LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON VOLUNTARY ASSISTED DYING BILL
Ms Suzanne Orr MLA (Chair), Ms Leanne Castley (Deputy Chair),
Mr Andrew Braddock MLA, Mr Ed Cocks MLA, Dr Marisa Paterson MLA

Submission Cover Sheet

Inquiry into the Voluntary Assisted Dying Bill 2023

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VADANZ

Voluntary Assisted Dying Australia and New Zealand

7th December 2023

RE: Submission on the inquiry into the Voluntary Assisted Dying Bill 2023 (ACT)

Who we are

Voluntary Assisted Dying Australia and New Zealand (VADANZ) is the peak body for health care professionals working in voluntary assisted dying (VAD). Our purpose is to represent the voices of health care professionals so they can deliver evidence-based, high quality voluntary assisted dying care.

We have been set up by health care professionals from across Australia and New Zealand who saw a need for an organisation to:

- support the growing community of multidisciplinary health professionals who make voluntary assisted dying possible, and to
- give a strong voice to frontline practitioners to share our insights with decision-makers so VAD continues to be a safe, accessible, and sustainable choice for eligible patients long-term.

Our submission

The Voluntary Assisted Dying Act 2023 (ACT) represents the next step in the evolving landscape of VAD legislation across Australia. Below, we have made general comments and then several recommendations.

Timeframes

We applaud the decision to exclude a prognostic requirement for eligibility – there is significant variability and unpredictability in prognostication, and the overall objective of VAD is to minimise suffering. If a patient is suffering greatly, they should not be excluded from access to VAD solely due to their prognosis being longer than any specified amount, as this may condemn them to struggle with their suffering against their will and is against objective 6(a), as well as Principle 7(c) and 7(e) of the Act.

Nurses

We applaud the inclusion of Nurse Practitioners in their ability to be involved in providing an assessment for VAD eligibility and feel this would be within their scope of practice and experience to assess prognosis, capacity, and coercion.

Strict liability offences

We note that offences against certain sections of the Act are regarded as strict liability offences, such as failure to notify the board within 2 working days at several steps of the process. We recommend reconsideration of this – if coordinating or consulting doctors undergo an accident, personal or family trauma, or telecommunications disturbance, these should be able to be considered with regards to the degree of liability.

Transfer of practitioner functions

We applaud the inclusion of the ability to transfer the functions of the coordinating medical practitioner under Division 3.5 – this has been an area of need in other jurisdictions without similar clauses, such as VIC. Similarly, the use of Administering practitioners and the ability to transfer administering practitioner functions will help doctors and nurse practitioners who are willing to provide assessments, but who are uneasy with the prospect of administration, be involved in the process, and also safeguard against periods of provider unavailability, such as leave.

Dealing with approved substances

We applaud the inclusion of the ability for the individual to ask another adult to assist in preparing the approved substance for the individual under Division 4.3. The requirement for the individual to prepare the substances is a significant barrier to self-administration.

Recommendations

11(4)(c) - the individual is in the last stages of their life

This wording is somewhat vague and open to wide interpretation, and we recommend this be more specific in some way in order to offer guidance as to its use. Common terminology used in end-of-life care in Australia has undergone standardisation using the definitions used by the Palliative Care Outcomes Collaboration (PCOC). These have been adopted by the Australian Institute of Health and Welfare (AIHW). Consideration may be given to utilising the PCOC phases of 'unstable', 'deteriorating', or 'terminal', for more practical use.

11(4)(c) – progressive

The Legislative Assembly should bear in mind there are many patients whose condition is stable, but renders them a quality of life that they do not wish to hold. Conditions such as a stroke, for example, may severely affect a patient's quality of life, and incur significant suffering, but would be excluded since it would not be considered to be a "progressive" disease. The Legislative Assembly may want to consider alternative wording such as "unlikely to improve".

19(1) – Referral for consulting assessment

The Legislative Assembly may consider whether referral for consulting assessment may be best done by a centralised service (such as the care navigator service). This would offer the coordinating

medical practitioner a layer of protection from being accused of “cherry-picking” the consulting practitioner.

Please do not hesitate to contact us if you need more information. We would be pleased to offer a frontline practitioner perspective to any panels you plan to host.

Yours faithfully

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