

VOLUNTARY ASSISTED DYING IN AUSTRALIA: A COMPARATIVE AND CRITICAL ANALYSIS OF STATE LAWS

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In the last five years, voluntary assisted dying ('VAD') has been legalised in all six Australian states, after more than two decades of unsuccessful law reform efforts. After Victoria first legalised VAD, other Australian states largely followed the Victorian framework. The resultant 'Australian model' of VAD is highly prescriptive and includes narrow eligibility requirements, a highly regulated request and assessment process, pre-authorisation before administration of VAD in four states, and contemporaneous reporting throughout the process. However, in light of the early Victorian experience, some state laws have significantly departed from the Victorian model: notably introducing more flexible eligibility criteria, different criteria to choose practitioner administration of VAD, and provisions regulating non-participation by facilities. This article compares and evaluates the key variations between Australian VAD laws and identifies opportunities for reform, which may inform the legislatively mandated reviews of each state's VAD laws and potential law reform in the territories.

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I INTRODUCTION

The last five years have been a watershed time for voluntary assisted dying ('VAD') in Australia, with all Australian states legalising this practice in quick succession. After two decades of unsuccessful attempts at law reform,¹ in November 2017,² Victoria became the first Australian state to legalise VAD.³ This reform followed several years of extensive public consultation⁴ and a wide-ranging parliamentary debate. The *Voluntary Assisted Dying Act 2017* (Vic) has been described by the government as the most conservative and safest VAD model in the world, containing 68 safeguards.⁵ It is a comprehensive and prescriptive piece of legislation which details the eligibility requirements to access VAD, the request and assessment process, and the rights and obligations of participating practitioners. It also creates a new independent statutory body (the Voluntary Assisted Dying Review Board) responsible for monitoring activity and ensuring compliance under the Act.⁶

As anticipated,⁷ other Australian states have largely based their laws on the Victorian model, reflecting the United States experience, where the VAD laws are modelled on the Oregon prototype.⁸

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- 1 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 ('Failed) Voluntary Euthanasia Law Reform').
 - 2 The *Voluntary Assisted Dying Act 2017* (Vic) ('VAD Act (Vic)') passed on 29 November 2017 and came into effect on 19 June 2019, after an 18-month implementation period.
 - 3 Assisted dying was briefly legal in the Northern Territory ('NT') from 1996–97: *Rights of the Terminally Ill Act 1995* (NT), until the Commonwealth Government removed the territory's power to legislate on the topic: *Euthanasia Laws Act 1997* (Cth).
 - 4 In 2015–16, the Victorian Parliament's Legal and Social Issues Committee conducted an inquiry into end-of-life choices. It received over 1,000 submissions and conducted numerous public hearings: Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, 9 June 2016) 3–6 ('Victorian Committee Report'). In 2017, the Victorian Government convened a Ministerial Advisory Panel on Voluntary Assisted Dying, which was responsible for developing a VAD framework for Victoria. The panel received 176 submissions and conducted a number of forums and roundtables with stakeholders: Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 21 July 2017) 10 ('Victorian Panel Report').
 - 5 Premier of Victoria, 'Voluntary Assisted Dying Model Established ahead of Vote in Parliament' (Media Release, 25 July 2017) <<https://www.premier.vic.gov.au/voluntary-assisted-dying-model-established-ahead-of-vote-in-parliament/>>.
 - 6 *VAD Act* (Vic) (n 2) ss 93(1)(a)–(b), (d).
 - 7 Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42(6) *Australian Health Review* 616, 616–20 <<https://doi.org/10.1071/ah18199>>.
 - 8 Thaddeus Mason Pope, 'Medical Aid in Dying: Key Variations among US State Laws' (2020) 14(1) *Journal of Health and Life Sciences Law* 25, 29 <<https://dx.doi.org/10.2139/ssrn.3743855>>.

When Western Australia ('WA') (the second state to legalise VAD) began its consultation process,⁹ the Ministerial Expert Panel considered international VAD frameworks,¹⁰ but chose to adopt the conservative and prescriptive Victorian framework as a starting point. It then focused its attention on aspects of the Victorian model that might not be suitable for WA, particularly in view of geographical and cultural differences between the states.¹¹ In 2021, Tasmania, South Australia ('SA') and Queensland all passed laws legalising VAD, followed by New South Wales ('NSW') in 2022. These laws all largely reflect the Victorian or WA VAD laws, particularly in relation to core components such as eligibility criteria and the detailed VAD request and assessment process.

The 'Australian model' of VAD that has emerged is distinctive and characterised by lengthy legislation containing much prescriptive detail. Access to VAD is restricted to those who are suffering from a terminal illness and are at the end of life, usually within six months of death, although this is extended to 12 months in certain circumstances. The laws contain a highly regulated request and assessment process, consisting of multiple requests by the person wishing to access VAD, at least two formal assessments, and contemporaneous reporting at all stages of the process. However, some states have departed from the Victorian model in some notable ways in light of the early Victorian experience.

This article undertakes the first comparative analysis of the broad contours of this new Australian model of VAD. It focuses on key similarities and differences between the Australian VAD laws across six central aspects of the framework. These are: the eligibility criteria (Part II), the request and assessment process (Part III), methods of administration (Part IV), participation by practitioners (Part V), conscientious objections of health practitioners (Part VI), and non-participation by facilities (Part VII). The analysis of key differences between states' laws will be especially significant for the emerging and future body of empirical research on the impact that variation in state law has on the operation of the different Australian states' VAD systems. The article concludes by critically evaluating the variations between Australian VAD laws (Part VIII) and by identifying opportunities for reform (Part IX). This analysis may inform the legislatively mandated reviews of each state's VAD laws,¹² and potential VAD law reform in the territories, now that

9 In 2017–18, VAD was considered by the Western Australian Parliament's Joint Select Committee on End of Life Choices: Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (Report No 1, 23 August 2018). It was then subject of a report by the specially commissioned Ministerial Expert Panel in 2019: Ministerial Expert Panel on Voluntary Assisted Dying, Department of Health (WA), *Final Report* (Report, 27 June 2019) ('*WA Panel Report*').

10 *WA Panel Report* (n 9) 2, 132–8.

11 *Ibid* 1–2.

12 The *VAD Act* (Vic) must be reviewed sometime between 19 June 2023 and 18 June 2024: *VAD Act* (Vic) (n 2) s 116. In Western Australia, the Act must be reviewed in the latter half of 2023: *Voluntary Assisted Dying Act 2019* (WA) s 164(1)(a) ('*VAD Act* (WA)'). The legislation in the other states will be reviewed between late 2025 and the end of 2027. The law must be reviewed after it has been operational for two years in New South Wales ('NSW') (after November 2025), and after it has been operational for three years in Queensland (2026) and Tasmania (after October 2025): *Voluntary Assisted Dying Act 2022* (NSW) s 186(1)(a) ('*VAD Act* (NSW)'); *Voluntary Assisted Dying Act 2021* (Qld) s 154(1) ('*VAD Act*

the ban prohibiting the territories from legalising VAD has been overturned by the federal government.¹³

A Terminology

The VAD laws in each state use slightly different terminology to refer to the formal roles of practitioners providing VAD. For convenience, this article uses standardised terminology. We refer to the main medical practitioner involved as the ‘*coordinating practitioner*’¹⁴ (termed the ‘coordinating medical practitioner’ in SA and Victoria¹⁵ and ‘primary medical practitioner’ in Tasmania).¹⁶ The ‘*consulting practitioner*’¹⁷ refers to the medical practitioner who performs the consulting assessment (called ‘consulting medical practitioner’ in SA, Tasmania and Victoria).¹⁸ The practitioner who administers the VAD substance is called the ‘*administering practitioner*’¹⁹ (known as the ‘administering health practitioner’ in Tasmania).²⁰

II ELIGIBILITY CRITERIA

As an essential part of the VAD framework, eligibility criteria determine who can access VAD. The Australian states have adopted narrow, prescriptive criteria for eligibility for VAD, significantly restricting access when compared with most international legislative models.²¹ Table 1 provides an overview of the eligibility criteria in all six states.

(Qld)’); *End-Of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 145(2) (‘*EOLC Act* (Tas)’). In South Australia (‘SA’), the law must be reviewed in its fifth year of operation (2027): *Voluntary Assisted Dying Act 2021* (SA) s 129(2) (‘*VAD Act* (SA)’).

13 From 1997 to 2022, the territories were banned from legalising voluntary assisted dying (‘VAD’) due to the passage of the *Euthanasia Laws Act 1997* (Cth). This ban was lifted in December 2022 with the enactment of the *Restoring Territory Rights Act 2022* (Cth).

14 *VAD Act* (NSW) (n 12) s 24; *VAD Act* (Qld) (n 12) s 18; *VAD Act* (WA) (n 12) s 23.

15 *VAD Act* (SA) (n 12) s 33; *VAD Act* (Vic) (n 2) s 15. In Victoria, the term is ‘co-ordinating medical practitioner’.

16 *EOLC Act* (Tas) (n 12) s 22.

17 *VAD Act* (NSW) (n 12) s 35; *VAD Act* (Qld) (n 12) s 29; *VAD Act* (WA) (n 12) s 34.

18 *VAD Act* (SA) (n 12) s 42; *EOLC Act* (Tas) (n 12) s 42; *VAD Act* (Vic) (n 2) s 24.

19 *VAD Act* (NSW) (n 12) sch 1 (definition of ‘administering practitioner’); *VAD Act* (Qld) (n 12) sch 1 (definition of ‘administering practitioner’); *VAD Act* (WA) (n 12) s 5 (definition of ‘administering practitioner’).

20 *EOLC Act* (Tas) (n 12) s 61. This separate role does not exist in SA or Victoria, as the coordinating practitioner administers the substance where practitioner administration is required in those states.

21 For an overview of eligibility criteria in other countries, see Sarah Mroz et al, ‘Assisted Dying around the World: A Status Quaestionis’ (2021) 10(3) *Annals of Palliative Medicine* 3540, 3546–7 <<https://doi.org/10.21037/apm-20-637>>. See also Ben P White et al, ‘Who Is Eligible for Voluntary Assisted Dying? Nine Medical Conditions Assessed against Five Legal Frameworks’ (2022) 45(1) *University of New South Wales Law Journal* 401 <<https://doi.org/10.53637/FYID9182>> (‘Who Is Eligible for Voluntary Assisted Dying?’).

Table 1: Eligibility Criteria

	Age	NSW	Queensland	SA	Tasmania	Victoria	WA
Residency	Over 18 Years Old	YES	YES	YES	YES	YES	YES
	Australian Citizen or Permanent Resident	YES (or has been a resident in Australia for at least 3 continuous years at the time of the first request)	YES (or has been ordinarily resident in Australia for at least 3 years immediately before the first request, or has been granted an exemption)	YES	YES (or has been a resident in Australia for at least 3 continuous years immediately before the first request)	YES	YES
	Ordinarily Resident in State for 12 Months at Time of First Request	YES (or has been granted an exemption)	YES (or has been granted an exemption)	YES	YES	YES	YES
	Diagnosed with a Disease, Illness or Medical Condition	YES	YES	YES	YES (or injury)	YES	YES
Condition	Advanced, Progressive and Will Cause Death	YES	YES	YES	Advanced, incurable, irreversible and is expected to cause death	YES	YES
	Incurable	NO	NO	YES	YES	YES	NO

Table 1: Eligibility Criteria (cont.)

Condition	Is Causing Suffering	NSW	Queensland	SA	Tasmania	Victoria	WA
		YES	YES	YES	YES	YES	YES
Mental State	Death Expected Within a Specific Timeframe	YES (6 months or 12 months for a neurodegenerative condition)	YES (12 months)	YES (6 months or 12 months for a neurodegenerative condition)	YES (6 months or 12 months for a neurodegenerative condition or has been granted an exemption)	YES (6 months or 12 months for a neurodegenerative condition)	YES (6 months or 12 months for a neurodegenerative condition)
	Decision-Making Capacity	YES	YES	YES	YES	YES	YES
	Voluntary and Without Coercion	YES	YES	YES	YES	YES (not in eligibility criteria but must be assessed at various stages)	YES
Enduring		YES	YES (not an express criterion but 3 separate requests required)	YES (not in eligibility criteria but must be determined at various stages)	YES (not an express criterion but 3 separate requests required)	YES (not in eligibility criteria but must be determined at various stages)	YES

A Age

In all six states, one of the eligibility criteria for access to VAD is that the person must be an adult: that is, be at least 18 years of age.²² This criterion is consistent with the presumption that adults have decision-making capacity to consent to medical treatment.

B Residency

All Australian states include two residency requirements as criteria of eligibility for VAD. One relates to Australian citizenship or long-term residence. The second requires a person to be a resident in the state for 12 months before applying to access VAD. Taken together, these criteria are designed to prevent people travelling from other countries or other Australian states or territories to access VAD.²³

1 Australian Citizenship or Residence

In SA, Victoria, and WA, a person must either be an Australian citizen or a permanent resident to access VAD.²⁴ These statutes do not define ‘permanent resident’, but government policy guidelines in Victoria and WA have interpreted the term to require a person to hold a permanent residency visa.²⁵ This means that some individuals who have resided in Australia for decades but have not applied for citizenship or permanent residency (including New Zealand citizens)²⁶ will not be eligible for VAD.²⁷

The laws in NSW, Queensland and Tasmania contain broader citizenship or permanent residency criteria, which ameliorate some of the rigidity of the Victorian requirements, particularly the ‘unintended consequences’ of excluding long-term residents from access to VAD.²⁸ In these three states, a person who has resided in

22 *VAD Act* (NSW) (n 12) s 16(1)(a); *VAD Act* (Qld) (n 12) s 10(1)(d); *VAD Act* (SA) (n 12) s 26(1)(a); *EOLC Act* (Tas) (n 12) s 7(a); *VAD Act* (Vic) (n 2) s 9(1)(a); *VAD Act* (WA) (n 12) s 16(1)(a).

23 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2948 (Jill Hennessy).

24 *VAD Act* (SA) (n 12) s 26(1)(b)(i); *VAD Act* (Vic) (n 2) s 9(1)(b)(i); *VAD Act* (WA) (n 12) s 16(1)(b)(i).

25 Department of Health (WA), ‘Western Australian Voluntary Assisted Dying Guidelines’ (Clinical Guideline, 2022) 34 (‘WA VAD Guidelines’); Department of Health and Human Services (Vic), ‘Voluntary Assisted Dying Guidance for Health Practitioners’ (Clinical Guideline, 4 July 2019) 1, 73 (‘Victorian VAD Guidance’). For a critique of this interpretation, see Katrine Del Villar, Lindy Willmott and Ben P White, ‘The Exclusion of Long-Term Australian Residents from Access to Voluntary Assisted Dying: A Critique of the “Permanent Resident” Eligibility Criterion’ 49(2) *Monash University Law Review* (forthcoming).

26 New Zealand citizens can reside indefinitely in Australia on a Special Category visa (subclass 444), which is designated a ‘temporary’ class of visa, so they are not classified as ‘permanent residents’. For further discussion of the status of New Zealand citizens and others who are not technically ‘permanent residents’, see Del Villar, Willmott and White (n 25).

27 This has already occurred in two reported cases: *YSB v YSB (Human Rights)* [2020] VCAT 1396; *Finding into Death without Inquest: Julian Victor Charles Bareuther* (Victorian Coroner’s Court, Coroner Byrne, 10 June 2020). For more discussion as to the extent of this problem, see Lindy Willmott et al, ‘Participating Doctors’ Perspectives on the Regulation of Voluntary Assisted Dying in Victoria: A Qualitative Study’ (2021) 215(3) *Medical Journal of Australia* 125, 125–7 <<https://doi.org/10.5694/mja2.51123>> (‘Participating Doctors’ Perspectives’); Del Villar, Willmott and White (n 25).

28 Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (Report No 79, May 2021) 151 [7.391], 161 [7.462] (‘QLRC Report’).

Australia for at least three years prior to making their first request²⁹ may be eligible for VAD without needing to provide documentary evidence of citizenship or a permanent resident visa.

Queensland's VAD law includes two additional classes of people as eligible for VAD: a New Zealand citizen;³⁰ and a person who is granted a residency exemption.³¹ A residency exemption must be granted if the person has a 'substantial connection' to Queensland and there are 'compassionate grounds' for granting the exemption,³² for example, a former Queensland resident who has family in that state.

2 State Residence

In addition to requirements relating to Australian citizenship or residence, VAD laws in all Australian states require the person to have been ordinarily resident in the relevant state for 12 months prior to making their first request.³³ This requirement is designed to prevent VAD 'tourism' within Australia, so that a resident of a jurisdiction where VAD is not lawful is unable to obtain VAD in a state where it is.³⁴

Only NSW³⁵ and Queensland³⁶ permit any flexibility in relation to the 12 month state residency requirement, permitting an exemption to be granted if there is a 'substantial connection' to the state and there are 'compassionate grounds' for granting the exemption.³⁷ Examples where an exemption may be granted include where a person lives close to the state border and works and receives medical care in the state, or is a former state resident who has family in that state.³⁸

C Medical Condition

The description of the person's medical condition which renders them eligible for VAD is similar in all six states.

29 In NSW and Tasmania, the person must have resided in Australia for at least three continuous years: *VAD Act* (NSW) (n 12) s 16(1)(b)(iii); *EOLC Act* (Tas) (n 12) s 11(1)(a)(iii). In Queensland, they must have been 'ordinarily resident' in Australia but may have left Australia for some periods of time: *VAD Act* (Qld) (n 12) s 10(1)(e)(iii).

30 Technically, this requirement applies to a New Zealand citizen who is resident in Australia on a special category visa (subclass 444), which is the visa automatically granted to most New Zealand residents living in Australia: *VAD Act* (Qld) (n 12) s 10(2)(b).

31 *Ibid* s 10(1)(e)(iv).

32 *Ibid* s 12(2).

33 *VAD Act* (NSW) (n 12) s 16(1)(c); *VAD Act* (Qld) (n 12) s 10(1)(f)(i); *VAD Act* (SA) (n 12) ss 26(1)(b)(ii)–(iii); *EOLC Act* (Tas) (n 12) s 11(1)(b); *VAD Act* (Vic) (n 2) ss 9(1)(b)(ii)–(iii); *VAD Act* (WA) (n 12) s 16(1)(b)(ii).

34 *Victorian Panel Report* (n 4) 56; *Victorian Committee Report* (n 4) 221; *WA Panel Report* (n 9) 20; *QLRC Report* (n 28) 158 [7.435].

35 *VAD Act* (NSW) (n 12) s 17(1).

36 *VAD Act* (Qld) (n 12) s 10(1)(f)(ii).

37 *VAD Act* (NSW) (n 12) s 17(2); *ibid* s 12(2).

38 *VAD Act* (Qld) (n 12) ss 10(1)(f)(ii), 12(2)(a). See also *VAD Act* (NSW) (n 12) s 17(2)(a).

1 Diagnosed with a Relevant Medical Condition

In all states, to be eligible for VAD, a person must be diagnosed with a ‘disease, illness or medical condition’.³⁹ Disability or mental illness alone will not satisfy this requirement.⁴⁰ The law in NSW also specifies that a person with dementia is not eligible for VAD by virtue of that condition alone.⁴¹ The Tasmanian statute includes ‘injury’ in its definition of ‘relevant medical condition’.⁴² It is unclear whether the inclusion of ‘injury’ broadens the eligibility criteria compared to those jurisdictions which require a person to have a ‘disease, illness or medical condition’, particularly given the injury must be advanced, incurable and expected to cause the person’s death within six months.

2 Medical Condition that Is Advanced and Progressive

The VAD laws in five states require that the person be diagnosed with a disease, illness or medical condition that is advanced and progressive.⁴³ The Tasmanian law requires only that the condition be advanced.⁴⁴

Neither ‘advanced’ nor ‘progressive’ are defined in the statutes. The Victorian and WA Departments of Health have suggested that the term ‘advanced’ ‘refers to a point in the trajectory of the patient’s medical condition’,⁴⁵ meaning that individuals in the early stages of a terminal condition will not be able to access VAD.⁴⁶ The term ‘progressive’ ‘indicates that the patient is experiencing an active deterioration that will continue to decline’.⁴⁷ Although Tasmania does not require the condition to be progressive, this omission is unlikely to widen access because of the required timeframe to death.

3 Medical Condition that Is Incurable and Irreversible

The Victorian, SA and Tasmanian laws require that the person’s condition be incurable. In Tasmania, whether a medical condition is ‘incurable’ is subjectively assessed, whereas in Victoria it is objectively assessed. This difference may be practically relevant in some cases.

While the term ‘incurable’ is not defined in the Victorian legislation, during parliamentary debates, Minister Jennings stated that whether or not a condition is

39 *VAD Act* (NSW) (n 12) s 16(1)(d); *VAD Act* (Qld) (n 12) s 10(1)(a); *VAD Act* (SA) (n 12) s 26(d); *EOLC Act* (Tas) (n 12) s 6(1); *VAD Act* (Vic) (n 2) s 9(d); *VAD Act* (WA) (n 12) s 16(c).

40 *VAD Act* (NSW) (n 12) ss 16(2)(a), (c); *VAD Act* (Qld) (n 12) s 13(1)(b); *VAD Act* (SA) (n 12) ss 26(2)–(3); *EOLC Act* (Tas) (n 12) s 10(2); *VAD Act* (Vic) (n 2) ss 9(2)–(3); *VAD Act* (WA) (n 12) s 16(2).

41 *VAD Act* (NSW) (n 12) s 16(2)(b).

42 *EOLC Act* (Tas) (n 12) s 6(1).

43 *VAD Act* (NSW) (n 12) s 16(1)(d)(i); *VAD Act* (Qld) (n 12) s 10(1)(a)(i); *VAD Act* (SA) (n 12) s 26(1)(d)(ii); *VAD Act* (Vic) (n 2) s 9(d)(ii); *VAD Act* (WA) (n 12) s 16(1)(c)(i).

44 *EOLC Act* (Tas) (n 12) s 6(1)(a).

45 *WA VAD Guidelines* (n 25) 35; *Victorian VAD Guidance* (n 25) 37.

46 Ben P White et al, ‘Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks’ (2021) 44(4) *University of New South Wales Law Journal* 1663, 1671 <<https://doi.org/10.53637/JUWL9208>> (‘Comparative and Critical Analysis’).

47 *WA VAD Guidelines* (n 25) 35; *Victorian VAD Guidance* (n 25) 37.

incurable is ‘an objective test *based on available medical treatments*’.⁴⁸ Applying this ‘objective’ test, a person would not be eligible for VAD if they refused treatment for a curable condition (for example, an operable tumour).⁴⁹ This is likely to also be the position in SA, given its legislation is closely based on the Victorian model.

The Tasmanian statute, by contrast, provides an explicitly ‘subjective test’ for determining whether a condition is ‘incurable and irreversible’: that is, only if there is no ‘reasonably available treatment that is *acceptable to the person*’ and that ‘can cure or reverse’ the condition.⁵⁰

The laws in NSW, Queensland and WA do not require the person’s condition to be incurable. During the WA parliamentary debate, it was stated that, consistent with the principle of autonomy, a person should be able to refuse treatment that they deem unreasonable, and the legislation should not require people to exhaust all treatment options to be eligible for VAD.⁵¹ Similarly, the Queensland Law Reform Commission (‘QLRC’) report suggested that including this criterion would be unnecessary and may lead to confusion.⁵²

4 Medical Condition that Causes Suffering

‘Suffering’ is required in all Australian states. The NSW, SA, Victorian and WA Acts require the person’s condition to be ‘causing suffering to the person that cannot be relieved in a manner that the person considers tolerable’.⁵³ The Queensland statute requires the condition to be ‘causing suffering that the person considers intolerable’⁵⁴ and the Tasmanian statute requires the person to be ‘suffering intolerably’ from the condition.⁵⁵ Each Act requires a causal link between the person’s suffering and their condition, although the Queensland and Tasmanian Acts also explicitly include suffering caused by the treatment of the person’s condition.⁵⁶

48 Victoria, *Parliamentary Debates*, Legislative Council, 21 November 2017, 6218 (Gavin Jennings) (emphasis added). See also Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 3 cl 9. In interpreting provisions of a statute, consideration may be given to extrinsic material including parliamentary proceedings, explanatory memoranda, and reports of Parliamentary Committees and other committees of inquiry: *Interpretation of Legislation Act 1984* (Vic) s 35(b). See also White et al, ‘Comparative and Critical Analysis’ (n 46) 1670–1.

49 Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6586 (Michael Nahan). See also White et al, ‘Comparative and Critical Analysis’ (n 46) 1695.

50 *EOLC Act* (Tas) (n 12) s 6(2) (emphasis added).

51 Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6586 (Mark McGowan, Premier).

52 *QLRC Report* (n 28) 100 [7.74].

53 *VAD Act* (NSW) (n 12) s 16(1)(d)(iii); *VAD Act* (SA) (n 12) s 26(1)(d)(iv); *VAD Act* (Vic) (n 2) s 9(1)(d)(iv); *VAD Act* (WA) (n 12) s 16(1)(c)(iii).

54 *VAD Act* (Qld) (n 12) s 10(1)(a)(iii).

55 *EOLC Act* (Tas) (n 12) s 10(1)(e).

56 *VAD Act* (Qld) (n 12) s 10(2); *ibid* s 14(b)(iii).

Suffering is broadly interpreted⁵⁷ or explicitly defined⁵⁸ to include both physical and non-physical suffering. The Tasmanian Act also requires the suffering to be ‘persistent’,⁵⁹ which may suggest a higher threshold requirement compared to other states. Despite some differences in wording between the states, these differences may be less significant in practice, as in each state the level of suffering is a ‘subjective’ assessment, determined by the person.⁶⁰

5 Timeframe until Death

In all six states, eligibility for VAD depends on the person being expected to die within a specified timeframe. In all states, except Queensland, a person must be expected to die within six months unless their condition is neurodegenerative, in which case death must be expected within 12 months. This differential timeframe was introduced during parliamentary debate in Victoria, to accommodate the varying clinical trajectories that people with neurodegenerative conditions may experience, such as an earlier loss of motor skills and potential decline in cognitive capacity.⁶¹ This approach was subsequently adopted in the other four Australian states. This differential timeframe has been criticised,⁶² and was not adopted in Queensland, where a single timeframe of being expected to die within 12 months was preferred,⁶³ as it does not discriminate against people with non-neurodegenerative conditions.⁶⁴

The difficulties of accurately predicting time until death are well-recognised.⁶⁵ In an attempt to address this complexity, the NSW and WA Acts contain a requirement that life expectancy be assessed on the ‘balance of probabilities’.⁶⁶ This requires medical practitioners to be satisfied that it is more likely than not⁶⁷

57 *Victorian VAD Guidance* (n 25) 39; *Victorian Panel Report* (n 4) 77; *WA VAD Guidelines* (n 25) 36; *WA Panel Report* (n 9) 34–5.

58 The Queensland Act specifically defines the term to include ‘physical or mental suffering’: *VAD Act* (Qld) (n 12) s 10(2). The Tasmanian Act includes ‘anticipation of the suffering’ in its definition: *EOLC Act* (Tas) (n 12) ss 14(b)(ii), (iv), (vi).

59 *EOLC Act* (Tas) (n 12) s 14(b).

60 *Victorian VAD Guidance* (n 25) 39; *WA VAD Guidelines* (n 25) 36. See generally White et al, ‘Comparative and Critical Analysis’ (n 46) 1692–3.

61 Victoria, *Parliamentary Debates*, Legislative Council, 16 November 2017, 6097–8 (Gavin Jennings); Victoria, *Parliamentary Debates*, Legislative Council, 21 November 2017, 6216 (Gavin Jennings).

62 Ben P White et al, ‘Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?’ (2020) 43(2) *University of New South Wales Law Journal* 417, 433–4 <<https://doi.org/10.53637/REQJ5610>> (‘Stated Policy Goals?’).

63 *VAD Act* (Qld) (n 12) s 10(1)(a)(ii).

64 *QLRC Report* (n 28) 111 [7.147]–[7.149].

65 Joanne Lynn et al, ‘Defining the “Terminally Ill”: Insights from SUPPORT’ (1996) 35(1) *Duquesne Law Review* 311, 324–5; Eric Chevlen, ‘The Limits of Prognostication’ (1996) 35(1) *Duquesne Law Review* 337; James Downar 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* E484–93 <<https://doi.org/10.1503/cmaj.160775>>; Paul Glare et al, ‘Predicting Survival in Patients with Advanced Disease’ (2008) 44(8) *European Journal of Cancer* 1146, 1147 <<https://doi.org/10.1016/j.ejca.2008.02.030>>.

66 *VAD Act* (NSW) (n 12) s 16(1)(d)(ii); *VAD Act* (WA) (n 12) s 16(1)(c)(ii).

67 JD Heydon, *Cross on Evidence* (LexisNexis Butterworths, 13th ed, 2021) 412–15 [9050].

that the person will die within the specified timeframe. While this departure from the Victorian model was recommended to provide more clarity to medical practitioners,⁶⁸ parliamentary debates confirmed that it was not intended to provide a lower standard than the Victorian requirement.⁶⁹ Tasmania adopted a different approach to this uncertainty: its legislation authorises the Voluntary Assisted Dying Commission (‘Tasmanian VAD Commission’) to grant exemptions to this criterion if it is satisfied that the person’s prognosis is such that the specified timeframe should not apply.⁷⁰

D Mental State

Consistent with the prescriptive Australian approach to regulation, legislation in all states contains explicit and detailed requirements for ensuring that a person requesting VAD has an enduring wish to access VAD, has decision-making capacity, and is making a voluntary decision.

1 Decision-Making Capacity

In each Australian state, one of the eligibility criteria is that a person must have decision-making capacity in relation to VAD.⁷¹ Practitioners must assess capacity at multiple points throughout the VAD process. A person is presumed to have decision-making capacity unless there is evidence to the contrary;⁷² and the laws in Queensland, SA and Victoria recognise that some people may require additional practicable and tailored assistance to support their decision-making.⁷³ VAD in Australia is not available to a person who has lost capacity and it cannot be requested in an advance directive.

Each Act provides a slightly different test to assess decision-making capacity (outlined in Table 2). These variations generally reflect the terminology used in their own state legislation dealing with medical treatment, mental health and guardianship matters,⁷⁴ and are unlikely to lead to different eligibility outcomes across states.

68 Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6582 (Mark McGowan, Premier), 6606 (Roger Cook).

69 Western Australia, *Parliamentary Debates*, Legislative Council, 26 November 2019, 9196 (Stephen Dawson).

70 *EOLC Act* (Tas) (n 12) ss 6(3)–(4). See Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 54 (Ruth Forrest).

71 *VAD Act* (NSW) (n 12) s 16(1)(e); *VAD Act* (Qld) (n 12) s 10(1)(b); *VAD Act* (SA) (n 12) s 26(1)(c); *EOLC Act* (Tas) (n 12) s 10(1)(c); *VAD Act* (Vic) (n 2) s 9(1)(c); *VAD Act* (WA) (n 12) s 16(1)(d).

72 *VAD Act* (NSW) (n 12) s 6(2)(b); *VAD Act* (Qld) (n 12) s 11(2); *VAD Act* (SA) (n 12) s 4(2); *EOLC Act* (Tas) (n 12) s 12(2)(a); *VAD Act* (Vic) (n 2) s 4(2); *VAD Act* (WA) (n 12) s 6(3).

73 *VAD Act* (Qld) (n 12) s 11(3)(d); *VAD Act* (SA) (n 12) s 4(4)(d); *VAD Act* (Vic) (n 2) s 4(4)(d). Each state also recognises the right to supported decision-making in their principles: *VAD Act* (NSW) (n 12) s 4(1)(c); *VAD Act* (Qld) (n 12) s 5(f); *VAD Act* (SA) (n 12) s 8(1)(c); *EOLC Act* (Tas) (n 12) s 3(2)(c); *VAD Act* (Vic) (n 2) s 5(1)(c); *VAD Act* (WA) (n 12) s 4(1)(c).

74 *QLRC Report* (n 28) 120–3.

Table 2: Decision-Making Capacity for VAD in Australian States

	Victoria	WA	Tasmania	SA	Queensland	NSW
Understand relevant information	✓	✓	✓	✓	✗	✓
Understand the effect of decisions about VAD	✓	✓	✗	✓	✓	✓
Retain the relevant information	✓	✗	✓	✓	✗	✓
Use the relevant information as part of the decision-making process	✓	✓	✓	✓	✗	✓
Freely and voluntarily make decisions about access to VAD	✗	✗	✗	✗	✓	✗
Communicate the decision in some way	✓	✓	✓	✓	✓	✓

2 Voluntary and Free from Coercion

In all states except Victoria, one of the eligibility criteria requires the person's request for VAD to be made voluntarily (or freely in SA)⁷⁵ and without coercion.⁷⁶ These requirements reinforce the concept that access to VAD must be entirely voluntary.⁷⁷ While voluntariness is not included in Victoria's formal eligibility criteria, both coordinating and consulting practitioners must be satisfied that 'the person is acting voluntarily and without coercion' when assessing the person's eligibility.⁷⁸

3 Enduring

While NSW and WA are the only states to include the requirement that a request for VAD be 'enduring' in their formal eligibility criteria,⁷⁹ both SA and Victoria require that it be assessed at multiple points throughout the process.⁸⁰ Queensland and Tasmania do not explicitly require a request for VAD to be enduring. However,

75 *VAD Act* (NSW) (n 12) s 16(1)(f); *VAD Act* (Qld) (n 12) s 10(1)(c); *VAD Act* (SA) (n 12) s 26(1)(e); *EOLC Act* (Tas) (n 12) s 10(1)(d); *VAD Act* (WA) (n 12) s 16(1)(e).

76 *VAD Act* (Qld) (n 12) s 10(1)(c); *VAD Act* (SA) (n 12) s 26(1)(e); *EOLC Act* (Tas) (n 12) s 13; *VAD Act* (WA) (n 12) s 16(1)(e). In NSW, this is framed as without 'pressure or duress': *VAD Act* (NSW) (n 12) s 16(1)(g).

77 Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5.

78 *VAD Act* (Vic) (n 2) ss 20(1)(c), 29(1)(c).

79 *VAD Act* (NSW) (n 12) s 16(1)(h); *VAD Act* (WA) (n 12) s 16(1)(f).

80 *VAD Act* (SA) (n 12) ss 38(1)(d), 47(1)(d), 64(c)(iv), 65(3)(b), 66(3)(c), 81(1)(c), 82(2)(a)(iii), 83(1)(d); *VAD Act* (Vic) (n 2) ss 20(1)(d), 29(1)(d), 47(3)(b), 48(3)(c), 64(1)(c), 66(1)(d).

this criterion is implicit in the procedural requirements of the VAD systems,⁸¹ as a person must make multiple requests for VAD over a period of time, and on multiple occasions are asked whether they would like to withdraw from the process.

E Discussion

The eligibility criteria for all states closely resemble the criteria first enacted in Victoria. The Australian VAD laws reflect a narrow model of VAD which is only available to adults who are already in the terminal phase of an advanced and progressive medical condition. The requirement that a person's medical condition is expected to cause death within six or 12 months is probably the most significant limitation on who may access VAD in the Australian states.⁸² The differential six- or 12-month timeframe until death (depending on whether the person has a neurodegenerative condition) is a unique Victorian provision (when compared to international models),⁸³ which has since been adopted in most other Australian states. The stated (but contested)⁸⁴ rationale for this distinction was to allow a person with neurodegenerative disease to commence the VAD process further out from expected death, to accommodate the possible loss of capacity as their disease progresses. While this increased timeframe from expected death may benefit people with certain neurodegenerative conditions, such as motor neurone disease, it will not assist people with the most common neurodegenerative conditions (dementia and Alzheimer's disease) to access VAD as they are likely to lose decision-making earlier than 12 months from death. Nor will it be helpful for Huntington's patients, who suffer cognitive decline relatively early in the disease progression.⁸⁵ This differential approach also fails to recognise that other medical conditions may also cause persons to lose physical and mental capacity while seeking access to VAD.⁸⁶

Queensland has deliberately departed from the Victorian model, specifying a 12-month anticipated timeframe until death for all persons, not just those with a neurodegenerative condition. It remains to be seen whether this will allow more individuals to access VAD in Queensland than the other Australian states. However, as a person may begin the process earlier, it may alleviate some of the difficulties of prognostication, and may mean that fewer individuals will die during the process, as has been the experience in Victoria.⁸⁷ Tasmania has also incorporated more flexibility regarding a person's prognosis, by enabling exemptions from the timeframe to death criterion to be granted.⁸⁸

81 *QLRC Report* (n 28) 175 [7.562]–[7.563].

82 For a detailed discussion of this, see White et al, 'Who Is Eligible for Voluntary Assisted Dying?' (n 21). See also White et al, 'Comparative and Critical Analysis' (n 46).

83 In New Zealand and the United States, all statutes currently limit access to assisted dying to a person with a terminal illness whose death is expected to occur within six months: *End of Life Choice Act 2019* (NZ) s 5(1)(c); Pope (n 8) 55–6. In other countries, no temporal limit applies: see Mroz et al (n 21) 3546.

84 White et al, 'Stated Policy Goals?' (n 62) 433–4.

85 See White et al, 'Who Is Eligible for Voluntary Assisted Dying?' (n 21) 429.

86 White et al, 'Stated Policy Goals?' (n 62) 433–4.

87 *QLRC Report* (n 28) 112 [7.152].

88 *EOLC Act* (Tas) (n 12) ss 6(3)–(4).

The Australian citizen or permanent resident requirement has already caused difficulties in practice in Victoria.⁸⁹ SA and WA have replicated this requirement, so are likely to experience similar problems in practice. Other states have departed from the Victorian model, with NSW, Queensland and Tasmania drafting the residence criteria more flexibly and inclusively. These amendments should substantially alleviate the difficulties experienced by long-term Victorian residents in obtaining access to VAD.

Whether two separate residence requirements are necessary is a matter of debate. Currently, the laws in all states require that person to be a permanent resident or citizen of Australia (with some flexibility around this in NSW, Queensland and Tasmania). They separately require a person to be resident in the relevant state for at least 12 months before making an application for VAD. The Australian citizen or long-term residence requirement is effective in preventing VAD tourists from other countries from visiting Australia. However, there are two reasons to contemplate abandoning the requirement of ordinary residence within a state. The first is that VAD tourism within Australia is now unlikely as laws have been passed in all states.⁹⁰ Second, the state residence requirement may be unconstitutional, given section 117 of the *Australian Constitution* prohibits discrimination against residents of other states.⁹¹

III THE REQUEST AND ASSESSMENT PROCESS

The VAD request and assessment process in Australia is highly prescriptive. The process is broadly similar in all states and requires the person to make at least three separate requests and be assessed by at least two independent medical practitioners. This section provides an overview of the process in each state, beginning with restrictions on certain health practitioners and healthcare workers initiating a discussion about VAD.

A Initiating Discussions about VAD and Requests for Information

In each state, there are restrictions on healthcare workers initiating discussions about VAD with patients, though the nature of the restrictions varies.⁹² The SA

89 For a discussion of these difficulties, see Del Villar, Willmott and White (n 25); Willmott et al, 'Participating Doctors' Perspectives' (n 27) 127.

90 See *QLRC Report* (n 28) 165 [7.498]. Indeed, in its most recent report, the Victorian VAD Review Board raised the possibility of reciprocal provision of VAD to residents of other Australian states and New Zealand, which have legalised VAD: Voluntary Assisted Dying Review Board, *Report of Operations: July 2021 to June 2022* (Report, 21 September 2022) 31 ('*VAD Review Board Report of Operations*').

91 Katrine Del Villar and Amelia Simpson, 'Voluntary Assisted Dying for (Some) Residents Only: Have States Infringed Section 117 of the *Constitution*?' (2022) 45(3) *Melbourne University Law Review* 996; *QLRC Report* (n 28) 158–60 [7.441]–[7.450].

92 Where the topic of VAD is initiated by a person, health practitioners can freely discuss the subject and provide information to their patients: *VAD Act* (NSW) (n 12) s 10(4); *VAD Act* (Qld) (n 12) s 7(3); *VAD Act* (SA) (n 12) s 12(2); *EOLC Act* (Tas) (n 12) s 17(4); *VAD Act* (Vic) (n 2) s 8(2); *VAD Act* (WA) (n 12) s 10(4).

and Victorian statutes prohibit any registered health practitioner (but not non-registered healthcare workers) from initiating discussions about VAD with a person while providing health or professional care services.⁹³ While these provisions were incorporated to avoid undue influence on persons by their health practitioner, concerns have been raised that they potentially create barriers to providing timely and comprehensive end-of-life discussions.⁹⁴

In response to these criticisms, other states (except for SA) have departed from the rigidity of the Victorian model. In NSW, Queensland, Tasmania and WA, medical practitioners (as well as nurse practitioners in Queensland and WA) may initiate conversations about VAD, but only if they simultaneously inform the person about available treatment and palliative care options and their likely outcome.⁹⁵ In Queensland and WA, all other healthcare workers are prohibited from initiating VAD discussions.⁹⁶ By contrast, other registered health practitioners (in Tasmania), and other healthcare workers (in NSW) who are not medical practitioners have more flexibility: they may initiate discussions about VAD with their patients, provided they inform them that a medical practitioner is the most appropriate person with whom to discuss VAD and other care and treatment options.⁹⁷

Once the topic of VAD has been raised, there are no limitations on health practitioners or healthcare workers discussing it. Further, there are no restrictions on providing information to a person who has requested it.⁹⁸

These prohibitions are highly unusual in the context of healthcare, particularly in the end-of-life setting where the provision of information is an important component of patient-centred care.⁹⁹ The prohibitions significantly affect the scope of discussions that health practitioners may have with patients at the end of life. Further, in most states, contravention of these requirements results in health practitioners being found to have engaged in unprofessional conduct under the Health Practitioner Regulation National Law.¹⁰⁰

93 *VAD Act* (SA) (n 12) s 12(1); *VAD Act* (Vic) (n 2) s 8(1).

94 *WA Panel Report* (n 9) 30–1. See also Carolyn Johnston and James Cameron, ‘Discussing Voluntary Assisted Dying’ (2018) 26(2) *Journal of Law and Medicine* 454; Lindy Willmott et al, ‘Restricting Conversations about Voluntary Assisted Dying: Implications for Clinical Practice’ (2020) 10(1) *BMJ Supportive and Palliative Care* 105 <<https://doi.org/10.1136/bmjspcare-2019-001887>> (‘Restricting Conversations about Voluntary Assisted Dying’); 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 <<https://doi.org/10.5694/mja2.50437>>.

95 *VAD Act* (NSW) (n 12) ss 10(1)–(2); *VAD Act* (Qld) (n 12) ss 7(1)–(2); *EOLC Act* (Tas) (n 12) ss 17(1)–(2); *VAD Act* (WA) (n 12) ss 10(2)–(3).

96 *VAD Act* (Qld) (n 12) s 7(1); *VAD Act* (WA) (n 12) s 10(2).

97 *VAD Act* (NSW) (n 12) s 10(3); *EOLC Act* (Tas) (n 12) s 17(3). In NSW, a healthcare worker must also inform the person of their palliative care and treatment options, as well as recommending they discuss their options with a medical practitioner.

98 See above n 92.

99 Willmott et al, ‘Restricting Conversations about Voluntary Assisted Dying’ (n 94).

100 *VAD Act* (NSW) (n 12) s 11(1); *VAD Act* (SA) (n 12) s 12(3); *EOLC Act* (Tas) (n 12) s 17(5); *VAD Act* (Vic) (n 2) s 8(3); *VAD Act* (WA) (n 12) s 10(5). A finding of unprofessional conduct may result in a fine, suspension, condition being placed on practice, or in extreme cases, deregistration: see, eg, *Health Practitioner Regulation National Law Act 2010* (SA) s 191(3).

Table 3: Initiating Discussions about VAD

Can Healthcare Workers Initiate Discussions about VAD?				
	Victoria and SA	WA and QLD	Tasmania	NSW
Medical Practitioners	NO	YES But at the same time, they must inform the person of: available treatment options and their likely outcome available palliative care options and their likely outcome		
Nurse Practitioners	NO	YES But at the same time, they must inform the person of: available treatment options and their likely outcome available palliative care options and their likely outcome	YES But they must also inform the person that a medical practitioner would be the most appropriate person with whom to discuss the VAD process and care and treatment options	YES But they must also inform the person that the person has palliative care and treatment options available, and should discuss these options with a medical practitioner
Other Registered Health Practitioners	NO	NO		
Other Healthcare Workers	YES The statutory prohibition does not apply to non-registered healthcare workers.	NO	NO	

B Requests, Assessments and Referrals

A person's request for VAD must be evaluated by more than one medical practitioner, and the laws in each state set out the VAD request and assessment process in detail (see Figure 1). The Australian model mandates that at each step of the process described below, participating practitioners (including pharmacists) must submit paperwork to the relevant state oversight body.¹⁰¹

¹⁰¹ The oversight body is named the 'Voluntary Assisted Dying Review Board' in Queensland, South Australia and Victoria. It is named the 'Voluntary Assisted Dying Board' in New South Wales and Western Australia, and the 'Voluntary Assisted Dying Commission' in Tasmania.

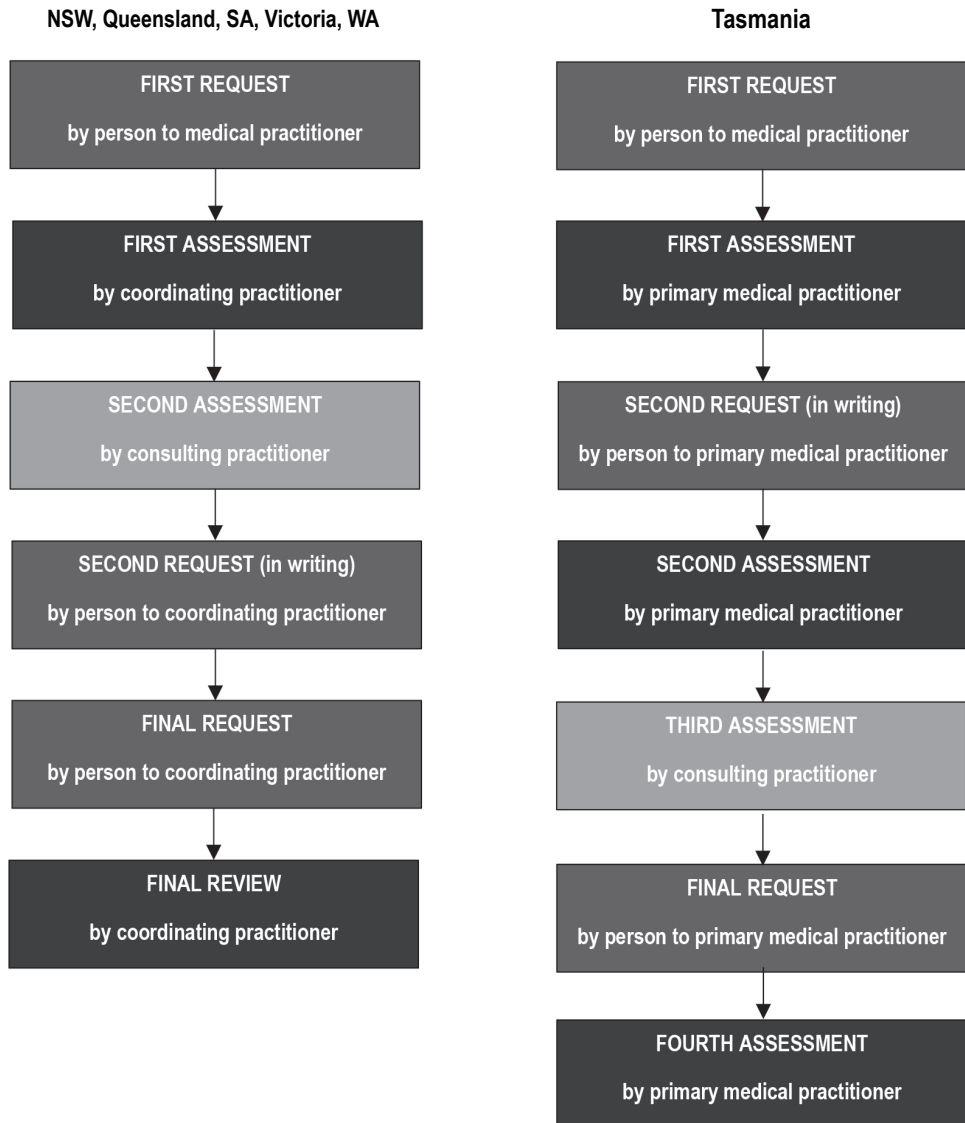


Figure 1: VAD request and assessment processes

Under the Victorian model (adopted, with only minor variations in all other states except Tasmania), a person must make three requests and be assessed by at least two independent medical practitioners to access VAD. The process is significantly different in Tasmania, where it involves four separate assessments by at least two independent medical practitioners.

In all states, the VAD process commences when a person makes a clear and unambiguous first request for VAD to a medical practitioner.¹⁰² A medical practitioner who accepts a first request becomes the person's coordinating practitioner.¹⁰³ The coordinating practitioner must assess whether the person meets the eligibility criteria¹⁰⁴ and, if so, must refer the person to a consulting practitioner,¹⁰⁵ who conducts a second independent assessment of eligibility.¹⁰⁶ (In Tasmania, the person must make two requests and be assessed twice by the coordinating practitioner before being referred for a consulting assessment.)¹⁰⁷ Sometimes additional assessments are required. If either the coordinating or consulting practitioner is unable to make a determination regarding specific eligibility criteria, they must refer the person to an independent person for evaluation.¹⁰⁸ Additionally, in SA and Victoria, it is compulsory to obtain a third assessment for all persons with neurodegenerative conditions who are expected to die after six but before 12 months: a specialist in their condition must confirm the prognosis.¹⁰⁹

After a person has completed the eligibility assessment process, and is determined to be eligible for VAD, the person makes a written request for VAD in the presence of two eligible witnesses.¹¹⁰ In Tasmania, the written request occurs earlier in the process, after the first eligibility assessment.¹¹¹ The final

102 *VAD Act* (NSW) (n 12) s 19(2)(a); *VAD Act* (Qld) (n 12) s 14(2)(a); *VAD Act* (SA) (n 12) s 29(2)(a); *VAD Act* (Vic) (n 2) s 11(2)(a); *VAD Act* (WA) (n 12) s 18(2)(a). In Tasmania, a patient cannot make a valid first request unless they have received approved information containing the 'relevant facts'. This includes information on the VAD process, the role of the Voluntary Assisted Dying Commission and access to palliative care: *EOLC Act* (Tas) (n 12) ss 8, 18(2)(a), 18(6).

103 If a medical practitioner accepts the first request, they are known in SA and Victoria as a 'coordinating medical practitioner': *VAD Act* (SA) (n 12) s 33; *VAD Act* (Vic) (n 2) s 15; in NSW, Queensland and WA as a 'coordinating practitioner': *VAD Act* (NSW) (n 12) s 24; *VAD Act* (Qld) (n 12) s 18; *VAD Act* (WA) (n 12) s 23; and in Tasmania as the 'primary medical practitioner': *EOLC Act* (Tas) (n 12) s 22.

104 *VAD Act* (NSW) (n 12) s 25; *VAD Act* (Qld) (n 12) s 19; *VAD Act* (SA) (n 12) s 34; *EOLC Act* (Tas) (n 12) s 26; *VAD Act* (Vic) (n 2) s 16; *VAD Act* (WA) (n 12) s 24.

105 The independent medical practitioner is known as 'consulting medical practitioner' in SA, Tasmania and Victoria: *VAD Act* (SA) (n 12) s 40; *EOLC Act* (Tas) (n 12) s 42; *VAD Act* (Vic) (n 2) s 22; and 'consulting practitioner' in NSW, Queensland and WA: *VAD Act* (NSW) (n 12) s 35; *VAD Act* (Qld) (n 12) s 25; *VAD Act* (WA) (n 12) s 30. For the sake of readability, we use the term 'consulting practitioner' to refer to all these medical practitioners.

106 *VAD Act* (NSW) (n 12) s 36; *VAD Act* (Qld) (n 12) s 30; *VAD Act* (SA) (n 12) s 43; *EOLC Act* (Tas) (n 12) s 37(1); *VAD Act* (Vic) (n 2) s 25; *VAD Act* (WA) (n 12) s 35.

107 *EOLC Act* (Tas) (n 12) s 33.

108 Five states require a referral where the practitioner is unable to determine if the patient has decision-making capacity or an eligible medical condition: *VAD Act* (NSW) (n 12) ss 26, 27(1)(a), 37, 38(1)(a); *VAD Act* (Qld) (n 12) ss 21(1)–(2), 32(1)–(2); *VAD Act* (SA) (n 12) ss 36(1)–(2), 45(1)–(2); *VAD Act* (Vic) (n 2) ss 18(1)–(2), 27(1)–(2); *VAD Act* (WA) (n 12) ss 26(1)–(2), 37(1)–(2). NSW, Queensland and WA also require a referral where necessary to evaluate whether a patient's request is voluntary and free from coercion: *VAD Act* (NSW) (n 12) ss 27(1)(b)–(c), 38(1)(b)–(c); *VAD Act* (Qld) (n 12) ss 21(3), 32(3); *VAD Act* (WA) (n 12) ss 26(3), 37(3). In Tasmania, a referral is only required if a practitioner is unable to determine if the person has decision-making capacity: *EOLC Act* (Tas) (n 12) s 12(4).

109 *VAD Act* (SA) (n 12) s 36(4); *VAD Act* (Vic) (n 2) s 18(4). The coordinating practitioner must adopt this determination: *VAD Act* (SA) (n 12) s 36(7); *VAD Act* (Vic) (n 2) s 18(6).

110 *VAD Act* (NSW) (n 12) s 43; *VAD Act* (Qld) (n 12) s 37; *VAD Act* (SA) (n 12) s 52; *EOLC Act* (Tas) (n 12) s 53(1); *VAD Act* (Vic) (n 2) s 34; *VAD Act* (WA) (n 12) s 42.

111 *EOLC Act* (Tas) (n 12) s 30(1).

request for VAD is made after the second medical practitioner has determined they are eligible.¹¹² The coordinating practitioner then conducts a fourth eligibility assessment.¹¹³

In all states except Tasmania, once a person has made a written request for VAD, they are eligible for VAD if they make one final request.¹¹⁴ After this, the coordinating practitioner must undertake a ‘final review’ of all paperwork and certify that the formal VAD request and assessment process has been complied with.¹¹⁵ In NSW, Queensland and WA, the coordinating practitioner must also certify that the person retains decision-making capacity, is acting voluntarily and without coercion, and that their request is enduring.¹¹⁶

Minimum timeframes apply to the VAD process in all states, to ensure the person’s request to die is enduring. In most states, the final request for VAD must occur at least nine days after the first request is made and at least one day after the consulting assessment is conducted.¹¹⁷ This period is five days in NSW.¹¹⁸ In Tasmania, the person must wait at least 48 hours between their first and second request, and between their second and final request.¹¹⁹ In all states, if the person is expected to die before the relevant time period has elapsed, this designated timeframe can be shortened.¹²⁰ In NSW, Queensland, Tasmania and WA, this timeframe may also be abridged if there is a risk of losing decision-making capacity.¹²¹

C Discussion

While reflecting the broad international approach to requesting and assessing VAD (eg, two doctors, multiple requests, and a cooling off period), the Australian VAD laws regulate this through a very detailed legislative process.¹²² VAD laws in Australia are lengthy, and this is largely due to the detailed prescription of specific steps that must occur for access to VAD to be permitted.

The requirement for two independent medical practitioners to confirm that a person meets the eligibility criteria for VAD aids public confidence in the system.

112 Ibid s 53(1).

113 Ibid s 55.

114 *VAD Act* (NSW) (n 12) s 48(1); *VAD Act* (Qld) (n 12) s 42(1); *VAD Act* (SA) (n 12) s 55(1); *VAD Act* (Vic) (n 2) s 37(1); *VAD Act* (WA) (n 12) s 47(1).

115 *VAD Act* (NSW) (n 12) s 52; *VAD Act* (Qld) (n 12) s 46; *VAD Act* (SA) (n 12) s 59; *VAD Act* (Vic) (n 2) s 41; *VAD Act* (WA) (n 12) s 51.

116 *VAD Act* (NSW) (n 12) s 52(3)(f); *VAD Act* (Qld) (n 12) s 46(3); *VAD Act* (WA) (n 12) s 51(3)(f).

117 *VAD Act* (Qld) (n 12) ss 43(1), (3); *VAD Act* (SA) (n 12) s 56(1); *VAD Act* (Vic) (n 2) s 38(1); *VAD Act* (WA) (n 12) ss 48(1)–(2).

118 *VAD Act* (NSW) (n 12) s 49(1), sch 1 (definition of ‘designated period’).

119 *EOLC Act* (Tas) (n 12) ss 30(2), 53(2).

120 *VAD Act* (NSW) (n 12) s 49(2); *VAD Act* (Qld) (n 12) s 43(2); *VAD Act* (SA) (n 12) s 56(2); *EOLC Act* (Tas) (n 12) s 53(2); *VAD Act* (Vic) (n 2) s 38(2); *VAD Act* (WA) (n 12) s 48(3).

121 *VAD Act* (NSW) (n 12) s 49(2)(a); *VAD Act* (Qld) (n 12) s 43(2)(a); *EOLC Act* (Tas) (n 12) s 53(2)(b); *VAD Act* (WA) (n 12) s 48(3)(a). In NSW, the coordinating and consulting practitioners must agree that the person is likely to die or lose capacity before the five-day period has elapsed: *VAD Act* (NSW) (n 12) s 49(2)(b).

122 See Mroz et al (n 21) 3547.

It provides a safeguard to ensure people who may not be suffering a terminal illness, may lack capacity or not be making a free and voluntary decision are not inadvertently permitted access to VAD.¹²³ Similarly, the inclusion of a minimum timeframe between requests for VAD is a measure designed to ensure a person's request for VAD is enduring. However, the requirement in Tasmania for four assessments of eligibility, three by the person's coordinating practitioner, is arguably more than is necessary to ensure a person's request is enduring.

However, the level of reporting required in all states is unparalleled.¹²⁴ The requirement for health practitioners to complete and submit a form at each step of the process adds to the administrative burden on participating practitioners.¹²⁵ Research on early Victorian practice demonstrated that this reporting may lengthen the VAD assessment process, 'often with serious consequences for eligible terminally ill patients who had been assessed as having intolerable suffering'.¹²⁶ While it is likely that regulatory processes in Victoria have improved since VAD commenced operation, the legislation itself necessitates a high level of administrative burden on practitioners which inevitably will affect patient access to VAD.

Specific requirements in some states may also add to the administrative burden of the VAD process, which will likely lengthen and complicate the process both for patients and participating practitioners. For example, in SA and Victoria, the mandatory third consultation with a specialist where a person has a neurodegenerative condition and death is expected to occur between six and 12 months will delay the VAD process, as will the requirement in Tasmania for four separate assessments of eligibility in at least four separate medical consultations. Delays in the process have the potential to compromise the ability of the VAD laws to provide person-centred care and respect the autonomy of those who are suffering and dying.¹²⁷ Further, these additional requirements disproportionately affect applicants located in regional areas and those with mobility issues.¹²⁸

While all states except Tasmania largely follow the Victorian model in terms of the request and assessment process, some variations introduced in the WA model and adopted in other states render the process more accessible. In four states, medical practitioners can initiate discussions about VAD with their patients (provided other information is given at the same time), and in some states nurse practitioners, registered health practitioners or other healthcare workers may also

123 *Victorian Panel Report* (n 4) 112.

124 White et al, 'Stated Policy Goals?' (n 62) 441.

125 Ibid; Willmott et al, 'Participating Doctors' Perspectives' (n 27) 127.

126 Willmott et al, 'Participating Doctors' Perspectives' (n 27) 127. Early research documents that the assessment process often takes weeks to complete, during which time a patient may lose capacity due to delirium or pain: Marcus Sellars et al, 'Medical Practitioners' Views and Experiences of Being Involved in Assisted Dying in Victoria, Australia: A Qualitative Interview Study among Participating Doctors' (2022) 292(1) *Social Science and Medicine* 114568:1–9, 4–5 <<https://doi.org/10.1016/j.socscimed.2021.114568>>. The Voluntary Assisted Dying Review Board reports that 50% of cases are finalised within 16 days between the first and final request, and 75% are finalised within 33 days: *VAD Review Board Report of Operations* (n 90) 13.

127 See White et al, 'Stated Policy Goals?' (n 62) 442.

128 *VAD Review Board Report of Operations* (n 90) 30.

initiate discussions about VAD, allowing for more transparent and comprehensive discussions of end-of-life options.

IV METHOD OF ADMINISTRATION

Once approved to access VAD, a person may either take the VAD medication themselves (self-administration) or be administered the medication by a health practitioner (practitioner administration). All Australian states allow both self-administration of VAD and practitioner administration. However, in all states except NSW, practitioner administration is permitted only in certain circumstances.

A Mode of Administration

In SA and Victoria, self-administration is the default position,¹²⁹ and practitioner administration is permitted only if the person is ‘physically incapable of the self-administration or digestion’ of the VAD substance.¹³⁰ Other Australian states allow practitioner administration in broader circumstances.¹³¹ In Queensland, WA and NSW, the person and their coordinating practitioner decide on the method of administration together. Self-administration remains the default position in Queensland and WA, but practitioner administration is available if the coordinating practitioner deems self-administration to be ‘inappropriate’ having regard to the person’s ability to self-administer, their concerns about self-administration or assisted self-administration, and the method of administering that is suitable for the person.¹³² In NSW, there are no requirements that must be met for a person to choose practitioner administration.

In Tasmania, the person indicates in their final written request for VAD their preferred method of administration out of four alternative modes of administration: self-administration with a health practitioner present; private self-administration;¹³³ assisted self-administration;¹³⁴ and practitioner administration.¹³⁵ The administering practitioner makes the final decision, and issues an administration certificate, which should be in accordance with the person’s expressed wishes,¹³⁶ and what method is appropriate for the person. As in Queensland and WA, if the person wishes to have practitioner administration, the administering practitioner must be satisfied

129 *VAD Act* (SA) (n 12) ss 63, 65; *VAD Act* (Vic) (n 2) ss 45, 47.

130 *VAD Act* (SA) (n 12) s 66(3)(a); *VAD Act* (Vic) (n 2) s 48(3)(a).

131 *VAD Act* (NSW) (n 12) s 57(1); *VAD Act* (Qld) (n 12) ss 50(1)–(2); *EOLC Act* (Tas) (n 12) s 86(5); *VAD Act* (WA) (n 12) ss 56(1)–(2).

132 *VAD Act* (Qld) (n 12) s 50(2); *VAD Act* (WA) (n 12) s 56(2).

133 *EOLC Act* (Tas) (n 12) s 83.

134 *Ibid* s 82(3)(c)(ii). Assisted self-administration is not defined in the *EOLC Act* (Tas) (n 12) or discussed in depth in the parliamentary debate on the Bill. It seems to refer to self-administration with active assistance by the administering health practitioner (for example, this may refer to mixing the VAD substance for the person to drink or setting up an intravenous line for the person to press to administer the VAD substance).

135 *Ibid* s 82(3)(c)(iii).

136 *Ibid* s 86(2)(c).

that self-administration or assisted self-administration is ‘inappropriate’. Table 4 sets out the circumstances in which practitioner administration is permitted in the Australian states.¹³⁷

Table 4: Circumstances in Which Practitioner Administration is Permitted

	SA and Victoria	Queensland, Tasmania and WA	NSW
The person cannot physically self-administer or digest the medication	✓	✓	✓
The person has concerns about self-administration	✗	✓	✓
Self-administration is not suitable for the person	✗	✓	✓
The person wishes to choose practitioner administration	✗	✗	✓

Tasmania is the only jurisdiction that requires a person to state their wishes should unexpected complications arise during practitioner administration (or assisted administration).¹³⁸ Indeed, a person must state in their final permission whether they wish the administering practitioner to administer a substance to enable them to die, or to help preserve their life, should an unexpected complication arise.¹³⁹

B Authorisation and Administration

The procedures set out in the VAD laws in each state for prescribing and administering a VAD substance are highly detailed. Figures 2 and 3 outline the main steps in these processes.

Four Australian states require pre-authorisation before VAD can be administered. In SA and Victoria, the coordinating practitioner must apply to the Secretary or Chief Executive of the Department of Health for a VAD permit before a person’s death can occur.¹⁴⁰ In Tasmania, the coordinating practitioner applies to the Tasmanian VAD Commission for a substance authorisation.¹⁴¹ In Queensland

137 *VAD Act* (Qld) (n 12) s 50(2); *VAD Act* (SA) (n 12) s 66(3); *EOLC Act* (Tas) (n 12) s 86(5); *VAD Act* (Vic) (n 2) s 48(3); *VAD Act* (WA) (n 12) s 56(2).

138 *EOLC Act* (Tas) (n 12) s 82(3)(d).

139 *Ibid.*

140 *VAD Act* (SA) (n 12) ss 61, 65–6; *VAD Act* (Vic) (n 2) ss 43, 47–8.

141 *EOLC Act* (Tas) (n 12) s 66.

and WA, no pre-authorisation is required: the person decides the method of administration ‘in consultation with and on the advice of’ their coordinating practitioner.¹⁴² NSW has adopted a unique system which incorporates both of these requirements: as in Queensland and WA, the person makes an administration decision ‘in consultation with and on the advice of’ their coordinating practitioner.¹⁴³ Following this decision, the coordinating practitioner must apply to the Board for a VAD substance authority¹⁴⁴ before the VAD substance may be prescribed and administered.¹⁴⁵

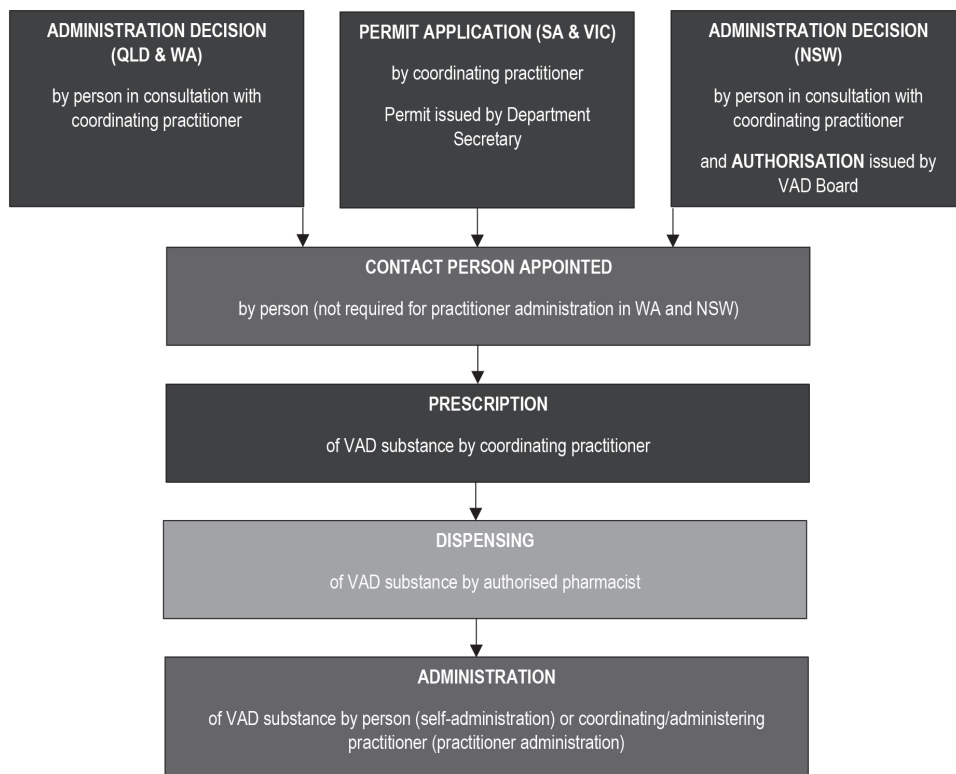


Figure 2: Prescription, supply and administration of VAD in NSW, Queensland, SA, Victoria and WA

142 *VAD Act* (Qld) (n 12) s 50(1); *VAD Act* (WA) (n 12) s 56(1).

143 *VAD Act* (NSW) (n 12) s 57(1).

144 In NSW, the legislation confusingly refers to both a ‘voluntary assisted dying substance authorisation’: *ibid* ss 70(1), 71(1), and a ‘voluntary assisted dying substance authority’: at ss 71(2), (3), (4), 72, 73(1)(b).

145 *Ibid* ss 59(3)(b), 60(3), 71.

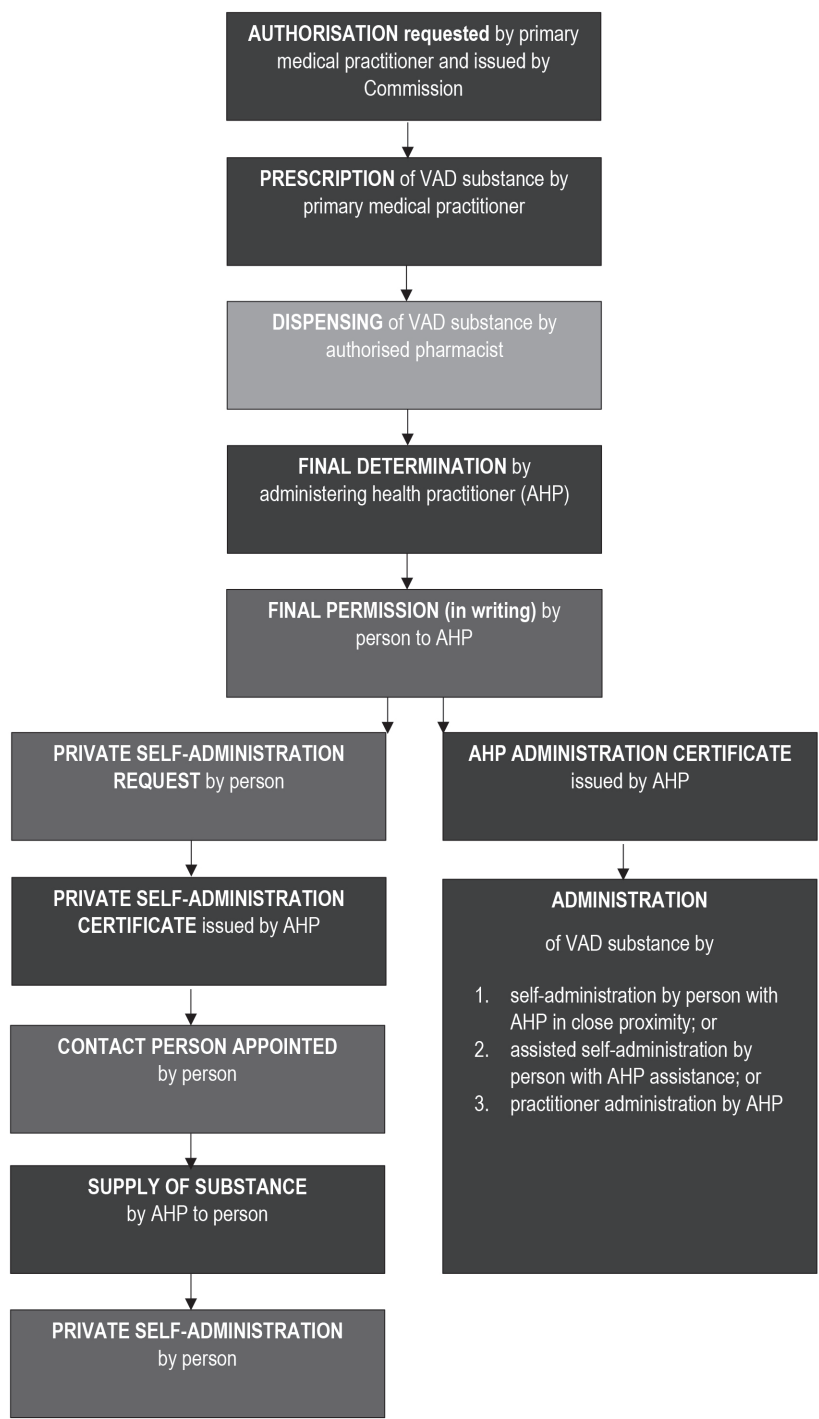


Figure 3: Prescription, supply and administration of VAD in Tasmania

C Safe Storage of VAD Medication

Another safeguard introduced in Victoria and adopted in other Australian states concerns the safe storage of VAD medication. The Australian VAD laws all allow a person to self-administer the VAD medication at home at a time of their choosing, and a medical practitioner is not required to be present.¹⁴⁶ Whereas practitioner administration is carried out by a medical practitioner (or in some states, a nurse practitioner or nurse) in the presence of an independent witness¹⁴⁷ (except in Tasmania), in all states, self-administration may occur with no witness present.

In most states, where the person will be self-administering, the VAD substance is dispensed by the pharmacist directly to the person or their agent,¹⁴⁸ and safely stored at the person's premises in a locked box¹⁴⁹ or in accordance with prescribed requirements¹⁵⁰ until required. The exception to this is Tasmania, where the VAD substance is always dispensed to the coordinating practitioner. If a different health practitioner is undertaking the role of administering practitioner, the coordinating practitioner is required to provide the substance to the administering practitioner.¹⁵¹ This practitioner can supply the VAD substance to the person directly only if the person has a private self-administration certificate.¹⁵² If the person has chosen self-administration with the administering practitioner in proximity, self-administration assisted by the administering practitioner, or practitioner administration, the administering practitioner retains the VAD substance until the time for administration.¹⁵³

In all states, where the method of VAD is self-administration, the legislation requires the patient to appoint a 'contact person', who is responsible for returning any unused or remaining VAD medication to the authorised pharmacy and informing the coordinating practitioner of the person's death (whether or not this was caused by taking the VAD substance).¹⁵⁴

146 In Tasmania, self-administration with a practitioner present, or assisted self-administration are the legislative preference, but 'private self-administration' is also permitted on the patient's request: *EOLC Act* (Tas) (n 12) s 84.

147 *VAD Act* (NSW) (n 12) s 60(6); *VAD Act* (Qld) (n 12) s 54(2); *VAD Act* (SA) (n 12) s 82; *VAD Act* (Vic) (n 2) s 65; *VAD Act* (WA) (n 12) s 62(3).

148 *VAD Act* (NSW) (n 12) s 76(1); *VAD Act* (Qld) (n 12) s 52(5)(a); *VAD Act* (SA) (n 12) s 63(b); *VAD Act* (Vic) (n 2) s 45(b); *VAD Act* (WA) (n 12) s 72(1).

149 *VAD Act* (NSW) (n 12) s 79; *Voluntary Assisted Dying Regulations 2022* (Qld) s 6; *VAD Act* (SA) (n 12) s 78; *EOLC Act* (Tas) (n 12) ss 73(1)(a), 75(1)(a), 91(2), 92(1); *VAD Act* (Vic) (n 2) s 61.

150 *VAD Act* (WA) (n 12) s 72(2)(b).

151 *EOLC Act* (Tas) (n 12) s 71(1).

152 *Ibid* s 89(1).

153 In those cases, *ibid* ss 86–7 apply.

154 *VAD Act* (NSW) (n 12) ss 66, 68; *VAD Act* (Qld) (n 12) ss 58, 61; *VAD Act* (SA) (n 12) s 57; *EOLC Act* (Tas) (n 12) s 92; *VAD Act* (Vic) (n 2) s 39; *VAD Act* (WA) (n 12) ss 65, 67. In Queensland, SA and Victoria, a contact person must also be appointed in the case of practitioner administration, although their role is limited to being a person whom the Board may contact for information: *VAD Act* (Qld) (n 12) ss 58(1), 62(3); *VAD Act* (SA) (n 12) ss 57(1), (3); *VAD Act* (Vic) (n 2) ss 39(1), (3). Additionally in Queensland, a contact person is required to notify the coordinating practitioner if the patient dies prior to administration: *VAD Act* (Qld) (n 12) s 62(2).

D Discussion

As previously observed, Australian VAD legislation is highly prescriptive, and it has been claimed that regulation of this kind ensures the system operates ‘safely’.¹⁵⁵ By way of contrast, less prescriptive legislative models, such as in the American states of Oregon and Washington, that have been operational for around twenty years, have not been criticised on the basis that these systems are not ‘safe’. Some requirements (unique to Australia), such as including explicit requirements for safe storage of the VAD substance and the appointment of a contact person to ensure the return of any unused VAD substance after a person’s death, provide confidence that the system is safe. Other elements of the Australian model (such as restrictions on the choice of the method of administration and the requirement of pre-authorisation) may have a significant constraining effect on the practice of VAD in the Australian states.

One of the primary reasons for legislating to authorise VAD was to respect the autonomous choices of people at the end of their lives.¹⁵⁶ Autonomy relates to both the timing and manner of a person’s death. While Australian VAD frameworks allow both self-administration and practitioner administration, the laws significantly constrain the exercise of this choice. SA and Victoria both have strict default positions favouring self-administration, only allowing practitioner administration when self-administration is not physically possible.¹⁵⁷ The laws in Queensland, Tasmania and WA also evince a preference for self-administration,¹⁵⁸ although practitioner administration is permitted in a broader range of circumstances, which include taking into account the person’s concerns regarding self-administration. Although the VAD framework in those states permits persons to choose the appropriate method of administration in consultation with their coordinating practitioner, patient preferences are still subject to legislative criteria, which prescribe the range of legitimate factors to be considered in making a decision concerning the administration of VAD. It has previously been observed that respecting autonomy would be better achieved by permitting persons to choose their preferred method of VAD.¹⁵⁹ Only the model adopted in NSW permits the person to independently choose their preferred method of administration.¹⁶⁰

The requirement of pre-authorisation before VAD can be administered in NSW, SA, Tasmania and Victoria adds an additional layer of bureaucracy to an already

155 Premier of Victoria (n 5).

156 *VAD Act* (NSW) (n 12) s 4(1)(b); *VAD Act* (Qld) (n 12) s 5(c); *VAD Act* (SA) (n 12) s 8(1)(b); *EOLC Act* (Tas) (n 12) s 3(2)(b); *VAD Act* (Vic) (n 2) s 5(1)(b); *VAD Act* (WA) (n 12) s 4(1)(b).

157 *VAD Act* (SA) (n 12) ss 63, 65; *VAD Act* (Vic) (n 2) ss 45, 47.

158 *VAD Act* (Qld) (n 12) s 50(2); *VAD Act* (WA) (n 12) s 56(2). The Tasmanian statutory preference is for self-administration with a practitioner present or in close proximity or assisted self-administration: *EOLC Act* (Tas) (n 12) s 82(3)(c). Private self-administration is permitted where the patient requests it and the administering practitioner is satisfied that the patient is able to self-administer without a practitioner being present: at ss 83, 84(1).

159 White et al, ‘Stated Policy Goals?’ (n 62) 429.

160 *VAD Act* (NSW) (n 12) s 57(1).

complex process.¹⁶¹ The cumulative effect of these procedural requirements may mean that medical practitioners are reluctant to become involved in the VAD process, or patients, given their condition, may struggle to navigate all these steps and pursue the process to its conclusion.¹⁶² It should be noted, however, that pre-authorisation (if conscientiously performed) may function as an important safeguard ensuring a person requesting VAD meets the eligibility criteria and the process has been correctly complied with.¹⁶³ The United Nations Human Rights Committee has recommended independent *ex ante* review as an important safeguard for jurisdictions implementing assisted dying regimes.¹⁶⁴

V PARTICIPATING PRACTITIONERS

The Australian VAD laws contain detailed requirements setting out the qualifications, expertise and training required of participating medical and other health practitioners.

A Registration Requirements

In each state, only suitably qualified medical practitioners (holding either general or specialist registration)¹⁶⁵ can act as a coordinating or consulting practitioner and conduct VAD eligibility assessments. Different minimum periods and types of registration apply, depending on the state, as set out in Table 5. In

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- 161 The burdensome nature of the administrative requirements has been noted by doctors involved in VAD in Victoria: Willmott et al, 'Participating Doctors' Perspectives' (n 27) 127; Sellars et al (n 126) 6.
- 162 White et al, 'Stated Policy Goals?' (n 62) 443. See also Ben P White et al, 'Prospective Oversight and Approval of Assisted Dying Cases in Victoria, Australia: A Qualitative Study of Doctors' Perspectives' (2022) *BMJ Supportive and Palliative Care* 0:1–10 <<https://doi.org/10.1136/bmjspcare-2021-002972>> ('Prospective Oversight and Approval').
- 163 Commenting on the Dutch system, some academics have also expressed concerns about a retrospective system of oversight, and expressed a preference for prospective oversight: 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* e017628:1–12, 9–10 <<https://doi.org/10.1136/bmjopen-2017-017628>>; David Gibbes Miller, Rebecca Dresser and Scott YH Kim, 'Advance Euthanasia Directives: A Controversial Case and Its Ethical Implications' (2019) 45(2) *Journal of Medical Ethics* 84, 88 <<https://doi.org/10.1136/medethics-2017-104644>>.
- 164 Human Rights Committee, *Consideration of Reports Submitted by State Parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Council: Netherlands*, 72nd sess, UN Doc CCPR/CO/72/NET (27 August 2001) 3 [5(d)]; Human Rights Committee, *Consideration of Reports Submitted by State Parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Council: Netherlands*, 96th sess, UN Doc CCPR/C/NLD/CO/4 (25 August 2009) 2–3 [7]; Human Rights Committee, *Concluding Observations of the Fifth Periodic Report of the Netherlands*, 3635th mtg, UN Doc CCPR/C/NLD/CO/5 (22 August 2019) 6 [28]–[29]; Human Rights Committee, *Consideration of Reports Submitted by State Parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Council: Switzerland*, 97th sess, UN Doc CCPR/C/CHE/CO/3 (3 November 2009) 4 [13].
- 165 In SA, Tasmania and Victoria, to be eligible a general practitioner may be a fellow with a specialist college, or vocationally registered: *VAD Act* (SA) (n 12) s 27(1); *EOLC Act* (Tas) (n 12) s 9(b); *VAD Act* (Vic) (n 2) s 10(1).

Queensland and WA, an overseas trained specialist with limited or provisional registration may also participate in VAD.¹⁶⁶

Table 5: Minimum Length of Practice of Participating Medical Practitioners

State	General registration	Specialist registration
Victoria and SA ¹⁶⁷	Not permitted	5 years (one practitioner only) No minimum (second practitioner) <i>Vocational GP registration also accepted</i>
Tasmania ¹⁶⁸	Not permitted	5 years <i>Vocational GP registration also accepted</i>
WA ¹⁶⁹	10 years	1 year <i>Overseas trained specialist also accepted</i>
Queensland ¹⁷⁰	5 years	1 year <i>Overseas trained specialist also accepted</i>
NSW ¹⁷¹	10 years	No minimum

In NSW, Queensland, and WA, practitioners must also meet other requirements approved by the chief executives of the Departments of Health,¹⁷² such as requirements relating to minimum hours of clinical practice, registration status and suitability matters.¹⁷³

In SA and Victoria, only a qualified medical practitioner can administer a VAD substance to a person. In the other four states a nurse practitioner, and in Queensland and Tasmania also a registered nurse, may take on the role of administering practitioner, provided they possess the minimum practising experience set out in Table 6.

166 *VAD Act* (Qld) (n 12) s 82(1)(a)(iv); *VAD Act* (WA) (n 12) s 17(2)(a)(iii).

167 *VAD Act* (SA) (n 12) s 27(2); *VAD Act* (Vic) (n 2) s 10(2).

168 *EOLC Act* (Tas) (n 12) s 9(b).

169 *VAD Act* (WA) (n 12) s 17(2).

170 *VAD Act* (Qld) (n 12) s 82(1)(a).

171 *VAD Act* (NSW) (n 12) s 18(a).

172 Ibid s 18(c); *VAD Act* (Qld) (n 12) s 82(1)(b); *VAD Act* (WA) (n 12) s 17(2)(a).

173 Department of Health (WA), 'CEO Practitioner Eligibility Requirements' (Practitioner Guide, 21 October 2020) <<https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/CEO-Practitioner-Eligibility-Requirements.pdf>>; Queensland Health, 'Becoming an Authorised Voluntary Assisted Dying Practitioner', *Voluntary Assisted Dying in Queensland* (Web Page, 12 May 2023) <www.health.qld.gov.au/system-governance/legislation/voluntary-assisted-dying-act/authorised-voluntary-assisted-dying-practitioner>.

Table 6: Minimum Length of Practice for Participating Nurse Practitioners and Nurses to Be Eligible to Act as Administering Practitioners

State	Nurse practitioner	Registered nurse
Victoria, SA	Not permitted	Not permitted
Tasmania ¹⁷⁴	Not separately stated, but likely 5 years as registered nurse	5 years
WA ¹⁷⁵	2 years	Not permitted
Queensland ¹⁷⁶	Yes (no minimum)	5 years
NSW ¹⁷⁷	Yes (no minimum)	Not permitted

B Expertise Requirements

In addition to formal qualifications and length of practice, some states require one or both of the participating medical practitioners to have particular expertise in the patient's terminal illness. In SA and Victoria, either the coordinating or consulting practitioner must have relevant expertise and experience in the person's condition. 'Relevant expertise and experience' is not defined in the legislation but the Victorian Department of Health's guidance document interprets this to mean that the practitioner must be a 'medical specialist in the patient's medical condition'.¹⁷⁸

In Tasmania, both coordinating and consulting practitioners must have 'relevant experience in treating or managing' the person's condition.¹⁷⁹ The Act does not define 'relevant experience' but the slight departure from the Victorian wording will likely result in practitioners not needing to be 'specialists' in the condition.

The laws in Queensland, NSW and WA do not require participating practitioners to have experience in the person's condition. In Queensland, however, participating practitioners must have experience in caring for people at the end-of-life and performing clinical assessments.¹⁸⁰

C Training Requirements

In all states, participating medical practitioners (and nurse practitioners or nurses where relevant) must have completed mandatory training specifically concerning the VAD process, prior to acting as coordinating, consulting or administering practitioner. In NSW and Tasmania, a medical practitioner must have completed

¹⁷⁴ *EOLC Act* (Tas) (n 12) s 63(2)(b).

¹⁷⁵ *VAD Act* (WA) (n 12) s 54(1)(a)(ii).

¹⁷⁶ *VAD Act* (Qld) (n 12) ss 83(a)(ii)–(iii).

¹⁷⁷ *VAD Act* (NSW) (n 12) s 55(a)(iv).

¹⁷⁸ *Victorian VAD Guidance* (n 25) 5.

¹⁷⁹ *EOLC Act* (Tas) (n 12) s 9(c).

¹⁸⁰ Queensland Health (n 173).

the approved VAD training course prior to accepting a first request or a referral to become the consulting practitioner.¹⁸¹ In the other states, a practitioner must have completed the training prior to undertaking VAD assessments.¹⁸² In states where a different medical practitioner, nurse practitioner or nurse may take on the role of administering practitioner, that practitioner must also have completed the approved training.¹⁸³

D Independence Requirements

All states except Victoria also expressly prohibit participating practitioners from providing VAD services to a member of their family, or in situations where they stand to benefit from the person's death financially or materially (besides receiving reasonable fees).¹⁸⁴

E Discussion

As with other aspects of the VAD process, the Australian model is very prescriptive about who may act as a participating practitioner. These requirements constitute important system safeguards. For example, the requirement to complete mandatory training about the legislative scheme, a unique Victorian initiative which has since been adopted in all Australian states, is aimed at ensuring compliance with the law. This should enhance public confidence in practitioner knowledge of the legislative parameters of the scheme.¹⁸⁵ The requirement that participating practitioners be independent from their patients is also sensible, although the authors do query whether this express legislative requirement is needed in light of obligations imposed by medical codes of ethics.¹⁸⁶

However, the very prescriptiveness of these requirements may cause problems of access to VAD. The cumulative requirements to have a minimum period of post-qualification experience, to undertake the mandatory VAD training (which has been estimated to take between four and eight hours to complete),¹⁸⁷ and in

181 *VAD Act* (NSW) (n 12) ss 18(b), 21(3); *EOLC Act* (Tas) (n 12) s 9(d).

182 *VAD Act* (Qld) (n 12) ss 20, 31; *VAD Act* (SA) (n 12) ss 35, 44; *VAD Act* (Vic) (n 2) ss 17, 26; *VAD Act* (WA) (n 12) ss 25, 36.

183 *VAD Act* (NSW) (n 12) s 55(b); *VAD Act* (Qld) (n 12) s 83(b); *EOLC Act* (Tas) (n 12) s 63(b)(i); *VAD Act* (WA) (n 12) s 54(1)(b).

184 *VAD Act* (NSW) (n 12) ss 18(d)–(e), 55(d)–(e); *VAD Act* (Qld) (n 12) ss 82(1)(c)–(d); *VAD Act* (SA) (n 12) s 28; *EOLC Act* (Tas) (n 12) ss 9(e)–(f); *VAD Act* (WA) (n 12) ss 17(2)(b)–(c).

185 Ben P White et al, 'Development of Voluntary Assisted Dying Training in Victoria, Australia: A Model for Consideration' (2021) 36(3) *Journal of Palliative Care* 162, 162–7 <<https://doi.org/10.1177/0825859720946897>>; Lindy Willmott et al, 'A Cross-Sectional Study of the First Two Years of Mandatory Training for Doctors Participating in Voluntary Assisted Dying' (2022) *Palliative and Supportive Care* (forthcoming) <<https://doi.org/10.1017/s1478951522000931>>.

186 See, eg, Medical Board of Australia, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (Code, October 2020) 4.15.

187 Official reports give a figure of four hours: Voluntary Assisted Dying Review Board, *Report of Operations: June to December 2019* (Report, 19 February 2020) 6. Participating doctors have reported the training takes six to eight hours and is the number one barrier to participation: Jodhi Rutherford, Lindy Willmott and Ben P White, 'What the Doctor Would Prescribe: Physician Experiences of

some jurisdictions to be a specialist in the person's condition,¹⁸⁸ will reduce the pool of medical practitioners able to participate in VAD. As demand for VAD increases, greater burdens will be placed on this relatively small pool of available practitioners,¹⁸⁹ and potentially cause delays for persons seeking access to VAD. These burdens are likely to be greatest in SA, Tasmania and Victoria, where the eligibility requirements are the most onerous.¹⁹⁰ In Victoria, the requirement that one medical practitioner assessing eligibility has relevant expertise in the person's condition has already resulted in access issues, particularly for persons with neurological conditions, as only fifteen neurologists are registered to provide VAD in the whole of Victoria, with only one in a regional area.¹⁹¹

In recognising potential access issues, especially in rural and remote areas, the Queensland¹⁹² and WA¹⁹³ systems have broadened who may participate in VAD. Both states allow internationally trained medical practitioners with provisional specialist registration, and medical practitioners with general registration, to participate in the assessment process. Further, neither state requires that one participating practitioner have 'relevant expertise and experience' in the person's condition. Finally, those states which have created a separate role of administering practitioner are also likely to improve access to VAD, as nurse practitioners (and in some states, registered nurses) are also eligible to take on this role.

VI CONSCIENTIOUS OBJECTION OF HEALTH PRACTITIONERS

The right of health practitioners to conscientiously object to participating in VAD is specifically protected in all Australian states.¹⁹⁴ This includes choosing not to participate in assessments, prescribe, supply or administer a VAD substance. In

Providing Voluntary Assisted Dying in Australia' (2021) 87(4) *Omega* 1063, 1072 <<https://doi.org/10.1177/00302228211033109>>.

188 *VAD Act* (SA) (n 12) ss 27(2)–(3); *VAD Act* (Vic) (n 2) ss 10(2)–(3); *Victorian VAD Guidance* (n 25) 5.

189 The burden on practitioners has already been noted in both Victoria and WA: Cameron McLaren, 'An Update on VAD: (Almost) A Year in Review' (Article, Dying with Dignity Victoria, 16 June 2020) 3; Angela Cooney, 'VAD Update: Reflections on the First Six Months' (Speech, WA VAD Forum, 10 February 2022).

190 In Tasmania, both practitioners must have a minimum of five years' post-qualification experience as well as experience in treating the patient's condition, which will exclude many practitioners from participating in the process: *EOLC Act* (Tas) (n 12) ss 9(b)–(c).

191 *VAD Review Board Report of Operations* (n 90) 7.

192 *QLRC Report* (n 28) 402–3.

193 *WA Panel Report* (n 9) xvii.

194 *VAD Act* (NSW) (n 12) s 9; *VAD Act* (Qld) (n 12) s 84; *VAD Act* (SA) (n 12) s 10; *VAD Act* (Vic) (n 2) s 7; *VAD Act* (WA) (n 12) s 9. The Queensland legislation also includes specific provisions outlining the rights and obligations of speech pathologists who conscientiously object to VAD: *VAD Act* (Qld) (n 12) s 85. As speech pathologists are not registered health practitioners, special provisions were incorporated into the legislation to protect their right to freedom of conscience: *QLRC Report* (n 28) 421. The Tasmanian legislation does not have one specific provision on conscientious objection but specifies throughout the Act which practices practitioners can conscientiously object to: *EOLC Act* (Tas) (n 12) ss 20(2), 40(2), 64, 71(3).

some states, objecting health practitioners have obligations to provide information to a person, or to refer them to another health practitioner or information service which could assist them.

A Providing Information

The SA and Victorian statutes expressly allow registered health practitioners to refuse to provide information about VAD.¹⁹⁵ This means there is no obligation to provide general information about VAD, contact details of a participating practitioner or an information service that can provide details of an assisting practitioner. In NSW, a medical practitioner to whom a first request is made may also refuse to provide this information if they have a conscientious objection to VAD.¹⁹⁶

In the other three states, it is mandatory to provide at least some information to a person who makes a request for VAD. In Queensland and Tasmania, a medical practitioner must provide contact details of a government body or a medical practitioner who is able to assist the person, even if the medical practitioner has a conscientious objection to VAD.¹⁹⁷ In Tasmania and WA, a medical practitioner must provide a person who requests VAD with an official information sheet about VAD notwithstanding having a conscientious objection to participating in VAD.¹⁹⁸

B Participating in the Request and Assessment Process

Each state permits registered health practitioners to refuse to participate in the request and assessment process.¹⁹⁹ In NSW, Queensland and WA, medical practitioners must notify patients immediately if they refuse to accept a first request or consulting referral on the basis of a conscientious objection.²⁰⁰ Equivalent obligations exist in other states, though timeframes for notifications vary.²⁰¹

The SA and Victorian laws allow registered health practitioners to object to applying for a VAD permit,²⁰² and the Queensland statute allows practitioners to refuse to participate in an administration decision.²⁰³ However, in practice these

195 *VAD Act* (SA) (n 12) s 10(a); *VAD Act* (Vic) (n 2) s 7(a).

196 *VAD Act* (NSW) (n 12) s 21(5). By way of contrast, if a medical practitioner chooses not to participate for reasons other than having a conscientious objection, they are obliged to provide the patient an approved information sheet about VAD: at s 21(4)(b).

197 In Queensland, the practitioner must supply the details of another health practitioner, provider or VAD navigator service: *VAD Act* (Qld) (n 12) ss 16(4), 84(2). In Tasmania, the practitioner must provide the Tasmanian VAD Commission's contact details: *EOLC Act* (Tas) (n 12) s 18(1).

198 *EOLC Act* (Tas) (n 12) ss 8, 18(6); *VAD Act* (WA) (n 12) s 20(5)(b).

199 *VAD Act* (NSW) (n 12) s 9(1)(a); *VAD Act* (Qld) (n 12) s 84(1)(b); *VAD Act* (SA) (n 12) s 10(b); *EOLC Act* (Tas) (n 12) ss 20(2), 40(2), 64; *VAD Act* (Vic) (n 2) s 7(b); *VAD Act* (WA) (n 12) s 9(1)(a).

200 *VAD Act* (NSW) (n 12) ss 21(5), 32(5); *VAD Act* (Qld) (n 12) ss 16(6)(a), 26(5)(a); *VAD Act* (WA) (n 12) ss 20(5), 31(5).

201 In SA and Victoria, a first request must be accepted or refused within seven days: *VAD Act* (SA) (n 12) s 31(1); *VAD Act* (Vic) (n 2) s 13(1). In NSW, it is two business days and in Tasmania, the medical practitioner has 48 hours to decide whether to accept or refuse the request, and an additional seven days to communicate their decision to the patient: *VAD Act* (NSW) (n 12) s 21(4); *EOLC Act* (Tas) (n 12) ss 19, 20, 23.

202 *VAD Act* (SA) (n 12) s 10(c); *VAD Act* (Vic) (n 2) s 7(c).

203 *VAD Act* (Qld) (n 12) s 84(1)(c).

provisions are unlikely to be enlivened, as these are duties of the coordinating practitioner, and practitioners not wishing to participate in these steps are unlikely to become a coordinating practitioner.²⁰⁴

C Prescribing, Supplying or Dispensing a VAD Substance

Legislation in five states allows registered health practitioners to refuse to prescribe or supply a VAD substance.²⁰⁵ Tasmania does not specifically state that practitioners may object to these practices; however, as these are duties performed by the coordinating practitioner, in practice doctors who object to these practices would be unlikely to accept a first request for VAD. In all states, the legislation allows pharmacists to refuse to dispense or supply a VAD substance.²⁰⁶

D Administering a VAD Substance and/or Being Present at the Time of Administration

Some practitioners may feel comfortable assessing eligibility for VAD, or prescribing medication for the person to take themselves, but have a conscientious or other objection to administering a VAD medication to a person. In recognition of this, each state allows registered health practitioners to refuse to administer a VAD substance,²⁰⁷ and sets out methods to transfer care to another practitioner to administer the VAD substance.

In SA and Victoria, the coordinating medical practitioner may transfer their role to the consulting practitioner if they do not wish to participate in practitioner administration.²⁰⁸ In NSW, Queensland, Tasmania and WA, there is a separate role of administering practitioner. By default, this is assumed by the coordinating practitioner, but the role can be transferred to another eligible medical or nurse practitioner, or registered nurse (in Queensland and Tasmania) if the coordinating practitioner is unavailable, has a conscientious objection or wishes not to take on this role.²⁰⁹

²⁰⁴ It is conceivable that a medical practitioner may agree to take on the role of coordinating practitioner for a person who is intending to self-administer VAD. If the person's situation changes and the patient is unable to self-administer, the coordinating practitioner may have a conscientious objection to practitioner administration of VAD. If this is the case, all three states allow for the role of coordinating practitioner to be transferred to the consulting practitioner: *VAD Act* (Qld) (n 12) s 47(1); *VAD Act* (SA) (n 12) s 51(1); *VAD Act* (Vic) (n 2) s 33(1).

²⁰⁵ *VAD Act* (NSW) (n 12) s 9(1)(b); *VAD Act* (Qld) (n 12) s 84(1)(d); *VAD Act* (SA) (n 12) s 10(d); *VAD Act* (Vic) (n 2) s 7(d); *VAD Act* (WA) (n 12) s 9(1)(b).

²⁰⁶ *VAD Act* (SA) (n 12) s 10(f); *EOLC Act* (Tas) (n 12) s 71(3); *VAD Act* (Vic) (n 2) s 7(f). In NSW, Queensland and WA, pharmacists are likely to be able to object to dispensing a VAD medication under the 'supply' provisions: *VAD Act* (NSW) (n 12) s 9(1)(b); *VAD Act* (Qld) (n 12) s 84(1)(d); *VAD Act* (WA) (n 12) s 9(1)(b).

²⁰⁷ *VAD Act* (NSW) (n 12) s 9(1)(b); *VAD Act* (Qld) (n 12) s 84(1)(d); *VAD Act* (SA) (n 12) s 10(d); *EOLC Act* (Tas) (n 12) s 64; *VAD Act* (Vic) (n 2) s 7(d); *VAD Act* (WA) (n 12) s 9(1)(b).

²⁰⁸ *VAD Act* (SA) (n 12) ss 50–1; *VAD Act* (Vic) (n 2) ss 32–3.

²⁰⁹ In NSW, Queensland and WA, the coordinating practitioner can transfer the role to another eligible practitioner if they are 'unable or unwilling for any reason to administer' the VAD substance: *VAD Act* (NSW) (n 12) s 64(1)(c); *VAD Act* (Qld) (n 12) s 56(1)(c), sch 1 (definition of 'administering practitioner'); *VAD Act* (WA) (n 12) ss 5 (definition of 'administering practitioner'), 63(1)(c). In

The NSW, Queensland, SA, Victorian and WA statutes also explicitly allow registered health practitioners to refuse to be present at the time of self-administration, or practitioner administration.²¹⁰ While the Tasmanian legislation is silent on this, the general ethical convention protecting conscientious objection would also allow this.

E Discussion

Consistent with the right to freedom of conscience, Australian VAD laws protect health practitioners who do not wish to be involved in or continue with the VAD process. Most states contain provisions enabling a medical practitioner, pharmacist or administering practitioner to refuse to participate at each stage of the request, assessment, administration decision, prescription, and administration of VAD on the basis of a conscientious objection.

There are some minor, but significant, variations between jurisdictions. In attempting to balance the rights of objecting practitioners with the need to support patients, the Queensland, Tasmanian and WA models have departed from the Victorian model by requiring that specific information be provided to patients at the time of a first request.²¹¹ Further, the Queensland and WA laws require that objecting practitioners inform the person immediately of their refusal to accept a first request,²¹² in order to avoid delays. These two obligations – to promptly inform patients, and to provide information about VAD or referrals to other services – will assist patients to access VAD, while recognising the right of practitioners not to be involved.

VII NON-PARTICIPATION BY FACILITIES

While some individuals accessing VAD will reside in private residences, others will be cared for in facilities such as hospitals, hospices, and residential aged care facilities. While facilities are not required to provide VAD in any of the six states, the three most recently enacted VAD statutes (those passed in NSW, Queensland and SA) contain detailed provisions regulating the participation of facilities.²¹³ The legislation in these three states limits, to varying degrees, the ability of such

Tasmania, the primary medical practitioner can elect not to become a person's administering practitioner: *EOLC Act* (Tas) (n 12) s 60. If this occurs, the Tasmanian VAD Commission appoints another eligible practitioner to take on the role: at s 62(2).

210 *VAD Act* (NSW) (n 12) s 9(1)(c); *VAD Act* (Qld) (n 12) s 84(1)(e); *VAD Act* (SA) (n 12) s 10(e); *VAD Act* (Vic) (n 2) s 7(e); *VAD Act* (WA) (n 12) s 9(1)(c).

211 *VAD Act* (Qld) (n 12) s 16(4); *VAD Act* (WA) (n 12) s 20(4); *EOLC Act* (Tas) (n 12) s 24.

212 *VAD Act* (Qld) (n 12) ss 16(5)–(6)(a); *VAD Act* (WA) (n 12) s 20(5).

213 *VAD Act* (NSW) (n 12) pt 5; *VAD Act* (Qld) (n 12) pt 6 div 2; *VAD Act* (SA) (n 12) pt 2. The legislation in NSW imposes obligations on the 'relevant entity' or 'health entity': *VAD Act* (NSW) (n 12) ss 88, 91, 100. In Queensland, it imposes obligations on the 'relevant entity': *VAD Act* (Qld) (n 12) s 87. In SA, obligations are imposed on an 'operator' or 'relevant entity': *VAD Act* (SA) (n 12) ss 15, 18 which runs residential or healthcare facilities. However, in practical terms, these obligations will be implemented at the facility level, so the discussion in this section uses the term 'facility' for convenience.

facilities to object to aspects of the VAD process occurring on their premises.²¹⁴ These provisions aim to balance the competing interests of persons wishing to access VAD, with those of non-participating facilities.²¹⁵

The Tasmanian, Victorian and WA Acts are silent on whether non-participating facilities have any obligations relating to providing information, allowing any aspect of the VAD process onsite, or facilitating transfers for residents or patients who wish to access VAD. Institutional objection has been addressed at a policy level in these states. Policy documents encourage health service establishments and residential aged care facilities to formulate policy responses at a local level, but do not mandate a particular approach to participation.²¹⁶

The relatively complex legislative provisions governing participation by facilities under the NSW, Queensland and SA legislation are explored below.

A Overview of Facilities' Obligations

In NSW, Queensland and SA, facilities are not obliged to actively participate in the VAD request, assessment, and administration process. However, in some circumstances, facilities must allow onsite access to the VAD process for patients or residents. The level of participation that is required varies between the three states, reflecting a different balance reached between the interests of the facility and the patient or resident. But in all three states, the obligations imposed on facilities differ depending on whether the person is a permanent resident at the facility, and the step in the VAD process.

214 On the issue of institutional conscientious objection generally, see Ben P White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' (2021) 3 *University of New South Wales Law Journal Forum* 1 ('Legislative Options'); Philip Shadd and Joshua Shadd, 'Institutional Non-Participation in Assisted Dying: Changing the Conversation' (2019) 33(1) *Bioethics* 207 <<https://doi.org/10.1111/bioe.12528>>; L W Sumner, 'Institutional Refusal to Offer Assisted Dying: A Response to Shadd and Shadd' (2019) 33(8) *Bioethics* 970 <<https://doi.org/10.1111/bioe.12641>>; Travis Carpenter and Lucas Vivas, 'Ethical Arguments against Coercing Provider Participation in MAiD (Medical Assistance in Dying) in Ontario, Canada' (2020) 21(1) *BMC Medical Ethics* 46:1–5 <<https://doi.org/10.1186/s12910-020-00486-2>>.

215 *QLRC Report* (n 28) 457.

216 Department of Health and Human Services (Vic) and Victorian Healthcare Association, *Voluntary Assisted Dying Model of Care Pathways for Health Services* (January 2019) <<https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/v/vad-model-of-care-pathways-for-health-services.pdf>>; Department of Health (WA), 'Managing Voluntary Assisted Dying Policy' (Policy Framework, 1 July 2021); Department of Health (Tas), 'Voluntary Assisted Dying in Tasmania: Planning for Voluntary Assisted Dying' (Guide, October 2022) <https://www.health.tas.gov.au/sites/default/files/2022-10/vad_-_minimum_requirements.pdf>. For a critical analysis of this approach and the publicly available institutional policies, see Eliana Close et al, 'Institutional Objection to Voluntary Assisted Dying in Victoria, Australia: An Analysis of Publicly Available Policies' (2022) *Journal of Bioethical Inquiry* (forthcoming). See also Ben P White et al, 'Mapping the Legal Regulation of Voluntary Assisted Dying in Victoria: The Coherence of a New Practice within the Wider Legal System' (2022) 29(3) *Journal of Law and Medicine* 783, 803–4.

1 Residential Facilities

Residential facilities – including residential aged care facilities,²¹⁷ nursing homes,²¹⁸ and retirement villages (in SA only)²¹⁹ – that do not offer VAD services have specific obligations in NSW, Queensland, and SA. They must disclose publicly if they do not provide VAD services.²²⁰ They must also allow relevant healthcare workers to visit residents who request information about VAD or wish to make a first or final request.

Other relevant provisions distinguish between permanent and non-permanent residents of a facility, with greater obligations being imposed in relation to permanent residents,²²¹ reflecting a policy decision that a person should not have to leave their home to access lawful medical services. Where a person is a permanent resident of a facility, the facility must allow access to relevant health practitioners so eligibility assessments and administration of VAD can occur on site.²²² Where a person is not a permanent resident, the primary obligation is to facilitate the transfer of the person to and from a place where they can receive VAD services.²²³ However, if it is not reasonable to transfer the person, given their circumstances, a facility must allow relevant health practitioners to attend for the purposes of providing VAD services, including administration, to the person.²²⁴

Table 7 outlines obligations at each step of the VAD process that residential facilities have towards their patients and residents.

217 Residential aged care facilities are defined as facilities that provide accommodation, nursing care and/or personal care services, including staff who provide meals and cleaning, furnishings, furniture and equipment: *VAD Act* (NSW) (n 12) s 88 (definition of ‘residential aged care’); *VAD Act* (Qld) (n 12) s 86 (definition of ‘residential aged care’); *VAD Act* (SA) (n 12) s 15 (definition of ‘residential aged care’).

218 ‘Nursing homes’ are not defined in the legislation, but are included with hostels and other facilities which provide accommodation, and personal or nursing care. These services are similar to residential aged care, but are provided to persons who need care because of ‘infirmity, illness, disease, incapacity or disability’, rather than necessarily because of age: *VAD Act* (NSW) (n 12) sch 1 (definition of ‘residential facility’); *VAD Act* (Qld) (n 12) s 86 (definition of ‘facility’ para (d)); *VAD Act* (SA) (n 12) s 15 (definition of ‘facility’ para (a)).

219 *VAD Act* (SA) (n 12) s 15 (definition of ‘facility’ para (c)).

220 *VAD Act* (NSW) (n 12) s 98; *VAD Act* (Qld) (n 12) s 98; *VAD Act* (SA) (n 12) s 25.

221 *VAD Act* (NSW) (n 12) ss 90, 92; *VAD Act* (Qld) (n 12) ss 90, 92; *VAD Act* (SA) (n 12) ss 17, 19.

222 *VAD Act* (NSW) (n 12) ss 93(2), 94(2), 96(2), 97(2); *VAD Act* (Qld) (n 12) ss 94(2), 95(2), 96(2), 97(2); *VAD Act* (SA) (n 12) ss 20(2), 21(2), 23(2), 24(2).

223 *VAD Act* (NSW) (n 12) ss 93(3), 94(3), 96(3), 97(3); *VAD Act* (Qld) (n 12) ss 94(3), 95(3), 96(3), 97(3); *VAD Act* (SA) (n 12) ss 20(3), 21(3), 23(3), 24(3).

224 *VAD Act* (NSW) (n 12) ss 93(4), 94(4), 96(4), 97(4); *VAD Act* (Qld) (n 12) ss 94(4), 95(4), 96(4), 97(4); *VAD Act* (SA) (n 12) ss 20(4), 21(4), 23(4), 24(4).

Table 7: Obligations of Residential Facilities to Provide Access to VAD in NSW, Queensland and SA

Step in VAD Process	Obligations		
Access to information	<u>ALL RESIDENTS (ALL 3 STATES)</u> - Not hinder the patient's access to information, AND - Allow reasonable access to the patient at the facility by a registered health practitioner (and other relevant persons)		
First and final requests	<u>ALL RESIDENTS (ALL 3 STATES)</u> - Allow reasonable access at the facility by the relevant practitioner for the patient to make a first request or final request, OR - Transfer the patient to and from a place where the request(s) can be made if the practitioner is not available to attend the facility		
Second request (written declaration)	<u>PERMANENT RESIDENTS (SA and NSW)</u> - Allow reasonable access at the facility by the coordinating practitioner and witnesses, OR - Transfer the patient to and from a place where the request can be made if the practitioner is not available to attend the facility	<u>NON-PERMANENT RESIDENTS (SA and NSW)</u> - Transfer the patient to and from a place where the request can be made, OR - If a transfer would not be reasonable, allow reasonable access at the facility by the coordinating practitioner and witnesses	<u>ALL RESIDENTS (Queensland)</u> - Allow reasonable access at the facility by the coordinating practitioner and witnesses, OR - Transfer the patient to and from a place where the request can be made if the practitioner is not available to attend the facility
First and consulting assessment, administration decision and/or authorisation consultation	<u>PERMANENT RESIDENTS (ALL 3 STATES)</u> - Allow reasonable access at the facility by the relevant practitioner(s) for the consultation(s), OR - Transfer the patient to and from a place where the consultation(s) can take place if the practitioner is not available to attend the facility		<u>NON-PERMANENT RESIDENTS (ALL 3 STATES)</u> - Transfer the patient to and from a place where consultation(s) can take place, OR - If a transfer would not be reasonable, allow reasonable access at the facility by the relevant practitioner(s) for the consultation(s)

Step in VAD Process	Obligations	
Administration	<u>PERMANENT RESIDENTS (ALL 3 STATES)</u> • Allow reasonable access at the facility for delivery of the VAD substance, AND • Allow reasonable access at the facility by the relevant practitioner and any other person lawfully participating in the administration of VAD	<u>NON-PERMANENT RESIDENTS (ALL 3 STATES)</u> • Transfer the patient to a place where administration can take place, OR • If a transfer would not be reasonable, allow reasonable access at the facility by the relevant practitioner and any other person lawfully participating in the administration of VAD

2 Non-Residential Facilities (Healthcare Facilities)

Obligations also apply to non-residential healthcare facilities, such as public²²⁵ and private hospitals,²²⁶ hospices in Queensland,²²⁷ and other healthcare facilities in SA.²²⁸

In SA, healthcare facilities have the right to refuse to participate in the VAD process and can also refuse to allow the carrying out of VAD services on their premises.²²⁹ They may also indicate in their contractual terms and conditions that they will not permit VAD services to be carried out on their premises, and require patients to acknowledge this and agree not to seek access to VAD at the facility.²³⁰ If a patient advises a non-participating healthcare facility that they wish to access VAD, the facility must notify the patient of their refusal to participate, and take reasonable steps to transfer the person to a facility at which VAD services may be provided.²³¹ If a person is unable to be transferred (for example because of their

225 *VAD Act* (NSW) (n 12) s 88 (definition of ‘health care establishment’ para (b)); *VAD Act* (Qld) (n 12) s 86 (definition of ‘facility’ para (c)); *VAD Act* (SA) (n 12) s 11 (definition of ‘health service establishment’ para (6)(c)).

226 *VAD Act* (NSW) (n 12) s 88 (definition of ‘health care establishment’ para (a)); *VAD Act* (Qld) (n 12) s 86 (definition of ‘facility’ para (a)); *VAD Act* (SA) (n 12) s 11 (definition of ‘health service establishment’ para (6)(a)).

227 *VAD Act* (Qld) (n 12) s 86 (definition of ‘facility’ para (b)).

228 In SA, the institutional non-participation provisions also apply to facilities that are designed to provide inpatient or outpatient treatment: *VAD Act* (SA) (n 12) s 11 (definition of ‘prescribed residential premises’ para (6)(b)).

229 *VAD Act* (SA) (n 12) s 11(1).

230 *Ibid* s 11(2).

231 *Ibid* ss 11(3)–(4).

deteriorating condition or the lack of an alternative facility) the patient might not be able to access VAD.

In NSW, non-participating healthcare facilities must allow a member of the VAD navigator service to visit a patient who has requested information about VAD.²³² For all other steps in the VAD process, the facility is required to take reasonable steps to facilitate the transfer of the patient to and from a place where the relevant consultation can take place.²³³ As in SA, if a person is unable to be transferred, they might not be able to access VAD.

The Queensland Act imposes the most significant obligations on healthcare facilities. In Queensland, the provisions that apply to non-permanent residents at residential facilities also apply to patients receiving care from healthcare facilities.²³⁴

Table 8 outlines obligations at each step of the VAD process that healthcare facilities have towards their patients in these three states.

Table 8: Obligations of Healthcare Facilities to Provide Access to VAD in NSW, Queensland and SA

Step In VAD Process	SA	Queensland	NSW
Access to information	- Advise the patient that the facility does not participate in the VAD process, AND - Have arrangements in place to transfer the patient to an alternative facility where the patient is likely to be able to receive VAD services, AND	- Not hinder the patient's access to information, AND - Allow reasonable access to the patient at the facility by a registered health practitioner (or official care navigator)	- Not hinder the patient's access to information, AND - Allow reasonable access to the patient at the facility by a registered health practitioner (and other persons)
First and final requests	Take reasonable steps to facilitate the transfer	- Allow reasonable access at the facility by the relevant practitioner for the patient to make a first request or final request, OR - Transfer the patient to and from a place where the request(s) can be made if the practitioner is not available to attend the facility	Take reasonable steps to facilitate patient transfer to and from a place where the requests can be made and where the consultations can take place

²³² *VAD Act* (NSW) (n 12) s 99(2)(b).

²³³ *Ibid* ss 101–6.

²³⁴ *VAD Act* (Qld) (n 12) ss 86 (definition of ‘facility’), 90–7.

Step In VAD Process	SA	Queensland	NSW
Second request (written declaration)	- Advise the patient that the facility does not participate in the VAD process, AND - Have arrangements in place to transfer the patient to an alternative facility where the patient is likely to be able to receive VAD services, AND	- Allow reasonable access at the facility by the coordinating practitioner and witnesses, OR - Transfer the patient to and from a place where the request can be made if the practitioner is not available to attend the facility	Take reasonable steps to facilitate patient transfer to and from a place where the requests can be made and where the consultations can take place
First and consulting assessment, administration decision and/or authorisation consultation	Take reasonable steps to facilitate the transfer	- Transfer the patient to and from a place where consultation(s) can take place, OR - If a transfer would not be reasonable, allow reasonable access at the facility by the relevant practitioner(s) for the consultation(s)	
Administration		- Transfer the patient to a place where administration can take place, OR - If a transfer would not be reasonable, allow reasonable access at the facility by the relevant practitioner and/or other persons participating in the process	Take reasonable steps to facilitate patient transfer to a place where administration can take place

B Discussion

The non-participation of healthcare facilities and residential facilities in VAD is a significant practical problem in Victoria, where VAD has been lawful for over three years.²³⁵ Some healthcare facilities have indicated an intention not to

235 For some reports of hospitals and medical practitioners obstructing access for patients, see *VAD Review Board Report of Operations* (n 90) 26–7. See also Ben P White et al, ‘The Impact on Patients of Objections by Institutions to Assisted Dying: A Qualitative Study of Family Caregivers’ Perceptions’ (2023) 24 *BMC Medical Ethics* 22:1–12 <<https://doi.org/10.1186/s12910-023-00902-3>> (‘The Impact on Patients of Objections’).

be involved in VAD at all.²³⁶ Most healthcare facilities in Victoria have chosen 'Pathway C', which means they will provide information and support about VAD, but not assessment consultations or administration of VAD on their premises.²³⁷ In those states where the law does not regulate the obligations of facilities to facilitate access to VAD, ultimately whether a person is able to access VAD depends on them finding a willing institution.

By contrast, in NSW, Queensland and SA, the legislation outlines obligations that non-participating facilities have towards patients and residents who wish to access VAD. While facilities are not required to actively participate in the VAD process, they must not hinder access to VAD services and must allow access to participating practitioners, or transfer patients to a location where they can receive VAD services. Permanent residents of residential facilities have a legislative right to access VAD consultations, assessments, and administration at the facility. Residential facilities in these states have a statutory obligation to transfer other patients to a place where they can receive relevant VAD services. These provisions represent a model of 'compromise or reasonable accommodation': that is, institutional objections to, or non-participation in VAD is permitted, but within reasonable limits imposed by the law.²³⁸

The obligations imposed on facilities are similar between the three states. However, one significant difference is that the NSW and Queensland provisions apply to a wider range of facilities, including public and private hospitals and hospices. The SA provisions apply to retirement villages, but not hospitals or hospices. Another significant difference is that where it is not reasonable to transfer a patient to another facility to receive VAD services, healthcare facilities in Queensland must allow the person to access VAD consultations, assessments, and administration on the premises. By contrast, in NSW, if a transfer is not appropriate in the circumstances,²³⁹ the patient might not be able to access VAD. Additionally, healthcare facilities in SA can expressly contract out of any obligation to provide VAD services to their patients. Given these differences, it seems likely that as the laws in these three states commence operation, we will see variation in the accessibility of VAD between these states.

236 See generally White et al, 'The Impact on Patients of Objections' (n 235) 6–7, 10–11.

237 Cameron McLaren and Greg Mewett, 'Update on Voluntary Assisted Dying in Australia' (2021) 215(3) *Medical Journal of Australia* 115, 115–16 <<https://doi.org/10.5694/mja2.51152>>. See also, describing a case where a patient was transferred to another hospital, Eswaran Waran and Leeroy William, 'Navigating the Complexities of Voluntary Assisted Dying in Palliative Care' (2020) 213(5) *Medical Journal of Australia* 204 <<https://doi.org/10.5694/mja2.50729>>. See also Close et al (n 216).

238 Mark R Wicclair, 'Preventing Conscientious Objection in Medicine from Running Amok: A Defense of Reasonable Accommodation' (2019) 40(6) *Theoretical Medicine and Bioethics* 539, 541 <<https://doi.org/10.1007/s11017-019-09514-8>> (emphasis omitted). This terminology was adopted in White et al, 'Legislative Options' (n 214) 13.

239 In determining whether a transfer would be reasonable, healthcare facilities in NSW must have regard to a number of considerations, including whether the transfer would likely cause serious harm to the person and whether the receiving facility can accommodate the person: *VAD Act* (NSW) (n 12) ss 102(3), 103(3), 104(3), 105(3), 106(3).

VIII COMPARATIVE ANALYSIS OF THE ‘AUSTRALIAN MODEL’

Drawing on the comparative analysis method,²⁴⁰ this section identifies some of the key similarities and differences of the various state VAD laws.

A The ‘Australian Model’ Has Largely Followed Victoria

Victoria’s unique framework for VAD, which emerged as a political compromise following extensive public consultation and parliamentary debate, has served as the model for what has become a distinctive ‘Australian model of VAD’.²⁴¹ Subsequent Australian states generally treated the fledgling Victorian model as the reference point when legalising VAD, rather than focusing their attention on international comparisons.²⁴² Indeed, in SA, a conscious decision was taken to largely adopt the Victorian model,²⁴³ without independently evaluating the merits of later innovations in WA and Tasmania. Using Victoria as a model extends to adopting some rather curious distinctions and requirements as essential features of the Australian model. For example, in all states except Queensland, a differential timeframe until death exists for persons with neurological conditions compared to persons with other conditions, a distinction that is unique worldwide.

B Common Features of the ‘Australian Model’ of VAD

The ‘Australian model’ of VAD has a number of distinctive common features. Perhaps the most immediately apparent is its detailed legislative control of the process. The VAD laws outline a carefully prescribed request and assessment process which consists of multiple requests for access to VAD, a minimum of two formal assessments (four in Tasmania), and contemporaneous reporting at all stages of the process. Assessments can only be conducted by a suitably experienced medical practitioner whose qualifications are legislatively prescribed, and who is required to have completed mandatory training to ensure a thorough understanding of the legislation.²⁴⁴ The VAD laws also address matters such as the process for

240 Mark Van Hoecke, ‘Methodology of Comparative Legal Research’ [2015] 12 *Law & Method* 1, 1–35 <<https://doi.org/10.5553/REM%2F.000010>>.

241 For a detailed consideration of the reform process in Victoria, see Lindy Willmott and Ben P White, ‘The Challenging Path to Voluntary Assisted Dying Law Reform in Australia: Victoria as a Successful Case Study’ in Ben P White and Lindy Willmott (eds), *International Perspectives on End-of-Life Law Reform: Politics, Persuasion and Persistence* (Cambridge University Press, 2021) 84.

242 WA considered international VAD frameworks but chose the Victorian framework as a starting point: *WA Panel Report* (n 9) 2, 132–8. See also the Queensland approach: *QLRC Report* (n 28) 15.

243 The terms of reference for the SA Parliamentary Committee expressly asked whether it would be appropriate for SA to enact legislation in similar terms to Victoria’s *Voluntary Assisted Dying Act 2017*: Joint Committee on End of Life Choices, Parliament of South Australia, *Report of the Joint Committee on End of Life Choices* (Report, 54th Parliament, 13 October 2020) 3. In Queensland, the Queensland Law Reform Commission stated that it would adopt ‘what is good in principle and workable in practice from laws in other States’. The legislation they recommended was heavily based on the Victorian model but with variations to better reflect these principles: *QLRC Report* (n 28) xii.

244 93% of medical practitioners who completed the mandatory training in Victoria felt they had good or very good knowledge of the law post training, and 88% felt confident in applying the law: Willmott et

seeking second opinions, the procedure for transferring care to another practitioner, prescribing and dispensing the VAD substance, and even what information must be discussed with a person during certain consultations. Very little is left to be interpreted in policy documents or subordinate legislation.

Another common characteristic of all the Australian VAD frameworks is how narrowly the eligibility criteria are framed. In all states, VAD is restricted to those who are suffering a terminal illness and are at the end of life. In all states besides Queensland, the person must be within six months of death, although this is extended to 12 months if they have a neurodegenerative condition. In Queensland, a person must be within 12 months of death. The 'Australian model' is therefore clearly intended to provide an option for the dying person to have some control over the time and manner of their death, not (as is the case in some other countries) to provide a broader right of self-determined dying focused primarily on the alleviation of suffering.

All Australian VAD laws also place a strong emphasis on this choice being a voluntary decision by the person themselves. The title of the legislation in each state includes the word 'voluntary', and a person must have decision-making capacity throughout the process and at the time of the final decision to request VAD, and not be subject to any duress or coercion affecting their ability to make a free and voluntary choice. No Australian state permits a person to request VAD through an advance directive. The availability of VAD is further restricted by the existence of the dual residence requirements discussed in Part II(B), which will prevent residents of other countries from accessing VAD in Australia, as well as preventing movement between Australian states and territories to access VAD.

The legislation in four states – NSW, SA, Tasmania and Victoria – requires prior authorisation before VAD occurs.²⁴⁵ This is different from most jurisdictions internationally, which operate using retrospective review.²⁴⁶ A formal permit or approval is not required in Queensland or WA, but there is periodic reporting to the oversight board during the request and assessment process.

In all states besides NSW, self-administration is the default method of VAD, although there is some variation regarding the criteria that must be met for practitioner administration to be permitted. In NSW, a person may choose between self- and practitioner administration.

Other common features of significance include specific requirements for the secure storage and safe disposal of the VAD substances and the appointment of a contact person (at least in cases of self-administration of VAD) to manage the medication in the community. All Australian laws also protect the right of conscientious objection of health practitioners.

al, 'A Cross-Sectional Study of the First Two Years of Mandatory Training for Doctors Participating in Voluntary Assisted Dying' (n 185).

245 It is required in NSW, SA, Tasmania and Victoria: *VAD Act* (NSW) (n 12) ss 70–2; *VAD Act* (SA) (n 12) s 61; *EOLC Act* (Tas) (n 12) s 66; *VAD Act* (Vic) (n 2) s 43. It is not required in WA or Queensland.

246 White et al, 'Stated Policy Goals?' (n 62) 441 n 176.

C Departures from the Victorian Model

In some instances, however, state laws have departed from the Victorian model. These departures were sometimes informed by difficulties experienced in Victoria during the early months after the VAD laws commenced operation.

One notable variation is the regulation of non-participating facilities in NSW, Queensland and SA, requiring them to provide access to VAD for persons in their care, either through permitting access for external participating practitioners, or transferring the person to a place where the relevant VAD service can be provided.²⁴⁷ No comparable provisions exist in Tasmania, Victoria or WA.

Other notable examples of this include the modification of Victoria's rigid residence requirements in NSW, Queensland and Tasmania;²⁴⁸ variation of the prohibition on raising the topic of VAD in NSW, Queensland, Tasmania and WA²⁴⁹ and the introduction of nurse practitioners or nurses as administering practitioners in some states with geographically dispersed populations.²⁵⁰

IX OPPORTUNITIES FOR IMPROVEMENT

All states are required to review the operation of their VAD laws after they have been operational for between two to five years (depending on the state).²⁵¹ At that time it will be important to think broadly and critically about the legislation and opportunities for improvement. If the Northern Territory and the Australian Capital Territory decide to legalise VAD, they will also likely consider which aspects of the 'Australian model' should be adopted in their respective jurisdiction. The current Australian VAD laws are easily the most prescriptive in the world,²⁵² and it is important to consider whether all of their requirements are appropriate and effective to achieve the purpose of the legislation, or whether aspects of other VAD frameworks may be worth adopting. This section discusses some areas for possible reform which have been identified through this comparative analysis, informed where appropriate by the emerging empirical evidence on how VAD has been operating to date in Victoria and WA.

247 *VAD Act* (NSW) (n 12) ss 88–107; *VAD Act* (Qld) (n 12) ss 86–98; *VAD Act* (SA) (n 12) ss 15–25.

248 See above, Part II(B).

249 See above, Part III(A).

250 See above, Part V(A) tbl 5.

251 The *VAD Act* (Vic) must be reviewed in the fifth year of its operation: that is, some time between 19 June 2023 and 18 June 2024: *VAD Act* (Vic) (n 2) s 116. In WA, a review of the operation of its Act is due as soon as practical after the Act has been operational for two years, that is, in the latter half of 2023: *VAD Act* (WA) (n 12) s 164(1)(a). The legislation in the other four states will be reviewed in 2026–27 – in NSW after November 2025, in Queensland in 2026, in SA in 2027 and in Tasmania after 23 October 2025: *VAD Act* (NSW) (n 12) s 186(1)(a); *VAD Act* (Qld) (n 12) s 154(1); *VAD Act* (SA) (n 12) s 129; *EOLC Act* (Tas) (n 12) s 145.

252 See Mroz et al (n 21).

A Eligibility Criteria

Although the eligibility criteria are generally clear and consistent across states, some amendments to these criteria may be worth considering. In Tasmania, the legislation defines a person's condition as 'incurable' based on a subjective test of whether any treatments that are acceptable to the person are available. By contrast, extrinsic material suggests that an objective test of whether a condition is 'incurable' applies in SA and Victoria.²⁵³ It is at least arguable that this distinction could preclude some people from accessing VAD in those two states.

The differential timeframe for eligibility of persons with neurological and other conditions, adopted as an amendment during parliamentary debate in Victoria, has been criticised as discriminatory and contrary to logic.²⁵⁴ Yet this anomalous eligibility criterion has been adopted in all states except Queensland, which has consciously chosen to incorporate a single 12-month timeframe until expected death.

The Victorian residence requirements, adopted in SA and WA, have proven problematic in practice, particularly for long-term residents who have not formalised their status by becoming Australian citizens or permanent residents.²⁵⁵ The inflexibility of this criterion may be somewhat ameliorated by the incorporation of a broader definition of 'permanent resident', the inclusion of more flexible residence criteria or the ability to apply for exemptions, as is the case in NSW, Queensland and Tasmania.²⁵⁶

Further, the state residence requirement could be repealed when VAD laws undergo their planned review. In its most recent report, the Victorian VAD Review Board suggested reciprocal access to VAD for residents of other Australian states and New Zealand (where VAD is also legal in certain circumstances) might be considered.²⁵⁷ Repealing the state residence requirement would achieve that, at least in relation to Australian residents. The Australian citizen or permanent resident criterion is sufficient to exclude residents of other countries from accessing VAD in Australia. Now that all states have legalised VAD, and the Australian Capital Territory has commenced the process of consultation prior to legislating,²⁵⁸ the need to exclude residents of other states has all but vanished, and the requirement (which may be unconstitutional)²⁵⁹ serves as little more than an additional administrative burden for patients and medical practitioners alike.

253 White et al, 'Comparative and Critical Analysis' (n 46) 1670–1.

254 White et al, 'Stated Policy Goals?' (n 62) 433–4.

255 The Australian citizen or permanent resident criterion has been criticised on the ground that the strict interpretation given to this requirement is not required by the text, context or purpose of the statute: Del Villar, Willmott and White (n 25).

256 *VAD Act* (NSW) (n 12) s 16(1)(b)(iii); *VAD Act* (Qld) (n 12) ss 10(1)(e)(iii), (iv); *EOLC Act* (Tas) (n 12) s 11(1)(a)(iii).

257 *VAD Review Board Report of Operations* (n 90) 31.

258 The Australian Capital Territory has commenced a process of public consultation, and has announced its intention to introduce a VAD bill in the second half of 2023: 'Voluntary Assisted Dying Laws in the ACT', *ACT Government* (Web Page) <<https://www.justice.act.gov.au/justice-programs-and-initiatives/voluntary-assisted-dying-laws-in-the-act>>.

259 Del Villar and Simpson (n 91).

B Request, Assessment and Administration Process

It has been frequently observed that the VAD process is highly prescriptive and imposes a substantial burden on patients and participating practitioners.²⁶⁰ However, specific requirements in some states increase the extent of this administrative burden. For example, in SA and Victoria, a third consultation with a specialist is required to confirm the prognosis of patients with a neurodegenerative condition whose death is expected to occur after six but before 12 months,²⁶¹ and Tasmania requires four eligibility assessments in at least four separate medical consultations.²⁶² Review of the VAD laws may provide an opportunity to streamline some of these aspects of the VAD process to reduce the burden on participants.

C Method of Administration of VAD

As has been observed, the SA and Victorian regimes have self-administration of VAD as the default method, allowing practitioner administration only where self-administration is not physically possible for the person. This lack of discretion runs counter to the legislative purpose of respecting the autonomous choices of people at the end of their lives to determine both the timing and manner of their deaths. Consideration should be given to permitting practitioner administration of VAD in a broader range of circumstances, as reflected in the Queensland, Tasmania and WA laws which allow consideration of what is appropriate for the patient,²⁶³ or the NSW model which allows a patient to elect between self-administration and practitioner administration.²⁶⁴

D Prohibition on Practitioners Discussing VAD

The prohibition on registered health practitioners initiating conversations about VAD with patients in SA and Victoria has also been subject to considerable criticism.²⁶⁵ Although understandable in its attempt to prevent undue influence

260 White et al, 'Stated Policy Goals?' (n 62) 444, 448.

261 *VAD Act* (SA) (n 12) s 36(4); *VAD Act* (Vic) (n 2) s 18(4). The coordinating practitioner must adopt this determination: *VAD Act* (SA) (n 12) s 36(7); *VAD Act* (Vic) (n 2) s 18(6). This requirement has been identified as an impediment in feedback to the Victorian VAD Review Board, which often requires extensive travel and causes delays, particularly for 'applicants with mobility issues and those situated in regional and remote areas': *VAD Review Board Report of Operations* (n 90) 30.

262 *EOLC Act* (Tas) (n 12) ss 26, 33, 37, 47, 55.

263 *VAD Act* (WA) (n 12) s 56; *EOLC Act* (Tas) (n 12) s 86(5); *VAD Act* (Qld) (n 12) s 50(2). This departure from the Victorian model is already having a significant impact in practice, as a much higher proportion of patients are accessing practitioner administration in WA: Voluntary Assisted Dying Board, Western Australia, *Annual Report 2021–22*, (Report 16 November 2022) 24.

264 *VAD Act* (NSW) (n 12) s 57(1).

265 See Ben P White et al, 'Access to Voluntary Assisted Dying in Victoria: A Qualitative Study of Family Caregivers' Perceptions of Barriers and Facilitators' (2023) 219(5) *Medical Journal of Australia* 211 ('Access to Voluntary Assisted Dying') <<https://doi.org/10.5694/mja2.52004>>; Ben P White et al, 'Barriers to Connecting with the Voluntary Assisted Dying System in Victoria, Australia: A Qualitative Mixed Method Study' (2023) *Health Expectations* (forthcoming) <<https://doi.org/10.1111/hex.13867>>. See also Johnston and Cameron (n 94); Willmott et al, 'Restricting Conversations about Voluntary Assisted Dying' (n 94); Moore, Hempton and Kendal (n 94); Willmott et al, 'Participating Doctors' Perspectives' (n 27) 127.

from medical practitioners on patient choice, it is likely to significantly hamper the ability of practitioners to have open and frank discussions with patients about all available end-of-life options. It is noteworthy that four Australian states have chosen not to include this provision in their VAD laws, and this alternative approach would be safe to adopt in SA and Victoria also.

E Participating Practitioner Requirements

The expertise and post-registration years of experience required for eligible medical practitioners participating in VAD in SA, Tasmania and Victoria also have the potential to restrict access to VAD. For example, in Tasmania, both practitioners must have a minimum of five years' post-specialist qualification experience as well as experience in treating the patient's condition.²⁶⁶ In SA and Victoria, one medical practitioner assessing eligibility must be a specialist in the patient's condition.²⁶⁷ These requirements will exclude many practitioners from participating in the VAD process and may impact the ability of patients to access VAD.

F Conscientious Objection of Health Practitioners

While the laws in each state specifically protect a practitioner's right to refuse to participate in VAD due to a conscientious objection, states have balanced the competing interests of practitioners and patients differently. This is apparent in different approaches taken in relation to timeframes in which medical practitioners must refuse a first request, and information provisions or referral obligations.

In NSW, Queensland and WA, if a medical practitioner refuses a first request due to a conscientious objection to VAD, they must let the patient know immediately.²⁶⁸ By contrast, SA and Victorian practitioners have up to seven days to notify the patient, which has the potential to create unnecessary delays in access.²⁶⁹ Likewise, the legislative requirement to provide the patient with specific information upon receiving a first request (a feature of the Queensland, Tasmanian and WA laws) is likely to improve consistency of access.²⁷⁰

G Institutional Objection

Another uniquely Australian innovation is the institutional objection provisions contained in the NSW, Queensland and SA VAD laws, which oblige non-participating facilities to either allow external practitioners access to the premises to provide VAD consultations, assessments and administration, or transfer the person elsewhere to access those services.²⁷¹ These provisions may serve as a model for future amendments to the laws in Tasmania, Victoria or WA, where

266 *EOLC Act* (Tas) (n 12) ss 9(b)–(c).

267 *VAD Act* (SA) (n 12) ss 27(2)–(3); *VAD Act* (Vic) (n 2) ss 10(2)–(3).

268 *VAD Act* (NSW) (n 12) s 21(5); *VAD Act* (Qld) (n 12) s 16(6)(a); *VAD Act* (WA) (n 12) s 20(5).

269 *VAD Act* (SA) (n 12) s 31(1); *VAD Act* (Vic) (n 2) s 13(1).

270 Rosalind McDougall and Bridget Pratt, 'Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation' (2020) 21(1) *BMC Medical Ethics* 38:1–10 <<https://doi.org/10.1186/s12910-020-00483-5>>.

271 *VAD Act* (Qld) (n 12) ss 86–98; *VAD Act* (SA) (n 12) ss 15–25; *VAD Act* (NSW) (n 12) ss 88–107.

institutional participation in VAD is governed solely by policy. These provisions may improve access to VAD for residents of aged care facilities, and patients in public and private health services.

X CONCLUSION

In 2015, before any VAD laws had been passed in Australia, two of the authors reviewed the dozens of prior legislative attempts to enact VAD legislation.²⁷² When comparing those Bills that were ‘close to passing’,²⁷³ we observed that the ultimate likelihood of passing was not dependent on the content of those Bills. However, subsequent Australian experience makes clear that the chance of legislative success very much depends on the content of the legislation.

This comparative analysis has demonstrated that there is a broad ‘Australian model’ of VAD that is now reflected in the six states which have such laws. While there are variations in the detail, VAD laws in all Australian states largely reflect the conservative and prescriptive ‘Australian model’ of detailed regulation of all aspects of the VAD process. This consistency in approach stems from the adoption, in large part, of the original Victorian model by other states. Despite overwhelming public support for assisted dying,²⁷⁴ the parliamentary debates and significant media attention that occurred in all states when VAD laws were being considered reflect the political challenges in enacting this kind of legislation. Given these challenges, politicians may have been reluctant to depart too far from the narrow model adopted in Victoria, even if such a model did not always reflect the policy goals of the law.²⁷⁵ The Australian model of VAD is not, however, uniform, and later jurisdictions have departed from aspects of the Victorian prototype when legalising VAD, particularly when confronted with evidence that some aspects of this model are causing problems in practice.²⁷⁶

As each state’s VAD laws fall due to be formally reviewed as required in the legislation, and as the territories consider legalising VAD,²⁷⁷ there are opportunities for each jurisdiction to consider the innovations and variations adopted in other

272 Willmott et al, ‘(Failed) Voluntary Euthanasia Law Reform’ (n 1).

273 Ibid 21–3.

274 Kresin et al trace support for VAD by a majority of Australians back to 1962: Tracee Kresin et al, ‘Attitudes and Arguments in the Voluntary Assisted Dying Debate in Australia: What Are They and How Have They Evolved over Time?’ (2021) 18(23) *International Journal of Environmental Research and Public Health* 12327:1–11, 5 <<https://doi.org/10.3390/ijerph182312327>>.

275 See generally White et al, ‘Stated Policy Goals?’ (n 62).

276 Such as the residency requirements: Del Villar, Willmott and White (n 25); the delays and administrative burdens caused by the request and assessment process: Willmott et al, ‘Participating Doctors’ Perspectives’ (n 27) 127; Sellars et al (n 126) 6; and access issues caused by the non-participation of institutions: White et al, ‘The Impact on Patients of Objections’ (n 235).

277 Since the passing of the Restoring Territory Rights Bill 2022 by the Federal Government in December 2022, the ACT has signalled that it will introduce VAD laws in 2023. The NT Government has stated that it will not consider VAD laws during the current parliamentary term: Markus Mannheim, ‘Federal Parliament Overturns 25-Year-Old Ban on Euthanasia Laws in ACT and Northern Territory’, *ABC News* (online, 1 December 2022) <<https://amp.abc.net.au/article/101692028>>.

states. One strength of the comparative law method adopted in this article is it provides the basis for critically evaluating one law through considering how other jurisdictions have addressed similar issues. At the time these reviews are to be undertaken, there will be an emerging body of evidence which sheds light on how particular state VAD laws are operating, in view of the variations described above. One source of evidence is the formal reports by the oversight bodies who are responsible for monitoring the operation of the VAD systems and proposing improvements. For example, the most recent reports of both the Victorian VAD Review Board and the WA VAD Board identify a series of issues relevant to that state's law and recommend amendments.²⁷⁸ Another source of evidence is the growing body of empirical research documenting the experiences of health professionals, patients, families and others involved in the VAD system.²⁷⁹ It too provides a basis to consider how the law and its operation could be improved. Notwithstanding the political challenges of passing VAD laws that we have witnessed, reform of the Australian VAD laws ought not to be dismissed as too controversial. The evidence of the oversight bodies monitoring the system, from the empirical research reporting on the experience of stakeholders participating in the VAD process, combined with the foregoing comparative legal analysis, provides a solid foundation for well-considered, measured reforms.²⁸⁰ Modest reforms such as those proposed in Part IX will ensure that all Australians enjoy the benefits of optimal VAD laws, which provide terminally ill patients with effective choices and remove unnecessary administrative and legal barriers to access, while continuing to ensure the safety of the system.

278 *VAD Review Board Report of Operations* (n 90) 30–1; Voluntary Assisted Dying Board, Western Australia (n 263) 37–9.

279 See, eg, Willmott et al, 'Participating Doctors' Perspectives' (n 27); Rutherford, Willmott and White (n 187); Sellars et al (n 126); White et al, 'Prospective Oversight and Approval' (n 162); White et al, 'Access to Voluntary Assisted Dying' (n 265).

280 For the case in support of evidence-based law making in relation to VAD, see Ben White and Lindy Willmott, 'Evidence-Based Law Making on Voluntary Assisted Dying' (2020) 44(4) *Australian Health Review* 544, 544–6.