Queensland's Voluntary Assisted Dying Act (2021)

Impact on freedom of conscience for health care practitioners and institutions

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EXECUTIVE SUMMARY

Queensland's Voluntary Assisted Dying Act (2021) was drafted by the Queensland Law Reform Commission ("the Commission") It will legalize euthanasia and assisted suicide (termed "voluntary assisted dying") in the Australian state when it comes into force in January, 2023. This review considers the impact the *Act* may have on freedom of conscience. Part I outlines the main features of the law, providing a context for discussion of provisions relevant to freedom of conscience in Part II (Practitioner Freedom of Conscience) and Part III (Institutional & Collective Freedom of Conscience).

Overview

Eligibility

People seeking euthanasia/assisted suicide (EAS) must be adults with an advanced, progressive disease or medical condition expected to cause death within 12 months, and who are enduring what they consider to be intolerable physical or mental suffering caused by the condition or treatment. They must be acting voluntarily and capable of making and communicating medical decisions. They can be mentally ill or disabled, but EAS cannot be provided for mental illness or disability alone. Decision-making capacity is presumed in the absence of evidence to the contrary, and it is acknowledged that it can fluctuate or be temporarily lost and regained. The *Act* imposes residency requirements that can be waived for compassionate reasons.

Practitioners

Only EAS-trained medical practitioners with least five years general practice experience can act as EAS coordinators and consultants. Other EAS-trained medical practitioners, nurses and nurse practitioners may administer euthanasia.

Discussion with patients

Medical and nurse practitioners (not nurses or other health or personal care service providers) may suggest or initiate discussion about euthanasia or assisted suicide even if a patient has not expressed an interest — but are not required to do so. If they initiate the discussion, the *Act* requires them to

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advise the patient about available alternatives and their likely outcomes. The *Act* does not require them to discuss alternatives if patients initiate the discussion. This introduces an undesirable difference between statutory and ethical/professional obligations. Others providing health or personal care services and other registered health practitioners may provide EAS information to patient who asks about it, but are not required to discuss other treatment options.

The EAS process

The EAS process begins with a "clear and unambiguous" first request to a medical practitioner made personally by a patient (not a third party). After discussing alternative options, the medical practitioner must accept or reject the request and promptly notify the patient. A practitioner who rejects a request must advise the patient that others may be able to assist and provide information about them or the Voluntary Assisted Dying Care Navigator Service. An EAS-qualified medical practitioner who accepts a request becomes the coordinating practitioner, responsible for supervising the EAS request, assessment and administration process.

A medical practitioner who accepts request must assess the patient's eligibility. Patients deemed eligible must be referred to a consulting practitioner to confirm the assessment, and can be referred repeatedly to consulting practitioners until eligibility is confirmed. Referrals to specialists are optional, and their opinions are not binding.

A patient deemed eligible by two medical practitioners and who wishes to proceed must make a second EAS request, written and witnessed by two people, then a final request, and then, with the coordinating practitioner's assistance, an administration decision: to opt for assisted suicide or euthanasia. Assisted suicide is the statutory norm, but is less reliable than euthanasia. Experience elsewhere demonstrates that very few choose assisted suicide when both euthanasia and assisted suicide are available.

The second request, final request, final review (verifying that forms have been correctly completed) and administration decision could all occur during the same consultation, although a final request cannot normally be made within 9 days of a first request. Nothing in the *Act* requires a medical practitioner to have person-to-person contact with a patient except when administering euthanasia, but on-line consultations are currently unavailable because of Australia's *Criminal Code*.

Providing EAS

A practitioner providing euthanasia must have an adult witness present and ensure that the patient has decision-making capacity and is acting voluntarily. A patient can self-administration lethal medication at any time and place, without notifying anyone. It is thus possible for death by self-administration to occur in public or inconvenient places or remain undiscovered for some time. Neither a witness or confirmation of decision-making capacity or voluntariness is required. If the patient is incapacitated but does not die after being administered or ingesting the lethal substance, it does not appear that an additional lethal dose can be given to kill the patient unless the patient regains capacity and consents.

Death certificates

The *Act* requires the cause of death be falsified by reporting it as the disease or medical condition for with EAS was approved. Falsification of the cause of death on death certificates is contrary to international standards for identifying causes of death that are acknowledged by the Australian government and applied by medical practitioners, pathologists and Queensland coroners. Falsification of death certificates contributed to the murder of over 200 patients by a British medical practitioner and led to unfavourable comments by the chairman of the subsequent inquiry into the murders.

Voluntary Assisted Dying Care Navigator Service

The Queensland government will establish the Voluntary Assisted Dying Care Navigator Service to assist those seeking "support, assistance and information" about EAS services. VADCNS will be a service dedicated to enabling euthanasia/assisted suicide, so it will not be equivalent to a service providing information and assistance in accessing a variety of government and health services.

Institutions ("entities")

Hospitals, hospices, residential care facilities, etc. are captured in the *Act* by the term "entity". The Act does not require entities to provide or refuse to provide EAS information, request or assessment services or euthanasia or assisted suicide, nor does it prohibit them from refusing to do so. Entities that do not provide the services are required to publicize the fact so that people receiving or likely to seek services at their facilities are made aware of it.

The Act imposes obligations on entities if a person in their care requests EAS information or services that they do not provide. They must allow all persons in their care access to EAS information by allowing registered health practitioners or a member or employee of VADCNS to allow EAS practitioners to consult patients in their facilities. Similarly, they must allow all persons in their care to make first, second and final EAS requests in their facilities, or, if EAS practitioners are unable to attend, must “take reasonable steps to facilitate" patient transfers to enable requests to be made and accepted elsewhere.

Entities must allow all EAS services, including euthanasia/assisted suicide, to be provided in their facilities to permanent residents (given an extended meaning by the Act), or, if EAS practitioners are unable to attend, “take reasonable steps to facilitate" patient transfers to enable the services to be provided elsewhere. In the case of other institutional occupants (such as hospital and hospice patients), entities can refuse to allow EAS services in their facilities, but only if they “take reasonable steps to facilitate" patient transfers to enable the services to be provided elsewhere. However, they can be forced to allow EAS services in their facilities if the responsible EAS practitioner considers transfer "unreasonable in the circumstances."

Oversight

The operation of the *Act* is to be overseen by an appointed Voluntary Assisted Dying Review Board, which is required to record, analyze and report at least annually upon information it acquires. The Queensland Civil and Administrative Tribunal (QCAT) is empowered to review and overturn decisions about residency, capacity, and voluntariness (not diagnosis or prognosis). Coordinating practitioners may refuse to continue if QCAT overturns a decision about capacity or voluntariness, but must then transfer the patient to the consulting practitioner or someone eligible to act as coordinating practitioner.

Illusion of neutrality

The *Act* identifies eight principles underpinning the statute and seems to give equal weight to all of them. This enables an adjudicator to impose subjective and contested views about the meaning and importance of each principle during an ostensibly neutral "rights balancing" analysis. No one should be under the illusion that the principles identified in the *Act* can be fairly and objectively applied in a "rights balancing" exercise when there is fundamental disagreement about what they mean.

The provision of euthanasia or assisted suicide under the *Act* is not considered palliative care, which is clearly distinguished as an alternative option. The Commission recognized that people hold different views about the moral acceptability of euthanasia and assisted suicide and whether or not the procedures are forms of health care or medical practice. While the Commission asserted that different views should be respected, the *Act* it drafted assumes that euthanasia and assisted suicide are morally acceptable forms of healthcare and must be characterized as death by natural causes rather than homicide or suicide. This does not demonstrate respect for different views. On the contrary, it effectively imposes a chokehold on public discourse, suppressing the words needed those opposed to the *Act* to express their reasoning.

Practitioner Freedom of Conscience

Conflicts of conscience

The health care professions are not divided into sharply defined groups of objecting and non-objecting practitioners. The position of many practitioners depends upon the nature of the illness or condition, opinions about decision-making capacity, voluntariness, or other issues they consider relevant.

The broader the grounds for euthanasia and assisted suicide, the more likely it is that conflicts of conscience will arise. By restricting eligibility to competent adults with terminal illnesses or conditions, and by explicitly ruling out EAS for mental illness and disability, the Act reduces the number of practitioners likely to experience conflicts of conscience when it comes into force.

Capacity assessments

The ability of practitioners to perform capacity assessments for euthanasia and assisted suicide is disputed, and assessment of limited, fluctuating and episodic capacity can be particularly troublesome. Patients could be deemed capable of choosing euthanasia/assisted suicide even if they are considered incapable of challenging medical decisions about alternative treatments and palliative care. The burden of illness may make it easier to understand the EAS process than alternative treatment options, and to choose what is more easily understood rather than what might offer significant symptom relief. Even practitioners willing to facilitate euthanasia for clear-headed patients may not be confident that they can safely act upon a request made when the clouds of major depressive disorder part for a time, or if the patient recovers what another colleague considers "enough" capacity to make a valid request.

Finally, risk assessments by EAS supporters, uncommitted practitioners and EAS opponents may reflect significantly different views about life-or-death decisions based on different underlying philosophical or ethical views. *A priori* biases in favour of an outcome cannot be avoided in EAS assessments.

Overturning practitioner decisions

The Queensland Civil and Administrative Tribunal (QCAT) can overturn a coordinating practitioner's conclusion that a patient is ineligible for EAS because of involuntariness or lack of capacity. This can cause a problem for practitioners who are certain of their conclusion because, though they can withdraw, the Act requires them to transfer the patient to a colleague willing to continue the EAS process. They may well consider this unacceptable, and it is completely unnecessary. The Act should be amended to require QCAT or a person or agency designated by QCAT to find a new coordinating practitioner should the coordinating practitioner withdraw in these circumstances.

Protection for objecting practitioners

Medical and nurse practitioners may initiate discussion about EAS but are not required to do so. By explicitly making discussion optional, the *Act* supports both practitioners who want to initiate discussion about EAS and those who think it best to let patients take the lead, responding to their enquiries or apparent interests. Further, all registered health practitioners who conscientiously object to EAS may refuse to provide information about or participate in any part of the EAS process, and refuse to be present when EAS is provided. These provisions are satisfactory, and the requirement that they inform patients that other practitioners may be able to assist them is unobjectionable. They allow objecting practitioners to step aside, advising patients that they are free to seek the services from willing colleagues.

The further requirement that they provide information about those who may be willing to provide EAS does not specify that objectors must direct patients to EAS practitioners or provide contact information for them. It is sufficient if the objector provides information about a "service . . . likely to be able to assist," such as Queensland's 13Health. This allows objecting practitioners to comply with the *Act* while avoiding any positive action causally connected to killing their patients, and it leaves patients free to pursue euthanasia/assisted suicide.

Protection for objecting speech pathologists

Objecting speech pathologists are accorded the same protection as registered health care practitioners, with the analogous requirement to notify employers and patients of the availability of other speech pathology services. They must notify employers who provide EAS services in advance, a reasonable requirement that helps to avoid needless conflicts. However, the *Act* also suggests that objectors are obliged to ensure that colleagues are not burdened and access to euthanasia and assisted suicide is not compromised. The *Act* does not suggest that health care practitioners have such duties because they can be found in existing professional guidance from the Australian Medical Association (AMA). Whether contained in the *Act* or in AMA guidance, this is unacceptable. The duty to ensure EAS access, accommodate objecting employees and balance workloads among staff should lie on the employer, not objecting employees. They may reasonably be expected to participate in discussion about and cooperate in accommodation, but the onus to fairly distribute employment tasks should be on the employer.

Falsification of death certificates

Regardless of their views about euthanasia and assisted suicide, some medical practitioners are likely to object to falsifying the cause of death in death certificates. They may be uncomfortable about lying or dissembling to families about how their loved ones died or concerned that falsifying records and lying is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. If the state insists that death certificates must be falsified, the Act should be amended to make a medical member of the Voluntary Assisted Dying Review Board responsible for completing EAS death certificates (assuming that a Board member's objection to doing so would also be accommodated).

Institutional & Collective Freedom of Conscience

The Commission explained that "entity" is intended to mean "a non-natural person, typically a corporation or body given legal status," and the *Act* describes an "entity" only as "other than an individual" It is reasonable to extend this to include unincorporated businesses and collectives of various kinds. Regardless of structure, "institution" in the sense relevant here is an entity that always manifests a collective enterprise by individuals.

The Commission rejected the notion of an institutional right to freedom of conscience, recognizing only an entity/collective's interests in maintaining institutional identity and integrity by exercising property rights - which can be overridden by statute. Thus, the *Act* recognizes and addresses conscientious objection by individuals but not by entities/collectives. It implicitly acknowledges that entities/collectives may or may not provide EAS, and it addresses the obligations of entities/collectives that do not, but at no point does it imply that constitutional guarantees of freedom of conscience are relevant to decision-making by entities/collectives about involvement in killing people. It places refusal to kill people for reasons of conscience on the same level as refusals based on pragmatic considerations like lack of trained personnel or management of institutional branding.

Participation, cooperation, collaboration

The *Act* does not require entities/collectives to provide euthanasia or assisted suicide or even to provide information about the procedures, so it does not threaten institutional freedom of conscience in relation to direct participation in EAS services. Instead, the *Act* is designed to enable the state to compel unwilling entities/collectives to cooperate and perhaps collaborate in killing people in their care or helping them kill themselves.

However, patients and practitioners cannot proceed with EAS in an objecting institution unless they notify institutional authorities at each stage in the EAS process. This is fortunate, because providing EAS services in a private apartment in a residential facility would be radically different from providing them behind a curtain in a room shared with others, and the Act does not distinguish between the two situations. Nothing in the *Act* prevents objecting entities/collectives from imposing conditions on EAS-related activities that they are required to permit in their facilities once they have been notified.

Cooperation

Two kinds of cooperation required by the *Act* pertain to all persons being cared for in a facility — enabling access to information about EAS and facilitating requests for EAS. The extent of cooperation demanded in relation to EAS assessments and actual provision of euthanasia/assisted suicide depends upon the legal occupancy status of the person in care.

EAS information

With respect to providing EAS information, objecting entities/collectives could direct all patient enquiries about EAS to staff members trained to provide patients with information necessary to enable informed decision-making without compromising institutional moral integrity. Hence, the cooperation required in providing information about EAS does not appear to undermine institutional freedom of conscience. However, the provisions concerning requests and other elements in the EAS process are problematic.

The EAS process

The *Act* was drafted by a Commission that considered a patient's first request only in relation to the EAS delivery process, not within the context of caring for patients. Nonetheless, the wording of the Act leaves room for objecting entities/collectives to direct staff to fully and compassionately explore and document first requests, refuse those found to be clear and unambiguous, and provide information enabling patients to seek EAS elsewhere. They can thus largely comply with the *Act* without compromising institutional moral integrity.

However, the *Act* also requires objecting entities/collectives to allow EAS practitioners to accept first, second and final requests in their facilities from anyone, and to allow them to provide all EAS assessments, consultations and euthanasia/assisted suicide in their facilities for all permanent residents (including people living in aged residential care facilities). Contingent cooperation of this kind is problematic, especially in relation to patients who do not have private personal accommodation. If EAS practitioners cannot attend, objecting entities/collectives must "take reasonable steps to facilitate the transfer" EAS candidates to a location where they can receive EAS services. This suggests that active collaboration might be expected, and it goes well beyond merely granting the equivalent of a residential tenancy right to service delivery at home. Landlords are not forced to help tenants travel to see EAS practitioners who can't make home visits.

Objecting entities/collectives may refuse to allow the EAS process for institutional occupants (like hospital and hospice patients) only if, once more, they "take reasonable steps to facilitate" transfers to enable the procedures elsewhere. If that means initiating rather than simply cooperating in a transfer requested by others, the purported compromise amounts to a choice between two objectionable alternatives. Further, the *Act* demands that objecting entities/collectives allow EAS procedures in their facilities (including euthanasia and assisted suicide) for hospital and hospice patients and other institutional occupants if transfer “would not be reasonable in the circumstances.”

Credentials (privileges)

The *Act's* demands that qualified practitioners be allowed to provide EAS services to patients in facilities poses a dilemma for objecting entities/collectives in granting credentials. Granting credentials for EAS would explicitly affirm the acceptability of euthanasia/assisted suicide and authorize the procedures, thus contradicting their moral commitments. However, granting credentials may be necessary to avoid legal liability, and it may be the only way for objecting entities/collectives to impose enforceable conditions and restrictions on provision of the service in order to protect other patients, staff and mitigate harm to institutional moral integrity.

Prejudice

The *Act* reflects the prejudice of its author, a Commission that found it "hard to see" why an entity/collective could reasonably object to allowing the EAS process to begin in its premises. This was not only because, as one would expect, the Commission believed it is morally acceptable to kill patients or help them kill themselves in accordance with the rules they proposed. The Commission was also unable to imagine or unwilling to concede that others could reasonably and collectively hold and live in accordance with the contrary view, and should be entitled to do so in a democratic state. This demonstrates a lack of moral imagination or unreflective and entrenched authoritarianism inconsistent with the best traditions of liberal democracy.

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PART III: INSTITUTIONAL & COLLECTIVE FREEDOM OF CONSCIENCE

PREFACE

Queensland's *Voluntary Assisted Dying Act (2021)*[1] was drafted by the Queensland Law Reform Commission ("the Commission").[2] Running to 114 pages, it will legalize euthanasia and assisted suicide (termed "voluntary assisted dying") in the Australian state when it comes into force in January, 2023. This review considers the impact the *Act* may have on health care workers opposed to euthanasia or assisted suicide (EAS) for reasons of conscience. Part I outlines the main features of the law, providing a context for discussion of provisions relevant to freedom of conscience in Part II (Practitioner Freedom of Conscience) and Part III (Institutional & Collective Freedom of Conscience).

PART I: OVERVIEW

Introduction

I.1 Part I of this paper sets out EAS eligibility criteria, explains how requests for EAS services are to be processed and draws attention to some aspects of the law. The overview assumes the willing participation of the practitioners involved and omits details not essential to a general understanding of how the *Act* is expected to function.

Not palliative care

I.2 Queensland's *Criminal Code* defines palliative care as "an act or. . . omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering" [§282A(5)] that does not include "an act . . . or omission made with intent to kill another person" or "aiding another person to kill himself or herself." [§282A(3)]. Hence, the provision of euthanasia or assisted suicide under the *Act* is not palliative care, which, when mentioned, is clearly distinguished as an alternative option [cf. §7(1) and (2)].

Eligibility

I.3 An eligible patient must be at least 18 years old, have an advanced, progressive and terminal "disease, illness or medical condition . . . that is expected to cause death within 12 months" and causes suffering the patient considers "intolerable." [§10(1)]. "Suffering" includes both physical and mental suffering caused by the terminal condition or its treatment [§10(2)]. The patient must act "voluntarily and without coercion" and must be capable of medical decision-making [§10(1)]. Finally, patients must have lived in Queensland for at least one year, and those who are not Australian citizens or permanent residents must have lived in Australia for at least three years,

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[1] *Voluntary Assisted Dying Act 2003* (Qsld) online: <https://www.legislation.qld.gov.au/view/html/asmade/act-2021-017>.

[2] Australia, Queensland Law Reform Commission, *A legal framework for voluntary assisted dying: Report No. 79* (Brisbane: QLRC, May 2021) (Peter Applegarth) [*QLRC 2021*], online: <https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf>.

though citizenship and residency requirements can be waived for compassionate reasons [§12].

I.4 Persons who meet these requirements are eligible for euthanasia and assisted suicide if they are disabled or mentally ill [§13 (1)], but EAS cannot be provided for disability or mental illness alone [§13(2)].

I.5 For purposes of EAS, a person must understand "the nature and effect of decisions about access" to the services [§11(1)a] and be able to make and communicate free and voluntary decisions [§11(1)b, c] (with "adequate and appropriate support" if need be [§11(3)d]).

Capacity

I.6 Decision-making capacity is presumed in the absence of "evidence to the contrary" [§11(2)]. Illness, disability and personal characteristics like age, appearance, language skills are not "evidence to the contrary," nor is the fact that others do not agree with a decision [§11(3)c]. The *Act* explicitly acknowledges that a person may be capable of making some decisions, but not others [§11(3)a], and that "capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it" [§11(3)b].

Practitioner participants

I.7 The *Act* authorizes direct participation in EAS by medical practitioners, nurse practitioners and nurses. Participants are functionally differentiated as coordinating practitioners, consulting practitioners and administering practitioners. A fourth group — identified here (but not in the *Act*) as "determiners" — includes registered health practitioners and other individuals who can be asked to provide expert opinions about diagnosis, prognosis, capacity and voluntariness.

I.8 Medical practitioners are the principal EAS agents; only they can act as coordinators and consultants [§82]. They must have at least five years general practice experience, fulfil EAS training requirements [§20(1),§30(1)], and not be a family member of the patient nor in a position to benefit from the patient's death [§16(1), §26(2), §82].

I.9 While only EAS-trained medical practitioners may act as coordinating and consulting practitioners, euthanasia can be provided by EAS-trained nurses, nurse practitioners and medical practitioners [§83]. Once the *Act* is in force it will be interesting to see how much this statutory division of responsibilities affects practice. It is possible that nurse practitioners and nurses will become the principal euthanasia providers, while most physicians might prefer to act as process decision-makers, supervisors and facilitators rather than personally providing euthanasia.

Discussion with patients

I.10 Only medical and nurse practitioners (not nurses or other health or personal care service providers) may *suggest* or *initiate* discussion about euthanasia or assisted suicide [§7(1)] — but only if they also advise the patient about available palliative care and treatment options and the likely outcomes of such alternatives. However, registered health practitioners and anyone providing "a health service or personal care service" may provide information about EAS services to a patient who asks for it [§7(3)]. Three elements in §7 are noteworthy.

I.11 First: medical and nurse practitioners *may* suggest euthanasia and assisted suicide or initiate discussion about EAS — even if a patient has not expressed an interest.

I.12 Second: as the *Act* is written, palliative care and other treatments need not be suggested as alternatives to EAS if they are not available for any reason (including the failure of state health authorities to make the options accessible).

I.13 Third: §7(3) was included for "health or personal care service" providers and nurses who respond to patient requests about EAS but lack the expertise to discuss other treatment options.[3] However, the subsection also applies to medical and nurse practitioners, thus relieving them of statutory responsibility to discuss alternatives to EAS if a patient initiates the conversation about EAS. Granted: the law does not relieve them of the ethical obligation to meet the requirements of informed consent, but the apparent difference introduced here between statutory and ethical obligations is undesirable.

Request and assessment process

I.14 The process involves three requests by a patient: the first by any means available to the patient [§14], the second in writing and witnessed [§37], and a final request by any means available to the patient [§42]. The final request cannot be made within 9 days of the first request unless, in the opinion of both the coordinating and consulting practitioner, the patient is likely to die or lose decision-making capacity within that period [§43].

I.15 Nothing in the *Act* requires a medical practitioner to have person-to-person contact with a patient except when administering a lethal injection. However, the request and assessment process cannot proceed via internet videoconferencing because Australia's *Criminal Code* prohibits the use of telecommunications and similar technology to counsel or recommend suicide. The government of Queensland and others want the *Criminal Code* amended to allow videoconferencing for EAS services, but the national government seems resistant to the change.[4,5]

First request

I.16 A patient must personally make a "clear and unambiguous" first request for EAS to a medical practitioner by any means; a request cannot be made by a third party on behalf of a patient [§14]. However, someone may help the patient communicate the request [§11(3)d]. A practitioner may

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[3] *Ibid* at para 6.124.

[4] Queensland Health, "Voluntary Assisted Dying in Queensland: Access for regional and remote Queenslanders" (17 September, 2021) Queensland Health (website), online:<https://www.health.qld.gov.au/system-governance/legislation/voluntary-assisted-dying-act/access-for-regional-and-remote-queenslanders>.

[5] Eliana Close et al, "Voluntary assisted dying and telehealth: Commonwealth carriage service laws are putting clinicians at risk" (Nov 2021) Medical J Australia 215:9 406, online: <https://www.mja.com.au/system/files/issues/215_09/mja251287.pdf>.

spend some time exploring a patient's request before concluding that it is "clear and unambiguous," since that must surely imply include an understanding of alternatives. Only if a practitioner reaches that conclusion do the other provisions concerning a first request become operative.

I.17 Upon concluding that a first request is clear and unambiguous, medical practitioners must accept or reject it and notify the patient accordingly. They must refuse the request if they are not qualified EAS practitioners [I.8]. If the practitioner refuses the request for reasons of conscience, the patient must be notified immediately [§16(6)a]: otherwise, within two business days [§16(6)b]. An EAS qualified medical practitioner who accepts the request becomes the coordinating practitioner, responsible for supervising the EAS request, assessment and administration process [§18]. Those who refuse must advise patients that other practitioners or service providers may be able to assist them, and provide information about them or about the Voluntary Assisted Dying Care Navigator Service [I.40].

Coordinator assessment and consultant assessment (First & second assessments)

I.18 The coordinating practitioner must assess the patient's eligibility for EAS. If the patient is found to be eligible, the coordinating practitioner must refer the patient for assessment by a consulting practitioner [§25]. A patient's eligibility must be confirmed by two medical practitioners (coordinating and consulting practitioners) [§19–35], with the assistance of specialist determiners if need be [§32].

I.19 If the consulting practitioner does not agree that the patient is eligible, the coordinating practitioner may (not must) refer the patient to another consulting practitioner [§36]. The *Act* does not require a coordinating practitioner to discontinue referrals and find the patient ineligible because coordinating and consulting practitioners disagree. Nor does the *Act* require a coordinating practitioner to adopt the consulting practitioner's opinion of ineligibility and reverse his own assessment. Unless the issue is resolved by a decision of the Queensland Civil and Administrative Tribunal (see I.51– I.53), coordinating practitioners can continue to make referrals to consulting practitioners until eligibility is confirmed by a second opinion, or the patient dies.[6] The request and assessment process ends if the coordinating practitioner concludes that the patient is not eligible [§23], unless the decision is overturned by the Queensland Civil and Administrative Tribunal (QCAT) (see I.51– I.53).

Determiners' specialist assessments (optional)

I.20 The determiner's input is intended to assist coordinating and consulting practitioners, who may (but need not) adopt their opinions [§21(4), §32(4)].

Second request

I.21 Once eligibility is confirmed by coordinating and consulting practitioners, a patient must make a second request for EAS, in writing, though it may be signed on his behalf by someone who is at least 18 years old, not a witness to the signature, and not the coordinating or consulting practitioner [§37]. The second request must be witnessed and certified by two persons who are at

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[6] "There is no limit on how many times this may occur." QLRC 2021, *supra* note 2 at para 8.68.

least 18 years old, not in a position to benefit from the patient's death, not an owner or manager of a health facility where the patient is being treated or resides, and not the coordinating or consulting practitioner [§38, §39]. The coordinating practitioner must record the second request [§40] and, within two business days, give notice of the request to the Voluntary Assisted Dying Review Board [§41].

Final request

I.22 After having made a second request, a patient must personally make a "clear and unambiguous" final request for EAS to the coordinating practitioner by any means; a request cannot be made by a third party on behalf of a patient [§42]. However, someone may help the patient communicate the request [§11(3)d]. If the patient makes a final request [§42], the coordinating practitioner must record it [§44], notify the Voluntary Assisted Dying Review Board within two business days [§45] and conduct a final review of the case. He must sign the final review form and provide copies to the patient and the Voluntary Assisted Dying Review Board [§46].

I.23 A final request could be made immediately after a second request, during the same consultation, although a final request cannot normally be made within nine days of a first request. The final review (which consists only of verifying that forms have been correctly completed) could be done at the same time.

Administration decision

I.24 Euthanasia (practitioner administration of a lethal substance) is not permitted by the *Act* unless the coordinating practitioner considers assisted suicide inappropriate because of a patient's inability to self-administer a lethal substance, a patient's concerns about doing so, or because the method of self-administration is otherwise unsuitable for the patient. [§50(2)] All but a small number of patients choose euthanasia in jurisdictions that authorize both euthanasia and assisted suicide and do not indicate a statutory preference for one or the other,[7] and assisted suicide is less reliable than euthanasia,[8,9,10,11] so it is not certain that the statutory preference for euthanasia will be realized in

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[7] *Ibid* at Table 10.1.

[8] C Harty et al, "The Oral MAiD Option in Canada, Part 2: Processes for Providing — Review and Recommendations." (18 Apr 2018) *Canadian Association of MAiD Assessors and Providers* (website) at 7, online: <https://camapcanada.ca/wp-content/uploads/2022/02/OralMAiD-Process.pdf>.

[9] C Harty et al, "The Oral MAiD Option in Canada, Part 1: Medication Protocols" (18 Apr 2018) *Canadian Association of MAiD Assessors and Providers* (website) at 6, online: <https://camapcanada.ca/wp-content/uploads/2022/02/OralMAiD-Med.pdf>.

[10] F Bakewell and VN Naik, "Complications with Medical Assistance in Dying (MAID) in the Community in Canada: Review and Recommendations" (28 Mar 2019) *Canadian Association of MAiD Assessors and Providers* (website) at 7, online: <https://camapcanada.ca/wp-content/uploads/2022/02/Failed-MAID-in-Community-FINAL-CA

practice.

I.25 In any case, a “clear and unambiguous” decision for self or practitioner administration must be made personally by the patient, “in consultation with and on the advice of the coordinating practitioner.” The decision must be recorded by the coordinating practitioner in the patient’s medical record [§50]. The patient may revoke an administration decision at any time [§51].

I.26 An administration decision could be made immediately after making a second and a final request, and during the same consultation.

I.27 Upon making an administration decision, the patient must appoint a contact person who is at least 18 years of age [§58] who can assist with obtaining a prescribed lethal substance, the safe disposal of unused parts of it [§61], and who will notify the coordinating practitioner if the patient dies [§61, §62]. A lethal substance must not be prescribed unless a contact person has been appointed [§59(6)].

I.28 Before prescribing a substance for self-administration, the coordinating practitioner must provide the patient with written information about the nature lethal substance and instructions about safekeeping, preparations for use, self-administration and disposal of it, as well as potential risks and the time it will likely take to die [§65(1)]. Similar information and instructions must be provided before prescribing a lethal substance that will be administered by a practitioner [§65(2)].

Administration of lethal substance

I.29 In the case of euthanasia, the administering practitioner must ensure that the patient has decision-making capacity, is acting voluntarily and without coercion, and must administer the lethal substance in the presence of a witness [§53(6)]. The witness must be at least 18 years old and certify that the patient “appeared to be acting voluntarily and without coercion.” [§54]

I.30 No one is required to witness self-administration, nor is anyone required to confirm the decision-making capacity of a patient who decides to ingest a lethal prescribed substance. The *Act* does not require self-administration to occur in private or in any particular place. A patient is not required to advise anyone of his plans. Thus, in some cases, death by self-administration may occur in public or inconvenient places or may not be discovered for some time.

I.31 Further, if the patient is incapacitated but does not die after being administered or ingesting the lethal substance, an additional lethal dose cannot be given to kill the patient unless the patient

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MAP-Revised.pdf>.

[11] Royal Dutch Medical Association (KNMG/RDMA), “Guidelines for the Practice of Euthanasia for the Practice of Euthanasia and Physician-Assisted Suicide 13 (Aug 2012) *KNMG/RDMA* (website), at 17 online: <https://www.knmg.nl/web/file?uuid=bc11990b-d37a-4fa9-9e36-69d34bd229db&owner=5c945405-d6ca-4deb-aa16-7af2088aa173&contentid=223>.

regains capacity and consents [§55(2)b(i)].[12] Presumably, a patient who does not recover capacity will die within 12 months from the underlying terminal illness or condition [§10(1)a(ii)].

I.32 Only an administering practitioner (i.e., an EAS trained medical or nurse practitioner or nurse) may administer a lethal substance prescribed under the *Act*. Anyone else who does so commits a crime and is liable to 14 years imprisonment. The offence is complete even if the patient does not die, so it appears that if death ensues the person administering the lethal substance is also liable to be charged for murder or manslaughter[§140]. On the other hand, it appears that anyone may assist a patient who needs help in self-administering a lethal substance in accordance with the *Act* [§52(7)c, §147(1)a].[13]

Falsification of death certificates

I.33 The *Act* does not require the medical practitioners responsible for euthanasia or assisted suicide to complete the death certificate for the patient; nurse practitioners and nurses cannot do so even if they act as administering practitioners.[14]

I.34 It was the Commission's view that a person who has been diagnosed with a terminal illness [incorrectly described as "a dying person"] does not commit suicide but "hastens his death" if he voluntarily consumes a lethal substance: "Health practitioners who follow an exacting process to assist a dying person to choose the timing of their death should not be characterised as assisting suicide."[15] Notwithstanding the Commission's claim that it "[did] not intend to dictate what language people use,"[16] the *Act* (which it drafted) does exactly that.

I.35 According to the *Act*, for legal purposes, someone who dies from ingesting a lethal substance by self-administration or by practitioner-administration under the specified conditions is declared not

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[12] *QLRC 2021*, *supra* note 2 at para 10.205, 10.209.

[13] *Ibid* at para 17.87-17.88. Note that in these paragraphs the Commission suggests that someone other than an administrating practitioner cannot legally assist in self-administration, but that is not consistent with the effect of §52(7)c and §147(1)a.

[14] *Births, Deaths and Marriages Registration Act 2003* (Qld) s 30, online: <https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-031?query=((Repealed%3DN+AND+PrintType%3D%22act.reprint%22+AND+PitValid%3D%40pointInTime(20220309000000))+OR+(Repealed%3DN+AND+PrintType%3D%22reprint%22+AND+PitValid%3D%40pointInTime(20220309000000)))+AND+Content%3D(%22births%2C%22+AND+%22marriages%22+AND+%22and%22+AND+%22deaths%22)&q-collection%5B%5D=inforceActs&q-collection%5B%5D=inforceSLs&q-documentTitle=&q-prefixCcl=&q-searchfor=births%2C+marriages+and+deaths&q-searchin=Content&q-searchusing=allwords&q-year=&q-no=&q-point-in-time=09%2F02%2F2022&q-searchform=basic#sec.30>.

[15] *QLRC 2021*, *supra* note 2 at para 1.50.

[16] *Ibid* at para 1.40.

to have died by “suicide” but from the underlying disease, illness or medical condition [§8]. The death is not reportable to the coroner [§171]. Medical practitioners required to provide a death certificate (who need not be either coordinating or consulting practitioners) are forbidden to refer to “voluntary assisted dying” (euthanasia or assisted suicide) in the certificate, and “must state . . . that the cause of death was the disease, illness or medical condition . . . from which the person suffered” [§81].

I.36 However, the Commission defined “voluntary assisted dying” (euthanasia and assisted suicide) as the administration or self-administration of a lethal substance “for the purpose of bringing about [a] person’s death.”[17] It stated that the cause of death in “voluntary assisted dying” is administration or self-administration of a lethal substance,[18] - not the underlying medical condition. The Commission explained that what the *Act* would allow was, under the law as it then stood, suicide, assisted suicide, murder or manslaughter.[19]

I.37 The *Act* goes to some lengths to avoid stating explicitly "voluntary assisted dying" causes the death of a patient. Ultimately, however, it implicitly acknowledges that administration or self-administration of a lethal substance - not the underlying condition - is the cause death. It defines "voluntary assisted dying" as "the administration of a voluntary assisted dying substance [Schedule 1], then defines "voluntary assisted dying substance" as "a substance approved by the chief executive under section 160" [Schedule 1]. Finally, in §160 it states that a voluntary assisted dying substance is used "for the purpose of causing death." This is affirmed when the *Act* states that such substances are prescribed in order to cause death [§22(1)d,e, §52(2)],and by provisions that protect EAS practitioners from prosecution for murder, assisted suicide and related offences [§147(2), §148(2)].

I.38 It is thus clear that the *Act* requires falsification of the cause of death. Falsification of the cause of death on death certificates is contrary to international standards for identifying causes of death[20] that are acknowledged by the Australian government and applied by medical practitioners, pathologists and Queensland coroners.[21] The contradiction becomes apparent if one compares death by lethal injection administered by legally authorized practitioners (EAS-trained medical and nurse

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[17] *Ibid* at para 1.5, 1.32.

[18] *Ibid* at para 15.264.

[19] *Ibid* at para 1.36.

[20] World Health Organization, *International Statistical Classification of Diseases and Related Health Problems, 10th revision,* 2nd ed vol 2 (Geneva, Switzerland: World Health Organization, 2004) para 4.1.2. online: <https://www.who.int/classifications/icd/ICD-10_2nd_ed_volume2.pdf#page=29>.

[21] "State Coroner’s Guidelines 2013 Chapter 8" (September 2014) Queensland Courts (website) at para 8.6 [Coroner’s Guidelines], online: <https://www.courts.qld.gov.au/__data/assets/pdf_file/0018/206127/osc-state-coroners-guidelines-chapter-8.pdf>.

practitioners and nurses) and death by lethal injection by unauthorized practitioners (non-EAS trained practitioners or pharmacists) in identical circumstances following exactly the same procedural guidelines and otherwise in accordance with the *Act*. The death of a patient from a lethal injection would be

> a) an unreportable death, certifiable as a natural death caused by the underlying illness, if the injection were given by an EAS trained nurse in accordance with the *Act* [§8,§81,§171];
>
> b) a reportable death,[22] certifiable as homicide caused by injection of a toxic substance, if the injection were given by a registered nurse who was not EAS-trained, or by a pharmacist.[23]

I.39 Falsification of death certificates was one factor enabling a British medical practitioner, Dr. Harold Shipman, to murder at least 215 and as many as 260 patients between 1974 and 1998.[24] The Chairman of the Shipman Inquiry commented unfavourably upon practitioner "modification" of the cause of death in death certificates so as not to "distress relatives" or "involve the coroner."[25]

Voluntary assisted dying care navigator service (VADCNS)

I.40 The government plans to approve a service "to provide support, assistance and information" about euthanasia and assisted suicide [§156]. Given this specific focus, the service will not be comparable to an agency that provides information and assistance in relation to a variety of government and health services. VADCNS will be dedicated specifically to enabling euthanasia and assisted suicide.[26]

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[22] *Coroners Act 2003* (Qsld), s 8(3)b and d, online: <https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.8>.

[23] Coroner's Guidelines, *supra* note 21 at para 8.6.

[24] United Kingdom, The Shipman Inquiry, *First Report: Death Disguised* (London: HMSO, 19 July 2002) vol 1 (Dame Janet Smith) at para 14.2, online: <https://webarchive.nationalarchives.gov.uk/ukgwa/20090809051504/http://www.the-shipman-inquiry.org.uk/fr_page.asp?ID=187>.

[25] United Kingdom, The Shipman Inquiry, *Third Report. Death Certification and Investigation of Deaths by Coroners* (London: HMSO, 14 July 2003) (Dame Janet Smith) at para 5.39—5.40, online: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf>.

[26] QLRC 2021, *supra* note 2 at para 21.67-21.69.

Institutional obligations

I.41 The *Act* refers to participation by "entities" [Part 6, Division 2], which refers to organizations (incorporated or not), such as religious denominations, charitable organizations, non-profit and for-profit companies or businesses, etc. that operate a "facility" that provides "a health service, residential aged care or personal care" [§86-88].

I.42 While it is not explicitly stated, it is clear that the *Act* does not require an entity to provide information about EAS services [§90(1)c], nor does it prohibit refusal to provide information. However, if a patient in a facility asks "an entity" (i.e., facility staff or an institutional representative) for such information and the information is not provided, the entity must not hinder the person from accessing information about EAS services. It must allow registered health practitioners or a member or employee of the official navigator service "reasonable access" to the person who is seeking such information [§90(2)].

I.43 Similarly, the *Act* does not require an entity to provide EAS request and assessment services [§92(1)b, §93(1)b, §94(1)c, §95(1)c, §96(1)c], nor to provide euthanasia or assisted suicide [§97(1)c]. Again, this is not explicitly stated, and refusal is not prohibited. Entities that do not provide the services are required to publicize the fact so that people receiving or likely to seek services at their facilities are made aware of it [§98].

I.44 A person receiving services at a facility that does not provide euthanasia or assisted suicide can advise the entity (personally or through an agent) that he wishes to request or have EAS [92(1)a, 93(1)a, 94(1)b, 95(1)b, 96(1)b, 97(1)b]. When this occurs, the *Act* imposes obligations on the entity related to the request and assessment process.

I.45 With respect to requests, the entity must allow medical practitioners and witnesses "reasonable access" to the person at the facility so that the requests can be made in accordance with the *Act* [§92(2), §93(2)]. If the requested medical practitioner is unable to attend, the entity "must take reasonable steps to facilitate the transfer of the person to and from a place" where the requests may be made [§92(3), §93(3)].

I.46 Obligations imposed in relation to assessments, administration decisions and the provision of euthanasia/assisted suicide depend upon whether or not the person requesting EAS is a "permanent resident" of the facility. People are "permanent residents" if the facility is their "settled and usual place of abode" where they normally live or if they have "security of tenure" at a residential aged care facility. Security of tenure refers to the legal protection afforded residential care recipients, who can be required to leave residential care service only for certain reasons, only if suitable alternative accommodation is available, and only if they are given 14 days' notice.[27] A person temporarily residing at a facility like a hospital or hospice is not a permanent resident [§89].

I.47 In the case of permanent residents, assessment, administration decisions and the provision of euthanasia/assisted suicide are expected to occur at the facilities where they reside, which the

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[27] *User Rights Principles 2014* (Cth) s 6– 7, online: <https://www.legislation.gov.au/Details/F2021C00861>.

Commission considered to be their homes.[28] For these purposes an entity must allow a medical practitioner "reasonable access" to the resident at the facility [§94(2)a, §95(2)a, §96(2)a, §97(2)a]. If the practitioner is unavailable, the entity "must take reasonable steps to facilitate the transfer of the person to and from a place" where the procedures can be carried out [§94(2)b, §95(2)b, §96(2)b, §97(2)b].

I.48 If the person to be assessed is *not* a permanent resident, assessment, administration decisions and the provision of euthanasia/assisted suicide are expected to occur elsewhere. The entity "must take reasonable steps to facilitate the transfer of the person to and from a place" where the procedures can be performed [§94(3)a, §95(3)a, §96(3)a, §97(3)a]. However, if such a transfer "would not be reasonable in the circumstances," the entity must allow a medical practitioner "reasonable access" to carry out the procedures at the facility. [§94(3)b, §95(3)b, §96(3)b, §97(3)b].

I.49 According to the *Act*, transfer would not be reasonable if it would be likely to cause "serious harm" to the person, adversely affect access to euthanasia/assisted suicide (eg, through loss of capacity), cause "undue delay and prolonged suffering", or if the transfer location is unable to receive the person. Possible financial loss or costs incurred by the person must also be considered [§94(4), §95(4), §96(4), §97(4)]. Decisions about transfers cannot be made by entities; they must be made by the coordinating practitioner, unless the person and entity choose a different medical practitioner to make the decision [§86]. While this seems to imply that disputed cases might be resolved by a binding third party decision, this is not required; the *Act* clearly allows a coordinating practitioner to proceed in the facility, notwithstanding entity/collective objections.

Oversight

I.50 The operation of the *Act* is to be overseen by a Voluntary Assisted Dying Review Board consisting of five to nine paid members appointed by a government minister ("the Minister" is not defined) for a term of not more than three years. A member must have expertise in medicine, nursing, pharmacology, psychology, social work, ethics, law, or some other field the minister considers relevant [§124]. The Board is to monitor and promote compliance with the *Act* by all participants and may refer cases to the police, registrar-general of births, deaths, and marriages, State Coroner, health ombudsman and state chief executive. It is required to record and analyze information it acquires[§117] and must report upon its operations at least annually [§134-135].

Administrative review of practitioner decisions

I.51 The Queensland Civil and Administrative Tribunal (QCAT) is empowered to review and overturn decisions about residency, capacity, and voluntariness (not diagnosis or prognosis) by coordinating and consulting practitioners [§99, §105]. An appeal to QCAT may be made by the patient, patient's agent or another person "who has a sufficient and genuine interest in the rights and interests" of the patient [§100].

I.52 If a QCAT panel decides the patient does *not* satisfy the conditions of residency, capacity or voluntariness, the patient is ineligible for EAS, the service may not be provided and the decision is

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[28] QLRC 2021, *supra* note 2 at para 15.229, 15.239, 15.261, 15.271, 15.277.

final. If a QCAT panel decides the patient *does* meet eligibility requirements, the decision can be appealed to an appeal tribunal if the panel did not include a Supreme Court or District Court judge [§106].

I.53 Coordinating practitioners may refuse to continue in their roles if QCAT overturns their decision about capacity or voluntariness, but must then transfer the patient to the consulting practitioner or someone eligible to act as coordinating practitioner. [§115].

Statutory principles

I.54 The *Act* identifies eight principles underpinning the statute:

(a) human life is of fundamental importance; and

(b) every person has inherent dignity and should be treated equally and with compassion and respect; and

(c) a person's autonomy, including autonomy in relation to end of life choices, should be respected; and

(d) every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life; and

(e) access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland; and

(f) a person should be supported in making informed decisions about end of life choices; and

(g) a person who is vulnerable should be protected from coercion and exploitation; and

(h) a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

I.55 It is possible to group the principles into three categories:

- (a) to (c) are broad principles relevant outside the context of the *Act*;
- (d) to (f) are specific to end-of-life issues;
- (g) and (h) are directed to the protection of individuals.

I.56 Principles within the first and second categories are arranged in order of increasing specificity; the order is reversed in the third category. However, the principles within each of the categories are all arranged in order of potentially diminishing consensus, depending upon the meaning given to the terms in each.

- In the first category, most people would agree with principle (a), some might question the meaning of "dignity" in principle (b), but support for principle (c) would depend upon the meaning and weight given to "autonomy".

- In the second, one can hardly imagine opposition to principle (d), but many would reject the presumption in principle (e) that euthanasia and assisted suicide are morally acceptable end-of-life choices. Even more would reject principle (f) if it were understood to impose an obligation on objecting practitioners to "support" a decision in favour of EAS — whatever "support" might mean.
- Similarly, one would expect consensus about (g), but not about (h) absent agreement about what respect for freedom of conscience, religion, belief and culture actually means.

The illusion of neutrality

"Rights balancing"

I.57 The *Act* seems to give equal weight to all of the principles. This enables an adjudicator to impose subjective and contested views about the meaning and importance of each principle during an ostensibly neutral "rights balancing" analysis. For example, freedom of conscience could be overridden because an adjudicator believes that patient autonomy or culture deserves more respect, or that practitioner freedom of conscience is less important than access to euthanasia and assisted suicide. An adjudicator with different underlying beliefs about autonomy, freedom and conscience could be expected to reach different conclusions. For present purposes it does not matter which conclusion is "correct." The point is that the principles identified in the *Act* cannot be fairly and objectively applied in a "rights balancing" exercise when there is fundamental disagreement about what they mean.

Therapeutic homicide and suicide

I.58 People reasonably disagree about whether or not it is morally acceptable to kill people and help them to kill themselves at a time of their choosing under conditions specified in the *Act*. Further, even if it is held to be morally acceptable under the conditions specified in the Act, there is disagreement about whether or not euthanasia and assisted suicide are health care or part of medical practice. The Commission recognized both issues,.[29] With respect to the latter, it said:

> Views differ as to whether voluntary assisted dying is health care. It is an end of life option governed by medical assessments and prescriptions by medical practitioners and designed to minimise suffering and maximize quality of life. In that context, many, including Queensland Health, consider it to be a form of health care. . . Others take an entirely different view, including various entities, some palliative care specialists, other health practitioners and individuals from many walks of life. They fundamentally object . . . on ethical, health policy or other grounds. The right of individuals and entities to take these different views should be respected.[30]

I.59 Queensland Health recommended that euthanasia and assisted suicide "should be clearly

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[29] *Ibid* at 420, n 2-3.

[30] *Ibid* at para 15.218.

defined in Queensland legislation to be a form of healthcare."[31] However, the *Act* avoids explicit definition. Instead, it simply assumes that euthanasia and assisted suicide are morally acceptable forms of healthcare and must be characterized as death by natural causes rather than homicide or suicide [I.34–I.35]. This does not demonstrate respect for different views. On the contrary, it effectively imposes a chokehold on public discourse, suppressing the words needed by objecting practitioners - and even judges - to express their reasoning.[32] Canadian physicians have explained the problem:

> By redefining euthanasia and assisted suicide as therapeutic medical services, the [Canadian Medical Association] made physician participation normative for the medical profession; refusing to provide them in the circumstances set out by law became an exception requiring justification or excuse. That is why public discourse in Canada has since centred largely on whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide (notes not included).[33]

Summary

I.60 People seeking euthanasia/assisted suicide (EAS) must be adults with an advanced, progressive disease or medical condition expected to cause death within 12 months, and who are enduring what they consider to be intolerable physcial or mental suffering caused by the condition or treatment. They must be acting voluntarily and capable of making and communicating medical decisions. They can be mentally ill or disabled, but EAS cannot be provided for mental illness or disability alone. Decision-making capacity is presumed in the absence of evidence to the contrary, and it is acknowledged that it can fluctuate or be temporarily lost and regained. The *Act* imposes residency requirements that can be waived for compassionate reasons.

I.61 Only EAS-trained medical practitioners with at least five years general practice experience can act as EAS coordinators and consultants. Other EAS trained medical practitioners, nurses and nurse practitioners may administer euthanasia.

I.62 Medical and nurse practitioners (not nurses or other health or personal care service providers) may suggest or initiate discussion about euthanasia or assisted suicide even if a patient has not expressed an interest — but are not required to do so. If they initiate the discussion, the *Act* requires them to advise the patient about available alternatives and their likely outcomes. The *Act* does not require them to discuss alternatives if patients initiate the discussion. This introduces an undesirable

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[31] *Ibid* at para 15.213, bullet 3.

[32] Sean Murphy, "To kill - or not to kill? That is the question. An answer for a Dying with Dignity Clinical Advisor" (27 Jan 2020) *Protection of Conscience Project* (website) online: <https://www.consciencelaws.org/law/commentary/legal105.aspx>.

[33] Rene Leiva et al, "Euthanasia in Canada: a Cautionary Tale" (2018) World Med J 64(3): 17 at 19, online: <https://www.wma.net/wp-content/uploads/2018/10/WMJ_3_2018-1.pdf>.

difference between statutory and ethical/professional obligations. Others providing health or personal care services and other registered health practitioners may provide EAS information to patient who asks about it, but are not required to discuss other treatment options.

I.63 The EAS process begins with a “clear and unambiguous” first request to a medical practitioner made personally by a patient (not a third party). After discussing alternative options, the medical practitioner must accept or reject the request and promptly notify the patient. A practitioner who rejects a request must advise the patient that others may be able to assist and provide information about them or the Voluntary Assisted Dying Care Navigator Service. An EAS-qualified medical practitioner who accepts a request becomes the coordinating practitioner, responsible for supervising the EAS request, assessment and administration process.

I.64 A medical practitioner who accepts a request must assess the patient's eligibility. Patients deemed eligible must be referred to a consulting practitioner to confirm the assessment, and can be referred repeatedly to consulting practitioners until eligibility is confirmed. Referrals to specialists are optional, and their opinions are not binding.

I.65 A patient deemed eligible by two medical practitioners and who wishes to proceed must make a second EAS request, written and witnessed by two people, then a final request, and then, with the coordinating practitioner's assistance, an administration decision: to opt for assisted suicide or euthanasia. Assisted suicide is the statutory norm, but is less reliable than euthanasia, and experience elsewhere demonstrates that very few choose assisted suicide when both euthanasia and assisted suicide are available.

I.66 The second request, final request, final review and administration decision could all occur during the same consultation, although a final request cannot normally be made within 9 days of a first request. Nothing in the *Act* requires a medical practitioner to have person-to-person contact with a patient except when administering euthanasia, but on-line consultations are currently unavailable because of Australia's *Criminal Code*.

I.67 A practitioner providing euthanasia must have an adult witness present and ensure that the patient has decision-making capacity and is acting voluntarily. A patient can self-administer lethal medication at any time and place, without notifying anyone. Neither a witness or confirmation of decision-making capacity or voluntariness is required. It is thus possible for death by self-administration to occur in public or inconvenient places or remain undiscovered for some time. If the patient is incapacitated but does not die after being administered or ingesting the lethal substance, it does not appear that an additional lethal dose can be given to kill the patient unless the patient regains capacity and consents.

I.68 The *Act* requires the cause of death be falsified by reporting it as the disease or medical condition for with EAS was approved. Falsification of the cause of death on death certificates is contrary to international standards for identifying causes of death that are acknowledged by the Australian government and applied by medical practitioners, pathologists and Queensland coroners. Falsification of death certificates contributed to the murder of over 200 patients by a British medical practitioner and led to unfavourable comments by the chairman of the subsequent inquiry into the murders.

I.69 The Queensland government will establish the Voluntary Assisted Dying Care Navigator service to assist those seeking "support, assistance and information" about EAS services. VADCNS will be a service dedicated to enabling euthanasia/assisted suicide, so it will not be equivalent to a service providing information and assistance related to a variety of government and health services.

I.70 Hospitals, hospices, residential care facilities, etc. are captured in the *Act* by the term "entity". The *Act* does not require entities to provide or refuse to provide EAS information, request or assessment services or euthanasia or assisted suicide, nor does it prohibit them from refusing to do so. Entities that do not provide the services are required to publicize the fact so that people receiving or likely to seek services at their facilities are made aware of it.

I.71 The *Act* imposes obligations on entities if a person in their care requests EAS information or services that they do not provide. They must allow all persons in their care access to EAS information by allowing registered health practitioners or a member or employee of VADCNS to allow EAS practitioners to consult patients in their facilities. Similarly, they must allow all persons in their care to make first, second and final EAS requests in their facilities, or, if EAS practitioners are unable to attend, “take reasonable steps to facilitate" patient transfers to enable requests to be made and accepted elsewhere.

I.72 Entities must allow all EAS services, including euthanasia/assisted suicide, to be provided in their facilities to permanent residents (given an extended meaning by the *Act*), or, if EAS practitioners are unable to attend, “take reasonable steps to facilitate" patient transfers to enable the services to be provided elsewhere. In the case of other institutional occupants (such as hospital and hospice patients), entities can refuse to allow EAS services in their facilities, but only if they “take reasonable steps to facilitate" patient transfers to enable the services to be provided elsewhere. However, they can be forced to allow EAS services in their facilities if the responsible EAS practitioner considers transfer "unreasonable in the circumstances."

I.73 The operation of the *Act* is to be overseen by an appointed Voluntary Assisted Dying Review Board, which is required to record, analyze and report at least annually upon information it acquires. The Queensland Civil and Administrative Tribunal (QCAT) is empowered to review and overturn decisions about residency, capacity, and voluntariness (not diagnosis or prognosis). Coordinating practitioners may refuse to continue if QCAT overturns a decision about capacity or voluntariness, but must then transfer the patient to the consulting practitioner or someone eligible to act as coordinating practitioner.

I.74 The *Act* identifies eight principles underpinning the statute and seems to give equal weight to all of them. This enables an adjudicator to impose subjective and contested views about the meaning and importance of each principle during an ostensibly neutral “rights balancing” analysis. No one should be under the illusion that the principles identified in the *Act* can be fairly and objectively applied in a “rights balancing” exercise when there is fundamental disagreement about what they mean.

I.75 The provision of euthanasia or assisted suicide under the *Act* is not considered palliative care, which is clearly distinguished as an alternative option. The Commission recognized that people hold different views about the moral acceptability of euthanasia and assisted suicide and whether or not the procedures are forms of health care or medical practice. While the Commission asserted that different views should be respected, the *Act* it drafted assumes that euthanasia and assisted suicide are morally acceptable forms of healthcare and must be characterized as death by natural causes rather than homicide or suicide. This does not demonstrate respect for different views. On the contrary, it effectively imposes a chokehold on public discourse, suppressing the words needed those opposed to the *Act* to express their reasoning.

PART II: PRACTITIONER FREEDOM OF CONSCIENCE

Introduction

II.1 Part I assumed the willing participation of health care practitioners and facilities with the provisions of the *Act*. We now consider provisions of the *Act* that have an impact on practitioners who, for reasons of conscience, are unwilling to participate in euthanasia and assisted suicide (EAS) or comply with other requirements of the law.

II.2 It is important to recognize that, with respect to EAS, the health care professions are not divided into sharply defined groups of objecting and non-objecting practitioners. An undetermined number may object absolutely to the procedures for reasons of conscience, but the position of many practitioners is more fluid, depending upon the nature of the illness or condition said to justify EAS. Their support or opposition is also likely to reflect their opinions about a patient's decision-making capacity, voluntary consent, or other issues they consider relevant in certain cases or certain kinds of cases. This is one reason why a policy of registering conscientious objectors is unfair and ill-advised, and why Part II considers the relevance of the *Act*'s provisions about eligibility, capacity, discussion with patients, etc. — not just provisions specific to conscientious objection.

Eligibility

II.3 In general, the broader the grounds for euthanasia and assisted suicide, the more likely it is that conflicts of conscience will arise among health care practitioners. Those willing to provide euthanasia or assisted suicide for terminally ill patients may be much less willing to end the lives of people with chronic illness, and many more would be inclined to resist calls to kill or assist in the suicide of physically or cognitively disabled patients. By restricting eligibility for EAS to competent adults with terminal illnesses or conditions, and by explicitly ruling out EAS for mental illness and disability, the *Act* reduces the number of practitioners likely to experience conflicts of conscience when it comes into force.

Capacity assessments

II.4 Practitioners not opposed to euthanasia and assisted suicide in principle may object to providing the services for patients whose decision-making capacity is questionable. Two factors relevant to assessing decision-making capacity are of particular interest: limited capacity and fluctuating capacity.

Limited capacity

II.5 A person may be capable of making some decisions, but not others [§11(3)a]. Applying this to euthanasia and assisted suicide introduces a problem apparently unrecognized by Queensland and Canadian legislators and by the Canadian judges who ordered the legalization of the procedures in the case of *Carter v Canada (Attorney General)*.[34]

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[34] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>.

II.6 The ability of practitioners to perform capacity assessments for euthanasia and assisted suicide is disputed. On the one hand, it is argued that assessing patient competence for these procedures requires expertise that is not necessarily possessed by the majority of physicians.[35] On the other, the plaintiffs convinced the *Carter* trial court judge (and ultimately the Supreme Court of Canada) that obtaining informed consent for assisted suicide and euthanasia is no more difficult than obtaining informed consent for customary medical treatment.[36] It is instructive to set side by side the comments about capacity later made by an objecting physician (Physician D) and evidence accepted on this point by the trial court judge in *Carter*:

Madam Justice Lynn Smith	**Physician D**
Dr. Ganzini, a geriatric psychiatrist and Professor of psychiatry and medicine. . . cites the decision whether to undergo a neurosurgical procedure as an example of a cognitively demanding one, since the risks, benefits, and various trade-offs between short-term and long-term gains can be very complex and challenging to understand.	The decision to have medical aid in dying requires significant "meta" thought and reflection. It is more complex than even a decision about level of care, antibiotic treatment for pneumonia, or blood pressure pills. It is even at a different level than the choice to take chemotherapy or not.
In contrast, she says, *the risks and benefits of a lethal prescription are straightforward and not cognitively complex. The risk is that the prescription might not work; the benefit is that the patient's life will end at a time of her choosing.*[37](emphasis added)	All of our patients are vulnerable, many of them have concomitant psychiatric disorders, and almost all of them are demoralized to a certain extent that is normal in the context of a life-threatening illness. These issues make the determination of competence very difficult *because of the gravity of deciding to end one's own life.*[38](emphasis added)

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[35] *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (CanLII) [*Carter 2012*] at para 770–774, online: <https://canlii.ca/t/frpws> .

[36] *Ibid* at para 831.

[37] *Ibid* at para 775.

[38] Response of Physician D to Administrator, Protection of Conscience Project (9 September, 2016). The response was an anecdotal report received as a result of a request from the Project Administrator for details about adverse effects experienced by Canadian health care practitioners attributable to the legalization of assisted suicide and euthanasia. The respondents identified themselves to the Administrator, who promised to preserve their anonymity in discussion of the reports at a symposium at the J. Reuben Clark Law School of Brigham Young University. Discussion of the methodology of capacity assessments here is drawn from an earlier version at Sean Murphy, "Legalization of Assisted Suicide and Euthanasia: Foundational Issues and Implications" (2017) 31:2 BYU J Pub Law 333 at 350–353, online: <https://digitalcommons.law.byu.edu/jpl/vol31/iss2/3> [Murphy 2017].

II.7 The italicized passages demonstrate that a life-or-death decision has, for Physician D, a completely different significance than it has for Dr. Ganzini. The risk perceived by Physician D is that the patient might die. The risk perceived by Dr. Ganzini is that the patient might live (at least, for a time). Here we see that different underlying philosophical or ethical views about life and life-ending acts can significantly affect one's views about the existence and nature of risk. The problem of *a priori* inescapable biases in favour of an outcome is intrinsic to capacity assessments and cannot be avoided in euthanasia and assisted suicide.

II.8 According to a knowledgeable and experienced physician, each capacity assessment must be made within the context of the kind of decision-making contemplated. It is also influenced by the risks involved in the decision, life-or-death consequences calling for the highest level of capacity.[39] A cognitively impaired patient may be considered competent to decide whether to take an aspirin for a headache, but not to make a decision about neurosurgery because of an inability to understand a complex procedure and evaluate its potential consequences.

II.9 In Dr. Ganzini's opinion, the only thing the patient needs to understand is that a lethal injection will end her suffering by causing her death, and that, if it fails, a second dose may be required. On this view, it is possible that, under §11(3)a, patients might be deemed capable of choosing to die by lethal injection even if they would be considered incapable of making challenging medical decisions about alternative treatments and palliative care. Closely related to this, the burden of illness may make it easier to understand the euthanasia/assisted suicide process than to understand alternative treatment options, inclining a patient to choose what is more easily understood than what may offer satisfactory relief. In either situation, practitioners otherwise willing to provide euthanasia/assisted suicide may be unwilling to do so, even if colleagues deem the patient legally capable of making the decision.

Fluctuating capacity

II.10 The *Act* recognizes that "capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it." [§11(3)b] This issue was considered by the Supreme Court of Canada in relation to approving euthanasia for patients suffering from clinical depression (major depressive disorder). The Court accepted the plaintiffs' argument that depression undermining capacity should be treated, and, if the patient recovers sufficient capacity (even temporarily), his decision for EAS should be accepted.

> **Sheila M. Tucker:** The evidence . . . was that you can have major depressive disorder and still be competent as a medical decision maker. What the further question was, if you are to make the further judgement about whether or not, even though you are competent, the major depressive disorder is influencing your decision about wanting to end your life, that that's a very fine judgement. And so, the recommended answer to her from the witness, and which she agreed with, was, it's

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[39] Physician H, explanation offered in the presence of the Administrator, Protection of Conscience Project, on 10 October, 2015: verified by the Administrator prior to publication in Murphy 2017, *supra* note 38 at 352.

> too fine of a judgement. Simply exclude people who are actively suffering from major depressive disorder.
>
> **Justice R.S. Abella:** Even if it results from the very suffering that is what you want to be able to alleviate by the decision to end your life.
>
> **Sheila M. Tucker:** Yes, because you cannot rely on their decision. . . But that's a very high threshold . . . of major depressive disorder, because she also said, it's expressed in the context of active suffering. She said such people should be treated . . . for major depressive disorder, and if they could recover *enough* to reliably make a decision — they weren't actively suffering from it *to the same degree* — then they should be allowed to make the decision (emphasis added).[40]

II.11 Even medical practitioners willing to provide or facilitate euthanasia or assisted suicide for clear-headed patients may not be confident that they can safely act upon a request made when the clouds of major depressive disorder part for a time, or if the patient recovers what a colleague considers "enough" capacity to make a valid request.

Disagreements about eligibility

II.12 The Queensland Civil and Administrative Tribunal (QCAT) can overturn decisions by coordinating and consulting practitioners about residency, capacity and voluntariness. A coordinating practitioner whose decision about eligibility is overturned by QCAT can refuse to continue in the role. If he withdraws, he must transfer the patient file to the consulting practitioner (if there is one) or to someone who can act as a coordinating practitioner. It is highly unlikely that such situations would involve practitioners absolutely opposed to euthanasia/assisted suicide because one would expect them to refuse to accept a first request (see II.17).

II.13 It is possible that a practitioner willing to consider EAS might accept a request but assess the patient as ineligible because of doubt (rather than conviction) about voluntariness or capacity. In such a case, reversal by QCAT might be accepted by the practitioner as resolving the doubt, allowing him to proceed.

II.14 Only if a practitioner were certain that the patient lacked capacity or was not acting freely would reversal by QCAT cause a conflict of conscience. The provision permitting the practitioner to withdraw recognizes and resolves this problem [§115(2)]. However, the *Act* also requires the withdrawing practitioner to transfer the patient to a colleague who can proceed with the EAS process [§115(3)]. This certainly implies that the onus is on the withdrawing practitioner to find someone willing to kill or assist in the suicide of a patient whom he believes lacks capacity or is acting

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[40] Supreme Court of Canada, "35591, Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15"(22 January, 2018) online: Supreme Court of Canada <https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2014/2014-10-15--35591&date=2014-10-15&fp=n&audio=n> 144:32/491:20 to 145:57/491:20.

involuntarily. A practitioner may find this requirement unacceptable, and it is completely unnecessary.

II.15 Many well-connected people would be involved with an appeal of a coordinating practitioner's decision to QCAT, and QCAT is a powerful and well-connected state instrument. The *Act* should be amended to require QCAT or a person or agency designated by QCAT to find a new coordinating practitioner should the coordinating practitioner withdraw in these circumstances. The new practitioner could then request the transfer of the patient from the original practitioner in the customary way. In the Project's experience, objecting physicians are typically willing to cooperate in patient-initiated transfers in such situations, but not to initiate the transfers themselves.

Discussion with patients

II.16 We have seen that medical and nurse practitioners *may* suggest euthanasia and assisted suicide or initiate discussion about EAS — even if a patient has not expressed an interest. What is significant within the context of freedom of conscience is that practitioners are *not required* to do so. Many practitioners — not just those opposed to EAS — are unwilling to introduce the subject absent some expression of interest by the patient. Their approach reflects concern that a patient who would not normally consider EAS might be induced to ask for it if a practitioner gratuitously initiates discussion. By explicitly making discussion optional the *Act* supports both practitioners who want to initiate discussion about EAS and those who think it best to let patients take the lead, responding to their enquiries or apparent interests.[41]

Objecting registered health practitioners

II.17 A medical practitioner who has a conscientious objection to euthanasia/assisted suicide may refuse to accept a first request [§16(2)a] or a referral for a consulting assessment [§26(3)a] and must immediately inform the patient or the coordinating practitioner, as the case may be [§16(6)a, §26(5)]. Further, medical practitioners and all other registered health practitioners who conscientiously object to EAS may refuse to provide information about the services, participate in the request, assessment and administration process, prescribe or supply a lethal substance and may refuse to be present when the substance is ingested or administered [§84(1)]. They must, on the other hand, inform the patient that other health practitioners or health service providers may be able to assist them [§84(2)a].

II.18 These provisions allow objecting practitioners to step aside, advising patients that they are free to seek the services from willing colleagues. Objecting practitioners are typically willing to work cooperatively with patients and others in relation to patient access to euthanasia and assisted suicide as long as cooperation does not involve an act that establishes a causal connection to or *de facto* support for killing patients. This enables an approach that accommodates both patients and practitioners. Presumably those who support the legislation — and there appears to be a very large number — would be willing to help patients connect with EAS practitioners. And EAS practitioners could make connection easier by advertising and identifying themselves to health service agencies and patient support groups.

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[41] QLRC 2021, *supra* note 2 at para 6.116–6.117.

II.19 The *Act* also requires objectors to provide

> (i) information about a health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person; or
>
> (ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person. [§84(2)b; also in §16(4)b(i)]

II.20 Providing information is not necessarily a morally neutral or morally acceptable form of contingent cooperation. For example, the Australian Medical Association states that physicians are forbidden to provide *knowledge* that facilitates torture or other cruel, inhumane or degrading treatment, and must not facilitate capital punishment by instructing or training executioners.[42] In 2002, the General Medical Council in the United Kingdom suspended the license of a physician for six months because he had provided information about live donor organ transplantation to undercover reporters and had thus encouraged the trade in human organs, even though he had not actually participated in the trade.[43]

II.21 In the Project's experience, objecting practitioners will provide patients with information about euthanasia and assisted suicide so that a patient can make an informed decision. They are also typically willing to provide information that facilitates patient contact with other health care service providers or agencies. By this means these practitioners avoid any positive action causally connected to killing their patients, while patients remain free to pursue euthanasia/assisted suicide.

II.22 On the other hand, objecting practitioners are likely to refuse to do something that they believe implies their support for or establishes a causal connection to killing their patients. Thus, they would provide contact information for health care providers or services generally, but may refuse to direct patients specifically to an EAS practitioner or EAS delivery service .

II.23 So, for example, objecting practitioners would likely be willing to direct patients to Queensland's 13HEALTH (13-43-25-84), which provides health information, advice or referrals 24 hours a day, 7 days a week,[44] but not the Voluntary Assisted Dying Care Navigator Service (VADCNS). Both services can connect patients to EAS practitioners, but VADCNS is dedicated to enabling euthanasia and assisted suicide, while 13HEALTH facilitates access to all services (including, presumably, palliative care). There is no significant practical difference for the patient with respect to accessing EAS, but there is a significant ethical difference for many objecting practitioners, and their judgement on this point is reasonable.

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[42] Australian Medical Association, "Medical Ethics in Custodial Settings - 2013. Amended 2015" (27 March, 2013), AMA (website), online: <https://www.ama.com.au/position-statement/medical-ethics-custodial-settings-2013>.

[43] "Organ trade GP suspended", BBC News (15 October, 2002), online: <http://news.bbc.co.uk/2/hi/health/2329447.stm>.

[44] Queensland Government: Queensland Health, "Contact us: Need medical advice?" *Qld Govt, Queensland Health* (website), online: <https://www.health.qld.gov.au/comments>.

II.24 This can be illustrated by considering the legal effect of the *Act*. But for the *Act*, practitioners providing contact information for a colleague willing to provide euthanasia or assisted suicide could be charged for murder or assisted suicide if patients were killed, or conspiracy to commit murder or assisted suicide if they were not.[45] Similarly, many objecting physicians hold that by providing contact information for EAS practitioners they are morally implicated in killing their patients or helping them commit suicide: in their view, grave wrongdoings. The reasoning that underpins their conclusions about moral culpability for referring patients to others for lethal injection is identical to that underlying provisions concerning parties to offences and conspiracy in criminal law.

II.25 One of the options available in §16(4)b(i) and §84(2)b(i) is a "service . . . likely to be able to assist." Clearly, Queensland's 13Health would be such a service, so it appears that objecting practitioners can comply with §16 and §84 while avoiding actions involving a causal connection to or *de facto* support for killing patients.

Objecting speech pathologists

II.26 The *Act* includes provisions specific to speech pathologists who conscientiously object to euthanasia/assisted suicide. They, too, may refuse to provide information about the services, participate in the request and assessment process, and may refuse to be present when the substance is ingested or administered [§85(1)].

II.27 Objecting speech pathologists must inform their employer or the patient of their objection [§85(2)] and advise them of "another speech pathologist or speech pathologist service . . . likely to be able to assist in providing the speech pathology services requested" [§85(2)b]. Additionally, they "must not intentionally impede" access to speech pathology services [§85(2)c].

II.28 "[T]he services requested" should *not* be understood to mean a speech pathologist or speech pathology service known to be willing to collaborate in euthanasia or assisted suicide. An objecting speech pathologist is unlikely to know which colleagues or services would be willing to do so, and, for reasons explained in II.22-11.24, may well be unwilling to assist in this way. The requirement should be understood to mean providing information about other available speech pathology services, full stop. This would be analogous to a physician providing information about other available health service providers; it would not be problematic, and it would be more realistic.

II.29 Speech pathologists employed by a health service provider whom they know "or ought reasonably to know" is or is likely to be an EAS practitioner must inform the provider of their objections [§85(4)a] and "discuss . . . how they can practise in accordance with their beliefs without placing a burden on their colleagues or compromising a person's access to voluntary assisted dying" [§85(4)b].

II.30 The requirement to provide advance notice to an employer who provides EAS services is reasonable. However, the *Act* appears to impose duties on an objecting speech pathologist to ensure that colleagues are not burdened and access to euthanasia and assisted suicide is not compromised. The *Act* does not impose these duties on health care practitioners because existing professional

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[45] QLRC 2021, *supra* note 2 at para 17.87

guidance from the Australian Medical Association AMA include the same provisions, from which the wording of the *Act* was taken.[46]

II.31 The obligations to ensure access to euthanasia and assisted suicide while accommodating objecting employees ought to be imposed on employers who are providing euthanasia and assisted suicide, not upon employees who find the procedures abhorrent. Similarly, employers — not employees — should ameliorate burdens that may have to be shifted. They can do so by arranging exchanges of unobjectionable tasks, adjusting timetables, etc. It is reasonable to expect objectors to participate in discussion about such arrangements and cooperate in accommodation, but the onus to fairly distribute employment tasks should be on the employer. This criticism applies also to the corresponding provision in AMA guidance.

II.32 The *Act* makes no provision for conscientious objection by interpreters, even though it explicitly recognizes that interpreters may be needed [§157]. This is because interpreters are engaged for specific assignments and "best practice" is to brief them before they are engaged, which permits them to refuse an assignment for reasons of conscience.[47]

Falsification of death certificates

II.33 Queensland legislators apparently believe that legal euthanasia and assisted suicide are beneficial forms of medical treatment. However, beneficial medical treatments do not require a bureaucracy of medical deception. Deception increases the likelihood of conflict and controversy. Indeed, some EAS supporters may worry that mandating deceptive practices is counterproductive.

II.34 Medical practitioners not responsible for euthanasia and assisted suicide deaths and who object to the procedures for reasons of conscience are likely to object to falsifying the cause of death in death certificates; so, too, may physicians who support but do not act as EAS practitioners. They may be uncomfortable lying or dissembling to families about how their loved ones died, which would seem to be unavoidably associated with falsifying causes of death. Some may be concerned that falsifying records and lying to families is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. EAS practitioners may share these concerns.

II.35 If the state insists that death certificates must be falsified, unwilling practitioners should not be compelled to participate in or support what they consider to be deceptive, unethical or professionally ill-advised practices. Since all EAS deaths must be reported to the Voluntary Assisted Dying Review Board [§55(4), §61(3), §80, §81(2)], the *Act* should be amended to make a medical member of the Board responsible for completing EAS death certificates (assuming that a Board member's objection to doing so would also be accommodated).

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[46] *Ibid* at para 14.10, 14.93-14.96.

[47] *Ibid* at para 14.92.

Summary

II.36 The health care professions are not divided into sharply defined groups of objecting and non-objecting practitioners. The position of many practitioners depends upon the nature of the illness or condition, opinions about decision-making capacity, voluntariness, or other issues they consider relevant.

II.37 The broader the grounds for euthanasia and assisted suicide, the more likely it is that conflicts of conscience will arise. By restricting eligibility to competent adults with terminal illnesses or conditions, and by explicitly ruling out EAS for mental illness and disability, the *Act* reduces the number of practitioners likely to experience conflicts of conscience when it comes into force.

II.38 The ability of practitioners to perform capacity assessments for euthanasia and assisted suicide is disputed, and assessment of limited, fluctuating and episodic capacity can be particularly troublesome. Patients could be deemed capable of choosing euthanasia/assisted suicide even if they are considered incapable of challenging medical decisions about alternative treatments and palliative care. The burden of illness may make it easier to understand the EAS process than alternative treatment options, and to choose what is more easily understood rather than what might offer significant symptom relief. Even practitioners willing to facilitate euthanasia for clear-headed patients may not be confident that they can safely act upon a request made when the clouds of major depressive disorder part for a time, or if the patient recovers what another colleague considers "enough" capacity to make a valid request.

II.39 Finally, risk assessments by EAS supporters, uncommitted practitioners and EAS opponents may reflect significantly different views about life-or-death decisions based on different underlying philosophical or ethical views. *A priori* biases in favour of an outcome are cannot be avoided in EAS assessments.

II.40 The Queensland Civil and Administrative Tribunal (QCAT) can overturn a coordinating practitioner's conclusion that a patient is ineligible for EAS because of involuntariness or lack of capacity. This can cause a problem for practitioners who are certain of their conclusion because, though they can withdraw, the *Act* requires them to transfer the patient to a colleague willing to continue the EAS process. They may well consider this unacceptable, and it is completely unnecessary. The *Act* should be amended to require QCAT or a person or agency designated by QCAT to find a new coordinating practitioner should the coordinating practitioner withdraw in these circumstances.

II.41 Medical and nurse practitioners may initiate discussion about EAS but are not required to do so. By explicitly making discussion optional, the *Act* supports both practitioners who want to initiate discussion about EAS and those who think it best to let patients take the lead, responding to their enquiries or apparent interests. Further, all registered health practitioners who conscientiously object to EAS may refuse to provide information about or participate in any part of the EAS process, and refuse to be present when EAS is provided. These provisions are satisfactory, and the requirement that they inform patients that other practitioners may be able to assist them is unobjectionable. They allow objecting practitioners to step aside, advising patients that they are free to seek the services from willing colleagues.

II.42 The further requirement that they provide information about those who may be willing to provide EAS does not specify that objectors must direct patients to EAS practitioners or provide contact information for them. It is sufficient if the objector provides information about a "service . . . likely to be able to assist," such Queensland's 13Health. This allows objecting practitioners to comply with the *Act* while avoiding any positive action causally connected to killing their patients, and it leaves patients free to pursue euthanasia/assisted suicide .

II.43 Objecting speech pathologists are accorded the same protection as registered health care practitioners, with the analogous requirement to notify employers and patients of the availability of other speech pathology services. They must notify employers who provide EAS services in advance, a reasonable requirement that helps to avoid needless conflicts. However, the *Act* also suggests that objectors are obliged to ensure that colleagues are not burdened and access to euthanasia and assisted suicide is not compromised. The *Act* does not suggest that health care practitioners have such duties because they can be found in existing professional guidance from the Australian Medical Association (AMA). Whether contained in the *Act* or in AMA guidance, this is unacceptable. The duty to ensure EAS access, accommodate objecting employees and balance workloads among staff should lie on the employer, not objecting employees. They may reasonably be expected to participate in discussion about and cooperate in accommodation, but the onus to fairly distribute employment tasks should be on the employer.

II.44 Regardless of their views about euthanasia and assisted suicide, some medical practitioners are likely to object to falsifying the cause of death in death certificates. They may be uncomfortable about lying or dissembling to families about how their loved ones died or concerned that falsifying records and lying is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. If the state insists that death certificates must be falsified, the *Act* should be amended to make a medical member of the Voluntary Assisted Dying Review Board responsible for completing EAS death certificates (assuming that a Board member's objection to doing so would also be accommodated).

PART III: INSTITUTIONAL & COLLECTIVE FREEDOM OF CONSCIENCE

Introduction

“Entities”

III.1 The Commission explained that “entity” is intended to mean “a non-natural person, *typically* a corporation or body given legal status” (emphasis added).[48] Consistent with this, the *Act* describes an “entity” only as “other than an individual” [§87]. It is reasonable to extend this to include unincorporated businesses and collectives of various kinds, and that is the meaning assumed in this Part. Regardless of structure, “institution” in the sense relevant here is an entity that always manifests a collective enterprise by individuals, so the term “entity/collective” is used in this Part to keep this in mind.

III.2 The *Act* refers to facilities operated by entities that provides “a health service, residential aged care or personal care.” Such facilities include private and public hospitals, hospices, and nursing homes, hostels or other facilities providing "nursing or personal care" for persons who require it "because of infirmity, illness, disease, incapacity or disability." They also include "residential aged care" facilities that provide accommodation, meals, cleaning services, furnishings, furniture and equipment and nursing and personal care staff [§86-88].

Institutional freedom of conscience

III.3 The concept of institutional freedom of conscience or religion has been examined and challenged repeatedly since at least the early 1970's. Claims that facilities like hospitals and hospices cannot rely on constitutional guarantees of freedom of conscience *because* they are not individuals are untenable because they are contradicted by legal history and widespread practice. At best, they provide superficial camouflage for efforts to compel unwilling institutions to provide morally contested services favoured by the claimants, or anti-religious discrimination, or both. [49]

III.4 The Commission acknowledged the controversy about whether or not an institution can exercise freedom of conscience. It casually decided against an institutional right to freedom of conscience, recognizing only an institutional interest in maintaining its identity and integrity.[50] Hence, the *Act* explicitly admits the possibility of conscientious objection by individuals [§84–85] — but not by entities/collectives [§86-98]. It addresses only the obligations of entities/collectives that do not participate in euthanasia or assisted suicide — for any reason.

III.5 It appears that one of the reasons underlying this strategy was a desire to avoid even implicitly acknowledging an institutional right to refuse to participate in euthanasia and assisted

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[48] QLRC 2021, *supra* note 2 at p 457.

[49] Sean Murphy, “Institutional freedom of conscience in relation to euthanasia and assisted suicide” (14 May, 2022) Protection of Conscience Project (website) [Murphy 2022] at para I.9–I.12, online:<https://www.consciencelaws.org/law/commentary/legal114.aspx>.

[50] QLRC 2021, *supra* note 2 at para 15.8.

suicide for reasons of conscience.[51] Consistent with this, the *Act* states that one of its main purposes is to protect health practitioners — not entities/collectives — who choose "to assist or not to assist" in euthanasia or assisted suicide [§3(d)]. Its statement of underlying principles acknowledges and presumes freedom of thought, conscience, religion, belief, and enjoyment of culture for individuals — *not* for entities/collectives [§5].

III.6 Thus, while the *Act* implicitly acknowledges that entities/collectives can refuse to participate in euthanasia and assisted suicide [§90(1)c, §92(1)b, §93(1)b, §94(1)c, §95(1)c, §96(1)c, §97(1)c], this is based merely on the exercise of property rights, which can be overridden by statute.[52] It places refusals based on moral/ethical objections to killing people on the same level as refusals based on pragmatic considerations like lack of trained personnel. Its message is that constitutional guarantees of freedom of conscience are irrelevant to decision-making by entities/collectives about involvement in killing people, and, if entities/collectives defend refusals on that basis, the *Act* is designed to put them at a disadvantage.

Critical presumption

III.7 Contrary to the position taken by the Commission, this paper presumes that entities/collectives are entitled to rely upon constitutional guarantees of freedom of conscience, notwithstanding differences between individuals and collectives in the exercise of that freedom. Individuals and entities/collectives are equally concerned to avoid complicity in perceived wrongdoing. This obviously includes taking part directly in what they deem to be a wrongful act, but also causally contributing to by collaboration or contingent cooperation. However, factors relevant to moral decision-making by entities/collectives are not necessarily identical to those affecting the exercise of freedom of conscience by individuals, nor do they play out in the same way. The concept of individual freedom of conscience is applied analogically to collectives, so some differences are to be expected.[53]

Scope

III.8 The focus here is the effect of the *Act* upon institutions in Queensland that refuse to provide or facilitate euthanasia/assisted suicide (EAS) for reasons of conscience. It is specific to the exercise of *preservative* freedom of conscience.[54,55] The policy of such institutions typically reflects desire to preserve institutional moral integrity by refusing to be complicit in, cooperate in or otherwise support or encourage the killing of patients and a desire to prevent harm to others. Institutional religious

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[51] QLRC 2021, *supra* note 2 at para 15.25, 15.27 bullet 1, 15.54, 15.217.

[52] *Ibid* at para 15.3–15.5.

[53] Murphy 2022, *supra* note 49 at I.13–I.14.

[54] Introduced in Sean Murphy & Stephen Genuis, "Freedom of Conscience in Healthcare: Distinctions and Limits" (2013) 10(3) J Bioethical Inquiry 347 [Murphy & Genuis], online: <https://link.springer.com/article/10.1007%2Fs11673-013-9451-x>.

[55] Discussed and applied in Sean Murphy et al, "The Declaration of Geneva: Conscience, Dignity and Good Medical Practice" (2020) 66(4) World Med J 41 [Murphy et al], online: <https://www.wma.net/wp-content/uploads/2020/12/wmj_4_2020_WEB.pdf>.

integrity is not addressed in this review.

Institutional challenges

Participation, collaboration and cooperation

III.9 The *Act* does not require entities/collectives to provide euthanasia or assisted suicide or even to provide information about the procedures, so it does not threaten institutional freedom of conscience in relation to direct participation in EAS services.

III.10 However, objecting individuals and entities/collectives also want to avoid contributing to EAS in morally significant ways: ordering, recommending or encouraging it and other forms of collaboration or facilitation, such as helping patients connect with someone willing to kill them or help them kill themselves. Beyond collaborative conduct entailing complicity, individuals and entities/collectives also wish to avoid forms of cooperation that they may consider morally wrong in certain circumstances [“contingent cooperation”].[56]

III.11 The problem of contingent cooperation is especially troublesome for institutions. [57] Providing advance notice of institutional policies is an important strategy for avoiding conflicts with patients and difficulties associated with contingent cooperation. Hence, the *Act’s* requirement that entities/collectives provide such notice furthers the accommodation of both patients who may want EAS services and entities/collectives unwilling to provide them [I.43].

III.12 Ideally, people who may want EAS services will avoid facilities operated by entities/collectives unwilling to provide or facilitate them. However, this may not always work out in practice, so the *Act* has been designed to enable the state to compel unwilling entities/collectives to at least cooperate in killing people in their care or helping them kill themselves.

III.13 Two kinds of cooperation demanded pertain to all persons being cared for in a facility — enabling access to information about EAS and facilitating requests for EAS. The extent of cooperation demanded in relation to EAS assessments and actual provision of euthanasia/assisted suicide depends upon the legal occupancy status of the person in care.

III.14 Obligations to cooperate imposed on objecting entities/collectives by the *Act* arise only if patients notify institutional staff or representatives that they want EAS information, want to make EAS requests, have EAS assessments, etc. Requests directed to non-institutional staff would not create institutional obligations. This is reasonable, since only entities/collectives aware of a request could be expected to act on an obligation, and they can become aware of requests only through their employees or representatives. But it also means that patients and practitioners cannot proceed with EAS in an objecting institution unless they notify institutional authorities at each stage in the EAS process. [§90(1)b, §92(1)a, §93(1)a, §94(1)b, §95(1)b, §96(1)b, §97(1)b].

Legal occupancy status

III.15 The *Act* groups EAS candidates into two classes based on legal occupancy status: “permanent

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[56] Murphy 2022, *supra* note 49 at para II.5.

[57] *Ibid* at para II.6–II.9.

residents" and those who are not. It describes members of the latter group as those who reside temporarily in a facility like a hospital or hospice, but does not name the group [I.46]. This implies that they are 'temporary residents,' inviting the unwarranted inference that they have some kind of residential rights. For this reason, those who are not "permanent residents" within the meaning of the *Act* are identified here as "institutional occupants."[58]

III.16 For present purposes, it is assumed that, apart from the *Act*, permanent residents have legal status analogous to residential tenants in relation to the institutional space they occupy, but institutional occupants do not.[59] It is further assumed that an entity/collective may not be able to include a no-EAS-on-premises condition in a permanent residency agreement, but can include such a condition in institutional occupancy agreements.[60]

III.17 To the extent this is correct, permanent residents would seem to be free to have visitors come and go as they choose, to communicate privately with visitors, and to do as they wish inside the premises they occupy, even if the premises is part of a larger facility. Owners and managers of a residential facility have no authority to manage or interfere in permanent residents' affairs without their consent, except to the extent necessary to protect the entity/collective's legitimate interests (including freedom of conscience), other residents and facility staff. Assuming these further inferences are correct, it is obvious that permanent residents would be able to arrange for and obtain EAS services *in their own premises*, notwithstanding opposition by owners of the facility, even if the *Act* did not address the issue. This would not be true of institutional occupants.

III.18 The facilities to which the *Act* pertains encompass a broad range of designs and living arrangements [III.2]. A permanent resident may have a self-contained private apartment or merely a small private room and bathroom (much like a private hospital room). Institutional occupants are more likely to share a room with one or more others, separated from them only by curtains, but this may also be true of some permanent residents who have security of tenure in residential aged care facilities [I.46], whom the Act declares to be permanent residents for the purpose of access to EAS.

III.19 It is obvious that, from the perspective of an entity/collective, facility staff and other occupants, the provision of EAS services in a private apartment in a residential facility would be radically different from providing them behind a curtain in a room shared with others, but the *Act* does not distinguish between the two situations. Fortunately, nothing in the *Act* prevents entities/collectives from imposing conditions on EAS-related activities that they are required to permit in order to protect other patients,[61] staff[62] and institutional moral integrity. For example: a

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[58] *Ibid* at para V.1–V.9.

[59] The assumption is consistent with the differential treatment of permanent residents and institutional occupants by the *Act* [I.41–1.43].

[60] The assumption is consistent with the *Act's* requirement that an objecting entity/collective give advance notice of such limitations [I.38].

[61] YouTube, "Allow Me to Die: Euthanasia in Belgium" (15 September, 2015) at 00h:40m:00s to 00h:43m:30s, online: <https://youtu.be/hCRpuTRA7-g>.

[62] "Nurse diagnosed with PTSD after interaction with patient seeking euthanasia: Tribunal rules 'her own convictions' caused her injury. Denies claim for compensation" (10 October, 2017),

nursing home that is unable to prevent EAS in a resident's room may refuse to take custody of EAS drugs, refuse to allow celebrations associated with anticipated EAS elsewhere in the facility, prohibit employees from participating in or supporting the procedure, and limit the provision of EAS to times when other residents are likely to be absent or sleeping.

Access to information

III.20 The *Act* imposes an institutional obligation to provide access to EAS information for all institutional occupants, regardless of legal occupancy status. however, the institutional obligation to provide access to EAS information arises *only* if a patient receiving treatment or care in a facility asks *institutional staff or representatives* about euthanasia or assisted suicide [I.44]. It does *not* apply when patients seek information from *non-institutional* medical or health care practitioners visiting the facility.

III.21 Independent practitioners are governed by other provisions in the *Act* [I.10-I.13] and professional regulations. If asked, they would be expected to provide information necessary to enable informed medical decision making. It is likely that most information sought by most patients would be provided in this way.

III.22 Were a patient to ask *institutional staff* for EAS information, the *Act* requires entities/colllectives to permit and enable the patient to obtain information about the services regardless of their legal occupancy status [I.37]. Objecting entities/collectives, like individual practitioners, may well be willing to provide patients with information necessary to enable them to make an informed decision about euthanasia and assisted suicide, as long as they can avoid doing so in a manner that causally connects them to killing their patients or makes it appear that they support or recommend the procedures [II.21–II.25].

III.23 To conform to the *Act*, objecting entities/collectives could require that all patient enquiries about EAS received by institutional employees be directed to staff members trained to provide patients with information necessary to enable informed decision-making without compromising institutional moral integrity. The policy could also require that discussion and communication of information take place in private, and could operate seamlessly with responses to first requests for EAS [III.28-III.31]. Note that an objecting entity/collective that provides EAS information in this way is not required by the *Act* to admit anyone else for the purpose of providing information [I.44].

III.24 However, a patient may ask for specific information that an entity/collective is unwilling to provide even through a designated employee, such as the name and contact information for an EAS practitioner or EAS enabling service like VADCNN [I.35].[63] Here the text of the *Act* is critical. It specifies that an entity/collective must allow a medical practitioner or a member of VADCNN reasonable access to the patient to provide "the information *that has been requested*" (§90(1)c and (2)b, emphasis added). It does not, however, require an objecting entity/collective to arrange for this:

Protection of Conscience Project (website), online: <https://www.consciencelaws.org/law/commentary/legal089-001.aspx>.

[63] Not all objecting entities/collectives would exclude VADCNN as a source of information: QLRC 2021, *supra* note 2 at para 15.233.

only that it not obstruct arrangements made by the patient. Like individual practitioners, objecting entities/collectives could comply with the *Act* by directing patients seeking EAS practitioner contact information to Queensland's 13HEALTH [II.23] and not obstructing the arrangements subsequently made by a patient or patient's representative to connect with someone willing to provide the information.

III.25 In sum, the cooperation required of objecting entities/collectives by the *Act* in relation to providing information about EAS does not appear to undermine institutional freedom of conscience.

Access to euthanasia and assisted suicide

III.26 The *Act* requires three requests (one witnessed), two assessments by different practitioners (and possibly assessments by determiners), and an administration decision before EAS is actually provided. From start to finish, Queensland's EAS process involves at least seven steps, and each has to take place somewhere. Had the *Act* been designed to accommodate institutional freedom of conscience, objecting entities/collectives seeking to avoid moral entanglement in the process would have had three options (subject to the legal occupancy status of a patient): permanent transfer of patients seeking EAS, temporary transfers for some or all of the steps in the process, and no transfer: allowing the full EAS process to take place in a facility, but without support or participation by facility staff.[64]

III.27 However, the *Act* effectively denies institutional freedom of conscience. It imposes a number of constraints and requirements on objecting entities/collectives specifically to compel their cooperation and even collaboration, some of which go beyond legal constraints arising from legal occupancy status.

Requests for EAS

First requests

III.28 The *Act* requires that a first request for euthanasia/assisted suicide be accepted or refused by a medical practitioner. Refusal does not prevent EAS because a patient remains free to ask other medical practitioners to accept the request. This arrangement underpins the provisions protecting practitioner freedom of conscience [II.17-II.19] and could have been applied to protect institutional freedom of conscience,[65] but the *Act* does not do this.

III.29 The Commission considered a patient's first request only within the context of an EAS delivery process, not within the context of caring for patients.[66] In reality, patients can request euthanasia/assisted suicide at any time, even where the procedures are illegal. For example, palliative care patients experiencing grave pain and suffering sometimes ask for EAS. Experienced

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[64] Murphy 2022, *supra* note 49 at para V.10–V.16.

[65] QLRC 2021, *supra* note 2 at para 15.136.

[66] *Ibid* at para 15.235.

palliative care practitioners consider this an expression of anguish and respond by attempting to identify and ameliorate the source of distress rather than by simply ignoring the request or shutting down the conversation. It is highly unlikely that objecting entity/institutions would be interested in suppressing this kind of request or patient-practitioner exploration, as it can lead to remediation of patients' distress and relieves them of inclinations toward euthanasia.

III.30 This kind of dialogue remains possible notwithstanding the *Act* because it requires a patient request to be "clear and unambiguous" [§14(2)a]. Only if a practitioner concludes that a request is clear and unambiguous (which must surely imply an understanding of alternatives) do the obligations imposed by the *Act* in relation to a first request become relevant. That conclusion need not be reached the same day the patient initiates the discussion.

III.31 Objecting entities/collectives would naturally instruct their medical staff to refuse a first request that is found to be "clear and unambiguous." They could instruct them to comply with the *Act* by (i) informing the patient that other health practitioners or health service providers may be able to assist them [§84(2)a], (ii) providing information about Queensland's 13HEALTH [II.23] and (iii) recording in the patient's medical record the refusal and information provided to the patient [§17]. They could also require that such consultations with patients must occur in private. It appears that non-institutional medical practitioners could be required through the credentialing process to conform to these policies.

III.32 By exploring, documenting and refusing first requests and providing information that enables patients to seek EAS elsewhere it would be possible for objecting entities/collectives (like individual practitioners) to respond compassionately to patients and manage first requests without compromising institutional moral integrity. What happens next would be up to the patient. A patient could arrange to consult with an EAS-qualified medical practitioner willing to accept a request and begin the EAS process by assessing his eligibility.

III.33 No issue would arise if the *Act* were to state only that an entity/collective must not obstruct patients who make such arrangements. However, it does more. It requires objecting entities/collectives to cooperate by letting EAS practitioners accept first requests *in their facilities* [§92(2)]: to allow a process designed to allow patients to be killed or helped to kill themselves to begin *in their facilities.* When an EAS practitioner cannot attend, objecting entities/collectives must "take reasonable steps to facilitate the transfer" of the patient to a location where first requests can be accepted [§92(3)]: arguably a demand for active collaboration if it is understood to mean that the entity/collective must initiate the transfer rather than merely cooperate in a transfer arranged by the patient or others.

Second and final requests

III.34 The *Act* makes the same demands of objecting entities/collectives in relation to subsequent requests. The required second request can be made only after a patient has been found eligible for EAS. It must be in writing and witnessed by two people [I.21]. A patient must then personally make a "clear and unambiguous" final request for EAS to a medical practitioner by any means [I.22]. The final request could be made immediately after a second request, during the same consultation. It is obvious that second and final requests are more deliberately supportive of and causally related to euthanasia and assisted suicide than first requests, and thus more significant in moral evaluation of collaboration and contingent cooperation. The Commission ignored this, supporting the *Act's* coercion of objecting entities/collectives in relation to all "requests or declarations" it requires.[67]

III.35 The Commission purported to justify this coercion with a casual remark: "[I]t is hard to see why a patient or resident *who is dying* should be put to the trouble of being transferred outside of a facility to make a 'first request' to a practitioner who is qualified and willing to receive it" (emphasis added).[68] In the first place, potential EAS candidates must be diagnosed with terminal illness, but they need not be dying, and most will not be dying when a first request is made [I.3].

III.36 The key point here, however, is the prejudice reflected by the Commission's dismissive comment. The Commission found it "hard to see" why an entity/collective could reasonably object to allowing the EAS process in its premises. This was not only because the Commission believed it is morally acceptable to kill patients or help them kill themselves in accordance with the *Act*: hardly surprising, since it drafted the *Act*. What is remarkable is that the Commission was unable to imagine or unwilling to concede that others could reasonably and collectively hold and act upon the contrary view, and be entitled to do so in a democratic state.

III.37 The remark is indicative of a lack of moral imagination or unreflective and entrenched authoritarianism in relation to the provision of euthanasia and assisted suicide. It is doubtful the Commission would find it "hard to see" why entities/collectives might refuse to allow their facilities to be used to enable eugenic sterilization of people described as "human wreckage,"[69] "degenerates"[70] and "defectives."[71] Hindsight would probably enable the Commission to see and to concede that it is reasonable, prudent and consistent with the best traditions of liberal democracy to honour collective refusal to cooperate or collaborate in such practices, notwithstanding popular opinion and the views of prominent establishment influencers.

EAS assessments, administration decisions, and administration of lethal substance

III.38 A medical practitioner who accepts a first request becomes the coordinating practitioner [I.17] and must assess a patient's eligibility for EAS [I.3-I.5]. This may (but need not) involve

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[67] *Ibid* at para 15.238.

[68] *Ibid*.

[69] Emily Murphy, "Sterilization of the Insane." The Vancouver Sun (3 September 1932).

[70] Richard Cairney,"Democracy was never intended for degenerates": Alberta's flirtation with eugenics comes back to haunt it" (1996) 155(6) CMAJ 789 at 791.

[71] Marie Stopes, Roman Catholic Methods of Birth Control (London: Peter Davies, 1933) at 197-215.

referring the patient to a specialist [I.19]. A coordinating practitioner who finds the patient eligible must refer the patient for a second eligibility assessment by another (consulting) practitioner [I.18].

III.39 If eligibility is confirmed and the patient makes second and final requests, the patient must consult further with the coordinating practitioner to make an administration decision: to decide whether to opt for euthanasia or assisted suicide [I.25-I.28].

III.40 The Act specifies assisted suicide (self-administration of a lethal substance) as the preferred method, in which case the patient is free to decide where and when it will occur. The timing and location of euthanasia (practitioner administration) will depend upon the availability of an EAS practitioner.

Permanent residents

III.41 The *Act* requires objecting entities/collectives to allow all permanent residents (as defined in the *Act*) to have all EAS assessments, consultations and euthanasia/assisted suicide provided in their facilities, or (if practitioner is unable to attend) to "take reasonable steps to facilitate" patient transfers to enable the procedures [I.47].

III.42 Recall that the *Act* defines permanent resident to include people with security of tenure who live in a residential aged care facility. Prior to this, security of tenure in a residential care facility restricted but did not preclude permanent transfer in some circumstances, nor did it preclude temporary transfers for procedures not provided in the facility [I.46]. But for the Act, it appears that entities/collectives could have prohibited the EAS process in their facilities by including a no-EAS clause in contracts services. The Commission considered and expressed doubt about these issues,[72] but used the *Act* to grant permanent residency status (and a right to have EAS services where they reside) to people living in aged residential care facilities. This significantly disadvantages objecting entities/collectives that might otherwise have been able to avoid entanglement in euthanasia/assisted suicide through conditional residency contracts and patient transfers.

III.43 One might argue that the *Act* simply extends rights and freedoms associated with residential tenancy: that aged care facilities are the homes of the people in care, and that objecting entities/collectives, like landlords, should not be able to prevent them from having euthanasia/assisted suicide in their own homes. The Commission suggested this argument.[73] However, landlords are not required to help tenants travel to see EAS practitioners who are unable to make home visits, so the analogy does not support the Act's demand that objecting entities/collectives must actively facilitate patient transfer to obtain the services elsewhere.

III.44 Moreover, as previously noted [III.33], it is important to know what is meant by taking "reasonable steps to facilitate" a transfer. No problem arises if it means only that the entity/collective must cooperate in a transfer or enable a transfer to be arranged by the patient or others. However,

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[72] QLRC 2021, *supra* note 2 at para 15.174.

[73] *Ibid* at para 15.2, 15.229, 15.239, 15.261, 15.271, 15.277.

requiring them to initiate a transfer to enable EAS demands what many would consider morally unacceptable cooperation, if not collaboration.

Institutional occupants

III.45 Objecting entities/collectives can disallow EAS assessments, consultations, administration decisions and the provision of euthanasia/assisted suicide for other institutional occupants (hospital and hospice patients, for example). However, they can do so only if they "take reasonable steps to facilitate" transfers to enable the procedures elsewhere [I.48]. If that means initiating rather than simply cooperating in a transfer requested by others, the purported compromise is actually a choice between two objectionable alternatives [III.44].

III.46 Moreover, objecting entities/collectives must allow EAS procedures in their facilities (including euthanasia and assisted suicide) if transfer “would not be reasonable in the circumstances” [I.48]. What this means in practice can be decided unilaterally by the responsible EAS practitioner [I.49]. In principle - and consistent with the prejudice previously noted [III.35-III.36], the *Act* reflects the view that it can be unreasonable to refuse to allow someone to be killed or helped to commit suicide in one's premises.

Practitioner credentialing (privileges)

III.47 An entity/collective may restrict the kinds of procedures and services it provides and what its employees or contracted health care personnel offer through its facilities. Public and private entities\collectives in Queensland are required by law[74,75,76] to ensure that “only appropriately qualified and experienced medical practitioners undertake clinical care” in their facilities.[77] Generally speaking, practitioners must be credentialed to provide services and act within a defined scope of practice.[78]

III.48 The law and related guidelines set only the minimum requirements for the credentialing

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[74] Private Health Facilities Act 1999 (Qld) s 48(1)(b) [*PHF Act*]; online: <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-1999-060>.

[75] Private Health Facilities Regulation 2016 (Qld) s 8. online: <https://www.legislation.qld.gov.au/view/pdf/inforce/2018-03-30/sl-2016-0140>

[76] Private Health Facilities (Standards) Notice 2016 (Qld) Schedule 1(2) online: <https://www.legislation.qld.gov.au/view/pdf/inforce/current/sl-2016-0127>.

[77] Queensland Health, “Credentials and clinical privileges standard (version 5)” (12 January 2021), Queensland Health (website), online: <https://www.health.qld.gov.au/__data/assets/pdf_file/0037/443998/phfa-standard-cred-clin-priv.pdf>.

[78] QLRC 2021, *supra* note 2 at para 15.190.

process in Queensland's public and private health care facilities.[79] Private nursing and aged care facilities are not subject to the same rules[80] but are required by national legislation to ensure that their employees are "competent" and have "qualifications and knowledge to effectively perform their roles."[81] This provides a legal mandate for credentialing by private facilities.

III.49 Since the *Act* requires EAS practitioners to have special training [I.8–I.9] one would expect EAS to be specifically identified when a facility recognizes practitioners' credentials and defines their scope of practice. On the other hand, one would expect objecting entities/collectives to refuse to include EAS in granting credentials because that would explicitly affirm the acceptability of euthanasia/assisted suicide and authorize the procedures, blatantly contradicting their moral commitments.

III.50 The *Act* is silent about credentialing, but it demands that entities/collectives allow qualified practitioners to provide EAS services to patients in their facilities. This poses a dilemma for objectors.

> i) They could refuse to grant credentials that permit EAS, and refuse to allow uncredentialled practitioners access to their facilities. However, this would leave objecting entities/collectives liable to legal action for non-compliance with the *Act*. Further, EAS practitioners may surreptitiously circumvent the prohibition, which, given the requirements of the *Act*, would leave the entities/collectives without legal recourse, and may have other adverse affects.[82]
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> ii) They could grant other privileges to non-facility EAS practitioners, and then tolerate their provision of EAS services if they abide by restrictions imposed [III.19]. However, allowing practitioners to provide services not permitted by institutional credentials may give rise to legal liability. Moreover, it would require

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[79] Queensland Health, "Guide to credentialing and defining scope of clinical practice for medical practitioners and dentists in Queensland: A best practice guide" (June, 2014), Queensland Health (website) online: <https://www.health.qld.gov.au/__data/assets/pdf_file/0026/440891/cred-best-practice-guid.pdf> .

[80] *PHF Act*, *supra* note 74 s 9(2)b.

[81] *Aged Care Quality Standards*, Standard 7(3)c (27 May 2022), Aged Care and Quality Safety Commission (website) online: <https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%20and%20resources_Standard%207.pdf>.

[82] Kelly Grant, "Vancouver doctor cleared of wrongdoing in probe into assisted death at Orthodox Jewish nursing home", The Globe and Mail (7 August, 2019), online:<https://www.theglobeandmail.com/canada/article-bc-doctor-cleared-of-wrongdoing-in-probe-into-assisted-death-at/>.

entities/collectives absolutely opposed to euthanasia/assisted suicide to make a policy explaining how euthanasia/assisted suicide should be provided in their facilities: an absurd or at least hopelessly convoluted approach.

iii) They could grant credentials explicitly authorizing EAS, making clear their opposition to the procedures and setting out conditions and restrictions on provision of the service in order to protect other patients, staff and mitigate harm to institutional moral integrity. This may be the only way to ensure that restrictions can be enforced.

III.51 Driving objecting entities/collectives into a trap from which they can only escape by explicitly authorizing something they find morally abhorrent is a clever but ugly example of coerced expression, but consistent with the prejudice previously noted [III.35-III.36].

Summary

III.52 The Commission explained that "entity" is intended to mean "a non-natural person, typically a corporation or body given legal status," and the *Act* describes an "entity" only as "other than an individual" It is reasonable to extend this to include unincorporated businesses and collectives of various kinds. Regardless of structure, "institution" in the sense relevant here is an entity that always manifests a collective enterprise by individuals.

III.53 The Commission rejected the notion of an institutional right to freedom of conscience, recognizing only an entity/collective's interests in maintaining institutional identity and integrity by exercising property rights - which can be overridden by statute. Thus, the *Act* recognizes and addresses conscientious objection by individuals but not by entities/collectives. It implicitly acknowledges that entities/collectives may or may not provide EAS, and it addresses the obligations of entities/collectives that do not, but at no point does it imply that constitutional guarantees of freedom of conscience are relevant to decision-making by entities/collectives about involvement in killing people. It places refusal to kill people for reasons of conscience on the same level as refusals based on pragmatic considerations like lack of trained personnel or management of institutional branding.

III.54 The *Act* does not require entities/collectives to provide euthanasia or assisted or even to provide information about the procedures, so it does not threaten institutional freedom of conscience in relation to direct participation in EAS services. Instead, the *Act* is designed to enable the state to compel unwilling entities/collectives to cooperate and perhaps collaborate in killing people in their care or helping them kill themselves.

III.55 However, patients and practitioners cannot proceed with EAS in an objecting institution unless they notify institutional authorities at each stage in the EAS process. This is fortunate, because providing EAS services in a private apartment in a residential facility would be radically different from providing them behind a curtain in a room shared with others, and the *Act* does not distinguish between the two situations. Nothing in the *Act* prevents objecting entities/collectives from imposing conditions on EAS-related activities that they are required to permit in their facilities once they have been notified.

III.56 Two kinds of cooperation required by the *Act* pertain to all persons being cared for in a facility — enabling access to information about EAS and facilitating requests for EAS. The extent of cooperation demanded in relation to EAS assessments and actual provision of euthanasia/assisted suicide depends upon the legal occupancy status of the person in care.

III.57 With respect to providing EAS information, objecting entities/collectives could direct all patient enquiries about EAS to staff members trained to provide patients with information necessary to enable informed decision-making without compromising institutional moral integrity. Hence, the cooperation required in providing information about EAS does not appear to undermine institutional freedom of conscience. However, the provisions concerning requests and other elements in the EAS process are problematic.

III.58 The *Act* was drafted by a Commission that considered a patient's first request only in relation to the EAS delivery process, not within the context of caring for patients. Nonetheless, the wording of the *Act* leaves room for objecting entities/collectives to direct staff to fully and compassionately explore and document first requests, refuse those found to be clear and unambiguous, and provide information enabling patients to seek EAS elsewhere. They can thus largely comply with the *Act* without compromising institutional moral integrity.

III.59 However, the *Act* also requires objecting entities/collectives to allow EAS practitioners to accept first, second and final requests *in their facilities* from anyone, and to allow them to provide all EAS assessments, consultations and euthanasia/assisted suicide *in their facilities* for all permanent residents (including people living in aged residential care facilities). Contingent cooperation of this kind is problematic, especially in relation to patients who share rooms with others. If EAS practitioners cannot attend, objecting entities/collectives must "take reasonable steps to facilitate the transfer" EAS candidates to a location where they can receive EAS services, including lethal injection. This suggests that active collaboration might be expected, and it goes well beyond merely granting the equivalent of a residential tenancy right to service delivery at home. Landlords are not forced to help tenants travel to see EAS practitioners who can't make home visits.

III.60 Objecting entities/collectives may refuse to allow the EAS process for institutional occupants (like hospital and hospice patients) only if, once more, they "take reasonable steps to facilitate" transfers to enable the procedures elsewhere [I.48]. If that means initiating rather than simply cooperating in a transfer requested by others, the purported compromise amounts to a choice between two objectionable alternatives. Further, the *Act* demands that objecting entities/collectives allow EAS procedures in their facilities (including euthanasia and assisted suicide) for hospital and hospice patients and other institutional occupants if transfer “would not be reasonable in the circumstances.”

III.61 The *Act's* demands that qualified practitioners be allowed to provide EAS services to patients in facilities poses a dilemma for objecting entities/collectives in granting credentials. Granting credentials for EAS would explicitly affirm the acceptability of euthanasia/assisted suicide and authorize the procedures, thus contradicting their moral commitments. However, granting credentials may be necessary to avoid legal liability, and it may be the only way for objecting entities/collectives to impose enforceable conditions and restrictions on provision of the service in order to protect other patients, staff and mitigate harm to institutional moral integrity.

III.62 The Act reflects the prejudice of its author, a Commission that found it "hard to see" why an entity/collective could reasonably object to allowing the EAS process to begin in its premises. This was not only because, as one would expect, the Commission believed it is morally acceptable to kill patients or help them kill themselves in accordance with the rules they proposed. The Commission was also unable to imagine or unwilling to concede that others could reasonably and collectively hold and live in accordance with the contrary view, and should be entitled to do so in a democratic state. This demonstrates a lack of moral imagination or unreflective and entrenched authoritarianism inconsistent with the best traditions of liberal democracy.