Health Practitioner Regulation Agency. In this discussion paper it usually refers to general practitioners and/or medical specialists.

Navigator

A navigator is a person who helps and supports another person to understand their way through a system (such as the health system).

Neurodegenerative conditions

Resulting in, or characterised by degeneration of the nervous system, especially the neurons in the brain²⁰. Examples include: motor neurone disease, Parkinson's disease, Huntington's disease and dementia.

Nurse practitioner

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role²¹. A nurse practitioner must be registered with the Australian Health Practitioner Regulation Agency to practice.

Registered health practitioner

Registered health practitioner refers to a person registered under the Health Practitioner Regulation National Law (Western Australia) to practice a health profession (other than as a student).

This includes: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioner, chiropractors, dental practitioners, medical practitioners, medical radiation practitioners, nurses and midwives, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, physiotherapists, podiatrists and psychologists.

(It should also be acknowledged that a term such as Allied Health Professional would more broadly include self-regulated professions such as social work and speech pathology, but that these professions are not registered).

¹⁹ Ibid.

²⁰ Ibid.

²¹ Australian Nursing and Midwifery Advisory Council.

Terminal

(Of a disease) predicted to lead to death, especially slowly; incurable²². Terminal care is care of the dying in the last days or hours of life²³.

The Panel

The Panel refers to the Ministerial Expert Panel on Voluntary Assisted Dying established by the Minister for Health, Hon. Roger Cook MLA. Refer to Appendix 1 for details of the panel members.

Victoria

References to Victoria in this discussion paper refer to the state of Victoria in Australia and not Victoria the capital city of British Columbia in Canada.

²² Oxford Dictionary (accessed online <https://en.oxforddictionaries.com>).

²³ WA End-of-Life and Palliative Care Strategy 2018-2028, Department of Health, Western Australia.

Guiding principles

During its discussions the Panel took an approach based on the guiding principles in the *Voluntary Assisted Dying Act 2017* (Victoria) and the Joint Select Committee considerations for promotion of core values in the legislation.

The Panel recognises the importance of consistency with human rights principles²⁴ including that everyone has the right to meaningfully participate in decisions that affect their lives. The Panel also sought to highlight the importance of privacy and confidentiality. Maintaining a balance between personal autonomy and appropriate safeguards is a central theme throughout these discussions.

The principles²⁵ adopted for consideration for inclusion in the Bill are:

- Every human life has intrinsic value.
- A person's autonomy should be respected.
- People have the right to be supported in making informed decisions about their medical treatment, and should be given, in a manner they understand, information about medical treatment options, including comfort and palliative care.
- People approaching the end of life should be provided with high quality care to minimise their suffering and maximise their quality of life.
- A therapeutic relationship between a person and their health practitioner should, wherever possible, be supported and maintained.
- People should be encouraged to openly discuss death and dying and their preferences and values should be encouraged and promoted.
- People should be supported in conversations with their health practitioners, family, carers and community about treatment and care preferences.
- People are entitled to genuine choices regarding their treatment and care.
- People should be supported in their right to privacy and confidentiality regarding their choices about treatment and care preferences.
- People who may be vulnerable should be protected from coercion and abuse in relation to end of life choices and decisions.
- All people, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

Questions to consider:

- Are there other guiding principles that should be considered for the Bill?

²⁴ Australian Human Rights Commission accessed at <https://www.humanrights.gov.au/human-rights-based-approaches>

²⁵ Reproduced with amendments. *Voluntary Assisted Dying Act 2017* (Victoria).

Key issues

Voluntary assisted dying in Western Australia would be an option only available to Western Australian adults that meet all requirements in a set of specific eligibility criteria. A specific and defined assessment and access process would ensure that voluntary assisted dying is implemented in a safe and compassionate way.

There is a broad range of issues and topics to be considered in relation to voluntary assisted dying. The key issues in this discussion paper reflect the findings of the Joint Select Committee, points of difference between Victoria and Western Australia and the questions that the Panel has identified for consideration.

The person

There are age and residency requirements when considering who would be eligible for voluntary assisted dying in Western Australia. As per the principles of non-discrimination, a person with a mental illness or a disability who meets the eligibility criteria would be able to access voluntary assisted dying (though these conditions alone would not make someone eligible).

The decision

The decision to choose voluntary assisted dying is significant and must be voluntary and enduring. There are many considerations to take into account and appropriate safeguards are necessary.

Eligible conditions

There are many aspects that relate specifically to the conditions and circumstances under which a person would be eligible to choose voluntary assisted dying. Refer to the page opposite for a flow chart summarising the Joint Select Committee proposal for eligibility criteria.

The process

Understanding key components of how voluntary assisted dying would be administered is critical to ensuring the right balance between the person's autonomy and important safeguards. A range of cultural and geographical factors will have an impact on how the right to choose and access voluntary assisted dying would work. The flow chart on page 18 is provided for reference to outline the steps in the process for access to voluntary assisted dying in Victoria. The flow chart on page 19 illustrates the proposed process for Western Australia as per the Joint Select Committee recommendations and links to the key issues raised in this discussion paper. Underpinning these requirements is the Joint Select Committee's recommendation to ensure integrity in the process without unnecessary delay.

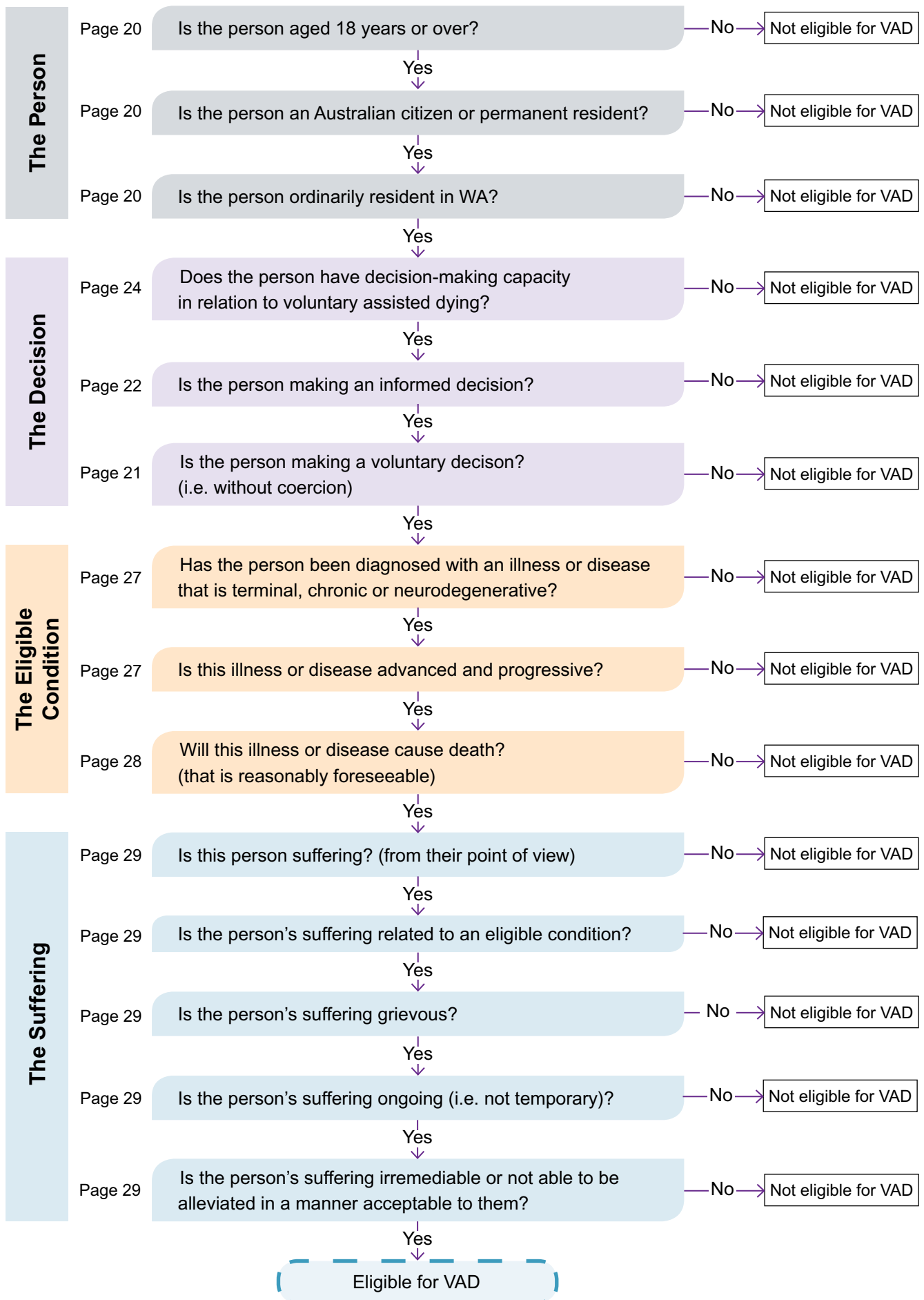
Death certification

The way in which a voluntary assisted death is recorded needs consideration.

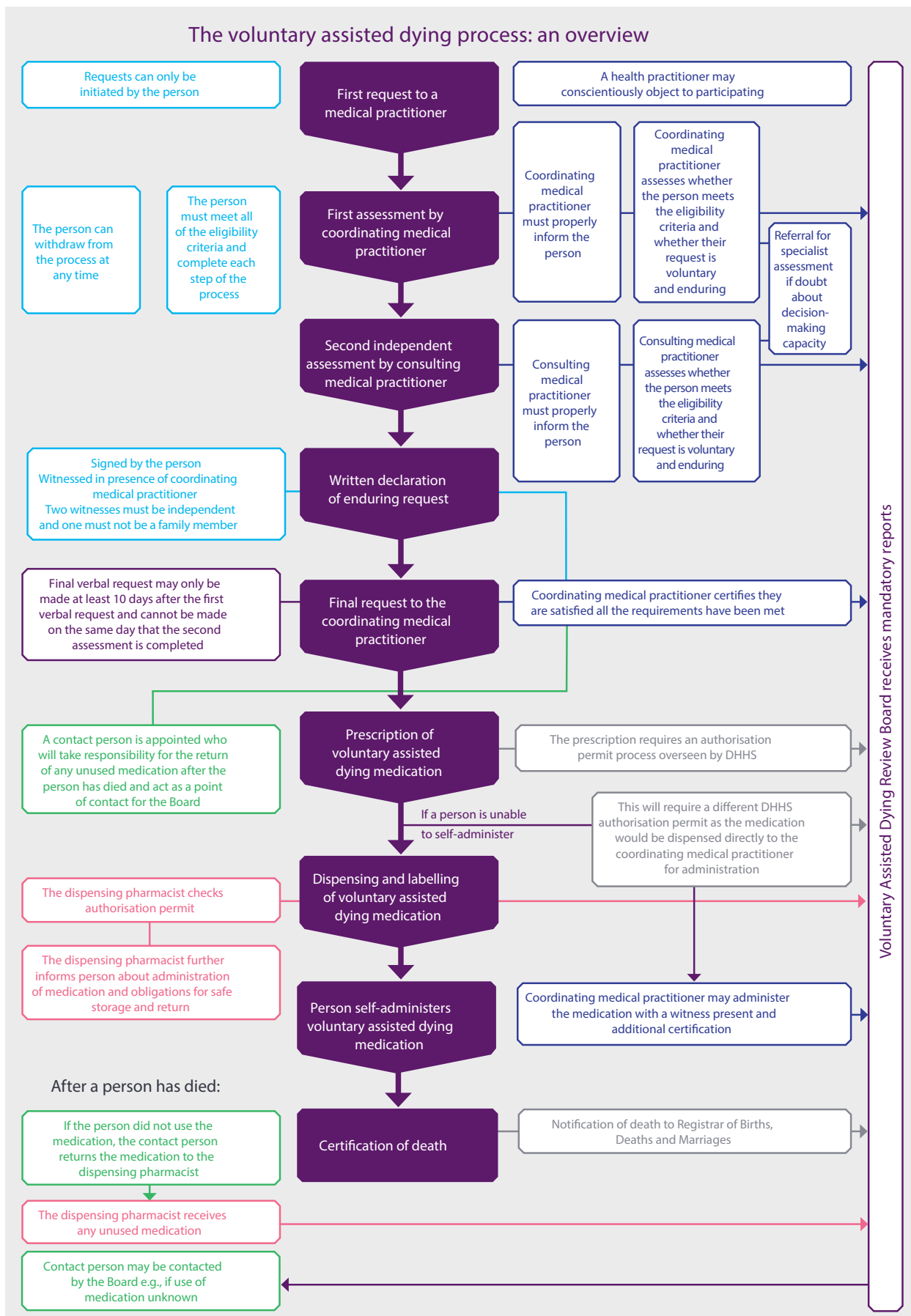
Oversight

The means by which oversight of voluntary assisted dying can provide safeguards as well as impact the process is explored.

Eligibility criteria for voluntary assisted dying as proposed by the Joint Select Committee

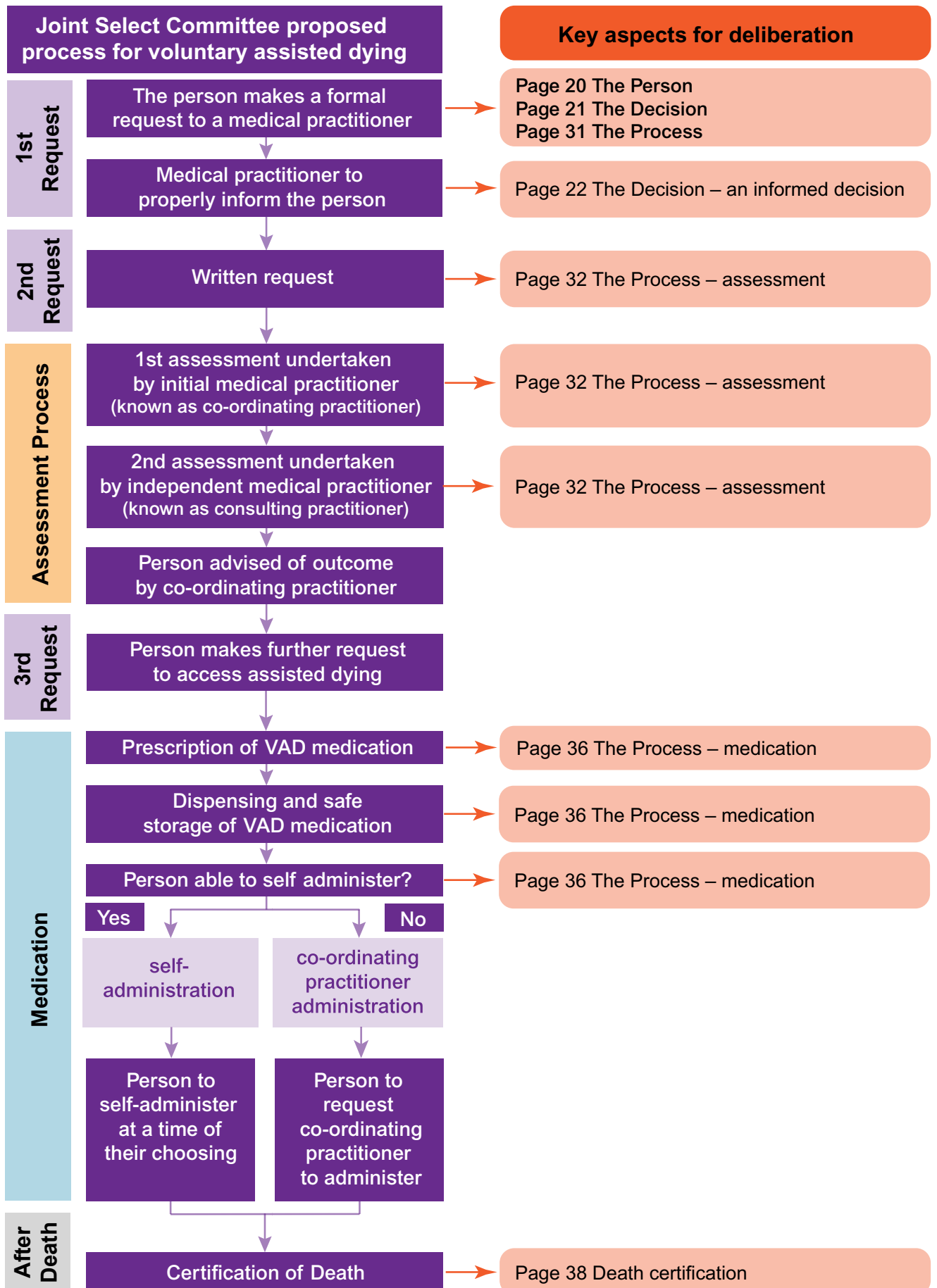


Overview of voluntary assisted dying process in Victoria



Reproduced from *Ministerial Advisory Panel on Voluntary Assisted Dying Final Report*, State of Victoria, Department of Health and Human Services (July 2017), p146.

Process proposed by the Joint Selection Committee



The person

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

Age

The person must be aged 18 years or over

Residency

Eligibility requires ordinary residence in Western Australia and either Australian citizenship or permanent residency

In Western Australia, only adults who are Australian citizens or permanent residents and who are ordinarily resident in Western Australia would be considered for access to voluntary assisted dying.

Question to consider:

- 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?

The decision

The ability of the person to make a valid decision to access voluntary assisted dying is a fundamental safeguard in the process.

In practice, this means the decision must be:

1. voluntary
2. properly informed
3. made by a person who has capacity
4. current
5. specific to voluntary assisted dying²⁶.

Medical and health practitioners are already practising in accordance with these principles of decision making and informed consent in their everyday work. Decision-making capacity is a fundamental safeguard in the voluntary assisted dying process.

Education, training and support for health practitioners on these key aspects of voluntary assisted dying decision making is an important part of achieving and maintaining high quality practice. This education, training and support should also include understanding of cultural context, culturally competent practice and the appropriate use of interpreters.

A voluntary decision

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

Assessment

- c) The request is voluntary, made without coercion or duress.

Referral for specialist assessment

A person is not required to undergo consultant or specialist assessment except where either doctor is unable to determine:

[a] ... [c]

- d) Capacity, and/or the absence of coercion, in which case they must refer to a consultant psychiatrist or a consultant geriatrician as appropriate

That the person's decision is voluntary is fundamental to the proposed model for assisted dying in Western Australia.

²⁶ Adapted from the WA Health Consent to Treatment Policy, 2016.

Most decisions, large or small, are made by people in the context of their usual life which includes family, friends and their community. People have the right to include or exclude whoever they choose in their deliberations on their decision and to seek support in their decision-making process. It is important to consider the needs of people from diverse backgrounds who may be from cultures that have a collectivist approach to decision making.

If a medical practitioner is unable to determine that the person's decision is voluntary and free from coercion or duress, the medical practitioner would need to refer to a specialist for assessment.

Questions to consider:

- 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?

An informed decision

Joint Select Committee recommendations:

7.89 Voluntary Assisted Dying Legislation Framework

Procedure

The doctor must provide the person with information regarding:

- a) The nature of the disease or illness;
- b) The prognosis;
- c) Any possible curative treatments;
- d) Any available palliative treatments;
- e) The nature, effects and risks of the lethal medication that may be prescribed; and,
- f) That the person's consent to assisted dying may be withdrawn at any time.

Joint Select Committee commentary:

6.78 The Victorian legislation prohibits medical [health] professionals from initiating discussions with patients regarding assisted dying. [...]

6.79 [...] the prohibition contained in the Victorian legislation should not be a feature of Western Australia's legislation.

It is usual practice for health practitioners to have discussions with patients about life and death decisions, and this includes appropriately informing people of the relevant options currently available to them. These may include discussions about treatment initiation and withdrawal, Advance Health Directives and decision making about Cardio Pulmonary Resuscitation (CPR). As well as informing the patient's decision, these discussions present another opportunity for the medical practitioner and person to review the situation and ensure that everything (that is acceptable to the person) that can be done to relieve suffering is being done. These discussions form an important part of good patient care.

Victoria is the only jurisdiction that prohibits health practitioners from starting a conversation about voluntary assisted dying²⁷.

Many health practitioners are reluctant to discuss end of life care with patients and it is also known that up to 60% of Australians have low levels of individual health literacy²⁸. This means that people may not have the knowledge or confidence to start discussions about specific treatment or options that have not already been raised by their health practitioner.

The Joint Select Committee specifically recommends that a prohibition on health practitioners starting a discussion about voluntary assisted dying is not adopted in Western Australia. It follows that it should not be an offence or reportable disciplinary matter for health practitioners to start discussions about voluntary assisted dying with patients. This is consistent with a view that there should not be an attempt to censor the conversations that health practitioners have with patients.

There are other factors to consider in relation to how people can be informed about voluntary assisted dying. Information needs to be accessible, understandable, translated and culturally appropriate. In some communities, particularly more remote communities, an association with voluntary assisted dying may impact the community's trust in the local health practitioner or health service. There may be times where the use of an independent navigator would provide additional safety and space for a person to make a decision that reflects their personal choice (particularly if their viewpoint differs from that of their family or community).

The Joint Select Committee made recommendations in relation to the establishment of a telephone advice line, community education and resources²⁹ and these types of initiatives may help to address the impacts outlined above. In Canada, a number of provinces and territories have set up centralised care co-ordination services that have specially trained doctors and nurse practitioners³⁰ to assist the person to make an informed and supported decision³¹ as well as providing a navigator that can assist working through the process.

Questions to consider:

- 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?
- What are the cultural and linguistic considerations in relation to how people may be informed about voluntary assisted dying?
- What, if any, additional initiatives should be considered to ensure people are properly informed about voluntary assisted dying and supported in the decision-making process?
For example: should there be a role for navigators?

27 Voluntary Assisted Dying Act 2017 (Victoria).

28 *Health Literacy: taking action to improve safety and quality*, Australian Commission on Safety and Quality in Health Care (August 2014).

29 7.89 *Voluntary Assisted Dying Legislation Framework in My Life, My Choice*, report of the Joint Select Committee on End of Life Choices, Parliament of Western Australia (August 2018).

30 <http://www.health.alberta.ca/health-info/medical-assistance-dying.html>

31 Downie, C 2017, 'Medical Assistance in dying: Lessons for Australia from Canada', *QUT Law Review*, vol. 17, Issue 1, pp. 127-146.

Decision-making capacity

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

Capacity

In order to request assisted dying the person must have decision-making capacity in relation to a decision about voluntary assisted dying.

Referral for specialist assessment

A person is not required to undergo consultant or specialist assessment except where either doctor is unable to determine:

[a] ... [c]

d) Capacity, and/or the absence of coercion, in which case they must refer to a consultant psychiatrist or a consultant geriatrician as appropriate

Capacity is a term used to describe whether or not someone is capable of making a decision. It is presumed that an adult is able to make decisions unless there is evidence to the contrary.

It is important to understand that capacity is specific, contextual and can vary over time. Someone could have the capacity to decide what to eat for breakfast but not have the capacity to make complex financial decisions. Of relevance here is that the determination of capacity is taken in the context of a decision about voluntary assisted dying only.

Existing Western Australian legislation makes a legal presumption about a person's capacity (refer to Appendix 4 for the actual legislation extracts):

- In relation to matters under the *Guardianship and Administration Act 1990*, it is clear that every person shall be presumed to be capable of looking after their own health and safety, managing their own affairs, and making reasonable judgements in respect of matters relating to themselves and to their estate. This legal presumption about a person's capacity applies until the State Administrative Tribunal deems otherwise (section 4(3) *Guardianship and Administration Act 1990*).
- In relation to matters under the *Mental Health Act 2014* (such as psychiatric treatment), an adult is presumed to have the capacity to make a decision relating to themselves unless shown to not have that capacity (section 13(1) *Mental Health Act 2014*).

The Joint Select Committee considers it appropriate that a general practitioner can usually determine capacity for the purposes of a person making a decision relating to voluntary assisted dying.

The *Mental Health Act 2014* sets out factors that must be demonstrated when assessing capacity under that Act. These include that a person must be able to understand any information or advice about the decision, the matters involved in the decision and the effect of the decision. The person must also be able to weigh up these factors for the purpose of making the decision and communicate the decision in some way (section 15 *Mental Health Act 2014*).

The Joint Select Committee recommended that when the medical practitioner is unable to determine capacity, they must refer the person to a specialist practitioner to make that assessment. In addition to the consultant psychiatrist and consultant geriatrician specified by the Joint Select Committee, other health practitioners (such as neuropsychologists) may be appropriate for the purpose of assessing capacity.

Requiring the person to have decision-making capacity at all stages in the process is consistent with most other jurisdictions with a form of legalised voluntary assisted dying³². It is a safeguard to ensure that the process remains self-determined throughout.

There may well be people whose suffering is at its most profound once decision-making capacity has been lost. Some people may have commenced the process for access to voluntary assisted dying but lose capacity prior to completing the process (e.g. as a result of needing a high dose of pain medication). In Canada the waiting time can be reduced in some circumstances of imminent loss of capacity³³ (refer also to page 26). The model proposed by the Joint Select Committee would not provide for voluntary assisted dying in these circumstances nor for circumstances in which a person requests voluntary assisted dying through an Advance Health Directive.

Questions to consider:

- 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)
- 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?
- Should there be particular consideration given to people who lose capacity after they have started the process?

32 Australia (Victoria); Canada; US States (California, Colorado, District of Columbia, Hawaii, Oregon, Washington State, Vermont).

33 Medical Assistance in Dying Act, Bill C-14 (Canada).

Reflecting on the decision

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

Procedure

The person's consent to assisted dying may be withdrawn at any time.

Reflection period

In order to provide a period of reflection a prescription for medication must not be filled sooner than prescribed under the legislation as determined by the expert panel.

The time between each step in the process would, of itself, provide some period for reflection. The person would always have the protection of being able to withdraw from the process at any stage.

That a person's decision is enduring would be shown through several of the proposed process steps: the initial request, the written request, participation in the first assessment, participation in the second assessment, the request that triggers the provision of the prescription and the request for administration of the medication (if unable to self-administer).

In most jurisdictions there is some form of prescribed waiting period of anywhere from 9-17 days (refer Appendix 2). The Joint Select Committee was clear that the process ought to enable a person to have proper reflection but also that access should not be unnecessarily delayed.

In Victoria the minimum nine day waiting period between the first and final request can be reduced to not less than one day if the opinion of both medical practitioners is that the person is likely to die before the end of the nine day waiting period³⁴.

In Canada³⁵ there must be 10 days between the signing of the written request (which is done after the first assessment) and the day on which medical assistance in dying is provided. The timeframe can be reduced if both assessing practitioners are of the opinion that death or loss of capacity is imminent.

The Joint Select Committee proposes a minimum time period between the first formal request and the filling of the prescription for the medication. This would require the pharmacist to be reliably informed of the date of the first formal request and would shift responsibility for compliance from the medical practitioner to the pharmacist.

Questions to consider:

- Should there be a minimum timeframe to enable reflection on the decision to access voluntary assisted dying?
If so, should this be able to be waived? Under what conditions?
- Between which points in the process should the minimum timeframe be measured?
- What should the minimum timeframe be?

³⁴ Voluntary Assisted Dying Act 2017 (Victoria).

³⁵ Medical Assistance in Dying Act, Bill C-14 (Canada).

Eligible conditions

Joint Select Committee recommendations:

7.89 Voluntary Assisted Dying Legislation Framework

Eligible conditions

The legislation is intended to provide assisted dying for those for whom death is a reasonably foreseeable outcome as a result of an eligible condition.

An eligible condition is an advanced and progressive:

- a) terminal illness or disease;
 - b) chronic illness or disease; or
 - c) neurodegenerative illness or disease,
- where death is a reasonably foreseeable outcome of the condition.

The person's suffering

The person's suffering must not be temporary nor able to be treated or remedied in a manner acceptable to the person. The suffering:

- a) must be related to an eligible condition;
- b) must be grievous and irremediable;
- c) cannot be alleviated in a manner acceptable to the person; and,
- d) must be subjectively assessed – that is, from the person's point of view.

Joint Select Committee commentary:

7.43 [...] A time until expected death may unfairly exclude those people who would otherwise qualify for voluntary assisted dying.

Eligible condition

Medical and health practitioners commonly use the word 'terminal' to describe a situation when an illness or disease is expected to lead to a foreseeable or imminent death. For people in the general community the word 'terminal' may bring to mind a specific interpretation such as a person with cancer who is very close to death. This difference in interpretation of the word 'terminal' means that the specific inclusion of chronic illness or disease and neurodegenerative diseases in the eligibility criteria helps to make it clear that people with these illnesses and diseases may also be eligible for voluntary assisted dying. The use of the phrase 'advanced and progressive' indicates that the medical illness or disease is very serious and on a deteriorating trajectory.

A person with a disability or mental health condition would not be discriminated against in access to voluntary assisted dying but must meet all the eligibility criteria. Having a disability or mental health condition in itself would not be considered to meet the eligibility requirements. This is consistent with the position of both the Joint Select Committee and the Victorian legislation³⁶.

³⁶ Voluntary Assisted Dying Act 2017 (Victoria).

The Joint Select Committee's recommendation would mean that a person with grievous, unbearable and incessant suffering which is irremediable, but who does not have an eligible condition would not have access to voluntary assisted dying. That is the case in most other jurisdictions where there is some form of voluntary assisted dying legislation, although not in the Netherlands, where it is sufficient that a person's suffering is unbearable, with no prospect of recovery (refer Appendix 2).

Time until death

Around the world there are varying approaches to the expected time to death. Some jurisdictions are specific in restricting eligibility to those expected to die within the next six months³⁷ (Victoria increases this to 12 months in the case of a neurodegenerative condition³⁸). Canada is an example of a jurisdiction that does not have a prescribed time requirement but requires that "natural death has become reasonably foreseeable" in relation to the eligible medical condition³⁹. Other jurisdictions have no time-bound requirement at all⁴⁰.

The underlying reasons for a jurisdiction including a timeframe until death in the eligibility criteria must be known, otherwise the requirement may be misunderstood. For example, United States jurisdictions require that the terminal condition is expected to "produce death within six months"⁴¹ – it is reported from doctors in Oregon that this is not a medical judgement but based on funding access to hospice benefits at that point⁴².

Recommendation 22 of the Joint Select Committee is that the legislation requires that death be reasonably foreseeable as a consequence of the eligible condition. This reflects their position that a terminal diagnosis should be sufficient cause, as well as ensuring that conditions in which protracted suffering is experienced over many months or years prior to an inevitable death are eligible for voluntary assisted dying⁴³. The Joint Select Committee also observed that, in general, proponents of assisted dying were not in favour of time frames "as they were viewed as arbitrary and clinically problematic"⁴⁴.

There have been recent reports of implementation and interpretation issues in Canada relating to the use of the term 'reasonably foreseeable' which have led to some provinces revising advice on the term to include a person-centred element⁴⁵. The Council on the College of Physicians and Surgeons of Nova Scotia (Canada) guides understanding of the Canadian eligibility element re '*the patient's natural death has become reasonably foreseeable*' by referencing a Supreme Court ruling in its interpretation:

37 Voluntary Assisted Dying Act 2017 (Victoria) and those states in the US that have legislated for assisted dying (California, Colorado, Oregon, Vermont and Washington).

38 Voluntary Assisted Dying Act 2017 (Victoria).

39 Medical Assistance in Dying Act, Bill C-14 (Canada).

40 Act on Euthanasia (Belgium); Termination of Life on Request and Assisted Suicide Act (Netherlands); Right to die with Dignity (Luxembourg).

41 Death with Dignity Act (Oregon).

42 "Inquiry into end of life choices – final report", Legislative Council Legal and Social Issues Committee, Parliament of Victoria, (June 2016).

43 7.43 and 7.44, "My Life, My Choice" report of the Joint Select Committee on End of Life Choices, Parliament of Western Australia (August 2018).

44 6.76, "My Life, My Choice" report of the Joint Select Committee on End of Life Choices, Parliament of Western Australia (August 2018).

45 Downie, C & Scallion, K 2018, 'Foreseeably unclear: The meaning of the 'reasonably foreseeable' criterion for access to medical assistance in dying in Canada', Forthcoming, *Dalhousie Law Journal*.

“natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.

In formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.

(AB v. Canada 2017 ONSC 3759, para 79-80)

Therefore, natural death will be reasonably foreseeable if a medical or nurse practitioner is of the opinion that a patient’s natural death will be sufficiently soon or that the patient’s cause of natural death has become predictable.”⁴⁶

In keeping with a person-centred approach, the phrase ‘where death is a reasonably foreseeable outcome for this person’ may aid recognition that the terminal nature of an illness or disease can be influenced by the person’s individual context and not only related to the condition.

Suffering

Suffering is an intensely personal experience and can take a variety of forms (physical, emotional, social or spiritual).

Although central to understanding the circumstances in which one might seek voluntary assisted dying, the fundamental principle remains the autonomy of the person who is approaching end of life and the person’s right to choose the manner and timing of death. Not all jurisdictions include suffering as a component of eligibility (e.g. the USA states that have legislated for assisted dying). Jurisdictions that include suffering as a component of eligibility typically require the suffering to be very serious – described as ‘intolerable’ (Canada), ‘constant and unbearable’ (Belgium) or ‘lasting and unbearable’ (the Netherlands)⁴⁷.

The use of an adjective such as ‘grievous’ (or a more common term such as ‘very severe’) risks imparting a judgement on the suffering of the person and implies that the person needs to prove the severity of their suffering.

In Victoria and Canada, the eligibility criteria include that the eligible condition is causing suffering that cannot be relieved in a manner acceptable to the person⁴⁸. This position was also taken by the Joint Select Committee.

The Joint Select Committee further recommended that suffering be subjectively assessed – that is, from the person’s point of view. This is consistent with a person-centred approach to voluntary assisted dying.

⁴⁶ College of Physicians & Surgeons of Nova Scotia 2018, ‘Professional standard regarding medical assistance in dying’.

⁴⁷ Refer Appendix 2.

⁴⁸ Voluntary Assisted Dying Act 2017 (Victoria) and Medical Assistance in Dying Act, Bill C-14 (Canada).

Questions to consider:

- 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?
- Must a person's suffering be 'grievous and irremediable' to be eligible?
- Must the person's suffering be related to the eligible condition?

The process

A competent person who has made a voluntary and informed decision to seek assisted dying should be able to make that choice in a timely way. Safeguards are essential and would be built into the process at multiple points.

The process for voluntary assisted dying needs to ensure that linguistic and culturally specific considerations are taken into account. It is recognised that there may be unintended impacts for individuals or communities through being involved in, or associated with, voluntary assisted dying. The process for accessing voluntary assisted dying in Western Australia should protect the person's fundamental right to choose while also taking into account community and cultural beliefs and practices.

For an overview of the proposed key steps in the process refer to the flow charts on pages 18 – 19. The first flow chart outlines the Victorian process; the second flow chart outlines the process with elements proposed by the Joint Select Committee and highlights key elements for consideration.

Questions to consider:

- How should the process take community, linguistic and cultural beliefs and practices into account while also ensuring human rights, personal autonomy, privacy and choice? What approaches or initiatives would assist in achieving this balance?

Access

The formal request to access voluntary assisted dying must be made by the person seeking it. Ensuring people can access the information they need and then access a medical practitioner is essential. It will be necessary to work with Aboriginal communities and health services, the many culturally and linguistically diverse communities represented in Western Australia and those who have alternative communication needs to raise awareness and design safe, appropriate ways for individuals to access voluntary assisted dying. Some individuals may wish to maintain confidentiality through all stages of the process. This is acknowledged though recognised to be challenging in some communities or individual situations. It may directly or indirectly impact a person's access to voluntary assisted dying. The Joint Select Committee has already made a number of recommendations such as development of a telephone access line, community education and resources that would help to facilitate access.

Questions to consider:

- What other ways are there to appropriately enable access to voluntary assisted dying?

Assessment

Joint Select Committee recommendations:

7.89 Voluntary Assisted Dying Legislation Framework

Assessment

Two doctors must assess the person. Either or both doctors can be a general practitioner and neither doctor is required to be a specialist regarding the person's disease or illness.

Each doctor must be independently satisfied that the person meets the eligibility criteria already outlined in the sections "the person", "the decision" and "eligible conditions".

Referral for specialist assessment

A person is not required to undergo consultant or specialist assessment except where either doctor is unable to determine:

- a) the precise nature of the disease or illness,
- b) whether the disease or illness is advanced and progressive,
- c) whether death is reasonably foreseeable,
- d) capacity and/or the absence of coercion.

Personal objection

At the time the patient makes the first verbal request, any doctor with a personal objection to providing assistance must inform the patient of the objection and offer to refer the patient to a doctor who is willing to provide assistance.

Where a person is an inpatient in a health service unwilling to provide assisted dying, that service must facilitate timely transfer to another service.

Oversight body

[...] provide health professional education and resources, including counselling and advice for practitioners.⁵⁰

A person seeking to access voluntary assisted dying must be assessed as eligible to do so. During the assessment process the enduring and voluntary nature of their decision would be confirmed and they would be able to withdraw at any stage.

The Joint Select Committee recommended that health practitioners have the right to conscientiously object to participating in voluntary assisted dying – this is a provision in all jurisdictions (refer Appendix 2). However, the Joint Select Committee additionally specified that if a doctor conscientiously objects then they have a responsibility to offer to refer the person to another doctor for assistance (or facilitate transfer if the person is an inpatient of a health service unwilling to provide voluntary assisted dying). Victoria has not included this requirement in voluntary assisted dying legislation⁴⁹. US jurisdictions remain silent on the issue but require transfer of relevant medical records to the new provider if the patient transfers care⁵⁰.

⁴⁹ Voluntary Assisted Dying Act 2017 (Victoria).

⁵⁰ Death with Dignity Act (Oregon); Death with Dignity Act (District of Columbia).

In Canada, there is no legislative obligation to refer⁵¹ (although the College of Physicians and Surgeons of Nova Scotia emphasises the responsibility of physicians to complete an “effective transfer of care”⁵²).

As detailed previously in the flowchart describing the process proposed by the Joint Select committee (refer page 19), the enduring nature of the person’s choice would be shown through several of the proposed process steps: the initial request, a written request, participation in the first assessment, participation in the second assessment, a request that triggers the provision of the prescription and a request for administration of the medication (if unable to self-administer). The written request would be required to be made in the presence of two independent witnesses and the assessing medical practitioner.

The timing of the written request in the voluntary assisted dying process in Victoria is different from that proposed by the Joint Select Committee – that it occurs between the first verbal request and the first assessment while in Victoria the written request takes place after the person has completed the two assessments and has been determined eligible.

Education, training and support for all health practitioners involved in voluntary assisted dying would be an important component of the implementation phase. This training should be developed to ensure that cultural context and competency is integrated with clinical and procedural education for voluntary assisted dying. Victoria is the only jurisdiction that makes it compulsory for the assessing medical practitioners to have completed approved assessment training before undertaking assessment for eligibility for voluntary assisted dying⁵³.

The requirement for two doctors to independently assess that the person meets all eligibility criteria and is making a voluntary, competent and informed decision is a fundamental safeguard. It is a requirement in all jurisdictions that have legislated for voluntary assisted dying. These mandatory first and second assessments would only be able to be undertaken by a registered medical practitioner who is a GP or specialist. In Victoria it is specified that at least one of the assessing medical practitioners must have practised as a registered medical practitioner for at least five years after completing their fellowship with a specialist medical college or becoming a vocationally registered general practitioner⁵⁴.

Where there is a lack of certainty in relation to decision-making capacity or elements related to the disease or illness meeting the eligibility criteria, the assessing medical practitioner would be required to refer for specialist assessment. This is a key safeguard for both the person and the medical practitioner.

Where required, the use of interpreters or other communication methods that meet the needs of the person being assessed are essential to achieving equity of access and outcome. The person has the right to be supported during the assessment process and may choose to have a support person or an independent navigator present. Any other person who is present cannot make a VAD decision on the person’s behalf.

The process must not disadvantage people living in rural and remote parts of Western Australia. The use of telehealth (a videoconferencing facility which is already integrated into many health services), as well as secure electronic information exchange, would assist to enable reliable and secure access for people across the State. For rural health practitioners, the availability of peer support alongside training and education requirements would be an additional measure to ensure safe and high quality service provision.

51 Medical Assistance in Dying, Bill C-14 (Canada).

52 Professional Standard Regarding Medical Assistance in Dying, College of Physicians and Surgeons of Nova Scotia (December 2018).

53 Voluntary Assisted Dying Act 2017 (Victoria).

54 Ibid.

Questions to consider:

- 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?
- 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)?
- 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)?
- 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?

Approval

Joint Select Committee commentary:

6.84 Some elements of the Victorian law are not commonly replicated in other jurisdictions. This includes the role of a senior bureaucrat in providing the final approval for a patient's decision to choose to end their own life. It is difficult to contemplate any other scenario where it would be appropriate for the government to insert itself into the private medical decisions made by a patient in consultation with their doctors. Indeed, such intervention is not currently required for other end of life options open to patients – government permission is not required, for example, for a person to receive terminal sedation, or to refuse artificial food and hydration.

The Joint Select Committee recommended that the Victorian requirement of departmental approval (and therefore associated permit system) for voluntary assisted dying should not be a feature of the model for Western Australia. In Victoria, the Department of Health and Human Services must approve and provide an authorisation permit prior to the medical practitioner prescribing the person a lethal dose of medication⁵⁵. This was included in the Victorian legislation as an additional check point to ensure the process has been completed correctly prior to prescription⁵⁶.

In Western Australia there are some situations in which certain controlled medications require notification to, or authorisation from, the Department of Health prior to prescription (*Medicines and Poisons Act 2014*). The notification or authorisation of voluntary assisted dying medications may provide an avenue for oversight and approval without an additional approval and permit process. A similar process occurs in Oregon where the medical practitioner notifies the Oregon Health Authority of prescription of a lethal dose of medication but no authorisation permit is required⁵⁷. This was noted by the Joint Select Committee in their deliberations as being potentially suitable for Western Australia as both a point of oversight and data collection⁵⁸.

In addition to the points noted above, an oversight body would undertake retrospective review of voluntary assisted dying deaths and other reporting points in the voluntary assisted dying process pathway (refer also to the section on Oversight on page 39) – this forms an important part of the overall safeguard measures.

Questions to consider:

- Should there be a separate approval and permit process for voluntary assisted dying (over and above any that may relate to the prescription of the medication)?

55 Ibid.

56 Ministerial Advisory Panel on Voluntary Assisted Dying Final Report, Department of Health and Human Services, State of Victoria (July 2017).

57 Death with Dignity Act (Oregon).

58 7.88 *My Life, My Choice* report of the Joint Select Committee on End of Life Choices, Parliament of Western Australia (August 2018).

Medication

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

Medication

The choice of lethal medication for voluntary assisted dying should remain a clinical decision based on the prescribed list of medications for this purpose. The WA Government should review current federal laws in relation to scheduling of medication in Australia, and negotiate with the Federal Government and the Therapeutic Goods Administration for the use of the best medication(s) for assisted dying.

Pharmacists dispensing lethal medication(s) must report the dispensing of the medication to the oversight body.

Assisted dying

The legislation should provide for self-administration of lethal medication where an eligible person is physically able to self-administer. In cases where the person is eligible but physically incapable of self-administration, the legislation should permit a doctor to administer the lethal medication.

The choice of medication would be a clinical decision by the medical practitioner who would be required to provide clear instructions for use to the person at the time of providing the prescription. Pharmacists would be required to provide relevant information at the time of dispensing and to notify the oversight body when medication is dispensed. As with all medication it should be stored safely. The proposed requirement for appointment of a contact person to be responsible for return of unused medication to the pharmacist, as in Victoria⁵⁹, would be a further safeguard.

The Joint Select Committee's recommendation is that the person self-administer, but that a medical practitioner be permitted to administer if the person is physically unable to do so. This recommendation was considered to strike the right balance between autonomy, access and safety.

There are other models operating internationally. They range from self-administration only⁶⁰ to a choice between self or medical practitioner administration⁶¹. As part of the process in Western Australia it would be important to balance the person's right to choose with cultural context and the potential impacts on individuals, family members, health services or health practitioners.

⁵⁹ Voluntary Assisted Dying Act 2017 (Victoria).

⁶⁰ Patient Choice and Control at End of Life Act (Vermont); Death with Dignity Act (Washington).

⁶¹ Medical Assistance in Dying, Bill C-14 (Canada).

Questions to consider:

- Should a medical practitioner only be permitted to administer the medication if the person is physically incapable of self-administration?
- What is the safest approach to returning any unused medication after death?
- How should the public be protected from the loss, misuse or misdirection of medication?
- Are there other safeguards to consider in relation to medication?

Death certification

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

Death certification

Where an assisted death takes place it must be noted on death certification documents. The WA government should amend the:

- a) Medical Certificate Cause of Death – completed by the doctor certifying cause of death;
- b) Manual Death Registration Form – completed by the funeral director to register a death;
- c) Death Certificate – issued by the Registrar of Births Deaths and Marriages,

to make provisions for the inclusion of voluntary assisted dying as a contributing cause of death, and to provide guidance for doctors and others who complete each of the documents

In Western Australia, the Medical Certificate Cause of Death is a form completed by the medical practitioner when a person dies. The form requires the medical practitioner to define the disease or condition directly leading to the death, other causes or conditions that contributed to their death and the manner of death. These details inform what is on the Death Certificate.

There are several aspects to be considered in relation to the Joint Select Committee proposal to list voluntary assisted dying on death certification documents. At the centre of the discussion is the balance between privacy and confidentiality of the person, and the need to collect information about voluntary assisted dying. In some communities there may be significant impact on extended family of a person who has died through accessing voluntary assisted dying.

In Victoria the cause of death is listed as the disease, illness or medical condition that was the basis for the person accessing voluntary assisted dying. The Medical Certificate Cause of Death also records that the person was the subject of a voluntary assisted dying permit (if they died through the use of the medication). However, this is not listed on the publicly available extract from the Births, Deaths and Marriages Register (also known as the Death Certificate).

Questions to consider:

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

Oversight

Joint Select Committee recommendation:

7.89 Voluntary Assisted Dying Legislation Framework

An oversight body must be established to:

- a) Provide policy and strategic direction for the State of Western Australia;
- b) Review all voluntary assisted dying deaths;
- c) Provide community education and resources;
- d) Provide health professional education and resources, including counselling and advice for practitioners;
- e) Provide a telephone advice line;
- f) Maintain a database of all relevant statistics related to assisted dying; and,
- g) Provide an annual report to Parliament.

Voluntary assisted dying process oversight

The Joint Select Committee recommendation for an oversight body with a retrospective review and reporting function is consistent with many jurisdictions that have legislated for a form of voluntary assisted dying (refer Appendix 2). In the Netherlands the review panel consists of a medical physician, a lawyer and an ethicist⁶². In Victoria, the members of the oversight board are appointed as deemed appropriate by the Minister – the Act does not specify qualifications or number of members⁶³.

The creation of a statutory body such as a Board to review and monitor voluntary assisted dying in Western Australia is both a key safeguard and a practical source of advice or recommendations to government.

The oversight body would receive relevant forms from the health practitioners involved in the voluntary assisted dying process to enable review, analysis and reporting (including reporting to Parliament). The oversight body may seek further information if required and can refer matters to other relevant authorities if required (for example compliance or misconduct issues). There would need to be consideration given to the type of data collected about voluntary assisted dying to ensure that it is comprehensive enough to meet the reporting requirements of the oversight body as well as deepening knowledge about voluntary assisted dying.

Right of appeal

In Western Australia the State Administrative Tribunal (SAT) deals with a broad range of administrative, commercial and personal matters. These matters span human rights, vocational regulation, commercial and civil disputes, and development and resources issues.

In the Victorian voluntary assisted dying legislation, provision is made for the Victorian Civil and Administrative Tribunal (VCAT) to review specific decisions related to determination of decision-making capacity or determination of usual residency⁶⁴. It is expected that Western Australia would apply similar provisions.

⁶² <https://english.euthanasiecommissie.nl/the-committees/the-committees>

⁶³ Voluntary Assisted Dying Act 2017 (Victoria).

⁶⁴ Ibid.

There are already pathways and processes that exist for people to raise concerns in relation to health and medical treatment or services. The Health and Disability Services Complaints Office (HaDSCO) operates as an impartial complaints resolution service for Western Australian health, disability and mental health services⁶⁵. There is also the potential that the statutory body, such as the Board described previously, would be able to receive complaints related to voluntary assisted dying.

Training, education and information resources

The importance of Western Australians being provided with accessible, accurate and high quality information about voluntary assisted dying has been highlighted at several points through this discussion paper. Education of health professionals is vital to ensuring the voluntary assisted dying process is undertaken appropriately and safely.

Questions to consider:

- What types of members should form the oversight body? (e.g. qualifications, relevant experience)
- What information should health practitioners be required to report to the oversight body?
- What data should be collected about voluntary assisted dying?
- How should community information and education be provided?
- How should health practitioner training and education be provided?
- How should complaints about voluntary assisted dying be handled?

⁶⁵ <https://www.hadSCO.wa.gov.au/home/>

Conclusion

Questions to consider:

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

The Joint Select Committee has provided a clear framework as a basis for discussing the issues relating to the development of voluntary assisted dying legislation in Western Australia. Responses to the discussion paper will inform the Panel and will be incorporated into a final report which will be presented to the Minister for Health.

Submissions that are considered by the Panel will be published on our website unless the submitter requests confidentiality.

The closing date for response to this discussion paper is 24 May 2019.

Please submit your response via the website health.wa.gov.au/voluntaryassisteddying, via email to VADconsultations@health.wa.gov.au, or via post addressed to: *The Ministerial Expert Panel on Voluntary Assisted Dying*, PO Box 8172, Perth Business Centre, Perth WA 6849.

To receive a hard copy of this discussion paper, please email VADconsultations@health.wa.gov.au and provide your name and postal address.

Appendix 1: Members of the Ministerial Expert Panel on Voluntary Assisted Dying

Mr Malcolm McCusker AC QC – Chair

Queen’s Counsel and former Governor of Western Australia.

Dr Penny Flett AO – Deputy Chair

Retired medical practitioner. Former Chief Executive Officer Brightwater, former Chair WA Aged Care Advisory Council.

Associate Professor Kirsten Auret

Associate Professor of rural and remote medicine and Deputy Director Rural Clinical School of WA, Palliative Care specialist and Adjunct Professor Curtin University and Notre Dame University.

Dr Scott Blackwell

General Practitioner with expertise in palliative care and aged care. Former President of the Australian Medical Association (AMA). Life member of the Royal Australian College of GPs.

Dr Elissa Campbell

President Palliative Care WA, Consultant Geriatrician and Palliative Care specialist.

Professor Phillip Della

Head of Nursing and Midwifery at Curtin University, former Chief Nurse of Western Australia.

Ms Noreen Fynn

Consumer representative with 30 years of experience in Western Australia in the carer, disability, aged care and mental health sectors, community and government organisations, state and federal level.

Ms Kate George

Company Director and senior lawyer specialising in human rights, international law and indigenous matters.

Dr Roger Hunt

Senior Consultant in Palliative Medicine. Former member of the Victorian Ministerial Advisory Panel on Voluntary Assisted Dying.

Ms Samantha Jenkinson

Executive Director People With disabilities WA (PWdWA) and former acting CEO Australian Federation of Disability Organisations. Senior advocate and advisor to government in relation to disability.

Ms Maria Osman

Senior Consultant and advisor for cultural and linguistically diverse communities, former Executive Director of the Office of Multicultural Interests.

Ms Fiona Seaward

Commissioner of the Law Reform Commission of Western Australia and Senior Assistant State Counsel for State Solicitor’s Office.

Dr Simon Towler

Clinical Lead South Metro Health Service Futures program. Staff Specialist Intensive Care, Fiona Stanley Hospital. Former Chief Medical Officer Western Australia.

Appendix 2: Voluntary Assisted Dying in other jurisdictions

Disclaimer: Every reasonable effort has been made to ensure that the information in this Appendix is complete and accurate. However the information relied upon from other jurisdictions is subject to change and interpretation, and the content of this appendix is for comparative purposes only.

Voluntary assisted dying in other jurisdictions⁶⁶

| Victoria | Canada | Oregon | Washington State | Vermont | California ⁶⁷ | Belgium | Netherlands |
|--|---|---|--|---|---|--|--|
| <p>At least 18 years of age, resident in Victoria for at least 12 months (must be Australian citizen or permanent resident) and has decision-making capacity. Has advanced disease that is expected to cause death within six months (or within 12 months for neurodegenerative diseases). Disease is causing suffering that cannot be alleviated in a manner that is tolerable for the person. Cannot qualify solely because of mental illness or disability.</p> | <p>At least 18 years of age and capable of making decisions and with a grievous and irremediable medical condition. Condition is serious and incurable illness, disease or disability; in an advanced state of irreversible decline; causing enduring suffering that is intolerable. Natural death has become reasonably foreseeable.</p> | <p>Adult resident suffering from a terminal disease as determined by physician. Disease will produce death within six months. Cannot qualify solely because of age or disability.</p> | <p>Competent adult resident determined by physician to be suffering from a terminal disease which will produce death within six months. Person does not qualify solely because of age or disability.</p> | <p>Capable resident at least 18 years of age, suffering from a terminal condition, which means incurable and irreversible disease that would result in death within six months.</p> | <p>Resident 18 years of age or older with terminal disease which will result in death within six months and with capacity. Person does not qualify solely because of age or disability.</p> | <p>Limited to those in medically futile condition with constant and unbearable suffering that cannot be alleviated. Not limited to people at the end of their life. Emancipated minors may access.</p> | <p>Must be lasting and unbearable suffering (in view of physician). No reference to condition. Not limited to people at the end of their life. The Act applies for patients aged 12 and over (with certain requirements for parental involvement).</p> |
| Eligibility | | | | | | | |

⁶⁶ Adapted from Ministerial Advisory Panel on Voluntary Assisted Dying Final Report, Department of Health and Human Services, State of Victoria (July 2017).

⁶⁷ Voluntary assisted dying has also been legislated for in the US states of Hawaii, Colorado and District of Columbia. The statutes in these states are very similar to those US states listed in the table.

| Voluntary assisted dying in other jurisdictions | | | | | | | |
|--|---|--|---|--|---|--|--|
| Victoria | Canada | Oregon | Washington State | Vermont | California | Belgium | Netherlands |
| Request | | | | | | | |
| <p>Patient must make a first verbal request, followed by a written request, witnessed by two independent individuals, and a final verbal request. The final request must be made at least nine days after the first request. The final request may not be made on the same day as the second independent assessment.</p> <p>Waiting period can be reduced if death is likely to occur before expiry of the waiting period.</p> | <p>Request is written and witnessed by two individuals. 10 days between written request and the day on which medical assistance in dying is provided. Supports those with communication difficulties.</p> <p>Waiting periods can be reduced if death or loss of capacity is imminent.</p> | <p>Request is written and witnessed by two independent individuals. Requests repeated with 15 days waiting period between two oral requests.</p> | <p>Request written and witnessed by two independent individuals. Second oral request reiterated at least 15 days after initial oral request.</p> <p>Prescription at least 48 hours after written request.</p> | <p>Written request in presence of two independent witnesses. Requests repeated with 15 days waiting period between two oral requests.</p> <p>Prescription at least 48 hours after whichever event occurred last.</p> | <p>Two oral requests 15 days apart and a written request, witnessed by two individuals.</p> | <p>Request must be voluntary, well-considered and repeated. Request in writing. May be included in an advance directive. No specified waiting periods but the doctor and person need to have had several conversations over a reasonable period of time.</p> | <p>Request must be voluntary and well-considered. No written request required.</p> |

Voluntary assisted dying in other jurisdictions

| Victoria | Canada | Oregon | Washington State | Vermont | California | Belgium | Netherlands |
|---|--|--|--|--|---|---|--|
| Assessment | | | | | | | |
| Both the coordinating practitioner and consulting practitioner independently assess eligibility, that the request is voluntary and inform the person. Referral for specialist assessment if doubt about decision-making capacity. | Assessment undertaken by medical or nurse practitioner, who must also ensure another independent practitioner has given written confirmation of person meeting criteria. | Attending physician assesses eligibility and informs patient. Consulting physician confirms and verifies. Counselling referral if suffering from psychiatric or psychological disorder or depression causing impaired judgement. | Attending physician assesses eligibility and informs patient. Refers to consulting physician for confirmation of diagnosis and verification that patient is competent and acting voluntarily. Counselling referral if suffering from psychiatric or psychological disorder or depression causing impaired judgement. | Physician assesses eligibility and informs patient. Refers patient to second physician for medical confirmation. Verifies judgement not impaired or referred for evaluation. | Attending physician assesses eligibility and informs patient. Refers if indication of mental disorder. Consulting physician conducts second assessment, and referral if required. | Assessment is undertaken by one physician, who consults an independent physician about the disorder. If the person is not expected to die in the near future, a psychiatrist or specialist in the disorder must conduct a second assessment and confirm the suffering cannot be alleviated. | Assessment undertaken by one physician who has consulted with one other independent physician who has seen the person and given written opinion. |
| Practitioner | | | | | | | |
| Participation is voluntary. Protection if participating in good faith. | No one is compelled to provide or assist in dying. Protection for those who participate. | Protection if participating in good faith compliance. No health care provider may be under a duty to participate. | Only willing health care providers shall participate. Protection if participating in good faith. | Physician or other person not under any duty to participate. Physician not subject to liability if complies with requirements. | Participation is voluntary. Protection if participating in good faith. | No physician compelled to participate. | Act is ground for exemption from criminal liability for physician who observes requirements. |

| Voluntary assisted dying in other jurisdictions | | | | | | |
|---|--|---|---|---|--|--|
| Victoria | Canada | Oregon | Washington State | Vermont | California | Belgium Netherlands |
| Medication Management | | | | | | |
| Prescription requires authorisation permit by Department of Health and Human Services. Any medication not used must be returned to dispensing pharmacist by contact person. | Medical practitioner informs dispensing pharmacist of purpose of medication. Silent about unused medication. | Dispensing record filed with authority. Silent about unused medication. | Any medication not used must be disposed of by lawful means. | Department of Health shall adopt rules for safe disposal of unused medications. | Unused medication personally delivered to facility or disposed of by lawful means. | Legislation is silent on medication management. |
| Medication Administration | | | | | | |
| If the person cannot self-administer, the coordinating practitioner may administer with a witness present and additional certification. | Medication may be self-administered or administered by medical or nurse practitioner. | Medication must be self-administered. No option for physician administration of medication. | Medication must be self-administered. No option for physician administration of medication. | Medication must be self-administered. No option for physician administration of medication. | Medication must be self-administered. Requires form 48 hours before self-administration. No option for physician administration of medication. | Physician may administer or assist in self-administration. |
| | | | | | | Legislation provides for physician administration (viz “physician who performs euthanasia”) though the oversight agency has accepted cases of assisted suicide as falling under the law. ⁶⁸ |

⁶⁸ Analysis of the Seventh Report of the Federal Commission for Euthanasia control and evaluation to the Legislative Chambers (for the years 2014 and 2015), Institut Européen de Bioéthique.

Voluntary assisted dying in other jurisdictions

| Victoria | Canada | Oregon | Washington State | Vermont | California | Belgium | Netherlands |
|---|---|--|---|--|---|---|--|
| Mandatory reporting | | | | | | | |
| Mandatory reporting to review board within seven days of completion of first assessment, completion of second assessment, completion of certification for authorisation and administration by medical practitioner. | Minister for Health makes regulations for provision and collection of information. | Request form is included in legislation. Details of request and assessment only filed in patient's medical record. Health care provider files copy of dispensing record with authority. Authority conducts annual review of a sample of records. | Administratively required documentation and a copy of dispensing record filed with Department of Health. Department conducts annual review of all records. | Physician to file a report with Department of Health documenting completion of all the requirements. | Request form is included in legislation. Physician documents information in individual's medical record. Dispensing record filed with Department. Department conducts annual review of a sample of records. | Oversight body sets out a registration form that must be filled in by physician whenever lethal dose of medication is administered. Must be submitted within four days of administration. | Physician notifies municipal autopsy via form and provides report on observance of due care requirements. |
| Oversight | | | | | | | |
| Voluntary Assisted Dying Review Board has multiple functions relating to reporting, monitoring, referral of issues, continuous improvement, analysis, research and provision of information and advice. | Minister for Health to make regulations for the collection of information for monitoring. Provides for five year review of legislation. | The law requires the Public Health Division of the Oregon Health Authority (OHA) to monitor compliance with the law and issue an annual report. | Department of Health annually reviews all records maintained. Department adopts rules to facilitate collection of information regarding compliance. Department publishes a biennial statistical report. | Department of Health shall adopt rules to facilitate collection of information regarding compliance. Department generates a biennial statistical report. | Department of Public Health collects and reviews a sample of records. Department publishes a statistical report every year. | Establishes a Commission that reviews reporting forms to determine if there has been compliance. Commission comprised of 16 members: 8 doctors, 4 lawyers and 4 others. Publishes two-year reports. | Establishes Regional Review Committees who determine if physician has acted in accordance with the requirements of due care. Committees issue annual report. Made up of a physician, a lawyer and an ethicist. |

Appendix 3: Joint Select Committee Voluntary Assisted Dying Legislation Framework⁶⁹

7.89 VOLUNTARY ASSISTED DYING LEGISLATION FRAMEWORK

Preamble

The Government should introduce legislation to provide for voluntary assisted dying.

The legislation should not merely provide a criminal defence to those assisting an eligible person to die. Nor should it merely provide for a change to prosecution guidelines relating to the prosecution of those assisting an eligible person to die. Rather, the legislation should reform the law with a standalone Act that permits voluntary assisted dying to eligible people in accordance with strict criteria.

The WA Government should establish a panel of experts to consider the implementation of legislation for voluntary assisted dying, based on elements contained in this framework.

Assisted dying

The legislation should provide for self-administration of lethal medication where an eligible person is physically able to self-administer. In cases where the person is eligible but physically incapable of self-administration, the legislation should permit a doctor to administer the lethal medication.

Eligibility

Eligible Conditions

The legislation is intended to provide assisted dying for those for whom death is a reasonably foreseeable outcome as a result of an eligible condition.

An eligible condition is an advanced and progressive:

- a. Terminal illness or disease;
- b. Chronic illness or disease; or
- c. Neurodegenerative illness or disease,

where death is a reasonably foreseeable outcome of the condition.

The person's suffering

The person's suffering must not be temporary nor able to be treated or remedied in a manner acceptable to the person. The suffering:

- a. Must be related to an eligible condition;
- b. Must be grievous and irremediable;
- c. Cannot be alleviated in a manner acceptable to the person; and
- d. Must be subjectively assessed – that is, from the person's point of view.

⁶⁹ *My Life, My Choice* report of the Joint Select Committee on End of Life Choices, Parliament of Western Australia (August 2018).

Age

The person must be aged 18 years or over.

Capacity

In order to request assisted dying the person must have decision-making capacity in relation to a decision about voluntary assisted dying.

Residency

Eligibility requires ordinary residence in Western Australia and either Australian citizenship or permanent residency.

Assessment

Two doctors must assess the person. Either or both doctors can be a general practitioner and neither doctor is required to be a specialist regarding the person's disease or illness. Each doctor must be independently satisfied that:

- a. The person is aged 18 or over;
- b. The person is ordinarily resident in Western Australia;
- c. The request is voluntary, made without coercion or duress;
- d. The person has decision making capacity in relation to a decision about voluntary assisted dying;
- e. The person has an advanced and progressive: terminal, chronic or neurodegenerative illness or disease;
- f. The person has grievous and irremediable suffering due to the disease or illness that cannot be alleviated in a manner acceptable to the person; and
- g. Death is reasonable foreseeable outcome of the condition.

Referral for specialist assessment

A person is not required to undergo consultant or specialist assessment except where either doctor is unable to determine:

- a. The precise nature of the disease or illness, in which case they must refer to a specialist in the relevant area of medicine.
- b. Whether the disease or illness is advanced and progressive, in which case they must refer to a specialist in the relevant area of medicine.
- c. Whether death is reasonably foreseeable.
- d. Capacity, and/or absence of coercion, in which case they must refer to a consultant psychiatrist or a consultant geriatrician as appropriate.

Procedure

A person must make an initial verbal request to a doctor to access assisted dying. A doctor must include a record that a verbal request has been made in a medical record. Following this request, providing that the doctor does not personally object to voluntary assisted dying, they must provide the person with information regarding:

- a. The nature of the disease or illness;
- b. The prognosis;

- c. Any possible curative treatments;
- d. Any available palliative treatments;
- e. The nature, effects and risks of the lethal medication that may be prescribed; and
- f. That the person's consent to assisted dying may be withdrawn at any time.

The person must provide the initial assessing doctor with a signed written request using a standard template. The written request must be filed with the oversight body.

The doctor should then carry out the assessment as described above. If satisfied that the person meets the assessment criteria, the doctor should complete a standard template referral to a second assessing doctor.

The second assessing doctor must then also carry out the assessment as described above. The second assessing doctor must then provide the initial doctor with written advice regarding the outcome of the assessment. The written advice by filed with the oversight body.

The initial assessing doctor must inform the person of the results of the assessment. If both doctors concur that the person meets the assessment criteria, and the person makes a further verbal request to access assisted dying, the initial assessing doctor may provide the prescription for the lethal medication to the person and must provide instructions on the manner of use.

Timelines for each step in the process should be advised by the expert panel to ensure integrity in the process without unnecessary delay.

Reflection period

In order to provide a period of reflection a prescription for medication must not be filled sooner than prescribed under the legislation as determined by the expert panel.

Personal objection

At the time the patient makes the first verbal request, any doctor with a personal objection to providing assisted dying must inform the patient of the objection and offer to refer the patients to a doctor who is willing to provide assistance.

Where a person is an inpatient in a health service unwilling to provide assisted dying, that service must facilitate timely transfer to another service.

Non-discrimination

Mental Illness

A person with a mental illness who meets the eligibility criteria shall not be denied access to voluntary assisted dying.

Disability

A person with a disability who meets the eligibility criteria shall not be denied access to voluntary assisted dying.

Medication

The choice of lethal medication for voluntary assisted dying should remain a clinical decision based on the prescribed list of medications for this purpose. The WA Government should review current federal laws in relation to scheduling of medication in Australia, and negotiate with the Federal Government and the Therapeutic Goods Administration for the use of the best medication(s) for assisted dying.

Pharmacists dispensing lethal medication(s) must report the dispensing of the medication to the oversight body.

Death Certification

Where an assisted death takes place it must be noted on death certification documents.

The WA Government should amend the:

- a. Medical Certificate Cause of Death – completed by the doctor certifying cause of death;
- b. Manual Death Registration Form – completed by the funeral director to register a death;
and
- c. The Death Certificate – issued by the Registrar of Births Deaths and Marriages.

To make provision for the inclusion of voluntary assisted dying as a contributing cause of death, and to provide guidance for doctors and others who complete each of the documents.

Oversight

An oversight body must be established to:

- a. Provide policy and strategic direction for the State of Western Australia
- b. Review all voluntary assisted dying deaths;
- c. Provide community education and resources;
- d. Provide health professional education and resources, including counselling and advice for practitioners;
- e. Provide a telephone advice line;
- f. Maintain a database of all relevant statistics related to assisted dying; and
- g. Provide an annual report to Parliament.

Appendix 4: References to decision-making capacity in Western Australian legislation

Legal presumption about a person's capacity:

S4(3) Every person shall be presumed to be capable of –

- (a) looking after his own health and safety;
- (b) making reasonable judgements in respect of matters relating to his person;
- (c) managing his own affairs; and
- (d) making reasonable judgements in respect of matters relating to his estate,

Until the contrary is proved to the satisfaction of the State Administrative Tribunal.

(extract from the *Guardianship and Administration Act 1990*)

s13(1) For the purposes of this Act, an adult is presumed to have the capacity to make a decision about a matter relating to himself or herself unless the adult is shown to not have that capacity.

(extract from the *Mental Health Act 2014*)

The Mental Health Act 2014 also provides what is required to be demonstrated when assessing capacity:

s15 For the purposes of this Act, a person has the capacity to make a decision about a matter relating to himself or herself if another person who is performing a function under this Act that requires that other person to determine that capacity is satisfied that the person has the capacity to —


- (a) understand any information or advice about the decision that is required under this Act to be provided to the person; and
- (b) understand the matters involved in the decision; and
- (c) understand the effect of the decision; and
- (d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the decision; and
- (e) communicate the decision in some way.

(extract from the *Mental Health Act 2014*)

Notes

Notes

Notes



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a person with disability.

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