

10<sup>th</sup> April 2017

Ministerial Advisory Panel  
Voluntary Assisted Dying Framework

cohealth  
365 Hoddle Street  
Collingwood, Vic. 3066

[Assisteddying.frameworkresponses@dhhs.vic.gov.au](mailto:Assisteddying.frameworkresponses@dhhs.vic.gov.au)

Dear Ministerial Advisory Panel,

## **Re: Voluntary Assisted Dying Framework**

cohealth welcomes the opportunity to respond to the *Voluntary Assisted Dying Bill Discussion Paper*. cohealth is Australia's largest not-for-profit community health service, operating across 14 local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities. We provide integrated medical, dental, allied health, mental health and community support services, and deliver programs to promote community health and wellbeing. Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from many mainstream health and other services.

Our work with individuals, families and communities is based on a model of person-centred, consumer directed care, founded on a rights based approach recognising the inherent right of all people to be active agents in decisions that affect them. This is underpinned by the Victorian Charter of Human Rights and Responsibilities Act (2006) and the Australian Charter of Healthcare Rights (2008). As such cohealth supports the principle of voluntary assisted dying, as an extension of consumer directed care and consumer choice and control. Some consumers have also expressed to us their interest in voluntary assisted dying. cohealth commends the government for its leadership in this sensitive area.

Our focus on prioritising working with people who experience social disadvantage leads us to advocate for equal access for all people in all areas of health care, and to ensure that those with less access to resources are not disadvantaged in their access to services. cohealth believes that these principles apply as much to decisions about end of life care as to other areas of care. As such, systems supporting voluntary assisted dying provisions should be available to all who meet the eligibility criteria, and access should not be limited to due factors related to income, language or where a person lives (eg rural or regional areas). Likewise, the framework must be developed in such a way that provisions don't restrict access through imposing onerous requirements that will be difficult to meet, or in



overly restrictive requirements as to who the medical practitioners are who can prescribe the medication.

A key consideration is that legislation allowing for voluntary assisted dying, and any associated implementation framework, is accompanied by adequately resourced and timely training and support for medical practitioners. For the legislative provisions to work in practice medical practitioners need to be willing to have the conversations with their patients, understand the processes and requirements and be willing to prescribe the medication. Our experience in working in other sensitive areas, for example pharmacotherapy prescribing, indicates that without the necessary training and support, medical practitioners may be reluctant to participate. We suggest that medical practitioners be consulted about the most appropriate supports and training, which could include: information provision to inform medical practitioners; provision of training, guidelines and templates via methods that best suit them; mentoring; and the provision of a telephone information line for medical practitioners.

In response to the Key Issues in the Discussion Paper, we make the following additional points:

In relation to **Access and eligibility**, cohealth supports the approach recommended by the Parliamentary Committee ('the Committee') that does not prescribe a set timeline for when a person is at the end of their life, rather 'allows doctors to determine whether a patient is at the end of their life according to the nature of their condition and the likely trajectory'. As described in the Discussion Paper it can be very difficult to predict with accuracy when a person will die, and to impose specific timelines would place medical practitioners in a difficult position. Likewise, cohealth supports the proposal that the definition of 'enduring and unbearable suffering' be a subjective measure determined by the patient, in line with principles of patient-centred care.

In **Making a request** the Committee recommended an enduring request be demonstrated by an initial verbal request, a formal written request, and a final verbal request. cohealth notes that some patients who possess capacity may not be able to either speak or write, due to their illness or pre-existing condition. The provisions relating to making such an enduring request need to allow these people to make the requests in formats appropriate to them. Likewise, communication about voluntary assisted dying, including written and verbal requests, should be available in a person's preferred language. The availability of professional translators, rather than using family members, is particularly important at such a sensitive time.

cohealth supports the Committee's approach to not specify a time period over which these three requests need to be made, to reduce the risk of someone



being prevented from accessing voluntary dying due to the interrelationship between the progress of their illness and their capacity.

The Committee recommends that a request cannot be made in an Advance Care Directive. cohealth has significant experience communicating with consumers about advance care planning, and sees these conversations as valuable opportunities for a person to express their values and preferences about a range of future care preferences – including about voluntary assisted dying. Doing so as part of an advance care planning conversation could be a valuable starting point for people to reflect on and discuss their views with loved ones, well before their health has seriously declined. cohealth suggests that consideration be given to enabling a non-binding preference for, or interest in, voluntary assisted dying to be able to be included in an advance care plan, to assist individuals, families and carers have these conversations.

To facilitate the provision of information about voluntary assisted dying, and to support individuals, their loved ones and medical practitioners conversations and decision making, cohealth recommends that training and support be provided to a range of clinical staff in addition to medical practitioners. Nurses, allied health practitioners and counsellors may be the first to hear a patient's interest in voluntary assisted dying, and training would support their ability to provide accurate information.

In relation to **Conscientious objections**, cohealth recognises that some medical practitioners and organisations may have objections to voluntary assisted dying. However, this should not impede a person's ability to direct and have control over their care. As such, a medical practitioner or organisation who has a conscientious objection to voluntary assisted dying should be required to refer a patient in a timely manner to other health practitioners who do not have such an objection.

In **Administering a lethal dose of medication** cohealth supports the Committee's recommendation that, if a person is unable to self administer the lethal dose, then a medical practitioner should be able to assist them. In keeping with principles of client directed care, the person should be able to request who assists them, and be able to determine, as far as practicable, the place where this medication is administered. Consideration could also be given to developing a community based approach where trained volunteers support the person and their family before and during the time medication is taken.

The Discussion Paper canvasses provisions for regarding disposal of medication **After a person has died**. In general this could be accommodated within the usual provisions regarding disposal of medication, given the other medications that will also need to be disposed. Consideration could be given to allowing for the



primary medical practitioner to visit family after the person has died as a form of 'debriefing'. Remaining medication, including any of the lethal dose, could be collected at this time for disposal.

In relation to how the cause of death is recorded, cohealth recommends that it is the underlying disease that is documented, reflecting the condition that led to a person choosing voluntary assisted dying. While we recognise the value of monitoring the number of people using voluntary assisted dying, this could be done in ways other than the official record of death. For example, medical practitioners prescribing a lethal dose, or the pharmacist dispensing it, could be required to inform the Assisted Dying Review Board who would maintain a register of de-identified participants.

Finally, the introduction of provisions enabling voluntary assisted dying will require a sensitive community awareness raising campaign to be implemented. Community health is well placed to make a key contribution to any such campaign, with its integrated health and medical services, strong, long-standing community links and extensive experience of providing appropriate health promotion and community education to diverse communities.

Yours sincerely



Lyn Morgain

Chief Executive

