Australian Nursing & Midwifery Federation
VICTORIAN BRANCH

ANMF House
540 Elizabeth Street
Melbourne Victoria 3000

Box 12600 A'Beckett Street PO
Melbourne Victoria 8006

www.anmfvic.asn.au
T 03 9275 9333
F 03 9275 9344
E records@anmfvic.asn.au

ABN 8057 1091192
RTO 3601

ANMF (Vic Branch) Submission to Voluntary Assisted Dying Bill Discussion paper

Lisa Fitzpatrick, Secretary
ANMF Vic Branch

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Introduction

The Australian Nursing and Midwifery Federation (Victorian Branch) (ANMF) was established in 1924. The ANMF (Vic Branch) is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.

The ANMF (Vic Branch) represents in excess of 75,000 nurses, midwives and personal care workers (the latter predominantly in the private residential aged care sector). Our members are employed in a wide range of enterprises in urban, rural and community care locations and the public and private health and aged care sectors.

The core business for the ANMF (Vic Branch) is the representation of the professional and industrial interests of our members and the professions of nursing and midwifery.

The ANMF (Vic Branch) participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare, health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANMF (Vic Branch) members are involved in the provision of quality end of life care, and support such care where it is consistent with their patients' preferences and values. The ANMF (Vic Branch) has developed policy in this regard which includes people having access to high quality palliative care, the right to consent and refuse medical treatments through advance care directives and, in limited circumstances, the option of voluntary assisted dying for those with a terminal illness who are dealing with unbearable suffering. ANMF members employed in end of life care know that even the best palliative care options will not always relieve pain for all people at the end of their lives. We consider that now is the time that Victoria must follow the lead of other countries and do more to offer people with terminal illness genuine choice at the end of their lives.

The ANMF (Vic Branch) has also made its contribution to the Victorian Parliamentary Committee Inquiry into end of life choices, through both written submission and verbal submissions and as a witness, in the public hearings. Therefore, the ANMF (Vic Branch) is supportive of the recommendations of that final report to introduce legislation into Parliament in 2017 to legalise voluntary assisted dying for terminally ill people in Victoria. We appreciate the opportunity to provide feedback to the Voluntary Assisted Dying Bill, Discussion paper.

Voluntary Assisted Dying Bill

The ANMF (Vic Branch) understands the Parliamentary Committee recommendation that the Bill relates to a framework that would permit adults with decision-making capacity, who are suffering from a serious and incurable condition and at the end of their life, to be provided with assistance to die in certain circumstances.

The ANMF (Vic Branch) acknowledges our members work who are employed in the Palliative Care sector in Victoria. We know that our members are the linchpin to the effective and efficient running the State's high-quality palliative care services. The ANMF (Vic Branch) strives to work with the Victorian Government to continue to improve these services. As we represent many of our members

that are employed in clinical practice in palliative care services and advance care planning nursing and we know people at end of life require optimal comfort and require quality pain relief, yet these people must be given genuine choice about their care, which may include a voluntary assisted dying request.

Even so, nurses and midwives who are involved in the care of terminally ill patients that come to end of life, work at the coal face of the decision making with patients who may feel that they cannot continue to suffer. In such circumstances many nurses are supportive of the development of law that enables medical practitioners to assist in voluntary assisted dying through robust legislation.

We know that ANMF members employed in these specialist areas of clinical practice are the reason the care in these services is second to none. We espouse that everything must be done to ensure that Victoria retains and improves its already has high-quality palliative care services, and the Victorian Government maintains its committed to continuing to fund these services in order to able further improvement and expansion. Nonetheless there continues to be circumstances in which palliative care cannot provide the relief needed to address the pain and suffering at the end of life.

The ANMF (Vic Branch) is well placed to provide this submission on behalf of our membership, having attended face to face consultation sessions in early February 2017, conducted by the Department of Health and Human Services Victoria. We have also conducted a member forum on the topic on April 4, 2017 with representatives of the Department of Health and Human Services Victoria and Parliamentary Committee members. Additionally, we also provided a written submission into the cross-party Parliamentary Committee in 2015-16, which tabled its final report on its Inquiry into end-of-life choices in June 2016.

The Person

Parliamentary Committee recommendation:

- **An adult, 18 years and over, with decision-making capacity about their own medical treatment.**
- **People whose decision-making capacity is in question due to mental illness must be referred to a psychiatrist for assessment.**
- **Ordinary resident in Victoria and an Australian citizen or permanent resident.**

Specific questions to consider:

- Is the existing decision-making capacity test in legislation such as the Medical Treatment Planning and Decisions Act 2016 sufficient?

The ANMF (Vic Branch) supports the above principles as the foundation for the Bill. The ANMF (Vic Branch) considers the existing decision-making capacity test in the legislation is a sufficient test.

- In what circumstances should a psychiatric assessment be required?

The Parliamentary Committee recommended that any person whose decision-making capacity is in question due to mental illness must be referred to a psychiatrist for assessment.

The ANMF (Vic Branch) considers the Parliamentary Committee's recommendation above is appropriate where the medical practitioner has a reasonable belief that the decision- making capacity of the person is impaired due to a mental illness is supported.

- Are there any other specialist referrals that would be appropriate for assessing decision-making capacity?

The ANMF (Vic Branch) does not see any reason to deviate from the current Medical Treatment Planning and Decisions Act and does not consider any additional referral to other medical specialists other than those outlined in the inquiry recommendation who are already required for inclusion in the Bill.

Access and eligibility

Parliamentary Committee recommendation:
The person must be:

- **at the end of life (final weeks or months of life); and**
- **suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable.**

Suffering as a result of a mental illness only does not satisfy the eligibility criteria.

Questions to consider:

- Is greater specificity required to identify what constitutes a person being at the end of life and, if so, how should that specificity be worded?

The Parliamentary Committee's framework sets out criteria that must be fulfilled in order to access voluntary assisted dying. While the Parliamentary Committee sets broad limits, what these limits mean in practice requires further exploration.

The Parliamentary Committee recommended that a person must be **'at the end of life (final weeks or months of life)'**. The Parliamentary Committee **did not** prescribe a set timeline and supports an approach that allows doctors to determine whether a patient is at the end of their life according to the nature of their condition and the likely trajectory.

The ANMF (Vic Branch) supports the above principles as the foundation for the Bill.

The ANMF (Vic Branch) considers that a doctor remain the appropriate person to determine whether a patient is at the end of their life according to the nature of their condition and the likely trajectory.

Whilst it may be desirable to set out the expectations of an acceptable timeline for accessing voluntary assisted dying; it may be an unrealistic expectation on medical practitioners who cannot always predict when a person is going to die.

For this reason, we support the principle that the medical practitioner is best placed to use their professional judgement in making that decision. Where a specialist medical practitioner has an advanced knowledge of a condition and understands the disease process they should be considered for a consultation and an expert opinion where they may not already be involved in the care of the patient.

- How should a 'serious and incurable condition' be defined?

The ANMF (Vic Branch) considers the Parliamentary Committee recommendation that the person be experiencing 'enduring and unbearable suffering' is reasonable. However, the legislation may be strengthened by including the words, 'progressive and terminal'.

We support the view of the Parliamentary Committee that a person who has been assessed as competent under the decision making framework should be the judge of whether they are experiencing the 'enduring and unbearable suffering'. Where a patient reports that they are meeting the definition of 'enduring and unbearable suffering', they should be offered psychological support.

Making a request

Parliamentary Committee recommendation:

- **The request must come from the person themselves.**
- **The request must be voluntary and free of coercion.**
- **The request cannot be made in an advance care directive.**
- **The request must be enduring.**
- **The person must be able to withdraw the request at any time.**

Questions to consider:

- What safeguards are necessary to ensure that a request is voluntary?

The ANMF (Vic Branch) supports the Parliamentary Committee recommended that once the person has made a request that the request be enduring. This is demonstrated by the person making the request **three times**.

1. There must be an initial verbal request,
2. A formal written request signed by two independent witnesses, and
3. A final verbal request.

The initial verbal request should be made within the context of the therapeutic doctor/patient relationship and be free from coercion.

The ANMF (Vic Branch) supports the above principles as the foundation for the Bill.

The ANMF (Vic Branch) supports the Parliamentary Committee's proposed safeguard to limit who may witness the formal written request. The ANMF believes that a family member may fulfil the

role of an independent witness (one of the two only) and sign the formal written request as long as that witness is not a Power of Attorney, a named beneficiary of the Will or the superannuation binding death nominee. No witness should benefit from the death of the person.

A legal representative should be considered as an independent witness.

- How should this be assessed?

The ANMF (Vic Branch) supports a model where a validation of the Request is assessed and confirmed by the Assisted Dying Review Board (page 21 of discussion paper). The steps in the request must be validated and finalized prior to any prescription and supply of medication to end life is supplied.

- Should there be a prescribed time period that must pass between the first and final request and, if so, what period?

The ANMF (Vic Branch) supports a model where there is objective testing by the medical practitioner that includes the possibility of it being conducted over a number of days, rather than weeks. We consider it would take at least a week to arrange and conduct such testing.

- Should there be specific offences for those who fail to comply with the requirements in the Act or are the offences of homicide or aiding or abetting suicide appropriate and sufficient?

The current offences of homicide or aiding or abetting suicide are likely to remain appropriate and sufficient should a person be found guilty of such an offence.

Properly informed

Parliamentary Committee recommendation:

A person must be properly informed. The primary and secondary doctor must each properly inform the person:

- **of the diagnosis and prognosis of their condition, as well as the treatment options available to them, including any therapeutic options and their likely results;**
- **of palliative care and its likely results;**
- **that they are under no obligation to continue with a request for assisted dying and may rescind their request at any time; and**
- **of the probable result and potential risks of taking the lethal drug.**

Questions to consider:

- Should the legislation include prescribed information that a medical practitioner must provide to a person requesting voluntary assisted dying and, if so, is the list recommended by the Parliamentary Committee in the box above sufficient?
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The ANMF (Vic Branch) supports the above principles as the foundation for the Bill.

ANMF (Vic Branch) supports that the legislation includes prescribed information that the medical practitioner is obliged to provide to a person requesting voluntary assisted dying. The Parliamentary Committee's recommendation should include that the medical practitioner is required to provide information that:

* **Relates to the diagnosis and prognosis of the condition of the person requesting voluntary assisted dying, as well as an explanation of their treatment options, including any therapeutic options and their likely results;**
* **Informs of palliative care and its likely results;**
* **They are under no obligation to continue with a request for assisted dying and may rescind their request at any time; and**
* **Informs of the result and potential risks (if any) of taking the lethal drug.**

The ANMF (Vic Branch) considers the above recommended list is satisfactory for the medical practitioner to advise the person making the request of their options.

However, given the 24/7 role of nurses in end of life care, the legislation must also protect nurses who provide information and education to patients and their families relating to diagnosis, prognosis and palliative care outcomes and potential risks (if any) of taking a lethal dose of a drug.

- What resources should be developed to support legislative obligations to provide information that would be useful in practice?

Seeking and gaining informed consent from the person is an important safeguard process because it ensures that the person requesting voluntary assisted dying has capacity, is acting voluntarily and that they understand the nature and effect of the decision they are making.

Medical practitioners are already required by law to obtain informed consent before administrating medical treatment. There are well-established requirements for ensuring that patients are giving informed consent, and medical practitioners must provide information on:

- the diagnosis
- the recommended treatment
- the material risks associated with the recommended treatment, other treatment options, not providing treatment

A medical practitioner already has a duty of care to provide appropriate information to their patients. Consistent with existing medical practice, informed consent would be required for voluntary assisted dying. The Parliamentary Committee's recommendation about what constitutes being 'properly informed' applies the key elements of existing informed consent requirements specifically to voluntary assisted dying.

The ANMF (Vic Branch) believes that additional resources should be developed to support the practical application of the legislation. These include:

- Face to Face education and associated materials for health practitioners,
- Inclusion of topic content in relevant undergraduate and post graduate education
- Frequently asked questions documents tailored for patients and families
- Pamphlets on the topic for consumers and the public
- Digital based websites and information through specific government portals
- Community education/campaigns/advertising that should be provided in formats that meet the needs of all individuals, including plain English and through appropriately accredited translators, available in a range of other languages relevant to the population, including Auslan interpreters.

- Who should undertake the assessments and provide information?

In the first instance the assessment and information must be provided by the consulting medical practitioner/s. It is the medical practitioner who is empowering a person to make a decision to end their own life. It is the medical practitioner that already has a duty of care to provide appropriate information to their patients. Therefore, it is logical to maintain consistency with existing medical practice, with informed consent being the principle underpinning a decision about voluntary assisted dying.

The Parliamentary Committee's recommendation about what constitutes being 'properly informed' applies the key elements of existing informed consent requirements specifically to voluntary assisted dying.

The Parliamentary Committee propose more prescriptive requirements to recognise that voluntary assisted dying is a *new* clinical intervention that requires new standards and practices to be introduced. It will be important to balance prescriptive requirements set out in legislation with the need to provide flexibility to respond to information requests from individual patients. Any details in legislation about the provision of information will also need to take into account any unintended outcomes that may limit existing informed consent requirements, such as limiting a medical practitioner's discretion to appropriately tailor information to the needs of their patient.

The provision of information to patients about voluntary assisted dying should take into account the evidence about what type of information patients want and how they want to receive it. Research regarding the provision of information to patients by health practitioners shows that patients generally want more, and better, information about their health, their healthcare and treatment options than they actually receive.

The ANMF (Vic Branch) does not propose any additional requirement than that above. However, we acknowledge that in some situations specialist **Palliative Care Nurses and Palliative Care Nurse Practitioner/s** may want to provide information to the patient regarding end of life care and information and advice on the full range of palliative care medicines, therapies and methods to control symptoms as part of their 'normal' practice, rather than specific information on relation to

voluntary assisted dying. In this circumstance the ANMF (Vic Branch) supports the professional judgement of the individual clinician.

The legislation is specifically focused on voluntary assisted dying and in undertake the assessments and provide information it is our view that the medical practitioner who assesses and provides the patient with the relevant information regarding the stage the disease has reached and what is the expected prognosis.

The legislation also needs to recognise that palliative care nurses and nurse practitioners in palliative care will be required to provide information on the process of accessing voluntary assisted dying from time to time.

Confirming a request

Parliamentary Committee recommendation:

- **The primary and secondary doctors must be independently satisfied that the patient's request is enduring and that a reasonable amount of time has passed between the patient's initial request and the provision of the lethal drug.**
- **In making this judgement the primary and secondary doctors must have regard to the patient's particular condition and its likely trajectory.**
- **The primary and secondary doctors must also assess the reasonableness of the request. This is to ensure that the patient truly understands and appreciates the nature and consequences of the decision to request assisted dying, as well as the alternatives to assisted dying, and that the patient's request is not ambivalent.**
- **Each doctor must be properly qualified to make a professional diagnosis and prognosis regarding the patient's specific condition. Each doctor must also assess the eligibility criteria.**

Questions to consider:

- Should the legislation prescribe specialist expertise required for medical practitioners to participate in voluntary assisted dying?

The ANMF (Vic Branch) notes that other jurisdictions do not include prescriptive requirements about additional or advanced qualifications of medical practitioners to participate in voluntary assisted dying in legislation. The Parliamentary Committee's framework outlines that the requirement is that two medical practitioners perform the same tasks independently of each other.

The second independent review is designed to ensure the primary medical practitioner's diagnosis and prognosis are accurate, that all the necessary information has been provided, and that the person understands the nature and effect of their decision.

The ANMF (Vic Branch) supports the above principles as the foundation for the Bill.

The ANMF (Vic Branch) supports that Parliamentary Committee's emphasis that medical practitioners must have the appropriate skills, competence and training to participate in voluntary assisted dying and to provide appropriate treatment advice to people, as this will become a new specialist area of medical practice. In so doing, the medical practitioner must have access to the most current diagnostic evidence in order to make a feasible assessment.

We concur that treatment advice includes an understanding of the person's disease and potential treatments, and the effectiveness of other treatments, including **palliative care**. Nonetheless, we acknowledge that necessary qualifications and expertise to understand a person's condition and potential treatments will vary significantly depending on the person's condition.

- Should there be a requirement for a palliative care specialist referral or consultation?

The ANMF (Vic Branch) supports the Parliamentary Committee's recommendation that palliative care information be provided. We support having access to palliative care specialist services consultation however, do not believe that the referral and being seen by palliative care specialist is a prerequisite for being able to access the legislation.

Conscientious objections

Parliamentary Committee recommendation:

- **No doctor, other health practitioner or health service can be forced to participate in assisted dying.**

Questions to consider:

- How should conscientious objection to voluntary assisted dying operate?

The ANMF (Vic Branch) supports the above principles as the foundation for the Bill.

The ANMF (Vic Branch) considers that it should operate in a way that is transparent for the patient, with health services or individual employees openly disclosing if they have a conscientious objection to voluntary assisted dying, whist continuing to offer palliative care services where they have been established.

- Should health practitioners who conscientiously object be required to refer patients to other health practitioners?

Yes. The ANMF (Vic Branch) considers that the legislation ought to include some detail in a similar way to the Abortion Law Reform Act 2008 to refer to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection. Where there is no known service available to refer to, no individual or service is to be penalised.

- Should health practitioners who conscientiously object be required to declare their objection?

Ideally yes. However, for some nurses working in specialist palliative care services some nurses may see such a disclosure as a barrier to providing holistic care. In such circumstances, there must not be any repercussion for individuals that choose not to declare their individual object to a client in their care.

If yes, when should this occur?

It should be disclosed by the participating individual medical practitioner to the referring GP prior to the initial referral/consultation. In addition a public website may provide education and information to the community, along with a list of health facilities/services and/or medical practitioners who consciously object to providing the voluntary assisted dying service, but acknowledging that they provide palliative care services only.

Administering a lethal dose of medication

Parliamentary Committee recommendation:

A person should self-administer the lethal drug; the singular exception is where people are physically unable to take a lethal drug themselves. In this case, a doctor should be able to assist the person to die by administering the drug.

The ANMF (Vic Branch) supports the above principles as the foundation for the Bill

Questions to consider:

- Are additional safeguards required when a medical practitioner administers the lethal dose of medication and, if so, what safeguards would be appropriate?

The ANMF (Vic Branch) considered that no additional safeguards are required when a medical practitioner administers the lethal dose of medication as the checks and balances have already been adhered to.

- Where should a medical practitioner administer the lethal dose of medication, and what practical and other challenges would this create?

The most appropriate place to administer the lethal dose of medication is in the persons own home or place of residence or a hospital/hospice or a nursing home.

The ANMF (Vic Branch) acknowledges that the administration of the lethal dose of medication in a health service or nursing home is likely to create practical issues for these health services and/or

health practitioners employed within the hospital/hospice/nursing home. There needs to be a high degree of professional judgement about safety and efficacy in these circumstances. The needs of each person accessing assisted dying will be different, and it is not clear that prescriptive requirements in legislation would be appropriate.

Where a medical practitioner is to administer the lethal dose of medication within a health service, there would need to be a solid understanding and clear policy development in relation to the roles and functions of any other health practitioners who assist the medical practitioner in any way to administer a lethal dose. In the case of registered health practitioners any policy development must be consistent with regulatory requirements under the Health Practitioners Regulation National Law (2009).
There would also need to be after death considerations made by health services that support the practice, which are addressed in the section on "After a Person Has Died".

Monitoring the use of a lethal dose of medication

Question to consider:

- How can a prescribed lethal dose of medication be effectively monitored without placing undue burdens or pressure on people accessing or using the medication?

The ANMF (Vic Branch) supports the Parliamentary Committee's recommendation that an accountability system for tracking assisted dying be established, and note they do not specify how it should occur. We know that the medical practitioner is currently responsible for the careful and proper prescribing of medication and it follows that the person receiving the prescription should also take care to ensure it is securely stored. There are already some 300 million community prescriptions dispensed in Australia in 2015[1] and other household items that may cause death if they are ingested. People are generally able to responsibly manage the risk for safely storing their medicine and it is expected that they will also be able to do so, if they are prescribed a lethal dose of medication for the purpose of assisted dying.

The ANMF (Vic Branch) is supportive of a process similar to the model in place in the USA where a series of steps must be taken to ensure the lethal dose of medication is appropriately monitored, without placing an undue burden or pressure on people accessing or using the medication.

Specifically, in California, the medical practitioner must record the request and prescription in the person's medical record and must file a copy of the dispensing record for the medication with their Department of Health within 30 days. The person must complete a form within 48 hours prior to self-administering the lethal dose of medication. Either this form or the medication must be returned when the person dies. The medical practitioner must submit a follow-up form with the Department of Health within 30 days of the person ingesting the medication.

[1] Australian Government Department of Health. 2016. Pharmaceutical Benefits Scheme (PBS) - Australian Statistics on Medicines 2015 Available at: https://www.pbs.gov.au/info/statistics/asm/asm-2015 accessed 6.3.17

During the ANMF member consultation, two members expressed their concern about how tracking of assisted dying can be enforced. Further the question of the disposal of unused medication dispensed to end life was raised as an area that will require stringent safeguards to be established to protect nurses involved in end of life care and are not aware that a client has a prescription for a medication to hasten end of life.

Attendance

Questions to consider:

- Should a health practitioner be allowed to be present at the time the person self-administers the lethal dose of medication?

The ANMF (Vic Branch) believes a health practitioner can be present if requested by the patient.

The ANMF (Vic Branch) recognises that nurses are often present at end of life and for many people they would feel comforted if their health practitioner was present at the time they took the lethal dose of medication. This might be particularly so where there are no family or friends available to be with the person should they wish to be in the presence of other people. It is acknowledged that one of the greatest fears people experience is that of dying alone and we should ensure, where possible, where the person and the health practitioner are agreeable, this can occur. We understand that it may be beneficial to have a health practitioner present.

If so, what should their role and obligations be?

The role of having someone present is as a support person. The ANMF (Vic Branch) considers that nurses' roles should be limited to care of the person at the time of end of life; and provision of supportive care to the support people, loved ones and families of the person at EOL for emotional support. Organisations will need to ensure that they have clear policy in place to guide the health practitioners practice in this regard.

Lethal dose of medication not effective

Questions to consider:

- What should the obligations of a health practitioner be to treat a person who has chosen to ingest a lethal dose of medication?

The obligation of a health practitioner to treat a person who has chosen to ingest a lethal dose of medication should be to administer a suitable anti-emetic and to support the person to ensure comfort at the time of death.

Our experience is currently limited to people overdosing on their stockpiled medicine in large quantities that may cause the person to vomit and require treatment. We understand the legal lethal dose will only be required in a small dose, of approximately 30 mls and not in a large quantity, thus the dose is likely to be effective at its onset, and should be administered following the ingestion of an antiemetic preparation.

We refer the Panel to review the Switzerland experience in relation to this point.

The ANMF (Vic Branch) is of the view, that given the person's clear intention to end their life with the lethal dose of medication, it would seem incongruent with the legislation's intent for the health practitioners to have to initiate or to provide life-sustaining treatment after the person has ingested the lethal dose of their prescribed medicine. Therefore, we recommend that the legislation clearly set out, any obligation considered necessary on the health practitioner, inclusive of any requirement to offer palliative care or obligation to treat a person who has chosen to ingest a lethal dose of medication. Some palliative care nurses may object to be present or attend to a client where a client has not been successful in ending their life following the ingestion of a lethal dose of a prescribed VAD medication.

- What is the best way to indicate that a person has chosen to take a lethal dose of medication?

The best way to indicate that a person has chosen to take a lethal dose of medication is for the health practitioner to be aware prior to the person taking the lethal dose. The ANMF (Vic Branch) advocates that ideally the person ought to disclose to the health/medical practitioner, their likelihood of self-administering the lethal dose within a forthcoming time period [approximate timeline of likelihood of up to 48 hours, similar to the Californian approach]; and that if the exact date is not known to the person, they be required to leave a copy of their formal written announcement of their request [provided to them in the form of an alert to the health/medical practitioner i.e. a letter or a visual sign] with their body, and for the responsible person involved in the after death procedure. This is a role for the prescribing medical practitioner to discuss with their patient.

After a person has died

Questions to consider:

- What safeguards are necessary to determine whether or not the person has ingested the lethal dose of medication and to destroy the medication if it has not been ingested?

The Parliamentary Committee did not make recommendations about what should occur after a person who has been prescribed the lethal dose of medication has died. Hence, the ANMF (Vic Branch) reiterates our previous comment in this regard:

> *that ideally the person ought to disclose to the health practitioner, their likelihood of self-administering the lethal dose within a forthcoming time period [approximate timeline of likelihood of up to 48 hours, similar to the Californian approach]; and that if the exact date is not known to the person, they be required to do something as simple as leave a* ***written proclamation of the fact [provided to them in the form of an alert to the health practitioner i.e. a letter or a sign] with their body,*** *and for the responsible person involved in the after death procedure.*

If the lethal dose of medication has not been ingested, it will need to be destroyed. The ANMF (Vic Branch) recommends the legislation must outline the obligation, including who has the obligation, to ensure the any unused lethal dose medication is destroyed to avoid any confusion in this regard or

to reduce the risk of lethal dose medicine finding its way into the broader community. It is our recommendation that any obligation rest with the prescribing medical practitioner.

- What should be recorded as the cause of death for a person who has ingested the lethal dose of medication?

This question arose during the public consultation sessions and it was suggested by those medical practitioners present that the cause of death for a person who has ingested the lethal dose of medication would be known and recorded on the death certificate as heart failure. The ANMF (Vic Branch) considers that this is ultimately a matter for the medical practitioner that is completing the death certificate.

- Should death as a result of voluntary assisted dying be a reportable death?

No. The ANMF (Vic Branch) does not consider that voluntary assisted dying should be a reportable death, in usual and planned circumstances.

We see no reason for the Coroner to investigate these deaths, as they will be reviewed by the establishment of the Assisted Dying Review Board, unless the Review Board considers such an investigation is warranted.

Oversight

Parliamentary Committee recommendation:
That an Assisted Dying Review Board be established to review each approved request for assisted dying. Membership of the Assisted Dying Review Board should include:

- **a representative of End of Life Care Victoria**
- **a doctor**
- **a nurse**
- **a legal professional**
- **a community member.**

The function of the Board will not be to approve or reject requests from patients to access assisted dying. That is the role of the primary doctor and independent secondary doctor in each case. Neither will the Board hear appeals from people whose requests to access assisted dying have been rejected.

The purpose of the Board is to ensure that doctors are complying with requirements of the assisted dying framework.

If the Board finds a breach of the assisted dying framework, it should forward its report to the appropriate authority. Depending on the nature of the breach, this may be Victoria Police, the Coroner or the Australian Health Practitioner Regulation Agency. Those bodies will then determine whether to investigate the case further.

The Board should report to Parliament on the operation of the assisted dying framework, including any trends it identifies and recommendations for improvement. For the purposes of increased transparency and accountability, during the first two years of operation these reports should be every six months. Following that the Board should report annually.

Questions to consider:

- What information should a medical practitioner be required to report to an oversight body such as the Assisted Dying Review Board?
- At what stage should medical practitioners or pharmacists be required to report to the Assisted Dying Review Board?
- When should an oversight body be required to refer a matter to another agency?
- Should an oversight body have any investigatory powers, or should this be conducted by other agencies?
- Should a stand-alone review board be established? What are the alternatives? For example, would it fit within the investigative role of the Coroner's Court or the quality and safety mandate of a consultative council?

The ANMF (Vic Branch) supports the establishment of an assisted dying standalone review board to:

1. Oversee the implementation of the legislation.
2. Receive reports from medical practitioners on the circumstances of the request and the outcome those requests.
3. Collect data on the diagnoses of people requesting access to the legislation.
4. Monitor the medication management processes, for example the disposal of unused prescribed medicine.
5. Monitor the process that supports health practitioners that have conscientious objections as well as patients being able to access alternative service/medical practitioner in circumstances when refused assistance. The oversight body should refer to other established agencies, like the Australian Health Practitioner Regulation Agency for example where matters require investigation, rather than having investigatory powers in its own right.

Additional safeguards

Questions to consider:

- Does the Parliamentary Committee's framework provide sufficient protection to vulnerable people?

The ANMF (Vic Branch) supports the Parliamentary Committee's recommended process for accessing voluntary assisted dying to include key requirements to protect vulnerable people and ensure that their request is voluntary. We note that the Parliamentary Committee's recommendation does this by setting out requirements to ensure only those who fully understand their diagnosis and prognosis, and nature and consequences of accessing voluntary assisted dying, will be prescribed a lethal dose of medication. The ANMF (Vic Branch) supports the safeguard that is

in place that stipulates that *where there is any doubt about a person's ability to make the decision, they will need to be referred to a psychiatrist* for a psychological assessment.

Moreover, the independent medical review and involvement of other independent witnesses will also ensure that any coercion or undue influence will be identified. The important fact here is the requirement that a person must make three requests, along with the inclusion of multiple points of review, which are all intended to ensure that a person is making a well-informed and considered decision/s, and is not requesting access to voluntary assisted dying at a point in time when they may be feeling particularly vulnerable or despairing. For these reasons we consider **the framework provides sufficient protection to vulnerable people,** as the process to make a request is robust.

Liability and insurance

Questions to consider:

- What protections would be necessary for health practitioners who act in accordance with the new legislation in good faith and without negligence?

The ANMF (Vic Branch) supports the new legislation clearly stating that a **medical practitioner** will face no criminal or civil liability for providing treatment that causes death if they have acted in accordance with the requirements in the legislation.

The ANMF (Vic Branch) also considers that it is critical that nurses working in end of life care services with medical practitioners who provide the assisted dying service are protected by the legislation.

- How should insurance and other annuities of people who access voluntary assisted dying be protected?

The ANMF (Vic Branch) believes that the insurance and other annuities of people who access voluntary assisted dying be protected and that they are not disadvantaged in accessing any entitlement they may have under any pre-existing insurance policy/arrangement they may own and this must be set out in the legislation.

Conclusion

The ANMF (Vic Branch) welcomes the opportunity to provide this submission to the Parliamentary Committee – Ministerial Advisory Panel, discussion paper into Voluntary Assisted Dying.

The ANMF (Vic Branch) considers the discussion paper articulates the intent of the Bill to enable a legal framework where Victorian adults with decision making capacity, who have an incurable condition and are experiencing intolerable suffering and are at the end of their life, to be provided with assistance to end their life in defined circumstances.

Our members continue to support people having access to high quality palliative care, the right to consent and refuse medical treatments through advance care directives and, in limited circumstances, the option of voluntary assisted dying for those with a terminal illness who are dealing with unbearable suffering.

We remain supportive of the work our members do that are employed in health services that provide palliative care and advanced care planning and emphasize our commitment to ensuring these services remain front and centre of Victorian health care provision and continue to strive for appropriate funding to ensure the continuation and growth of these services in order to provide case management and care provision to all people at end of life, whether they seek a voluntary assisted death or not.