

**Written evidence submitted by Mr Alex Greenwich (Member for Sydney at NSW Legislative Assembly)  
(ADY0229)**

Introduction

My name is Alex Greenwich MP and I am the independent Member for Sydney. I have sat in the New South Wales Legislative Assembly since 2012.

On 14 October 2021, I introduced the Voluntary Assisted Dying Bill 2021 to the Legislative Assembly. It had 28 co-sponsors from across both houses - the greatest number of co-sponsors ever achieved in Australia for a piece of legislation. The major parties granted members a conscience vote on the bill.

The bill passed the Legislative Assembly with some minor amendments on 26 November 2021. It was then introduced in the Legislative Council by the Honourable Adam Searle MLC where it was referred to the Legislative Council's Standing Committee on Law and Justice for an inquiry before being referred back to the Legislative Council. The Legislative Council approved the bill with minor amendments on 19 May 2022 and the bill was returned to the Legislative Assembly and passed that day. It was given Royal assent on 27 May 2022.

We are currently eight months into the 18-month implementation process, with our law set to take effect on 26 November 2023.

Approach

My bill was prepared in consultation with experts, academics, frontline workers, health practitioners, community members including people with a terminal illness, or family members of someone who died a bad death, and participants in the Victorian scheme. I assessed legislative processes in other Australian states and international jurisdictions. I will share how our law works.

Context

Before my bill passed, three similar bills had been introduced and defeated in the NSW Parliament, including a 2017 bill that I co-sponsored.

My strong support for reform arose from listening to constituents with desperately sad situations, looking for help. The stories were heartbreaking and highlighted the ludicrousness of refusing to let people experiencing appalling suffering that could not be relieved, whose death was imminent and inevitable, get medical help to end their life peacefully with their family by their side.

Over many years, Australian and New South Wales polls consistently showed strong and growing support for voluntary assisted dying laws. When I introduced the bill, support had grown to around 80 percent and crossed party voting lines. Almost everyone I spoke to knew someone who had been affected by a terminal illness and who had suffered because of the state's failure to legislate.

## Why legislate?

Among the compelling reasons to grant choice to people at the end-of-life, there is also the high rate of death among people who are terminally ill.

Data from the National Coronial Information System shows that in New South Wales at least 20 per cent of suicides in people over 40 are associated with a terminal illness. That accounts for over 10 per cent of all suicides. Hardworking police, paramedics and health workers on the front line do not find those statistics surprising. They regularly attend call-outs where there have been suicides and suicide attempts by people who are terminally ill. That's why the Australian Paramedics Association, the Police Association, the Health Services Union and the NSW Nurses and Midwives' Association strongly supported my bill.

A modern, advanced healthcare system should not leave anyone to feel that their only options are either a slow, cruel, agonising death or a violent and lonely suicide.

## New South Wales Voluntary Assisted Dying Bill

In summary, the Voluntary Assisted Dying Bill 2021 provides a safe framework for patients whose death is imminent and whose pain and suffering has become unbearable to get help to end that suffering.

The laws were largely based on the Western Australian model, which improved on the Victorian law. It also adopted provisions from laws in other states which were legislating while we began to draft the bill.

The Act sets out in detail the eligibility criteria to access voluntary assisted dying; the steps that a person must take before they can get access; the protections for healthcare workers, including to ensure that they can conscientiously object; the rights and responsibilities of institutions and facilities that refuse to provide voluntary assisted dying services; the eligibility criteria of other persons involved in the process such as doctors, nurses and witnesses; the make-up of a Voluntary Assisted Dying Board; the option to request a review through the Supreme Court; offences; and requirements to review the legislation.

To be eligible to receive voluntary assisted dying, a patient must be at least 18 years of age and an Australian citizen, permanent resident, or have been living in Australia for at least three continuous years and ordinarily reside in New South Wales. A patient must be diagnosed with at least one disease, illness or medical condition that is advanced, progressive and that, on the balance of probabilities, will cause death within six months or, in the case of a neurodegenerative disease, within 12 months. The disease, illness or medical condition must cause suffering to the patient in a way that cannot be tolerably relieved. Importantly, the patient must have decision-making capacity to make a voluntary assisted dying decision. In seeking assistance, the patient must be acting voluntarily and without any pressure or duress. Pressure or duress includes coercion, intimidation, threats and undue influence.

The bill requires a patient's request for voluntary assisted dying to be enduring. It sets out in detail each step that a patient must take before they can access voluntary assisted dying, from the first request to disposing of any unused substance. Each step must be recorded in specific forms that are sent to the Voluntary Assisted Dying Board. The process is entirely voluntary. There is no obligation on a patient to continue and the patient is told multiple times throughout the process that they can withdraw at any time. The first step is for the patient to make a first request to a doctor. The doctor must either accept or refuse the request. A doctor can refuse because they have a conscientious objection to voluntary assisted dying, or are unwilling or unable to perform the duties of a coordinating practitioner.

To be eligible to act as a coordinating practitioner, a doctor must be highly experienced. They must either be a specialist, an overseas-trained specialist or a practitioner with general registration who has practised for at least 10 years. The doctor must have completed training approved by the Secretary of NSW Health, which will cover eligibility criteria and how to identify risk factors for pressure or duress. If the doctor accepts the first request, they become the coordinating practitioner. The coordinating practitioner must then conduct a first assessment of a patient against each eligibility criteria. That covers residency, diagnosis, prognosis, decision-making capacity, whether the request is voluntary and without pressure or duress, and whether the request is enduring.

The bill makes it absolutely clear that if a coordinating practitioner is uncertain about whether a patient has a disease, illness or medical condition that complies with the requirements, they must refer the patient to a medical practitioner who is qualified to make that decision such as an oncologist or a neurologist. Similarly, if a coordinating practitioner is uncertain about whether a patient has decision-making capacity for a voluntary assisted dying decision, or whether the person could be subject to pressure or duress, they must refer the person to a registered health practitioner who is qualified to make that decision, such as a psychiatrist or a geriatrician. In the case of pressure or duress, if appropriate a patient can be referred to a person who is not a registered health practitioner provided they have the skills to make an assessment—an example could be a social worker.

If the coordinating practitioner determines after the first assessment that the patient meets the eligibility criteria, they must provide the patient with extensive information about their diagnosis, prognosis, treatment and palliative care options, and the process going forward if the patient chooses to continue. The coordinating practitioner must tell the patient that they may decide at any time not to continue further. The coordinating practitioner must then refer the patient to another doctor for an independent assessment. However, if the coordinating practitioner is not satisfied that the patient meets any criteria then they must assess the patient as ineligible and the process ends.

The doctor who receives a referral of a patient assessed as eligible in the first assessment can accept or refuse the referral. A doctor can refuse a referral because they have a conscientious objection to voluntary assisted dying, or because they are unwilling or unable to perform the duties of a consulting practitioner. They must refuse the referral if they are not eligible to act as a consulting practitioner. The eligibility criteria for a consulting practitioner is the same as the coordinating practitioner. If the doctor accepts the referral they become the consulting practitioner and must independently assess the patient against each eligibility criterion. The mandatory obligations on the consulting practitioner to refer a patient, if they are uncertain about a particular eligibility criteria, reflect those of the coordinating practitioner in the first assessment.

If the consulting practitioner is not satisfied that the patient meets any criterion then they must assess the patient as ineligible. If the consulting practitioner assesses the patient as eligible, they must provide the patient with the same information required of the coordinating practitioner after the first assessment to ensure that the patient is kept informed about their medical situation and the outcomes of their decisions throughout the process. Importantly, the patient is told again that they are under no obligation to proceed with the process.

Patients assessed as eligible in this rigorous process who choose to proceed with their application must then make a written declaration. The written declaration involves making a request for access to voluntary assisted dying in writing, which declares that the request is voluntary and without pressure or duress, and that the patient understands the nature and effect of voluntary assisted dying. The patient is required to sign their written declaration in front of two witnesses. Each witness must certify in the declaration that in their presence the patient appeared to freely and voluntarily sign the declaration.

After the patient has given the written declaration to their coordinating practitioner they must make a final request to the coordinating practitioner. The final request cannot be made earlier than five days after the first request was made. However, if both the coordinating practitioner and consulting practitioner agree that the patient is likely to die or lose decision-making capacity within that period, the final request can be made earlier. The coordinating practitioner must then conduct a final review of all assessment forms and certify that the assessment process has been complete and that the patient has decision-making capacity, is acting voluntarily and not because of pressure or duress, and that their request for voluntary assisted dying is enduring.

The coordinating practitioner must then request an authorisation to prescribe a substance from the Voluntary Assisted Dying Board. The board can refuse the authorisation if it suspects that the eligibility requirements have not been met. Before issuing a prescription, the coordinating practitioner must provide the patient information on the substance, including how the substance is to be administered, stored and prepared; the expected effects and risks of taking the substance; and the period after taking the substance when the patient is expected to die. The patient must be told at this time that they are under no obligation to proceed. The coordinating practitioner can then prescribe a substance to assist the patient to die. The prescription is sent directly to an authorised supplier.

The patient will need to make an administrative decision on whether they would like to self-administer the voluntary assisted dying substance or have a health practitioner administer the substance for them. A patient who chooses to self-administer must appoint a contact person to be responsible for returning any unused substance to an authorised disposer and informing the coordinating practitioner if the patient dies. Where a patient has chosen to self-administer the substance, the substance can be supplied to the patient, their agent or the contact person and it must be stored in a locked box at all times. Where a patient has chosen to have the substance administered by a health practitioner the substance is supplied directly to the administering practitioner.

The administering practitioner is likely to be the coordinating practitioner; however, they can also be a specialist, an overseas trained specialist, a practitioner with general registration who has practised for at least five years, a nurse practitioner or a registered nurse who has practised for at least five years. They must have completed the Health Secretary's training. The administering practitioner must administer the substance in front of an independent witness who will need to certify to the board that the patient's request for access appeared to be free, voluntary and enduring.

The bill enshrines the power for facilities such as aged care and nursing homes, or hospitals not to provide voluntary assisted dying services, while setting out responsibilities towards patients and residents, depending on whether the facility is residential or a hospital. Residential facilities have greater responsibilities towards residents because they are people's homes and nobody should be denied a legal medical option in their home because of the views held by management, especially given choice in residential care is often limited. Residential facilities that do not provide voluntary assisted dying services are required to let doctors and other participants attend the premises to provide voluntary assisted dying services. Those in residential facilities seeking voluntary assisted dying are told to inform their residential facility. Hospitals referred to as "health care establishments" in the Act are only required to help transfer patients to and from the hospital to access voluntary assisted dying services elsewhere. There is no obligation on a hospital to allow external doctors on site.

The Voluntary Assisted Dying Board plays an important oversight role. It collects and publishes data; provides advice, information and reports to the Minister and the Health Secretary; and refers matters, for

example to the police or Coroner. The board is responsible for determining applications to prescribe a voluntary assisted dying substance and for sending information to the patient's contact person to ensure that they know how to comply with obligations. The board is made up of five members jointly appointed by the Minister for Health and the Attorney General. The chairperson and the deputy chairperson will be required to have minimum specified practical legal experience.

The bill creates a comprehensive set of offences to protect against any misuse of voluntary assisted dying. These will act in addition to the safeguards that are built into the very robust statutory process. A new offence for administering a prescribed substance to another person outside of the provisions of the bill will incur a maximum penalty of life imprisonment, as does the new offence for inducing someone to take a prescribed substance. Inducing someone to apply for voluntary assisted dying attracts a maximum of seven years' imprisonment. Advertising of schedule 4 or 8 poisons as voluntary assisted dying substances attracts a maximum penalty of three years' imprisonment. A contact person who fails to return any unused substance that remains after a person dies will be subject to a maximum penalty of 12 months' imprisonment. There are offences to protect people's privacy.

The Act provides for the introduction of a care navigator service. All states have established these, which provide a point of contact for patients, the community, health practitioners, health services and residential facilities. Care navigators provide general information and connect people with medical practitioners who provide services.

The legislation is subject to regular review every five years after an initial review that must commence two years after the provisions come into force. Reviews will look at the operations and effectiveness of the laws as well as access issues in regional areas or challenges associated with language and culture.

#### A note on palliative care

New South Wales has one of the best palliative care systems in the world, receiving \$743m additional funding as a result of voluntary assisted dying legislation. Equitable access to palliative care is also one of the objects to the bill and I hope the law will increase demand for palliative care as more people discuss their end-of-life options with doctors. However, the best palliative care cannot alleviate all end-of-life suffering for all people.

Evidence suggests that palliative care cannot effectively control 10 to 20 percent of end-of-life symptoms. The 2016 Palliative Care Outcomes Collaboration report found that four percent of terminal patients had severe pain and 6.5 percent had other severe physical symptoms. A majority of doctors surveyed by the Australian Medical Association in 2016 reported treating patients who palliative care could not help.

Palliative care and voluntary assisted dying laws do not compete but can complement one another.

#### Conclusion

The process to legislate voluntary assisted dying laws was an overwhelmingly positive experience for members of the NSW Parliament. Members worked collaboratively across the political divide, including supporters and opponents of the bill to ensure laws were safe and accessible, and there was a strong sense that the process brought members closer together. Members found new opportunities to connect with and hear from their constituents in a meaningful way. The positive response from media, including from traditionally conservative media, was also affirming.

Ultimately, the most rewarding aspect was the gratitude and relief expressed by people who were facing a terminal illness or who had seen a loved one die a bad death. They had shared very personal and intimate stories and felt that their representatives showed compassion and competence in legislating a voluntary assisted dying framework. This is what members of parliament are elected to do.

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