DOES THE *VOLUNTARY ASSISTED DYING ACT 2017* (VIC) REFLECT ITS STATED POLICY GOALS?

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With the commencement of the Voluntary Assisted Dying Act 2017 (Vic) in June 2019, Victoria became the first Australian State to permit voluntary assisted dying. This article considers the extent to which this novel Act reflects its stated policy goals. The first part of the article identifies the purported policy goals of the Act. This analysis draws on the explanatory material accompanying the law, in particular the expert Ministerial Advisory Panel Report which shaped the law. The article then critically evaluates the extent to which key aspects of the Act reflect those identified policy goals. Overall, the article concludes that the Voluntary Assisted Dying Act 2017 (Vic) is not consistent with its policy goals in some important respects.

I INTRODUCTION

When the *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act*') commenced in June 2019, Victoria became the first Australian jurisdiction in over 20 years to have an operative voluntary assisted dying ('VAD') system. It joins just a small number of jurisdictions in a handful of countries internationally that permit VAD.[1] One reason such

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1 Currently, nine states in the United States of America, the federal government in Canada, and one Canadian province have passed laws regulating VAD: *Death with Dignity Act*, Or Rev Stat §§ 127.800–127.995 (1994) (Oregon); *Death with Dignity Act*, Wash Rev Code §§ 70.245.010–70.245.903 (2008) (Washington); *Patient Choice and Control at End of Life Act*, Vt Stat Ann §§ 5281–93 (2013) (Vermont); *End of Life Option Act*, Cal Health and Safety Code §§ 443–443.22 (2015) (California); *Death with Dignity Act of 2016*, DC Code §§ 7–661 (2017) (District of Columbia); *End-of-Life Options Act*, Colo Rev Stat §§ 25-48-101–25-48-123 (2017)

laws are rare is that reform in this area is very difficult. VAD is seen by many as politically risky[2] and so in Australia there has been a long history of unsuccessful attempts to reform the law.[3]

The political challenges involved in VAD reform are evident in the *VAD Act* and the process leading to its enactment in three ways. The first is the staged and very consultative process adopted to facilitate reform. This began with a parliamentary committee of inquiry, which received extensive evidence[4] and numerous submissions from a large number of individuals and organisations.[5] In its report, the parliamentary committee recommended the enactment of legislation permitting VAD in certain circumstances.[6] The Victorian Government then adopted this recommendation and appointed a multidisciplinary Ministerial Advisory Panel ('the Panel'), whose role was to advise on the form of the legislation, taking into consideration a range of policy, clinical and legal issues.[7] The Panel also followed a consultative process, receiving

(Colorado); *Our Care, Our Choice Act 2018*, Hawaii Rev Stat §§ 327-1–327-25 (2018) (Hawaii); *Medical Aid in Dying for the Terminally Ill Act*, NJ Stat Ann §§ 26:16-1–26:16-20 (2019) (New Jersey); *An Act to Enact the Maine Death with Dignity Act,* 22 Me Rev Stat Ann § 2140 (2019) (Maine), note this Act commenced in September 2019; *Criminal Code of Canada,* RSC 1985, c C-46, ss 241.1-241.4 (Canada); *An Act Respecting End-of-Life Care,* RSQ 2014, c S-32.0001 (Quebec). It is also legal in Montana by virtue of the court ruling in *Baxter v Montana* 224 P 3d 1211 (Mont, 2009), but no legislation has been passed in that State. Parts of Europe have legalised VAD through legislation: *Wet Toetsing Levensbeëindiging op Verzoek en Hulp Bij Zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001] (The Netherlands); *Loi Relative à L'euthanasie* [Act on Euthanasia 2002] (Belgium) and *Legislation Reglementant Les Soins Palliatifs Ainsi Que L'euthanasie Et L'assistance Au Suicide 2009* [Legislation Regulating Palliative Care and Euthanasia and Assisted Suicide 2009] (Luxembourg). Assisting a person's suicide is also lawful under certain circumstances in Switzerland (discussed in Samia A Hurst and Alex Mauron, 'Assisted Suicide in Switzerland: Clarifying Liberties and Claims' (2017) 31(3) *Bioethics* 199, 199) and Germany (see recent decision of the second Senate of the Federal Constitutional Court, Zum Urteil des Zweiten Senats vom 26 February 2020, Bundesverfassungsgericht), but there is no legislation regulating its provision in these countries. Finally, a court decision in Colombia permitted VAD in 1997: Constitutional Court of the Republic of Colombia, Sentence C-239/97, Ref Expedient D-1490, 20 May 1997), which was followed by Government regulations to facilitate the practice in 2015: *Protocolo Para La Aplicación Del Procedimiento De Eutanasia En Colombia*: Government of Colombia, *Protocol for the Application of the Procedure of Euthanasia in Colombia* (Report, 2015) <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/Protocolo-aplicacion-procedimiento-eutanasia-colombia.pdf>. For more information on these jurisdictions, see Lindy Willmott and Ben White, 'Assisted Dying in Australia: A Values-Based Model for Reform' in Ian Freckelton and Kerry Anne Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 484–8.

2 Margaret Otlowski, 'Another Voluntary Euthanasia Bill Bites the Dust', *The Conversation* (online, 19 November 2013) <https://theconversation.com/another-voluntary-euthanasia-bill-bites-the-dust-19442>; Ben White and Lindy Willmott, 'Victoria May Soon Have Assisted Dying Laws for Terminally Ill Patients', *The Conversation* (online, 21 July 2017) <https://theconversation.com/victoria-may-soon-have-assisted-dying-laws-for-terminally-ill-patients-81401>; Giles Scofield, writing in the American context, goes so far as to say that 'promoting assisted suicide is politically suicidal': Giles Scofield, 'Privacy (or Liberty) and Assisted Suicide' (1991) 6(5) *Journal of Pain and Symptom Management* 280, 286.

3 For a detailed discussion of the history of attempts at law reform in Australia, see Lindy Willmott et al, '(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics' (2016) 39(1) *University of New South Wales Law Journal* 1. See also updated data in Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42 *Australian Health Review* 616.

4 The Committee conducted an extensive program of site visits and public hearings around Victoria over an eight-month period between July 2015 and February 2016. It held 17 days of public hearings and heard from 154 witnesses: Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, 9 June 2016) xix ('*Parliamentary Report*').

5 The Committee received 1037 submissions; 925 from individuals in a private capacity and 112 from organisations: ibid.

6 Ibid xxxv.

7 See Margaret M O'Connor et al, 'Documenting the Process of Developing the Victorian Voluntary Assisted Dying Legislation' (2018) 42(6) *Australian Health Review* 621, 623.

written submissions,[8] and conducting 14 consultation forums across Victoria[9] to receive views as to practical ways to 'implement a compassionate, safe and practical framework' for VAD.[10] The Panel's detailed report (the '*Report*') recommended the system and processes which were ultimately largely enacted in the *VAD Act*.

A second way in which the political challenges of VAD law reform are reflected is in the design of the *VAD Act*. It is narrow in scope in terms of eligibility, with access to VAD only for competent adult residents of Victoria with an incurable disease, illness or medical condition that is advanced, progressive and will cause death within six months (or twelve months for neurodegenerative conditions).[11] That condition must also be causing suffering that cannot be relieved in a manner that the person considers tolerable.[12] Generally, the *VAD Act* only permits a person to take the lethal medication themselves (often called physician-assisted suicide).[13] An exception allowing voluntary euthanasia (a medical practitioner administering the medication) arises only if a person cannot physically take or digest that medication themselves.[14]

The *VAD Act* also contains a large number of safeguards. When first introduced into Parliament, its 68 safeguards[15] led the Victorian Government to describe the Act as the 'safest, and most conservative model in the world'.[16] These safeguards include: the need for repeated requests by a person for VAD; ensuring requests are voluntary and made without coercion; assessment and confirmation that a person meets the eligibility criteria; medication management; and prescribing a designated process to access VAD. The *VAD Act* also contains mandatory reporting to an independent statutory authority throughout the process, and numerous offence provisions intended to ensure strict compliance with the legislation. The design of the Act, with its narrow scope and extensive safeguards, was intentionally crafted to attract the political support needed for it to pass both houses of the Victorian Parliament.

The third impact of the political challenges of VAD reform is inconsistency between the policy objectives of the Act and some of its provisions. Politics often requires compromise[17] and when this occurs in an ad hoc way, the overall scheme and objectives

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8 One hundred and seventy-six written submissions were received, although some only expressed a view in support of or opposing assisted dying, and did not address the substantive content of the law: Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 21 July 2017) 36 ('*Report*').

9 Five of these forums were held in regional Victoria. Approximately 300 people attended the forums. The Panel noted 'each forum provided stakeholders with an opportunity to discuss, with members of the Panel, the key areas of the eligibility criteria, the voluntary assisted dying request process, and the oversight and safeguards required to implement a compassionate, safe and practical framework': ibid 37.

10 Ibid. The quality of the law reform process leading to the *VAD Act* has been commended by some commentators: Matthew Lesh, *Evidence Based Policy Research Project: 20 Case Studies* (Institute of Public Affairs, October 2018) 60–1.

11 *Voluntary Assisted Dying Act 2017* (Vic) s 9 ('*VAD Act*'). The eligibility criteria are discussed further below.

12 Ibid s 9(1)(d)(iv).

13 Ibid ss 45, 47.

14 Ibid s 48(3)(a).

15 For a complete list of these safeguards, see *Report* (n 8) 221–8. Some of these safeguards relate to the eligibility criteria described above.

16 Daniel Andrews, 'Voluntary Assisted Dying Model Established Ahead of Vote in Parliament' (Media Release, 25 July 2017).

17 Baldwin, Cave and Lodge describe the conflicting interest groups and pressure that legislators are subject to: Robert Baldwin, Martin Cave and Martin Lodge, *Understanding Regulation: Theory, Strategy, and Practice* (Oxford University Press, 2nd ed, 2012) 42–6.

of an Act can be distorted. The final legislation that ultimately passes through Parliament may no longer completely align with the overall intended policy goals. An example of this, considered later in the article, is amendments to the *VAD Act* that occurred in Victoria's Upper House, the Legislative Council, during its review of the Voluntary Assisted Dying Bill 2017 (Vic) ('VAD Bill').

This article focuses on the third potential consequence of these political challenges. It aims to address the question: does the *VAD Act* reflect its stated policy goals? It is important to distinguish this inquiry from the question of whether or not VAD legislation, and this particular *VAD Act*, are 'good' or appropriate reforms. There are a range of views on whether VAD should be permitted[18] and, if so, whether the Victorian VAD system is a good one.[19] These arguments for and against VAD are outside the scope of this article. Instead, it considers a proposition that all would endorse: that legislation should reflect and advance the policy objectives that it was designed to address. This goes to the effectiveness of that legislation in guiding behaviour as intended. Whether or not it is effective in doing this, in turn, has implications for societal acceptance of that legislation or what some call its 'regulatory legitimacy'.[20]

To undertake this exercise, this article is comprised of two substantive parts. It first determines the purported policy goals of the *VAD Act*. This is done through analysing the explanatory material accompanying the *VAD Act*, in particular the Report and the second reading debate. Secondly, it evaluates whether the key aspects of the *VAD Act* reflect those identified policy goals. Overall, the article concludes that the *VAD Act* is not consistent with its policy goals in some important respects.

Before undertaking this analysis, issues of terminology and some limitations of this analysis will be addressed. In relation to terminology, VAD is the term used in the *VAD Act* and is a global concept describing the two main practices in this area: voluntary euthanasia and physician-assisted suicide. As noted above, the former involves the medical practitioner administering a lethal medication and in the *VAD Act* is referred to as 'practitioner administration'. By contrast, the latter involves the medical practitioner providing a person with the medication which they then take themselves and is labelled 'self-administration' by the *VAD Act*. It is also acknowledged that this analysis is in

18 Those who oppose VAD reform include Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (McGill-Queen's University Press, 2nd ed, 2014); Ian Hayes, 'Ethical Challenges about Voluntary Assisted Dying' (2018) 39(3) *Australasian Science* 49; Jeremy Prichard, 'Euthanasia: A Reply to Bartels and Otlowski' (2012) 19(3) *Journal of Law and Medicine* 610; Brian H Le and Jennifer Philip, 'Voluntary Assisted Dying: Time to Consider the Details' (2018) 209(6) *Medical Journal of Australia* 279. Those who support VAD reform include Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17(4) *Journal of Law and Medicine* 532*;* Margaret Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press, 1997); Nicholas Cowdery, 'A Dignified Ending' (2017) 33 *LSJ* 28; Nicholas Cowdery, 'Will We Legalise Euthanasia?' (2017) 34 *LSJ* 26; Willmott and White (n 1).

19 For some early and contrasting discussions of the *VAD Act*, see, eg, Danuta Mendelson, 'Voluntary Assisted Dying Legislation in Victoria: What Can We Learn from the Netherlands Experience?' (2017) 25(1) *Journal of Law and Medicine* 30; Ben P White, Lindy Willmott and Eliana Close, 'Victoria's Voluntary Assisted Dying Law: Clinical Implementation as the Next Challenge' (2019) 210(5) *Medical Journal of Australia* 207; Bernadette Richards and John Coggon, 'Assisted Dying in Australia and Limiting Court Involvement in Withdrawal of Nutrition and Hydration' (2018) 15(1) *Bioethical Inquiry* 15.

20 Regulatory legitimacy is a contested concept, but Yeung reduces it to two broad aspects: whether a regime achieves its stated goals effectively, and whether it conforms with principles of good governance: see Karen Yeung, 'Regulating Assisted Dying' (2012) 23(2) *King's Law Journal* 163, 164–5. This approach draws on Yeung's earlier work: Karen Yeung, *Securing Compliance: A Principled Approach* (Hart Publishing, 2004) 30–6. This article focuses on the first of these objectives: whether the regulation achieves its stated policy goals in an effective manner.

relation to the legislation itself rather than how it might be implemented in practice. Although the *VAD Act* is supported by a suite of resources such as clinical guidance documents, models of care guidelines, medication protocols and training for medical practitioners,[21] this article is being written as the *VAD Act* commences so is focused on the legislation itself rather than the way it is implemented. The effectiveness of implementation will be important research to undertake in the future, but for present purposes, this analysis focuses on the legislation.

II WHAT ARE THE *VAD ACT*'S POLICY GOALS?

Section 1 of the *VAD Act* sets out its main purposes, which are (in summary):

a) to regulate access to VAD;
b) to establish the VAD Review Board; and
c) to make consequential amendments to other legislation.

These purposes are very broad and provide little insight into how the Act is intended to function. Instead, it is the more concrete policy goals of the Government that determine the nature of the VAD system the Act creates. In this section, those policy goals are discerned from two main (and related) sources. The first source is the Report. As described above, the *VAD Act* was developed through a staged, public process,[22] and its policy goals were explicitly set out in a manner which is unusual when developing legislation. The Panel identified nine 'guiding principles' which 'helped guide … its deliberations'.[23] These principles reflect the intended policy goals and assisted the Panel to design the legislative framework. The Panel also recommended that these principles be included in the Act to 'help guide interpretation'.[24] This was done and so the second source for discerning the policy goals of the *VAD Act* is the list of principles stated in the legislation. The Report's nine guiding principles became 10 in the Act and section 5 requires a person exercising a power or performing a function or duty under the Act to have regard to those principles. As discussed below, the *VAD Act's* principles largely reflect those set out in the Report.

Before turning to these principles, and analysing how they assist in discerning the key policy goals underpinning the *VAD Act*, an observation is made about a phrase that was frequently used in the Report which provides important context for considering the principles and policy goals in this section. A stated overarching goal in the development of the *VAD Act* was to design a legislative framework that is 'safe and compassionate'.

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21 Department of Health and Human Services, State Government of Victoria, *Voluntary Assisted Dying* (Web Page, 2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying>.

22 See also the description of the process by the members of the Panel itself: O'Connor et al (n 7) 621–6. The Panel's contribution to policy formulation is described in Stephen Duckett, 'The Long and Winding Road to Assisted Dying in Australia' (2019) *Australian Journal of Social Issues* 1, and see also Lesh (n 10) 60–1. For criticism of this process, in particular of the *Parliamentary Report* (n 4) (although it is not the focus of this article), see John Keown, '"Voluntary Assisted Dying" in Australia: The Victorian Parliamentary Committee's Tenuous Case for Legalization' (2018) 33(1) *Issues in Law and Medicine* 55.

23 *Report* (n 8) 43–6.

24 Ibid 46. These guiding principles were also referred to in the second reading speech of Health Minister Jill Hennessy: Victoria, *Parliamentary Debates,* Legislative Assembly, 21 September 2017, 2944 (Jill Hennessy).

This phrase, derived from the Panel's terms of reference,[25] was used repeatedly throughout the Report.[26] 'Compassion', as used in the Report, refers to understanding, sympathy, care and concern for individuals at the end of their lives[27] who are suffering and wish to reduce that suffering.[28] The term 'safe' was most commonly employed to refer to community safety, for example in relation to the careful handling of the VAD medication,[29] or in relation to the system as a whole, encompassing a range of safeguards and oversight mechanisms.[30] Interestingly, it was only infrequently used to refer to the safety of the individual potentially receiving assistance to die, for example in ensuring there was no abuse or coercion,[31] and that a request for VAD was voluntary and properly informed.[32]

The catchphrase 'safe and compassionate' may be seen as a shorthand way to reflect some of the principles underlying the *VAD Act*: namely, compassionate respect for the autonomous choices of suffering individuals at the end of their lives, and the need to ensure the safety of the community. The need to balance these considerations is outlined in the statement of the Panel's Chair, Professor Brian Owler, in presenting the Report:

> The framework focuses on the eligible person who expresses their enduring wish to end their own suffering through access to voluntary assisted dying. It respects their personal autonomy and choice. That autonomy must of course be balanced against the safety of the community. We seek to provide a compassionate outcome for those people who are at the end of their life, while also addressing the concerns of the community.[33]

A Ten Principles

As noted above, although section 1 of the *VAD Act* contains express statements about its wider purposes, it is the 10 principles in section 5[34] that provide concrete insight into the policy goals underpinning the system. These principles are:

- valuing every human life equally;[35]
- respecting autonomy;[36]
- supporting informed decision making;[37]

25 The terms of reference tasked the Panel with proposing a 'compassionate and safe legislative framework for voluntary assisted dying': *Report* (n 8) 5.

26 This phrase was used 13 times throughout: *Report* (n 8) 1, 2, 10, 11, 12 (two mentions), 21, 36, 47, 48, 188, 200 and 211. There are also four references to the inverse phrase 'compassionate and safe': *Report* (n 8) 5 (two mentions), 33 and 36. This phrase was also used four times in the second reading speech: Victoria, *Parliamentary Debates* (n 24) 2943, 2947, 2950, 2955 (Jill Hennessy). The notion of balancing compassion for the preferences of those who are suffering at the end of life with safeguards for the community was also discussed twice, using the terms 'compassion' and 'safeguards' without using the composite phrase 'safe and compassionate': Victoria, *Parliamentary Debates* (n 24) 2944, 2949 (Jill Hennessy).

27 See *Report* (n 8) 1, 13; Victoria, *Parliamentary Debates* (n 24) 2949 (Jill Hennessy).

28 See *Report* (n 8) 77, 79; 154; Victoria, *Parliamentary Debates* (n 24) 2944 (Jill Hennessy). There is also a single instance where 'compassion' is used to denote sensitivity to the needs of the family in undertaking monitoring to ensure compliance with the legislative requirements after a person's death by means of VAD: *Report* (n 8) 149.

29 Panel Recommendations 31–33 (concerning safe handling of medication): *Report* (n 8) 1, 6, 17, 26, 45, 129, 131, 135–6, 156–7, 170–1, 213.

30 For example, ibid 11, 12, 20, 21, 47, 148, 154.

31 For example, ibid 10, 18.

32 Ibid 15, 45.

33 Ibid 1.

34 See also Victoria, *Parliamentary Debates* (n 24) 2943–4 (Jill Hennessy).

35 *VAD Act* s 5(1)(a).

36 Ibid s 5(1)(b).

37 Ibid s 5(1)(c), including providing information about medical treatment options and palliative care.

- providing quality care that minimises suffering and maximises quality of life;[38]
- supporting therapeutic relationships;[39]
- encouraging open discussions about dying, death and people's preferences;[40]
- supporting conversations with health practitioners and family about treatment and care preferences;[41]
- promoting genuine choices;[42]
- protecting individuals from abuse;[43] and
- respecting diversity of beliefs and values, including among health practitioners.[44]

These principles directly correspond to the nine guiding principles outlined by the Panel to underpin its recommendations.[45]

In addition to identifying these guiding principles, the Panel noted that the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('Charter') also informed its deliberations. Indeed, members of the Panel noted that the guiding principles were drawn from the Charter.[46] Seven human rights were specifically listed as being significant, including the right to equality, the right to privacy (which includes the right to personal autonomy and dignity) and the right to life.[47] The Minister's second reading speech on the introduction of the VAD Bill also contains a detailed statement of compatibility with these Charter rights.[48] She noted that the Panel 'used the [C]harter as a framework' for considering how best to respect the rights of all Victorians, and for formulating the VAD model, including the guiding principles.[49]

B Six Core Policy Goals

For the purposes of our analysis, the principles listed above can be grouped into six broader policy goals (or some may call them values).[50] Our distillation of how the 10 principles support the six policy goals that underpin the VAD legislation is represented in Table 1 (recognising of course that there are necessarily overlaps across categories).

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38 Ibid s 5(1)(d).
39 Ibid s 5(1)(e).
40 Ibid s 5(1)(f).
41 Ibid s 5(1)(g).
42 Ibid s 5(1)(h).
43 Ibid s 5(1)(i).
44 Ibid s 5(1)(j).
45 These principles are elaborated on in more detail: *Report* (n 8) 43–6. There are 10 principles in the legislation, rather than nine, because the legislative drafters chose to split the eighth principle in two. The Report stated: 'providing people with genuine choice must be balanced with the need to safeguard people who might be subject to abuse': *Report* (n 8) 11. By contrast, the *VAD Act* separates this into two distinct concepts – 'individuals are entitled to genuine choices regarding their treatment and care' and 'there is a need to protect individuals who may be subject to abuse' – and does not expressly refer to balancing: *VAD Act* ss 5(1)(h), (i).
46 O'Connor et al (n 7) 625.
47 The seven human rights listed were the rights to equality; life; protection from torture and cruel, inhuman or degrading treatment; privacy and reputation; freedom of thought, conscience, religion and belief; protection of the best interests of the child; and liberty and security of person: *Report* (n 8) 43 and Appendix 2.
48 Victoria, *Parliamentary Debates* (n 24) 2943–9 (Jill Hennessy).
49 Ibid 2943 (Jill Hennessy).
50 For a more detailed discussion of the values underpinning the law that are relevant in the context of VAD, see Willmott and White (n 1) 479–510.

Table 1: Six Policy Goals Derived from 10 Principles

Six policy goals	Relevant principles
1. To respect all human life	• Valuing every human life equally
2. To respect personal autonomy	• Respecting autonomy • Supporting informed decision making • Promoting genuine choices • Encouraging open discussions about dying, death and people's preferences • Supporting conversations with health practitioners and family about treatment and care preferences
3. To safeguard the vulnerable and the community	• Protecting individuals from abuse
4. To provide high-quality care	• Providing quality care that minimises suffering and maximises quality of life • Supporting therapeutic relationships • Encouraging open discussions about dying, death and people's preferences • Supporting conversations with health practitioners and family about treatment and care preferences
5. To respect individual conscience	• Respecting diversity of beliefs and values, including among health practitioners
6. To alleviate human suffering (compassion)	• Providing quality care that minimises suffering and maximises quality of life
Goals 2 and 3 are bolded because, as argued below, while all goals are important, these two appeared to be the dominant ones when making decisions about the scope and nature of the legislation.	

The Minister herself summarised the principles as recognising three values: 'the value of every human life, respect for autonomy and a person's preferences, choices and values, and the provision of high-quality care'.[51] The second of these values – respect for personal autonomy – encompasses the principles of supporting informed decision-making, and promoting genuine choices. The principles of open discussions and supporting conversations will also be relevant to the provision of adequate information about treatment and care options to enable genuine and autonomous choices to be made. The Minister's third value – the provision of high-quality care – incorporates the principles of supporting therapeutic relationships with health practitioners, encouraging open discussions about dying and death, and supporting conversations with family, friends and carers about treatment and care preferences. In addition to the three goals mentioned by the Minister, three other important policy goals are discerned from those principles that underpin the legislation, namely: compassion to alleviate human suffering, safeguarding the vulnerable and the community, and

51 Victoria, *Parliamentary Debates* (n 24) 2951 (Jill Hennessy).

respecting individual conscience. Each of these policy goals will be discussed briefly in turn.

1 Respect All Human Life

The equal value of every human life is the first principle in the Act[52] and was also recognised as the first guiding principle by the Panel.[53] Twice in the second reading speech, the Minister stated that the right to life is the primary or supreme value in these debates.[54] However, it was also clear, for example from the Minister's statement of compatibility tabled in accordance with the Charter, that despite the significance of the right to life, it is not absolute and can be subject to justifiable limitations.[55]

2 Respect Personal Autonomy

The Panel repeatedly referred to the need for 'genuine choice' at the end of life. This included the provision of information about treatment options, and the provision of a range of choices about treatment and care, including the ability to choose the timing and manner of one's impending death.[56] This shows the importance placed on respecting a person's individual autonomy and freedom to 'choose to end their life according to their own preferences'.[57] Similarly, the deliberate choice of the term 'voluntary assisted dying', instead of the term 'dying with dignity' used in some American jurisdictions, reflected the emphasis on individual choice from a range of available end-of-life options.[58]

However, the Panel was at pains to point out that the aim of the *VAD Act* is not to give effect to *all* personal autonomy. Rather, autonomy is to be respected in a narrower set of circumstances: to provide alternative end-of-life care for people with terminal conditions who are suffering. The Panel noted respecting autonomy does not mean allowing people 'to do whatever they want' or to 'choose whether to live or die'.[59] Instead, the autonomy protected is choice over the 'timing and manner' of a death that is otherwise inevitable.[60]

3 Safeguard the Vulnerable and the Community

Another core concern expressed throughout the Report is the need to safeguard vulnerable individuals in the community from abuse or coercion. This principle, recognised in the Report and as a legislative principle,[61] was highly significant in the design of the system as the Report mentions the importance of safeguarding the vulnerable over 30 times.[62] Four potentially vulnerable groups that were discussed in

52 *VAD Act* s 5(1)(a).
53 *Report* (n 8) 43.
54 Victoria, *Parliamentary Debates* (n 24) 2943–4 (Jill Hennessy).
55 Ibid 2944 (Jill Hennessy).
56 There were 17 references to 'genuine choice' in the report: *Report* (n 8) 6, 10, 11, 22, 34 (twice), 38, 43, 44 (twice), 45 (twice), 46, 86 (twice), 99 and 117.
57 Victoria, *Parliamentary Debates* (n 24) 2945 (Jill Hennessy).
58 *Report* (n 8) 7.
59 Ibid 44.
60 Ibid.
61 Ibid 11, 22, 46; *VAD Act* s 5(1)(i).
62 *Report* (n 8) 5, 17 (twice), 18, 24, 51, 58, 63, 80, 82, 84, 87, 88 (3 times), 89, 91, 106, 127, 148, 180, 210 (3 times), 211 (3 times), 212 (3 times), 213, 215.

detail were the elderly,[63] children,[64] people with disabilities,[65] and people with mental illness.[66] The critical importance of this policy goal is also reflected in the emphasis on designing a 'safe and compassionate' VAD system as required by the Panel's terms of reference. Of note though, this policy goal of a safe system was framed to include the protection not only of potentially vulnerable groups but also the wider community.

4 Provide High-Quality Care

The Victorian model situates VAD within the healthcare system as one of a number of medical choices available to a person in the context of end-of-life care.[67] This creates the imperative, as with all healthcare, for any assessment for, or provision of, VAD to be of high quality. This is reflected in the Panel's recognition of the 'critical role of health practitioners' in VAD and the importance of continuity of care within an ongoing therapeutic relationship.[68] This was also noted by the Minister in her second reading speech.[69] In particular, the Report repeatedly recognises that open discussions within an existing therapeutic relationship would be the best way to ensure that any decisions about VAD were appropriate in the context of the person's needs and preferences.[70]

5 Respect Individual Conscience

Respecting medical practitioners' freedom of conscience was part of the terms of reference given to the Panel when advising about the form of *VAD Act*.[71] Respect for 'culture, beliefs, values and personal characteristics' was one of the Report's guiding principles[72] and was likewise included as a legislative principle in the *VAD Act*.[73] The right to freedom of thought, conscience, religion and belief was also noted as one of the core Charter rights engaged in the legislation.[74]

The Panel explains what conscientious objection to VAD means for medical practitioners, referring to this issue on several occasions in its Report.[75] The *VAD Act* respects the right of medical practitioners to choose on conscientious grounds not to participate in the provision of VAD, while continuing to provide holistic care to relieve the suffering and meet the needs of persons in their care.[76] But the Panel emphasised that this must not impede individuals who wish to access VAD from doing so.[77]

6 Alleviate Human Suffering (Compassion)

Compassion was a significant driver at the macro policy level for the *VAD Act*, as reflected in earlier discussions about the need for a 'safe and compassionate'

63 This was discussed in depth in ibid 88–90, and mentioned again at 180.
64 Ibid 53–54.
65 Ibid 84, 91.
66 Ibid 82.
67 Victoria, *Parliamentary Debates* (n 24) 2949–50 (Jill Hennessy).
68 *Report* (n 8) 45.
69 Victoria, *Parliamentary Debates* (n 24) 2952–3 (Jill Hennessy).
70 *Report* (n 8) 186 (Panel Recommendation 58). See also *Report* (n 8) 20, 92, 99, 101, 190.
71 Ibid 5.
72 Ibid 11, 22.
73 *VAD Act* s 5(1)(j).
74 See *Report* (n 8) 211; Victoria, *Parliamentary Debates* (n 24) 2947 (Jill Hennessy).
75 *Report* (n 8) 2, 15, 21, 40, 107, 109–11, 143, 190, 206, 214.
76 Ibid 40.
77 See, eg, ibid 15.

framework. This policy goal aims to alleviate the suffering of individuals at the end of their lives.[78] However, as the Panel shifted to operationalise its recommendations, compassion appeared to assume a less significant role. For example, it receives only limited recognition in the Report and legislative principles and indeed it was sometimes subsumed within two other policy goals. The first was respecting autonomy, with some references framed in terms of compassionate respect for autonomous choices to receive assistance to die.[79] The other was high-quality care, with both the Report and legislative principles referring to 'quality care to minimise the person's suffering'.[80] This may indicate that compassion played an important role in deciding whether or not to enact a VAD law, but then had less influence on the shape of that law; a notable exception is the eligibility requirement relating to suffering discussed below.

C Two Dominant Policy Goals: Respecting Autonomy and Safeguarding the Vulnerable and Community

As the discussion in relation to the policy goal of compassion shows, there are different ways in which policy goals can shape law. Some may establish important macro-level policy settings but do very little beyond that, whereas other goals may be integral in shaping the contours of the law and the detail of what is permitted and what is not. Sometimes policy goals will do both.

Although all six of the identified policy goals were important in framing the *VAD Act*, two goals were particularly dominant in determining the content of that law: respecting autonomy and safeguarding the vulnerable and community. This is evident from the number of references throughout the Report and the second reading speech to the need to balance freedom of choice with safeguards for vulnerable individuals and the wider community, as well as the frequent repetition of the key phrase: a 'safe and compassionate' system for VAD.

The eighth guiding principle in the Report explicitly states: 'providing people with genuine choice must be balanced with the need to safeguard people who might be subject to abuse'.[81] The need to balance these (potentially) competing policy objectives is also recognised in frequent statements such as: '[p]romoting individual autonomy and providing appropriate safeguards are critical, and neither aim is paramount. Instead, they must be balanced'.[82] Although all policy goals were important, this suggests that striking an appropriate balance between these two competing goals was a particular focus in the development of the *VAD Act*.

Minister Hennessy's second reading speech presenting the VAD Bill reinforces this conclusion. Although all 10 principles were listed at the outset of the speech,[83] it was her concluding paragraph that best captured the purpose of the legislation:

> This bill establishes a *safe* and compassionate framework to give Victorians who are suffering the ability to choose the timing and manner of their death. The bill provides a rigorous process with *safeguards* embedded at every step to ensure that only those who

78 See ibid 1, 13 and Victoria, *Parliamentary Debates* (n 24) 2949 (Jill Hennessy).

79 *Report* (n 8) 13 and Victoria, *Parliamentary Debates* (n 24) 2949–50 (Jill Hennessy). Reference was also made to a compassionate framework allowing individual choice, and not requiring a person to demonstrate unbearable suffering to be eligible for VAD: *Report* (n 8) 77–8.

80 *VAD Act* s 5(1)(d) and *Report* (n 8) 11.

81 *Report* (n 8) 22.

82 Ibid 210. See also Ibid 11, 15, 43, 87, 210, 211; Victoria, *Parliamentary Debates* (n 24) 2943 (Jill Hennessy).

83 Victoria, *Parliamentary Debates* (n 24) 2943 (Jill Hennessy).

> meet the eligibility criteria and who are making an *informed, voluntary and enduring decision* will be able to access voluntary assisted dying. The clear and considered details reflected in this bill will provide the Victorian community with the confidence that voluntary assisted dying can be *safely* provided to give Victorians *genuine choice* at the end of their lives.[84]

For this reason, the policy goals of respecting autonomy and safeguarding the vulnerable and the community are often discussed in more detail than the other policy goals in the analysis that follows.

III DOES THE *VAD ACT* REFLECT THESE POLICY GOALS?

The following analysis of whether the *VAD Act* reflects its stated policy goals is arranged according to the main components of the Act: method of VAD permitted; eligibility criteria; the process of requesting VAD, being assessed and then accessing VAD; conscientious objection by health practitioners; and oversight, reporting and compliance. The length and complexity of the *VAD Act* means that the discussion below can be only an overview of its key provisions. Further, and again for reasons of scope, this analysis pays particular attention to aspects of the VAD Act that do *not* comply with the identified policy goals. As legislation is generally expected to implement its stated objectives, it is this divergence that is of most interest in this article. A final point to note in relation to this analysis is that, as mentioned above in relation to respecting autonomy and safeguarding the vulnerable and the community, there will sometimes be tension between different policy goals.[85] Advancing one goal may require reduced recognition of another. The process of this balancing exercise will be outlined as necessary in the analysis below.

A Method of VAD Permitted

1 Overview of Law

The default method of VAD permitted under the *VAD Act* is self-administration; in other words, a medical practitioner prescribing medication which the person takes themselves.[86] It is only if a person is 'physically incapable of the self-administration or digestion' of the medication[87] that they can ask a medical practitioner to administer it (practitioner administration). This limited exception to permit practitioner administration was included to avoid discrimination on the basis of disability where a person's condition would preclude self-administration.[88] The *VAD Act* contains additional safeguards when the person receives practitioner administration: an independent witness of the person's request to administer the VAD medication must certify the person's apparent capacity and voluntariness, and the enduring nature of the request to die.[89]

84 Ibid 2955 (Jill Hennessy) (emphasis added).
85 Yeung also recognises this: Yeung, *Securing Compliance: A Principled Approach* (n 20) 31.
86 A co-ordinating medical practitioner applies for a 'self-administration permit', which enables the medical practitioner to prescribe and supply a lethal substance in a sufficient dose, and authorises the person concerned to possess that substance and administer it to themselves: *VAD Act* ss 45, 47.
87 Ibid s 48(3)(a).
88 *Report* (n 8) 141; Victoria, *Parliamentary Debates* (n 24) 2953 (Jill Hennessy).
89 *VAD Act* ss 46, 65(2).

2 Conformity with Policy Goals

The key policy goals of relevance here are: safeguarding the vulnerable, respect for autonomy and providing high-quality care. For the Panel, the most important goal appeared to be safeguarding the vulnerable, for example from coercion. Its report noted that '[w]hen a person self-administers a lethal dose of medication it is a final indication that their decision is voluntary'.[90] A person physically taking the medication themselves could also be seen as advancing the policy goal of autonomy in that it ensures the choice for VAD is truly the person's.

However, the Panel must have reached the view that practitioner administration of VAD medication is also safe with appropriate additional safeguards. This is reflected in their report and subsequently in the proposed legislation, as per the safeguards noted above. These safeguards are designed to ensure capacity and voluntariness of a person's request so that vulnerable people are not coerced into making requests for VAD. This raises the question though: if it is accepted that practitioner administration is safe, can safeguarding the vulnerable be a defensible basis for restricting VAD primarily to self-administration? Indeed, it could be argued that practitioner administration, which requires additional checks on capacity and voluntariness at the time VAD is provided, may better protect the vulnerable than permitting a person to self-administer unsupervised, which may occur at a later date when capacity has been lost. In a similar vein, later self-administration may also provide less protection against coercion.

In terms of respecting autonomy, the limitations placed on access to practitioner administration of VAD do not accord with this policy goal. The Report refers repeatedly to the importance of choosing the 'timing and *manner'* (emphasis added) of a person's death, yet only one of the two possible lawful methods of VAD is open to the majority of eligible people. The policy goal of respecting autonomy would be better achieved if a person was able to choose to self-administer the VAD medication or have assistance from a medical practitioner for practitioner administration.[91] This choice between self-administration and practitioner administration is available in a number of the other jurisdictions which permit VAD,[92] and where both options are available, available data show practitioner administration is overwhelmingly used.[93] Some people may find self-

90 *Report* (n 8) 141.

91 See Willmott and White (n 1) 479, 490–492, 500–501.

92 *Criminal Code of Canada* s 241.1 (definition of 'medical assistance in dying'); *Wet Toetsing Levensbeëindiging op Verzoek en Hulp Bij Zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001] art 2.1(f) (The Netherlands). Other countries which allow a choice between euthanasia and assisted dying are Belgium, Luxembourg and Colombia: Emanuel Ezekiel et al, 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe' (2016) 316(1) *Journal of the American Medical Association* 79, 79. While the law in Belgium does not address physician-assisted suicide directly, the Federal Control and Evaluation Committee for Euthanasia in Belgium considers it to be a form of euthanasia: at 82.

93 For example, in the Netherlands in 2017, of 6,585 cases reported to Euthanasia Review Committees, 6,303 were of euthanasia, 250 were of assisted suicide, and 29 cases involved a combination of both: Regional Euthanasia Review Committees, *Annual Report 2017* (Report, May 2017) 10. In Canada, drawing on the last two federal government reports covering the period from 1 January 2017 to 31 October 2018, of the 4,575 medically assisted deaths reported, only 2 were self-administered (note: this does not include data from some provinces as outlined in the report): Health Canada, *Fourth Interim Report on Medical Assistance in Dying Canada* (Report, April 2019) 5. Belgium does not differentiate in its reporting between euthanasia and assisted suicide, but data shows that for the period 2016–17, of 4337 deaths, 23 were by oral ingestion of barbiturates, 10 by other methods, and the remaining 4,304 (99%) were by intravenous injection: Commission Fédérale de Contrôle et D'évaluation de L'euthanasie*, Huitième Rapport aux Chambres Législatives Années 2016 – 2017*, (Report, 17 July 2018) 6.

administration to be an unacceptable option, or an unduly burdensome option, even if it is physically possible for them. Others may prefer practitioner administration because it may be safer (see below). It is not simply the ability to choose an option which leads to death, but the choice of a particular option for causing death which is preferred by some individuals.

The third key policy goal is to provide high-quality care and it could be argued that this goal is better served when people also have access to practitioner administered VAD rather than only self-administration. Although there is limited evidence, a Dutch study found that, while both means of providing VAD can experience complications and technical problems, the rate of these is higher with self-administration when compared with practitioner administration.[94] This suggests practitioner administration may be safer, and the legislative prohibition on practitioner administration for those able to self-administer precludes these people from accessing a potentially safer option.[95]

3 Conclusion

Limiting practitioner administration of VAD to those who are physically unable to administer or ingest the medication themselves is not consistent with the policy goals of the *VAD Act*. In particular, respecting autonomy and providing high-quality care would favour allowing eligible persons to choose whether to receive VAD by self-administration or from their medical practitioner. This allows a person both greater choice as to the manner of their death and access to the safer of the two options. Arguments about safeguarding the vulnerable lack traction in this setting, given that practitioner administration is permitted by the *VAD Act* with appropriate safeguards, therefore recognising practitioner administration as a safe VAD option.

94 The study reported on three types of problems: technical problems (eg, difficulty administering the medication); complications (eg, spasm, nausea, and vomiting); and problems with completion (eg, longer time than expected to death). In all categories, physician assisted suicide cases had higher rates of clinical problems compared to euthanasia. Technical problems arose in approximately 10% of cases of physician-assisted suicide (versus approximately 4% of euthanasia cases); complications arose in approximately 9% of physician assisted suicide cases (versus approximately 4% of euthanasia cases) and problems with completion arose in 14% of physician assisted suicide cases (versus 5% of euthanasia cases). The study found approximately 2% of physician assisted suicide patients awoke from a coma, and approximately 12% took longer than anticipated to die or never lost consciousness, compared to less than 1% and 4% respectively of euthanasia cases: Johanna Groenewoud et al, 'Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands' (2000) 342(8) *New England Journal of Medicine* 551, 555. More robust data from other jurisdictions which permit both euthanasia and physician assisted suicide are needed to support this conclusion: see Christopher Harty et al, 'Oral Medical Assistance in Dying (MAiD): Informing Practice to Enhance Utilization in Canada' (2019) 66(9) *Canadian Journal of Anesthesia* 1106. Data on complications from the US States of Oregon and Washington are available, but as these States permit only physician-assisted suicide, comparison with the rate of complications in euthanasia cases is not possible: Ezekiel et al (n 92) 86. Nevertheless, complication rates for physician assisted suicide appear to vary. The most recent statistics from Oregon found that just 2.8% of cases had reported complications (although in 52.6% of cases whether or not there were complications was unknown): Oregon Health Authority, *Oregon Death with Dignity Act 2018 Data Summary* (Report, 25 April 2019) 12. Riley also provides recent evidence of complications experienced with lethal injections of medication: Sean Riley, 'Navigating the New Era of Assisted Suicide and Execution Drugs' (2017) 4(2) *Journal of Law and the Biosciences* 424.

95 In the Netherlands, it is recommended to have a physician present during an assisted suicide, to be able to administer a lethal injection if the assisted suicide fails. This occurred in 21 out of 114 cases of assisted suicide in the study in question: Groenewoud et al (n 94) 554–6.

B Eligibility Criteria

1 Overview of Law

Section 9(1) of the *VAD Act* states that '[f]or a person to be eligible for access to voluntary assisted dying':

(a) the person must be aged 18 years or more; and
(b) the person must–
  (i) be an Australian citizen or permanent resident; and
  (ii) be ordinarily resident in Victoria; and
  (iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months; and
(c) the person must have decision-making capacity in relation to voluntary assisted dying; and
(d) the person must be diagnosed with a disease, illness or medical condition that–
  (i) is incurable; and
  (ii) is advanced, progressive and will cause death; and
  (iii) is expected to cause death within weeks or months, not exceeding 6 months [or 12 months if the disease, illness or medical condition is neurodegenerative];[96] and
  (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.

Disability and mental illness alone are not grounds to access VAD,[97] however, the Panel noted that having a disability or a mental illness does not preclude a person from accessing VAD if all the eligibility criteria are met.[98]

2 Conformity with Policy Goals

Before considering the four domains of the *VAD Act's* eligibility criteria – age, capacity, residence and nature of disease, illness or medical condition – it is noted that globally these requirements reflect a balancing of several of the identified policy goals. The threshold choice to allow VAD reflects the policy goals of respecting autonomy and the compassionate alleviation of human suffering (in relation to the latter, recognising that suffering is one of the eligibility requirements). But limiting VAD to those whose deaths are expected to occur within six months (or 12 months in the case of neurodegenerative conditions) reflects the policy goal of respecting all human life, by ensuring that only people who are close to death are eligible to request VAD. Excluding people from accessing VAD on the basis of disability or mental illness alone may be seen as safeguarding the vulnerable. The capacity and age requirements advance the policy goal of safeguarding vulnerable people by ensuring that only competent adults are able to request assistance to die, but a requirement to have capacity to access VAD also promotes autonomy. Finally, the decision to restrict access to Victorian residents was designed to ensure that VAD occurs in the context of an ongoing, caring therapeutic relationship,[99] which is part of the policy goal of providing high-quality care.

96 The words in square brackets have been inserted based on *VAD Act* s 9(4).
97 *VAD Act* ss 9(2)–(3).
98 Panel Recommendation 5: see *Report* (n 8) 80–2 (in respect of mental illness); Panel Recommendation 6: at 83–5 (in respect of disability).
99 Ibid 56; Victoria, *Parliamentary Debates* (n 24) 2948 (Jill Hennessy).

(a) Illness, Disease or Medical Condition

Of the four domains, it is the criterion of the illness, disease or medical condition of the person seeking access to VAD that is the most complex in terms of analysing its compliance with the policy goals.

(i) Will Cause Death

The requirement to have a condition that 'will cause death' reflects a tension between both respecting autonomy and alleviating human suffering on the one hand and respecting all human life on the other. Some other jurisdictions have chosen to preference autonomous choice and the alleviation of suffering by allowing wider access to VAD by individuals who do not have a terminal illness. For example, one of the criteria in Belgium is that a person has a 'medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated'.[100] Nevertheless, on balance, the requirement in the *VAD Act* that the person have a medical condition that will cause death is a defensible balancing of its stated policy goals. As the Panel stated, the purpose of the *VAD Act* was not to foster *all* autonomous choices in relation to the end of life, but only choices concerning the timing and manner of deaths that were already inevitable and impending.[101]

(ii) Six Months until Death

The position in relation to time limits is less able to be justified in light of the policy goals. First, the policy goals individually and when balanced collectively do not necessarily indicate a particular time from death as being an appropriate point at which to grant access to VAD. The selection of a six-month period is arbitrary.[102] This is illustrated by the fact that a 12-month period was initially included in the Report[103] and the VAD Bill that was originally passed by the Victorian Legislative Assembly.[104] While this was the initial preferred policy position, as will be discussed shortly below, this time limit was halved in the Bill presented to the Legislative Council after political negotiations, ultimately resulting in the six-month limit in the *VAD Act*.

One justification for this time limit could be that balancing the policy goals of respect for autonomy and respect for human life led the Panel and Parliament to restrict access to VAD to those who are in the process of dying.[105] But selecting a time period – of six months or some other duration – to restrict access to VAD to a cohort who are in the process of dying has problems. Prognostication about time until death is notoriously difficult.[106] Different diseases have different trajectories, and some are more

100 *Loi Relative à L'euthanasie* [Act on Euthanasia 2002] s 3§1.

101 See *Report* (n 8) 44.

102 Willmott and White (n 1) 503–4.

103 Panel Recommendation 2: *Report* (n 8) 22. See also *Report* (n 8) 13, 68, 70.

104 The Voluntary Assisted Dying Bill 2017 (Vic) ('VAD Bill'), as introduced and passed by the Victorian Legislative Assembly, stated that a person was eligible to receive VAD if they were suffering from an incurable and progressive condition that was 'expected to cause death within … 12 months': at cl 9.

105 This is similar to the restrictions contained within the US laws in force at that time: *Death with Dignity Act 1997*, Or Rev Stat §§ 127.800–127.995 (1994) (Oregon); *Death with Dignity Act 2009*, Wash Rev Code §§ 70.245.010–70.245.903 (2008) (Washington); *Patient Choice at End of Life Act 2013*, Vt Stat Ann §§ 5281–93 (2013) (Vermont); *End of Life Option Act 2016*, Cal Health and Safety Code §§ 443–443.22 (2015) (California); *End of Life Options Act 2016*, §§ 25-48-101–25-48-123 (2017) (Colorado). See *Report* (n 8) 221.

106 Joanne Lynn et al, 'Defining the "Terminally Ill": Insights from SUPPORT' (1996) 35(1) *Duquesne Law Review* 311, 324; Eric Chevlen, 'The Limits of Prognostication' (1996) 35(1) *Duquesne Law Review* 337; James Downar

predictable than others.[107] Studies, as well as anecdotal reports,[108] also demonstrate that a significant percentage of people predicted to die within six months are still alive after two to three years.[109] Lynn and colleagues have concluded that, because prognoses are unavoidably ambiguous:

> Deciding who should be counted 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide. Allowing physicians (or anyone else) to decide who is terminally ill without standards or guidance will result in uneven application with unjustified variations across diseases, across physicians, and across regions.[110]

Accordingly, this criterion does not sufficiently respect the value of life, as prognostic uncertainty may inappropriately grant access to VAD to people who have more (perhaps much more) than six months of life remaining.[111] This criterion may also fail to respect autonomy and alleviation of human suffering through the inappropriate exclusion of people who are suffering and close to death, if this proximity to death is not recognised by medical practitioners.[112]

Although problematic for the reasons outlined above, perhaps the best justification for adopting a six-month time period is that it could be seen as a practical compromise representing an imperfect proxy for being close to death. This reflects a pragmatic choice to preference certainty in the legislation (although the uncertainty of this eligibility criterion is noted above) even if doing so means it can only approximately reflect the policy goals of the *VAD Act*.

(iii) Twelve Months until Death for Neurological Conditions

As noted above, when the Legislative Assembly passed the VAD Bill, the eligibility criterion required that death was expected to occur within 12 months. This was reduced to six months when the VAD Bill was presented to the Legislative Council, and this ultimately became law. An exception was made, however, for persons with neurodegenerative conditions, who remained eligible for VAD if their death was expected within 12 months. If a time limit in itself is questionable, having different time

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et al, 'The "Surprise Question" for Predicting Death in Seriously Ill Patients: A Systematic Review and Meta-analysis' (2017) 189(13) *Canadian Medical Association Journal* E484. Glare and colleagues observe that predictions estimating that a certain percentage of patients will survive for a certain time have a 50–75% accuracy rate, whereas predictions estimating the time the patient will survive are only 25% accurate: Paul Glare et al, 'Predicting Survival in Patients with Advanced Disease' (2008) 44(8) *European Journal of Cancer* 1146, 1147. In the Victorian debate on the VAD Bill, Ms Crozier also noted evidence from Washington and Oregon of a considerable proportion of people diagnosed as eligible for VAD being expected to live less than 6 months, whose deaths occur 1–2 years or longer after this diagnosis: Victoria, *Parliamentary Debates,* Legislative Council, 21 November 2017, 6221 (Georgina Crozier).

107 Lynn et al (n 106) 326–7; Downar et al (n 106).

108 Mr Ondarchie referred to his own father's death, which was predicted to occur within three months, but did not in fact occur for another 21 months: Victoria, *Parliamentary Debates,* Legislative Council, 14 November 2017, 5837 (Craig Ondarchie).

109 Lynn and colleagues have demonstrated that 20–40% of those predicted to have a 50% chance to die within the next six months are still alive after two to three years. Even among those predicted to have only a 20% chance of surviving six months, up to 10% survive for two to three years: Lynn et al (n 106) 321–2.

110 Ibid 334.

111 Statistics from Washington and Oregon quoted in the Victorian debate bear this out: Victoria, *Parliamentary Debates* (n 106) 6221 (Georgina Crozier).

112 Colleen Cartwright, 'The Six-Month Amendment Could Defeat the Purpose of Victoria's Assisted Dying Bill' *The Conversation* (online, 23 November 2017) <https://theconversation.com/the-six-month-amendment-could-defeat-the-purpose-of-victorias-assisted-dying-bill-87941>.

limits for different conditions requires a compelling justification. For reasons outlined below, it is argued that this justification is absent.

The stated reason for this differential treatment was a concern that people with neurodegenerative conditions might either lose capacity to apply for, or to self-administer, VAD medication if the eligibility period was restricted to six months.[113] This cannot be justified by reference to the policy objectives of the *VAD Act*. In relation to capacity, allowing only people with neurodegenerative conditions this additional time to access VAD before they lose capacity to request it gives greater protection to the autonomous choices only of a narrow class of individuals.[114] No such provision is made in relation to people with other illnesses which may affect a person's decision-making capacity.[115] Further, the concern to ensure access to self-administration is misplaced, given the law permits practitioner administration where a person is no longer physically capable of taking or ingesting the VAD medication.

(b) Adult with Decision-Making Capacity

The policy goals of respecting autonomy and safeguarding the vulnerable align with the eligibility criteria that a person must be an adult and must have decision-making capacity to access VAD.[116] In relation to the requirement to be an adult, although it may be argued that this devalues the autonomy of competent minors or that 18 years of age is an arbitrary line to draw, the Panel and the Victorian Government formed the view that children do not have sufficient maturity or capacity for abstract reasoning to make difficult decisions concerning death and dying. This accordingly renders them vulnerable, which justified the need to protect them, by imposing a prohibition on minors accessing VAD.[117] This view is not inconsistent with the legal position in Australia which recognises that there are limits on the ability of minors to request the withdrawal of life-saving medical treatment.[118] It also reflects the consensus in the majority of overseas jurisdictions that access to assisted dying be limited to adults.[119] Only Belgium, the Netherlands and Colombia permit requests for VAD to be made by children under the age of 18, and this occurs in practice only in very rare cases.[120]

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113 Victoria, *Parliamentary Debates,* Legislative Council, 16 November 2017, 6098 (Gavin Jennings); Victoria, *Parliamentary Debates,* Legislative Council, 21 November 2017, 6216 (Gavin Jennings). No evidence was cited showing that people with neurodegenerative conditions tend to lose capacity earlier than people with other kinds of terminal illness.

114 For example, recent data from Canada found that from 1 January to 31 October 2018, neurodegenerative conditions accounted for just 11% of all cases of medical assistance in dying, while 16% were due to circulatory and respiratory conditions, and another 9% from other causes or unknown. The majority (64%) were cancer-related: Health Canada (n 93) 6.

115 Cartwright observes that '[p]atients suffering from conditions such as congestive cardiac failure, chronic obstructive pulmonary disease and chronic renal (kidney) failure can be given such strong medication at the end of life, which may render them incapable of clear decision-making': Cartwright (n 112).

116 Willmott and White (n 1) 501.

117 *Report* (n 8) 54, 215; Victoria, *Parliamentary Debates* (n 24) 2947–8 (Jill Hennessy).

118 *X v Sydney Children's Hospitals Network* (2013) 85 NSWLR 294. See also *Royal Alexandra Hospital for Children Trading as Children's Hospital at Westmead v J* (2005) 33 Fam LR 448; *Minister for Health v AS* (2004) 33 Fam LR 223.

119 See *Report* (n 8) 53.

120 In the Netherlands between 2002 and 2014, only five cases of euthanasia involving minors were reported: Judith Rietjens, Lenzo Robijn and Agnes van der Heide, 'Euthanasia for Minors in Belgium' (2014) 312(12) *Journal of the American Medical Association* 1258; Ezekiel et al (n 92) 84. In Belgium, euthanasia of minors became lawful in 2014, with the first three cases involving children (aged 9, 11 and 17) reported between 2016 and 2017: Commission Fédérale de Contrôle et D'évaluation de L'euthanasie (n 93) 11–12. On 9 March 2018,

In relation to requiring decision-making capacity at the time of accessing VAD, not permitting advance requests was argued to advance the policy goals of respecting autonomy and safeguarding the vulnerable. For example, the Panel considered that the person making a final choice for VAD at the point it is provided ensures the voluntary nature of the decision and avoids 'manipulation and abuse'.[121] There are contrary views, however, and many argue, for example, that recognition of advance requests is needed to give appropriate respect to a person's autonomy.[122] Nevertheless, requiring capacity at the time of accessing VAD may be regarded as a defensible position in light of the *VAD Act's* stated policy goals. Not recognising advance requests in the *VAD Act* is also consistent with the majority of overseas jurisdictions. Only Belgium, the Netherlands and Luxembourg permit advance requests for VAD and they are only acted on infrequently in those jurisdictions.[123]

(c) Residency Requirements

From the Report, the *VAD Act's* requirements in relation to residency appear to be based primarily on it being 'Victorian legislation that is intended to apply to Victorian residents'.[124] Perhaps the only policy goal that could be said to be relevant is that of providing high-quality care. The Panel observed that while European jurisdictions do not expressly impose residency requirements, they are 'considered to be enforced' through requiring an ongoing therapeutic relationship.[125] The Panel also noted the

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Colombia passed a resolution permitting euthanasia of children aged seven or over: Ministerio de Salud y Protección Social [Department of Health and Social Protection], *Resolución Número 825 de 2018* [Resolution 825 of 2018], 9 March 2018. This resolution was issued in compliance with judgment T-544 of 2017, in which the Constitutional Court required the Department to issue a 'procedure to give effect to the right to die with dignity for children and adolescents': *Judgment T-544 of 2017* (Unreported, Constitutional Court of Colombia, Magistrate Ortiz Delgado, 25 August 2017). See Nubia Leonor Posada-González and Nora Helena Riani Llano, 'Eutanasia: Conceptos de la Fundación Colombiana de Ética y Bioética FUCEB, Dirigidos a la Corte Constitucional (Sentencia T-721-17) y al Ministerio de Salud y Protección Social (Borrador de Resolución Sobre Sentencia T-544-2017 de Eutanasia Infantil)' (2018) 22(1) *Persona y Bioética* 148.

121 *Report* (n 8) 61–3.

122 See, eg, Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom* (Alfred A Knopf, 1993); Paul T Menzel and Bonnie Steinbock, 'Advance Directives, Dementia, and Physician-Assisted Death' (2013) 41(2) *Journal of Law, Medicine & Ethics* 484; Thaddeus Mason Pope, 'Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles', *The ASCO Post* (online, 25 December 2017) <https://www.ascopost.com/issues/december-25-2017/medical-aid-in-dying-when-legal-safeguards-become-burdensome-obstacles/>. See also the discussion of 'key concepts' in this area: Council of Canadian Academies, *The State of Knowledge on Advance Requests for Medical Assistance in Dying* (Report, 2018) 48–58.

123 Emily Tomlinson and Joshua Stott, 'Assisted Dying in Dementia: A Systematic Review of the International Literature on the Attitudes of Health Professionals, Patients, Carers and the Public, and the Factors Associated with These' (2015) 30(1) *International Journal of Geriatric Psychiatry* 10, 11; Sigrid Dierickx et al, 'Euthanasia for People with Psychiatric Disorders or Dementia in Belgium: Analysis of Officially Reported Cases' (2017) 17(1) *BMC Psychiatry* 203. For some discussion of the complexity of the issue, see Johannes van Delden, 'The Unfeasibility of Requests for Euthanasia in Advance Directives' (2004) 30 *Journal of Medical Ethics* 447; Paul Mevis et al, 'Advance Directives Requesting Euthanasia in the Netherlands: Do They Enable Euthanasia for Patients Who Lack Mental Capacity?' (2016) 4(2) *Journal of Medical Law and Ethics* 127; David Gibbes Miller, Rebecca Dresser and Scott Y H Kim, 'Advance Euthanasia Directives: A Controversial Case and its Ethical Implications' (2019) 45(2) *Journal of Medical Ethics* 84; Menzel and Steinbock (n 122).

124 *Report* (n 8) 56. Note that the requirement to be a resident 12 months prior to the first request was not recommended by the Panel but was introduced in the Legislative Council amendments.

125 Ibid.

undesirability of 'death tourism'[126] or 'suicide tourism'[127] in jurisdictions such as Switzerland where VAD is available to non-residents, which a residency requirement would prevent.

That said, while a residence requirement might exclude some cases where a person has only limited contact with a medical practitioner who provides VAD, it does little to promote high-quality care and may in fact impede it in some cases where a non-resident's primary medical practitioner is based in Victoria.[128] In summary, the identified policy goals provide only limited support for imposing residence requirements and some other broader justification may be needed to support them.

3 Conclusion

Some of the *VAD Act's* eligibility criteria align with its stated policy goals. The need to be an adult with decision-making capacity can be said to reflect the goals of respecting autonomy and safeguarding the vulnerable. Likewise, requiring a person to have an illness that will cause death defensibly balances the goals of respecting autonomy, alleviating suffering and respecting all human life. However, the imposition of the general time limit of six months until death is harder to justify by reference to these policy goals, and having a different expected time until death for different conditions cannot be justified at all. Residency requirements are also questionable from the perspective of the stated policy goals.

C VAD Request and Assessment Process, and Access to VAD

1 Overview of Law

The process for requesting, being assessed for and then accessing VAD is very complex so the following discussion can only provide a brief overview of the main steps involved.

(a) A First Request and Two Independent Assessments

The *VAD Act* specifies a very detailed request and assessment process which is triggered by a first request made by a person to a medical practitioner. The request for VAD must be made by the person themselves and it must be clear and unambiguous.[129]

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126 Rohith Srinivas, 'Exploring the Potential for American Death Tourism' (2009) 13(1) *Michigan State University Journal of Medicine and Law* 91; Alexander R Safyan, 'A Call for International Regulation of the Thriving Industry of Death Tourism' (2011) 33(2) *Loyola of Los Angeles International and Comparative Law Review* 287; Mary Spooner, 'Swiss Irked by Arrival of "Death Tourists"' (2003) 168(5) *Canadian Medical Association Journal* 600.

127 The name likely stems from a documentary concerning the death in Switzerland of Chicago man Craig Ewert: 'The Suicide Tourist', *Frontline* (CTV, 14 November 2007). See Saskia Gauthier et al, 'Suicide Tourism: A Pilot Study on the Swiss Phenomenon' (2015) 41 *Journal of Medical Ethics* 611; Charles Foster, 'Suicide Tourism May Change Attitudes to Assisted Suicide, but Not through the Courts' (2015) 41 *Journal of Medical Ethics* 620.

128 The Panel briefly acknowledged the 'potential for cross-border issues to arise' but then affirmed its position: *Report* (n 8) 57. There is an established (rebuttable) presumption of interpretation that State laws apply only to regulate conduct within the territory of the legislating State: *Jumbunna Coal Mine NL v Victorian Coal Miners' Association* (1908) 6 CLR 309, 363 (O'Connor J). See also *Interpretation of Legislation Act 1984* (Vic) s 48. However, laws that apply only to residents of one State may infringe upon the guarantee in s 117 of the *Constitution*, unless a relevant exception applies: Amelia Simpson, 'The (Limited) Significance of the Individual in Section 117 State Residence Discrimination' (2008) 32(2) *Melbourne University Law Review* 639.

129 The patient 'may make the request verbally or by gestures or other means of communication available to the person': *VAD Act* s 11(3).

When a medical practitioner receives a first request from the person, if that practitioner is available and willing to be involved, they become the 'co-ordinating medical practitioner'.[130] They then conduct the first eligibility assessment[131] and, if the person is eligible, the co-ordinating medical practitioner will refer the person to another medical practitioner.[132] If that second medical practitioner accepts the referral, they become the 'consulting medical practitioner', and will conduct the second eligibility assessment (called the 'consulting assessment').[133]

Two important safeguards are relevant here. The first is that the *VAD Act* specifically prohibits all registered health practitioners[134] from initiating a discussion about VAD (directly or indirectly) or suggesting VAD to a person, in the course of providing care.[135] The second safeguard is that the medical practitioners who wish to be involved with VAD must have particular qualifications and experience.[136] Both must be either a medical specialist or a vocationally registered general practitioner,[137] and one must have practised for at least five years after completing their fellowship with a specialist medical college or vocational registration.[138] One of the medical practitioners must also have expertise and experience in the disease, illness or medical condition expected to cause the person's death.[139]

(b) Providing Information and Ensuring Voluntary and Enduring Requests

If the co-ordinating medical practitioner or the consulting medical practitioner assesses a person as being eligible for VAD, they must provide certain information to the person. This includes information about diagnosis, prognosis and possible treatment options, as well as that the person may decide at any time not to seek VAD.[140] The medical practitioners must be satisfied that this information is understood and also that the person is acting voluntarily and their request for access to VAD is enduring.[141]

130 Ibid s 15.
131 Ibid s 16.
132 Ibid s 22.
133 Ibid ss 23–5.
134 '[R]egistered health practitioner' is defined as a person registered under the *Health Practitioner Regulation National Law*, which includes the professions of dentist, chiropractor, doctor, medical radiation practitioner, nurse, midwife, occupational therapist, optometrist, osteopath, paramedic, pharmacist, physiotherapist, podiatrist and psychologist, as well as Chinese medicine practitioner and Aboriginal and Torres Strait islander health practitioner: *Health Practitioner Regulation National Law Regulation 2018* (Cth) reg 4.
135 *VAD Act* s 8.
136 Ibid s 10.
137 Vocationally registered general practitioners are those who are Fellows of the Royal Australian College of General Practitioners or of the Australian College of Rural and Remote Medicine, or on the Vocational Register with Medicare. For information, see Quality Practice Accreditation, 'Vocationally registered GP's' (Information Sheet) <https://files.gpa.net.au/resources/QPA_Vocationally_registered_GPs.pdf>.
138 *VAD Act* s 10(2).
139 Ibid s 10(3).
140 Ibid ss 19, 28. In full, this includes information about: their diagnosis and prognosis; the treatment options available and their likely outcomes; the palliative care options available and their likely outcomes; the potential risks of taking the VAD medication for the purpose of causing death; that the expected outcome of taking the VAD medication is death; that they may decide at any time not to continue the process; and that they are encouraged to tell their usual registered medical practitioners (eg their GP and/or specialists, if they are not the co-ordinating medical practitioner) of their VAD request.
141 Ibid ss 20, 29.

(c) Two Further Requests and a Waiting Period

A person who has been assessed as eligible to access VAD by the co-ordinating and consulting medical practitioners must then make two further requests for VAD. One is a written declaration, witnessed by two people,[142] that VAD is sought voluntarily and that the nature and effect of seeking VAD is understood.[143] The second is the 'final request' which can be made verbally.[144] This final request must be made at least nine days after the first request and at least one day after the consulting assessment,[145] although the nine day period can be shortened if the person is likely to die first.[146]

The last step in this stage is for the person to appoint a 'contact person', whose duties include returning unused VAD medication to the pharmacy and being a contact point for the VAD Review Board ('the Board') (the Board is discussed further below).[147]

(d) Accessing VAD

After undertaking a 'final review' to ensure the VAD process has been complied with,[148] the co-ordinating medical practitioner may then apply to the Department of Health and Human Services ('the Department') for a VAD permit for either self-administration by the person or practitioner administration.[149] The Department will decide whether or not to issue the permit for the person to receive VAD within three business days.[150]

For self-administration, on prescribing the VAD medication, the co-ordinating medical practitioner must inform the person about how to take the medication, how it must be stored (in a locked box),[151] there being no obligation to proceed with VAD, and duties (including on the contact person) to return unused VAD medication to the pharmacy.[152] The dispensing pharmacist also must inform the person of this same information when dispensing the VAD medication[153] and include some of this information on the labelling statement.[154] Once dispensed, the person may take the VAD medication at a time of their choosing.

Where VAD is provided through practitioner administration, the co-ordinating medical practitioner is responsible for the VAD medication,[155] so the above information requirements do not apply. The person must make a further (fourth) request for VAD (an 'administration request'), in the presence of an independent witness,[156] immediately

142 Ibid s 35.
143 Ibid s 34.
144 Ibid s 37. This request may also be made by gestures or other means of communication available to the patient.
145 Ibid s 38(1).
146 Ibid s 38(2).
147 Ibid s 39.
148 Ibid s 41.
149 Ibid s 43.
150 *Voluntary Assisted Dying Regulations 2018* (Vic) reg 7.
151 There is also a statutory duty imposed on the patient to store the VAD medication in a locked box: *VAD Act* s 61.
152 Ibid s 57.
153 Ibid s 58.
154 The labelling statement must warn of the purpose of the dose, state the dangers of self-administration, state that the VAD medication is required to be stored in a locked box of certain specifications, and state that any unused or remaining medication must be returned to the dispensing pharmacy: Ibid s 59.
155 Ibid s 46(c).
156 Ibid s 64(4). The witness must be aged 18 or over, and be independent of the co-ordinating medical practitioner: at s 65(1). The witness must also be present when the VAD medication is administered and certify this: at s 65(2).

before the co-ordinating medical practitioner administers the VAD medication.[157] The co-ordinating medical practitioner must be satisfied that the person has capacity, is acting voluntarily and without coercion and the request for VAD is enduring.[158]

2 Conformity with Policy Goals

Many parts of the *VAD Act* outlining the VAD request and assessment process, and how access to VAD is provided, advance the legislation's stated policy goals. One example is the requirement to provide information to a person seeking VAD at key points in the process. This clearly aligns with policy goals such as respecting autonomy and promoting high-quality care by ensuring any decision to seek VAD is fully informed. Another is the waiting period of nine days between first and final requests. The policy intent of ensuring the person's request is 'enduring and well-considered'[159] reflects the policy goals of respecting human life, safeguarding the vulnerable, and respecting autonomy.

As noted above, alignment between legislation and its policy goals is unremarkable and indeed is to be expected. Accordingly, and particularly given it is not feasible to comprehensively review all of the detailed processes outlined in the *VAD Act*, this analysis focuses on three key areas where the law's stated policy goals may not be advanced: the prohibition on initiating VAD discussions, pre-authorisation permits and overall complexity of the system.

(a) Prohibition on Health Practitioners Initiating Conversations about VAD

Most problematic in the request and assessment process is the prohibition on initiating conversations about VAD. Section 8(1) of the *VAD Act* states:[160]

> A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person–
>
> (a) initiate discussion with that person that is in substance about voluntary assisted dying; or
>
> (b) in substance, suggest voluntary assisted dying to that person.

The policy intent of this provision was 'to ensure a person is not coerced or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person's own voluntary decision'.[161] This prohibition attempts to further the two central goals of the *VAD Act*: safeguarding the vulnerable and promoting autonomy. The Report prefaced this recommendation with a discussion of elder abuse and abuse of persons with a disability,[162] and considered that the prohibition on raising VAD was justified because '[h]ealth practitioners have considerable influence over the decisions and treatment options their patients may consider'.[163] The Panel also recognised the importance of providing people with

157 Ibid s 64. The final request may be made verbally or by gestures or other means of communication: at s 64(3).
158 Ibid ss 64(1), (5).
159 *Report* (n 8) 125.
160 Breach of section 8 can lead to sanctions for unprofessional conduct or professional misconduct: *VAD Act* s 8(3).
161 *Report* (n 8) 91.
162 Ibid 90–1.
163 Ibid 92–3. See also the Explanatory Memorandum of the VAD Bill, which stated more explicitly that purpose of this prohibition was to 'protect individuals who may be open to suggestion or coercion by registered health practitioners': Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 2.

appropriate information about VAD and other end-of-life options,[164] which has implications for the policy goal of providing high-quality care.

Despite the stated policy intent, this prohibition on initiating discussions about VAD conflicts with the policy goal of respecting autonomy. This is illustrated by the fact that a person asking for all possible end-of-life options to inform their treatment decisions cannot be told about VAD unless they know to ask about it first and do so. It is also highlighted by contrasting this prohibition with some of the relevant legislative principles in the *VAD Act* that underpin the policy goal of respecting autonomy: supporting informed decision making;[165] encouraging open discussions about dying, death and people's preferences;[166] supporting conversations with health practitioners and family about treatment and care preferences;[167] and promoting genuine choices.[168]

Further, the prohibition is problematic because precluding the open dialogue needed at the end of life between health practitioners and persons may compromise the policy goal of providing high-quality care. There are no other lawful medical services that health practitioners are similarly prevented from raising, and this prohibition does not exist in any overseas jurisdictions that have legalised VAD.[169] A final concern is the uncertainty about the scope of the provision:[170] what conversations would it prohibit and what would be permitted?[171] Given medical practitioners' lack of knowledge in other areas of end-of-life law,[172] this could have a chilling effect on open discussions about end-of-life care if health practitioners are uncertain about the permissible boundaries of discussions.

In summary, although this prohibition may align with the policy goal of safeguarding the vulnerable (and some may dispute the premise that medical practitioners would be influential in a person's decision to make a request), the significant conflict with respecting autonomy and the risk to high-quality care means it is not consistent with the *VAD Act's* policy goals overall.

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164 The Report noted 'although a health practitioner should never initiate a discussion about voluntary assisted dying, when asked for information it is important that they are able to provide it, or at least explain where such information may be found': *Report* (n 8) 93.

165 *VAD Act* s 5(1)(c).

166 Ibid s 5(1)(f).

167 Ibid s 5(1)(g).

168 Ibid s 5(1)(h).

169 Carolyn Johnston and James Cameron, 'Discussing Voluntary Assisted Dying' (2018) 26(2) *Journal of Law and Medicine* 454. We note, however, that as this article was being written, Western Australia passed its *Voluntary Assisted Dying Act 2019* (WA). That Act includes a similar prohibition on 'health care worker[s]' but is more limited in scope because it does not apply to medical practitioners or nurse practitioners if they also provide certain information to the patient about treatment options and palliative care: s 10.

170 Johnston and Cameron (n 169) 454.

171 For some of the complexities about permissible discussions in light of this prohibition, see Lindy Willmott et al, 'Restricting Conversations about Voluntary Assisted Dying with Patients: Implications for Clinical Practice' (2020) 10(1) *BMJ Supportive and Palliative Care* 1. See also Bryanna Moore, Courtney Hempton and Evie Kendal, 'Victoria's Voluntary Assisted Dying Act: Navigating the Section 8 Gag Clause' (2020) 212(2) *Medical Journal of Australia* 67.

172 Ben White et al, 'Doctors' Knowledge of the Law on Withholding and Withdrawing Life-sustaining Medical Treatment' (2014) 201(4) *Medical Journal of Australia* 229; Ben White et al, 'The Knowledge and Practice of Doctors in Relation to the Law That Governs Withholding and Withdrawing Life-Sustaining Treatment from Adults Who Lack Capacity' (2016) 24(2) *Journal of Law and Medicine* 356.

(b) Pre-Authorisation of VAD by Government Permit[173]

The requirement to obtain a permit from the Department *prior* to providing VAD to a person is unusual, as most other VAD systems rely on *post hoc* reporting mechanisms.[174] The stated policy intent in the Report for the permit requirement was 'to establish clear monitoring and accountability for the safe prescription of the lethal dose of medication for voluntary assisted dying'.[175] This reflects the policy goal of safeguarding the vulnerable and the community, but it also appears to address the policy goal of respecting all human life by scrutinising proposed VAD before it is provided. In support of the permit requirement, the Panel cited stakeholder concerns that 'review after the fact may produce evidence of wrongdoing, but … voluntary assisted dying is irreversible'.[176]

Pre-authorisation permits also have implications for other policy goals. The delay of up to three business days is a constraint on a person's autonomy. This time also extends the period during which an eligible person is enduring suffering, so sits awkwardly with the policy goal of alleviating that suffering. This may represent an appropriate compromise between competing policy goals if the permit system is effective in ensuring only eligible persons can have access to VAD. However, this is unlikely to be so. Although the nature of the scrutiny proposed by the Department is unclear, the focus of the permit issuing process appears to be ensuring that all of the relevant prescribed forms have been completed appropriately and submitted. Such a procedurally-focused review is unlikely to be an effective safeguard to ensure compliance in practice with the substantive criteria of the legislation, making the cost to the policy goals of respecting autonomy and alleviating suffering unjustifiable.

(c) Overall Complexity

The final issue to note in relation to the request and assessment process and gaining access to VAD is the complexity of the scheme as a whole. As outlined earlier, the *VAD Act* was proclaimed to be the 'safest, and most conservative model in the world',[177] with much made of its extensive safeguards. Many of those safeguards are in the request and assessment process and they are specified in great detail in the *VAD Act*. This highly prescriptive detail in the legislation itself is unusual[178] and as a result, the *VAD Act* is significantly longer than other VAD legislation internationally.

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173 There are other models that propose pre-authorisation of VAD, such as requiring prior court approval. Such approaches raise different considerations from those below; for example, court approval is more effective in safeguarding the vulnerable given the substantive review but comes with greater cost and delay. For a wider discussion of pre-authorisation in this context, see Yeung, 'Regulating Assisted Dying' (n 20).

174 An exception is Colombia, which requires prior approval by independent committee: Ezekiel et al (n 92) 81.

175 *Report* (n 8) 134.

176 Ibid 133. Concerns about a retrospective review system have also been recently expressed in relation to a case of euthanasia of a patient with dementia in the Netherlands: Miller, Dresser and Kim (n 123) 88. See also more general concerns about the limits of the retrospective system of oversight in David Gibbes Miller and Scott Y H Kim, 'Euthanasia and Physician-Assisted Suicide Not Meeting Due Care Criteria in the Netherlands: A Qualitative Review of Review Committee Judgements' (2017) 7(10) *BMJ Open* 1. For example, they note that the Dutch review process, which is retrospective, in practice focuses on procedural criteria and professionalism of medical practitioners, rather than whether the substantive eligibility criteria are met.

177 Andrews (n 16).

178 More commonly, such prescriptive detail is placed in the Act's regulations or clinical or administrative guidelines.

As briefly described above, the VAD system requires at least three formal requests (four in the case of practitioner administration), two independent assessments of the person, and repeated checks of informed consent, the enduring nature of the decision, voluntariness and coercion. Appropriate witnesses[179] (and sometimes interpreters) must be organised and the co-ordinating medical practitioner must also obtain a permit before prescribing VAD medication or administering it.[180] An appropriate contact person must be found and properly appointed, and in the case of self-administration, the person must then obtain the medication and store it in a locked box.[181]

The goal of this process is to be rigorous in ensuring those who are not eligible do not gain access to VAD.[182] This advances the policy goal of safeguarding the vulnerable and the community, and it also promotes the goal of respect for human life by permitting VAD only in accordance with a strict process.[183] It is also designed to promote autonomy and high-quality care, with the Panel noting that the purpose behind the three request process is twofold: to ensure the request for VAD is 'voluntary, considered and enduring' and to provide 'multiple opportunities for a person and their assessing medical practitioners to discuss the person's request'.[184] The VAD system, at least on its face, meets these key goals.

However, when these procedural steps are viewed as a whole, there are concerns that persons will find accessing VAD very difficult.[185] A process that is described as rigorous could be experienced as onerous, and the process outlined above is also complex. This may complicate, or even frustrate, the policy goals of respecting autonomy and alleviating suffering by precluding, or at least delaying, eligible persons' access to VAD. These persons – who by definition must be suffering and generally be expected to die within six months – may find the process overwhelming and too difficult to navigate and consequently choose not to proceed. Those who do start the process might die (or lose capacity) before they make their way through it, or give up part way through. This complexity may be particularly difficult for persons from diverse cultural and linguistic backgrounds, especially if interpreters are required, as they must be accredited professionals and not a family member.[186] Even if a person is able to navigate the process, the hurdles involved and the stress in navigating them could intensify the person's suffering.

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179 *VAD Act* ss 34–6, 65.

180 Ibid ss 47, 48.

181 Ibid s 61.

182 *Report* (n 8) 112.

183 The Panel justified the stages in the request and assessment process with reference to preventing 'doctor shopping', stating that

> even if a person finds one medical practitioner willing to break the law by providing an assessment that a person meets the eligibility criteria even though they do not, this medical practitioner would also need to find another medical practitioner willing to collude with them. Even if they are able to do this, the Department and the Voluntary Assisted Dying Review Board would be able to identify irregularities or wrong doing before a permit for prescription is given.

Ibid 122.

184 Ibid 113.

185 The Panel itself acknowledged this risk. It recognised 'that the person who has requested access to voluntary assisted dying is suffering … so the process should not create undue burden or anxiety or be a tick-box process … [and] should be undertaken in the spirit of person-centred care': Ibid 112. See also White, Willmott and Close (n 19).

186 *VAD Act* s 115. Similar considerations apply to those with communication difficulties who require a speech pathologist to assist in interpreting.

The nature of the VAD process and what it requires may also mean that few medical practitioners will agree to be involved. For example, the duties of a co-ordinating medical practitioner, who oversees the process as a whole, are significant both from a clinical and administrative perspective. (The substantial reporting duties on medical practitioners involved in VAD and the implications for their participation are also discussed further below at Part III(E).) A lack of medical practitioners willing to participate would further compromise the policy goals of autonomy and alleviation of suffering as well as the provision of high-quality care.

In conclusion, while the policy goals of safeguarding the vulnerable and the community, and respecting all human life are advanced by the rigorous VAD process, its many stages and complexity may pose a risk to access and undermine the policy goals of respecting autonomy and alleviating suffering. Although these issues can be identified on the face of the legislation, how and whether these competing policy goals are achieved will depend on how the legislation is implemented. It is possible that good design of the VAD system may mean that its complexity can be 'internally facing' and may not impede access for eligible persons nor create burdens for the medical practitioners involved.[187] Firm conclusions on this will have to wait until after the law has commenced and its operation has been evaluated.

3 Conclusion

In general, the main parts of the process for requesting VAD, having eligibility assessed, and then receiving access to it, align with the *VAD Act's* stated policy goals. The primary policy advanced is safeguarding the vulnerable, but there is also recognition of respecting human life, respecting autonomy and promoting high-quality care. However, policy goals do not appear to be met, and may be impeded, by prohibiting health practitioners from discussing VAD with persons and through the requirement to obtain pre-authorisation for VAD via a government permit. Further, when the process is viewed in its entirety, its complexity may limit the *VAD Act's* fulfilment of the key policy goals of respecting autonomy and alleviating suffering. While individual components or safeguards may be justifiable, a global assessment of them reveals a different picture. This has implications for the overall design of VAD systems which will be revisited in the article's conclusion.

D Conscientious Objection

1 Overview of Law

The *VAD Act* allows medical practitioners and other health practitioners to conscientiously object to participate in VAD. Section 7 protects the right of health practitioners to refuse to:

- provide information about VAD;
- participate in the request and assessment process;
- apply for a VAD permit;
- supply, prescribe or administer a VAD substance;
- be present at the time of administration of a VAD substance; or

187 White, Willmott and Close (n 19) 207.

- dispense a prescription for a VAD substance.

Other provisions also anticipate conscientious objection. One is the requirement to accept or refuse the role of co-ordinating or consulting medical practitioner within 7 days.[188]

2 Conformity with Policy Goals

The right of medical practitioners and other health practitioners to refuse to provide information about or participate in VAD[189] clearly advances the policy goal of respect for individual conscience.[190] Notably, however, there is no duty to refer a person to another medical practitioner who is willing to be involved in VAD. The Panel considered, but rejected, such an approach,[191] instead relying on existing obligations of medical practitioners under their code of conduct not to impede persons' access to lawful care or treatment.[192] The absence of a specific legislative duty to refer stands in stark contrast to the very detailed and prescriptive process outlined for other matters in the *VAD Act*.

While promoting respect for conscience, the lack of a legislative duty to refer may impede access to a lawful end-of-life option.[193] If this happens in relation to VAD, this would compromise the realisation of other important policy goals: respect for autonomous choices, alleviation of suffering and the provision of high-quality care.

E Oversight, Reporting and Compliance

1 Overview of Law

The *VAD Act* contains a number of mechanisms for monitoring VAD and ensuring compliance with the legislative regime.

188 *VAD Act* ss 13(1)(b), 23(1)(b).

189 The Report contained two recommendations specifically with the policy intent of respecting individual conscience. They are: Panel Recommendation 18 – that medical practitioners have a right to conscientiously object, and Panel Recommendation 39 – that where the co-ordinating and consulting medical practitioner both conscientiously object to administering a lethal injection, they may transfer care to a different medical practitioner who is willing to administer the medication: *Report* (n 8) 24, 27.

190 For further discussion of the value of conscience in the Australian legal system, see Willmott and White (n 1). In Victoria, this is reflected in the right to freedom of thought, conscience, religion and belief contained in the *Charter of Human Rights and Responsibilities 2006* (Vic) s 14. See also the *Report* (n 8) 214.

191 *Report* (n 8) 109–11.This duty exists under Victorian law governing termination of pregnancy: *Abortion Law Reform Act 2008* (Vic) s 8.

192 *Report* (n 8) 15, 110. See Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Guideline, March 2014) para 2.4.6 <http://www.medicalboard.gov.au/ Codes-Guidelines-Policies.aspx>.

193 Although a legislative duty to refer may provide stronger normative force than simply relying on existing ethical duties, it still may not be effective. For example, there is evidence that the legislative duty to refer when a medical practitioner has a conscientious objection to a termination of pregnancy is being ignored or evaded by some Victorian medical practitioners: Louise Anne Keogh et al, 'Conscientious Objection to Abortion, the Law and Its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20 *BMC Medical Ethics* 11:1–15.

(a) Board Oversight of the System

The Board is a new independent statutory body[194] that has overall oversight of the VAD system. Its primary function is to monitor activity under the *VAD Act* to ensure compliance.[195] This includes reviewing each case where VAD has been requested, to ascertain compliance with legal requirements. The Board must also evaluate overall patterns and trends of access to VAD, such as discerning possible instances of 'doctor shopping':[196] that is, overuse of one or more medical practitioners who repeatedly find a person to be eligible for VAD despite other medical practitioners finding them to be ineligible.

The Board will be supported in its oversight function by the mandatory reporting obligations imposed on medical practitioners, dispensing pharmacists and others by the *VAD Act*, as outlined in Table 2. In addition to reporting to the Board, all deaths of people who were the subject of a VAD permit are notifiable to the Coroner,[197] although these deaths are not investigated as possible suicides.

194 The Board is established by the *VAD Act* s 92. This model of a separate body, independent of the health department, follows the European models in place in Belgium, the Netherlands and Luxembourg, rather than in the US States, where monitoring is done within existing health departments: *Report* (n 8) 159.

195 *VAD Act* ss 93(1)(a), (b).

196 *Report* (n 8) 168.

197 A medical practitioner attending a person who has died must notify if the person was the subject of a VAD permit, and state their knowledge or belief whether or not the person died as a result of VAD, or VAD was not administered: *VAD Act* s 67(2). These deaths are also notifiable to the Registrar of Births, Deaths and Marriages: at s 67(1). However, VAD is not required to be recorded as the cause of death on the death certificate: *Report* (n 8) 150–3.

Table 2: Reporting to the Board

Matter reported	Person reporting	Form or other document	Legislative provision
That a person was assessed as eligible or ineligible for VAD after a first assessment	Coordinating medical practitioner	First assessment report form (Form 1)	*VAD Act* s 21
That a person was assessed as eligible or ineligible for VAD after a consulting assessment	Consulting medical practitioner	Consulting assessment report form (Form 2)	*VAD Act* s 30
That the request and assessment process has been completed	Coordinating medical practitioner	Final Review Form (Form 5). Note that attached to this Form are copies of Forms 1, 2, 3 (Written declaration) and 4 (Contact person appointment form).	*VAD Act* s 41
That a self-administration permit or practitioner administration permit has been issued (or has been amended)	Secretary of Department of Health and Human Services	VAD permit (or its amendment)	*VAD Act* s 49 (and s 51 for amendment)
That VAD medication was dispensed	Dispensing pharmacist	VAD substance dispensing form (Form 6)	*VAD Act* s 60
That any returned VAD medication was disposed of	Dispensing pharmacist	VAD substance disposal form (Form 7)	*VAD Act* s 63
That VAD was administered to a person by a medical practitioner	Coordinating medical practitioner	Coordinating medical practitioner administration form (Form 8)	*VAD Act* s 66
That an application for review has been lodged with VCAT That VCAT has made an order or determination	Principal Registrar of VCAT	Notice of application to VCAT Copy of VCAT's order or determination	*VAD Act* s 69(c)

(b) Victorian Civil and Administrative Tribunal Review of Eligibility Decisions

The Victorian Civil and Administrative Tribunal ('VCAT') has a more limited role in relation to VAD. It has jurisdiction only to review assessments by a co-ordinating or consulting medical practitioner about residency and decision-making capacity, as these are questions of fact.[198] VCAT does not review clinical issues such as disease-related eligibility criteria.

198 *VAD Act* s 68 and Part 6.

(c) Health Practitioners' Duties to Report

Registered health practitioners (including medical practitioners, nurses, allied health practitioners and pharmacists)[199] are required to report colleagues to the Australian Health Practitioner Regulation Agency (AHPRA) if they believe another registered health practitioner has initiated a discussion about VAD or suggested it to a person, or has offered to provide VAD to a person not eligible under the Act.[200] This reporting obligation also applies to health practitioners' employers, such as hospitals or institutional care providers.[201]

(d) Offences

The *VAD Act* adds several new offences, which are designed to promote compliance with the Act and deter people from intentionally acting outside the law.[202] These offences relate to:

- coercing a person to access VAD;[203]
- administering VAD medication to a person who has been issued a self-administration permit;[204]
- acting contrary to a practitioner administration permit;[205]
- a contact person failing to return unused or remaining VAD medication after the person's death;[206]
- falsifying forms and statements;[207] and
- failing to report to the Board.[208]

(e) Protection from Criminal and Civil Liability

The *VAD Act* specifically protects medical practitioners who provide VAD in accordance with the Act from any criminal or civil liability, or liability for professional misconduct or contravention of a professional code of conduct.[209] It also protects those (including health practitioners, family or carers) who assist or facilitate a request for VAD.[210] These legal protections provide certainty and confidence for those who help a person to access VAD in accordance with the Act.

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199 See *Health Practitioner Regulation National Law Regulation 2018* (Cth) for definition of registered health practitioner.

200 *VAD Act* s 75.

201 Ibid s 76.

202 The offence provisions are broadly modelled on offences in force in some US States: *Report* (n 8) 179.

203 This includes both inducing a person to request access to VAD, and inducing a person to self-administer VAD medication: *VAD Act* ss 85, 86. The maximum penalty in both cases is 5 years imprisonment.

204 *VAD Act* s 84. The maximum penalty is life imprisonment.

205 Ibid s 83. The maximum penalty is life imprisonment.

206 Ibid s 89. The maximum penalty is 12 months imprisonment or 120 penalty units or both.

207 Ibid ss 87, 88. The maximum penalty for both offences is 5 years imprisonment for a natural person, or 2400 penalty units for a body corporate. The value of a penalty unit changes annually, and is set by the Treasurer: *Monetary Units Act 2004* (Vic) s 5(3). From 1 July 2018 to 30 June 2019, one penalty unit was $161.19, so the maximum penalty was $386,856.

208 *VAD Act* s 90. The maximum penalty for this offence is 60 penalty units, which at the time of writing was $9,671.40.

209 Ibid s 80. This includes protecting a health practitioner or paramedic who does not administer life-saving treatment to a person who is dying after the administration of VAD medication: at s 81.

210 Ibid s 79.

2 Conformity with Policy Goals

Collectively, these provisions of the *VAD Act* are designed to ensure that the VAD system operates as intended: that VAD is provided within the law and that unlawful behaviour does not occur. In this way, these provisions generally advance the overall key policy goals of protecting human life and safeguarding the vulnerable and the community, while ensuring that human suffering can be alleviated through people exercising their autonomy within the law. It could be further argued, though, that some of these provisions give greater emphasis to particular policy goals. For example, the Board's oversight of all cases of VAD and the reporting that underpins this[211] are especially aimed at safeguarding the vulnerable. Offence provisions also safeguard the vulnerable and the community, and, arguably, those that prohibit the causing of death outside the Act are also aligned with the policy goal of respecting all human life.

Accordingly, when looking at these provisions in general, each can be justified as aligned with policy goals of the Act. One concern, though, is that when these provisions are considered cumulatively, they become burdensome such that the balance between permitting eligible persons access to VAD on the grounds of autonomy and compassion and safeguarding the vulnerable is tilted so as to hinder reasonable access to VAD. The prime example is the volume of reporting, particularly that required of the co-ordinating medical practitioner. This may mean that health practitioners decline to be involved in VAD due to these burdens, especially when added to the significant duties noted above in relation to the request, assessment and access processes. While the manner in which these reporting duties will be implemented is not yet clear, it is at least noted on the face of the legislation that this reporting burden may deter involvement and hinder access to VAD, thus potentially compromising the policy goals of respect for autonomy and alleviation of suffering.

IV CONCLUSION

Stepping beyond entrenched arguments for and against VAD, this article evaluated instead whether the *VAD Act* reflects its own stated policy goals. It first analysed the Report that provided the foundation for the Act, along with its legislative principles, to discern six key policy goals that underpin the legislation:

- To respect all human life;
- To respect personal autonomy;
- To safeguard the vulnerable and the community;
- To provide high-quality care;
- To respect individual conscience; and
- To alleviate human suffering (compassion).

The article then analysed the major parts of the *VAD Act* to determine whether they reflected those identified policy goals. A failure to align with goals was the focus of this analysis, as legislation that achieves intended objectives is to be anticipated. The overall conclusion was that there are important respects in which the Act fails to reflect its own

211 Researchers agree that reporting all cases of VAD is important to safeguard the quality of the process: Tinne Smets et al, 'Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases' (2010) 341(7777) *British Medical Journal* 819, 825.

policy goals. Key examples of this are: having self-administration as the default means of providing VAD and allowing practitioner administration only in very limited circumstances; requiring time limits to death and those time limits varying depending on the nature of a person's illness; prohibiting medical practitioners from raising VAD with persons; and creating a system that when considered globally is very complex and arguably burdensome for persons seeking access to VAD and medical practitioners.

While being critical in relation to these findings of policy misalignment, it is important to consider how and why they occurred. It was suggested earlier that the design of the Act was a reflection of the political strategy necessary for it to pass the Victorian Parliament. Indeed, the original Bill, which was already very narrow and with many safeguards, was not conservative enough initially to pass Victoria's upper house, the Legislative Council. It is suggested that decisions about the design of the law, including by the Panel, were shaped by an awareness of what might be needed to secure necessary political support. This is not to suggest that the Panel's deliberations were purely political, and without careful regard to its nine guiding principles underpinning the six policy goals set out above. However, it is argued that the Panel, and the Victorian Government in drafting the VAD Bill, also had regard to more pragmatic considerations such as what sort of law would be capable of attracting the necessary political support. This understandable intrusion of politics into decision-making about policy is one reason the *VAD Act* does not adequately reflect its stated policy goals in some key respects.

This policy misalignment was also exacerbated by the need for more overt political compromise. As noted above, alterations to the VAD Bill were required for the Legislative Council to pass the *VAD Act*. Arguably, such late changes to Bills are not principle-based decisions but rather pragmatic concessions needed to garner sufficient support to pass a law. As such, instead of being new ways to advance the legislation's stated policy goals, these 'add-ons' can often actually be in conflict with those goals. An example of this, as mentioned earlier, is the changes to the period of time expected until the person's death. The original VAD Bill that was passed by the Victorian Legislative Assembly provided for a 12-month period. This period was then halved to six months, except for a subset of medical conditions that had a neurological basis, for which cases the 12-month period was retained.[212] The imposition of a time limit, and particularly different time limits for different conditions, was critiqued earlier in this article as inconsistent with stated policy goals. This is an obvious example of where overt but necessary political compromise caused policy misalignment.

The analysis in this article has focused on the legislation itself rather than implementation. It is acknowledged, however, that it is possible for effective implementation to address some of the ways in which the legislation fails to best reflect its policy goals.[213] One example is the complexity of, and the burdens imposed by, the VAD request and assessment processes, and the corresponding duties of reporting. It is possible that well-designed systems could facilitate access to VAD for eligible persons and avoid undue burdens for medical practitioners, while still effectively safeguarding the vulnerable. While those responsible for the law's implementation should be mindful of opportunities to better advance policy goals, this will not always be possible. Some

212 See Part III(B)(2)(ii) 'Six Months until Death'.

213 White, Willmott and Close (n 19).

gaps between policy goals and the *VAD Act* are structurally embedded in the legislation and cannot be alleviated. An example is eligibility limits relating to expected times until death and the prohibition on raising VAD with persons.

A final observation is to note is that this analysis has implications for wider VAD reform in Australia as other states actively consider law reform in this area. As this article was being written, Western Australia passed its *Voluntary Assisted Dying Act 2019* (WA), following reports by a Parliamentary Committee[214] and then a Ministerial Expert Panel.[215] Both Queensland and South Australia have established Parliamentary Committees whose terms of reference include VAD, with the Queensland Committee recommending VAD reform.[216] A draft Tasmanian Bill has been released for consultation by the Hon Michael Gaffney[217] and a Bill is also expected to be introduced into the New South Wales parliament within the foreseeable future.[218] The default position for other states is likely to be adopting the Victorian model, or at least to use it as a starting point for their proposed law.[219] This was the case with the Western Australian Act which is very similar to the Victorian law. However, this analysis has concluded that the *VAD Act* does not advance its stated policy goals in important respects. This suggests critical review is needed by other states considering reform. A more principled approach is suggested,[220] with each aspect of proposed laws being tested against those principles or policy goals to ensure policy coherence of the law.

This needs to be done individually in relation to each aspect of the law but it must also be done globally in relation to the law as a whole and how it will operate. The claim of the Victorian VAD system to be the most conservative in the world has implications for access for VAD. The many safeguards and processes that form part of that claim, when considered in total, are likely to present challenges for persons seeking access to VAD and medical practitioners. These concerns were specifically identified in this article both in relation to reporting and also the processes for requesting, being assessed and then accessing VAD. It is only when the Act as a whole is considered that the complexity in the VAD system becomes clear.

When thinking about the politics of reform, it can be tempting to only consider each safeguard or process individually. Each may have merit and advance a particular policy goal. It may also be difficult politically to argue that a specific safeguard is not needed, particularly if it appears to achieve at least some useful purpose. However, when the safeguards are aggregated, the VAD system as a whole can become very complex and

214 Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (First Report, 23 August 2018).

215 Government of Western Australia, Department of Health, *Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, July 2019).

216 Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland*, Voluntary Assisted Dying* (Report No 34, 31 March 2020) 105 (Recommendation 1); Joint Committee on End of Life Choices, Parliament of South Australia, *Terms of Reference* (April 2019).

217 End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) <http://www.parliament.tas.gov.au/LC/gaffney/EOL.pdf>.

218 Carla Mascarenhas, 'Port Macquarie State Election Candidates Debate Assisted Dying for the Terminally Ill', *Port Macquarie News* (online, 26 February 2019) <https://www.portnews.com.au/story/5925502/state-election-candidates-debate-assisted-dying-for-the-terminally-ill/>.

219 White and Willmott, 'Victoria May Soon Have Assisted Dying Laws for Terminally Ill Patients' (n 2). Note, however, that this is not the case in Queensland: see Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland (n 216) 105 (Recommendation 1), which proposed instead that the starting point for reform be the draft Bill outlined in Ben White and Lindy Willmott, 'A Model Voluntary Assisted Dying Bill' (2019) 7(2) *Griffith Journal of Law and Human Dignity* 1.

220 Willmott and White (n 1) 484–8. Such a model is presented in Bill form in White and Willmott (n 219).

unwieldly, and slowly take the legislation away from its policy goals. This 'policy drift by a thousand cuts' – the incremental loss of policy focus through accumulation of individual safeguards without reference to the whole – is a key issue for other states to consider when evaluating their proposed VAD reforms. It is suggested that each part of the law be evaluated both on its own, and also for its impact on the functioning of the overall system. This is needed to enable VAD laws to meet their policy goals, in particular, the two key goals at the core of the design of the *VAD Act*: safeguarding the vulnerable while respecting the autonomy of eligible persons who wish to access to VAD.