VOLUNTARY ASSISTED DYING:
A GAGGING CLAUSE THAT UNDERMINES RESPECT FOR AUTONOMY AND THE DOCTOR-PATIENT RELATIONSHIP

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ABSTRACT

Voluntary assisted dying has long been a controversial topic. Nevertheless, Victoria and Western Australia became one of the first states in Australia to legislate and permit voluntary assisted dying. With the new voluntary assisted dying laws coming into effect, the debate becomes less focused on whether such laws are morally right or wrong to justify legalisation but on which legislative framework is better. The voluntary assisted dying laws clearly outlines stringent requirements for a person to access voluntary assisted dying. However, one particular provision dictates when doctors can and cannot disclose voluntary assisted dying information to a person, which can affect a person's ability to access voluntary assisted dying ('the prohibition provision'). There is currently no judicial decision or commentary on the scope and application of the prohibition provision. Therefore, this Thesis will examine and determine the scope and application of the prohibition provision.

The Victorian and Western Australian prohibition provision model differs from one another. There is no literature that thoroughly examines the differences between the two prohibition provisions, nor is there empirical data to indicate which model operates better in medical practice. This Thesis will adopt a comparative approach against a framework drawn upon the concepts of autonomy and the doctor-patient relationship. Those concepts will be solidified through the Australian common law, the Medical Code, and the voluntary assisted dying legislation. Overall, this Thesis will conclude that the Victorian model undermines respect for autonomy and the doctor-patient relationship. In contrast, the Western Australian model supports respect for autonomy and the doctor-patient relationship.

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To my dearest mother,

Mẹ,
Cảm ơn cho tất cả sự hy sinh của mẹ.
Nếu không có mẹ, con không có thể đạt được những thành công của con.
Con hy vọng là con đã làm cho mẹ tự hào.
Con thương mẹ nhiều lắm.

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I INTRODUCTION

In 1995, the Northern Territory became the first jurisdiction in the world to have operative legislation that permitted a terminally ill patient to end their life by enacting the *Rights of the Terminally Ill Act 1995* (NT).[1] However, the Northern Territory Act lived a short life span. In less than two years after its enactment, the Commonwealth Government passed the *Euthanasia Laws Act 1997* (Cth) that deprived the Territories of their power to legislate voluntary assisted dying laws.[2] There were then numerous failed attempts to legislate voluntary assisted dying ('VAD') laws. A study on VAD law reform documented 51 bills, up until the end of 2015, that introduced at the Commonwealth, state, and territory levels, dealing with the issue of VAD.[3]

Nonetheless, Victoria became the first state to legislate VAD laws which came into effect on 19 June 2019.[4] Then Western Australia became the second state to legalise VAD, and its VAD legislation commenced on 1 July 2021.[5] Moreover, this year became a significant year for VAD laws in other states. The Tasmanian Parliament passed their VAD laws on 22 April 2021,[6] South Australia on 24 June 2021,[7] and more recently Queensland on 16 September 2021.[8] The only state that remains to pass VAD laws is New South Wales.

A *Scope and Terminology of the Thesis*

At the initial research phase of this Thesis, Victoria and WA were the only states that passed VAD laws. It will be some time until the VAD laws will come into effect in Tasmania, South Australia, and Queensland. Therefore, in this Thesis, all subsequent references to the Voluntary Assisted Dying Acts are limited to Victoria and WA.

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[1] Lorana Bartels and Margaret Otlowski, 'A right to die? Euthanasia and the law in Australia' (2010) 17(4) *Journal of Law and Medicine* 532, 540.

[2] Kerstin Braun, 'Voluntary Assisted Dying and the Merits of Offence-specific Prosecutorial Guidelines in Australia' (2021) 45(2) *Criminal Law Journal* 81.

[3] Ben White, et al, '(Failed) Voluntary euthanasia law reform in Australia: two decades of trends, models and politics' (2016) 39(1) *University of New South Wales Law Journal* 46; Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42 *Australian Health Review* 616.

[4] *Voluntary Assisted Dying Act 2019* (Vic) ('*Victorian VAD Act*').

[5] *Voluntary Assisted Dying Act 2019* (WA) ('*Western Australian VAD Act*').

[6] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ('*Tasmanian VAD Act*').

[7] *Voluntary Assisted Dying Act 2021* (SA) ('*South Australian VAD Act*').

[8] *Voluntary Assisted Dying Bill 2021* (QLD) ('*Queensland VAD Bill*').

To some extent, the VAD Acts mirror each other. For instance, the VAD Acts have incorporated the same stringent eligibility criteria that enables a person to access VAD. This Thesis will focus on one particular provision that differentiates the two VAD Acts. That particular provision dictates when doctors can and cannot disclose VAD information.[9] The Thesis will describe this particular provision as the "prohibition provision" on the basis that it prohibits doctors from engaging specific dialogue. The difference between the two states' prohibition provision affects can affect a person's ability to access VAD.

The terminology used in the VAD Acts relating to the prohibition provision varies. The WA VAD Act has used the term 'health care worker', where it has been defined as 'a registered health practitioner'.[10] Whereas the Victorian VAD Act has simply used 'a registered health practitioner'.[11] The Thesis will solely adopt the term 'registered health practitioner'. Moreover, the Thesis will use the term 'doctor' and 'medical practitioner' interchangeably.

B *Significance, Contribution, and Methodology*

The VAD Acts are relatively new. As a result, there is a limited body of relevant and available literature, especially relating to the prohibition provision. The literature that does comment on the prohibition provision predominately considers the Victorian model. The commentary includes the ethical difficulties and potential benefits of the Victorian model,[12] comparing the Victorian model to other European jurisdictions,[13] or mentions the differences of the WA model in passing.[14] The Thesis will draw upon the concepts of autonomy and the doctor-patient relationship, and solidifying those concepts through the Australian common law, *Good Medical Practice: A Code of Conduct for Doctors* ('Medical Code'),[15] and the VAD Acts. The framework to compare the Victorian and WA prohibition provisions will be

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[9] *Victorian VAD Act* (n 4) s 8; *Western Australian VAD Act* (n 5) s 10.

[10] *Western Australian VAD Act* (n 5) s 10(1).

[11] *Victorian VAD Act* (n 4) s 8.

[12] Hugh Platt, 'The Voluntary Assisted Dying Law in Victoria – A Good First Step But Many Problems Remain' (2020) 27(3) *Journal of Law and Medicine* 535, 538-540;

[13] Carolyn Johnston and James Cameron, 'Discussing Voluntary Assisted Dying' (2018) 26 *Journal of Law and Medicine* 454, 456 ('*Discussing Voluntary Assisted Dying*').

[14] Lindy Wilmott, et al, 'Participating doctors' perspective on the regulation of voluntary assisted dying in Victoria: a qualitative study' (2021) 215(3) *Medical Journal of Australia* 125, 127.

[15] Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors* (at October 2020) ('Medical Code') <https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2f30051&dbid=AP&chksum=9BSTs75R4%2fcPJY7vrmzHPg%3d%3d>.

the defined parameters of autonomy and the doctor-patient relationship. The Thesis will argue and conclude that the WA prohibition provision model is better.

C *The Structure of this Thesis*

This Thesis is made up of three substantive Chapters. Chapter II will outline the two key features that are similar in the VAD Acts; that is, the eligibility criteria for a person to access VAD, and the VAD procedural framework. Subsequently, the Chapter turns to the prohibition provisions that sets the VAD Acts apart and then determine its scope and application. Chapter III explores the concepts autonomy and the doctor-patient relationship and seek to narrow the scope of its definition through the Australian common law, Medical Code and VAD Acts. Chapter IV will critically analyse and compare the two different provisions under the set of defined parameters in Chapter III and evaluate which of the two models are better. Chapter IV will conclude that the WA model is better in comparison to the Victorian model on the basis that WA model aligns with the principle of autonomy and the doctor-patient relationship.

II LEGISLATIVE FRAMEWORK OF THE VAD ACTS

Before analysing and comparing the Victorian and Western Australian Voluntary Assisted Dying Acts (‘the VAD Acts’), it is first prudent to understand some fundamental mechanics and aspects of the VAD Acts. This Chapter will provide an overview of the strict requirements of the eligibility criteria, the procedural framework of accessing VAD, and the key difference of the prohibition provision between the VAD Acts. The discussion of these aspects has been selected because it has elements of autonomy and the doctor-patient relationship. However, more importantly, the difference in the prohibition provision has the most significant impact on autonomy and the doctor-patient relationship.

A *Eligibility Criteria*

The eligibility is a critical aspect that determines whether a person can access VAD. The VAD Acts only permits Australian citizens or permanent resident adults to be eligible for VAD[16] and must be ordinarily resident in the VAD Acts’ respective State for at least 12 months.[17] In addition to the demographic requirements:

(1) the person must be either diagnosed with a disease, illness or medical condition that is incurable, advanced, progressive and will cause death within six months,[18] or, the person must be diagnosed with a disease, illness or medical condition that is neurodegenerative and will cause death within 12 months;[19]
(2) the person must have decision-making capacity in relation to VAD;[20]
(3) the person must be suffering in a way that cannot be relieved in a manner that the person considers tolerable;[21]
(4) the person must be acting voluntarily and without coercion;[22] and
(5) the person’s request for access to VAD is enduring.[23]

As illustrated, the Acts have set unambiguous eligibility criteria—an aspect that medical practitioners will not have any difficulties in determining whether a person will be eligible to access VAD.

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[16] *Victorian VAD Act* (n 4) ss 9(1)(a), (b)(i); *Western Australian VAD Act* (n 5) ss 16(1)(a), (1)(b).
[17] *Victorian VAD Act* (n 4) ss 9(1)(b)(ii)-(iii); *Western Australian VAD Act* (n 5) s 16(1)(b).
[18] *Victorian VAD Act* (n 4) ss 9(1)(d)(i)-(iii); *Western Australian VAD Act* (n 5) ss 16(1)(c)(i)-(ii).
[19] *Victorian VAD Act* (n 4) s 9(4); *Western Australian VAD Act* (n 5) ss 16(1)(c)(i)-(ii).
[20] *Victorian VAD Act* (n 4) s 9(1)(c); *Western Australian VAD Act* (n 5) s 16(d).
[21] *Victorian VAD Act* (n 4) s 9(1)(d)(iv); *Western Australian VAD Act* (n 5) s 16(1)(c)(iii).
[22] *Victorian VAD Act* (n 4) s 20(1)(c); *Western Australian VAD Act* (n 5) s 16(1)(e).
[23] *Victorian VAD Act* (n 4) s 20(1)(c); *Western Australian VAD Act* (n 5) s 16(1)(f)

B *VAD Procedural Framework*

In the VAD processes, there are two medical practitioners with different roles and functions involved. The professional requirements for a medical practitioner to participate in the VAD process differ in each State.[24] While acknowledging the States' different professional requirements, this Chapter will only engage in a brief outline of the different functions and roles of the medical practitioners. This aims to provide a contextual understanding of the terminology and identify the medical participants at any given stage in the VAD process.

The VAD Acts have a mandatory requirement that both a coordinating and a consulting medical practitioner participate in a patient's request to access VAD.[25] The medical practitioners must be registered under their respective Health Practitioner Regulation National Law[26] and be practicing in the medical profession.[27] A coordinating medical practitioner, for the patient, is a medical practitioner who accepts the patient's first request; or becomes the coordinating practitioner for the patient by transferring from the role of the consulting medical practitioner.[28] The consulting medical practitioner, for the patient, is a medical practitioner who accepts a referral to conduct the patient's consulting assessment.[29] Turning to the VAD procedural framework, it can be understood as seven core steps that consist of (1) the first request; (2) the first assessment; (3) the consulting assessment (second assessment); (4) the written declaration (second request); (5) the final request; (6) the review and (7) the VAD substance administration.[30]

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[24] See *Victorian VAD Act* (n 4) ss 10(1)-(3), *Western Australian VAD Act* ss 18(1), (2)(a) and Department of Health of Western Australia, 'providing voluntary assisted dying in Western Australia', *Health Professional participation* (Information sheet) 3 <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Health-Professional-Participation.pdf> for the difference in the professional requirements in each state.

[25] *Victorian VAD Act* (n 4) ss 10-44; *Western Australian VAD Act* (n 5) ss 17-53.

[26] *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 196(1*)* ('Western Australian National Health Law')*; Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) s 196(2) ('Victorian National Health Law').

[27] *Victorian VAD Act* (n 4) s 3; *Western Australian VAD Act* (n 5) s 5.

[28] *Victorian VAD Act* (n 4) s 3; *Western Australian VAD Act* (n 5) s 5.

[29] Ibid.

[30] See Government of Western Australia, Department of Health, *High-level Process Diagram* (at 21 May 2021) <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Voluntary-Assisted-Dying-Act-2019-process-summary.pdf> for a high-level summary of the VAD process.

1 *The first request*

The initial step for a person to access VAD is to make the first request to a registered medical practitioner.[31] The person may make the request verbally, or by gestures or by any other communication methods available to them.[32] The person's first request must be clear and unambiguous and made by the person personally.[33]

Once the person has made the first request, the registered medical practitioner may accept or refuse the first request and must inform the person of that decision.[34] The medical practitioner's right to refuse participation in the VAD process is discussed in section 6 of this part of the Chapter below. As to the consequences of a medical practitioner refusing to participate, that will be discussed in Chapter IV with reference to a medical practitioner having a long-standing and non-existent relationship with a patient.

Regardless of the registered medical practitioners' decision, once the person has made the first request, the VAD Acts refers to the person as a patient. Therefore, from this point of the Thesis, the term 'patient' will be used to describe the person interacting with a health practitioner, and the term 'person' will be used to describe an ordinary person. In circumstances where the registered medical practitioner has accepted the first request, they must record the first request and the acceptance decision in the patient's medical record.[35] The registered medical practitioner then becomes the coordinating medical practitioner for the patient.[36] After the registered medical practitioner has become the coordinating medical practitioner, they must complete an approved assessment training (if not having done so).[37] Once the coordinating medical practitioner is qualified, they can commence the first assessment in determining whether the patient meets the eligibility criteria.[38]

2 *The first assessment*

During the first assessment process, if the coordinating medical practitioner has difficulty determining whether the patient satisfies one of the eligibility criteria, they must refer the

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[31] *Victorian VAD Act* (n 4) s 11(1); *Western Australian VAD Act* (n 5) s 18(1).
[32] *Victorian VAD Act* (n 4) s 11(3); *Western Australian VAD Act* (n 5) s 18(3).
[33] *Victorian VAD Act* (n 4) s 11(2); *Western Australian VAD Act* (n 5) s 18(2).
[34] *Victorian VAD Act* (n 4) s 13; *Western Australian VAD Act* (n 5) s 20.
[35] *Victorian VAD Act* (n 4) s 14; *Western Australian VAD Act* (n 5) s 21.
[36] *Victorian VAD Act* (n 4) s 15; *Western Australian VAD Act* (n 5) s 23.
[37] *Victorian VAD Act* (n 4) s 17; *Western Australian VAD Act* (n 5) s 25.
[38] *Victorian VAD Act* (n 4) s 16; *Western Australian VAD Act* (n 5) s 24(1).

patient for a second opinion.[39] However, each State operates under a different referral system. In Victoria, the referral must direct the patient to a specialist for their opinion.[40] For example, in cases of mental illness, the Victorian VAD Act explicitly requires the opinion of a psychiatrist.[41] Once a specialist (e.g. psychiatrist) has provided their second opinion, the coordinating medical practitioner may adopt the determination of those specialists.[42] However, the Victorian VAD Act mandates that the coordinating medical practitioner adopt the specialist's determination vis-à-vis medical conditions that are neurodegenerative.[43]

Whereas the WA VAD Act does not mandate that a second opinion be sought from a specific specialist but must refer the patient to a registered health practitioner 'who has appropriate skills and training to make a determination'.[44] The WA Ministerial Panel identified that incorporating a specialist in the Western Australian Act may cause a delay to the process[45] and unreasonably restrict access to VAD,[46] especially when a specific specialist may not be readily accessible to those rural and remote communities.[47] Therefore, the Western Australian Ministerial Panel recommended against the requirement of a specialist during the referral process.[48] In cases of mental illnesses, the Western Australian Ministerial Panel was of the opinion that a general practitioner with the relevant information is capable of assessing decision-making capacity[49] and may include a report from a specialist.[50]

Under both VAD Acts, once the coordinating medical practitioner is satisfied that the patient meets the eligibility criteria, the coordinating medical practitioner must inform the patient about specific matters. These specific matters are outlined in section 19 of the Victorian VAD Act or section 27 of the Western Australian VAD Act. These matters include, inter alia, the patient's diagnosis and prognosis,[51] and the treatment options available to the patient and the

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[39] *Victorian VAD Act* (n 4) s 18; *Western Australian VAD Act* (n 5) s 26.
[40] *Victorian VAD Act* (n 4) s 18.
[41] Ibid.
[42] Ibid s 18(3).
[43] Ibid ss 18(4), (6).
[44] Ibid s 26(2)-(3).
[45] Western Australian Government, *Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, 2019) 23 ('Western Australian Ministerial Final Report'); Royal Australian and New Zealand College of Psychiatrist (WA Branch), Submission to Joint Select Committee, *End of Life Choices* (18 October 2017).
[46] Western Australian Ministerial Final Report (n 45) xii.
[47] Western Australian Ministerial Final Report (n 45) 23.
[48] Western Australian Ministerial Final Report (n 45) xii.
[49] Western Australian Ministerial Final Report (n 45) 23; Medical Insurance Group of Australia, Submission to Ministerial Expert Panel, *My Life, My Choice* (2019) ('My Life, My Choice').
[50] Western Australian Ministerial Final Report (n 45) 23.
[51] *Victorian VAD Act* s 19(1)(a); *Western Australian VAD Act* s 27(1)(a).

likely outcomes of that treatment.[52] The coordinating medical practitioner must then notify the patient of the outcome of the first assessment.[53] After that notification, the coordinating medical practitioner must complete the first assessment report form and give a copy of that form to their respective State's VAD Board.[54] Finally, the coordinating medical practitioner must refer the patient to a consulting medical practitioner for a second assessment (the consulting assessment).[55]

3 *The second assessment (consulting assessment)*

The second assessment process is essentially a repeat of the first assessment with the consulting medical practitioner.[56] The consulting medical practitioner may accept the referral from the coordinating medical practitioner.[57] The Acts mandates that the consulting medical practitioner complete an approved assessment training before commencing the consulting assessment.[58] The consulting medical practitioner then determines whether the patient meets the eligibility criteria.[59] In circumstances where the consulting medical practitioner cannot determine whether the patient meets one of the eligibility criteria, then the consulting medical practitioner must refer the patient according to their respective State's referral system as described above.[60] The consulting medical practitioner may adopt the opinion and determination from that referral.[61] Once the consulting medical practitioner is satisfied that the patient meets the eligibility criteria, the consulting medical practitioner must inform the patient of specific matters outlined in section 28 of the Victorian Act or section 38 of the WA Act. Subsequently, the consulting medical practitioner must notify the patient of the outcome,[62] complete the consulting assessment report, and give a copy to their respective State's VAD Board and the patient's medical practitioner.[63]

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[52] *Victorian VAD Act* s 19(1)(b); *Western Australian VAD Act* s 27(1)(b).
[53] *Victorian VAD Act* s 21(1); *Western Australian VAD Act* s 28(1).
[54] *Victorian VAD Act* ss 3, 21(2), 92; *Western Australian VAD Act* ss 22(1), 29.
[55] *Victorian VAD Act* s 22; *Western Australian VAD Act* s 30.
[56] *Victorian VAD Act* Div 4; *Western Australian VAD Act* Div 4.
[57] *Victorian VAD Act* s 23; *Western Australian VAD Act* s 31.
[58] *Victorian VAD Act* s 25; *Western Australian VAD Act* s 36.
[59] *Victorian VAD Act* s 25; *Western Australian VAD Act* s 35.
[60] *Victorian VAD Act* s 27; *Western Australian VAD Act* s 37.
[61] Ibid.
[62] *Victorian VAD Act* s 29; *Western Australian VAD Act* s 39.
[63] *Victorian VAD Act* s 30; *Western Australian VAD Act* s 40.

4 *The written declaration (second request), final request and review*

The second request is in the form of a written declaration outlining their request to access VAD.[64] A second request is an option that the patient may choose to exercise. The patient must duly execute and abide by the VAD Acts requirements relating to the second request's written declaration.[65] Otherwise, the patient must make a final request to access VAD to their coordinating medical practitioner.[66] Upon receipt of the final request, the coordinating medical practitioner must review the following documents ('Final Review Documents'):[67]

(1) the first assessment report form;

(2) all consulting assessment report forms;

(3) the written declaration; and

(4) the contact person appointment form.

Furthermore, the coordinating medical practitioner must complete the final review form and certify whether the request and assessment process had been completed as required by the VAD Acts.[68] The coordinating practitioner must notify their respective State's VAD Board that the request and assessment process has been completed.[69] If there are any minor or technical errors in any of the Final Review Documents, it does not invalidate the patient's request to access VAD and the assessment process.[70]

5 *VAD substance administration*

Before the patient ingests the drug that will cause their death, the final step is to determine whether the VAD substance is self-administered or practitioner-administered. The only circumstances, in both jurisdictions, where practitioner administration is permitted is if the patient cannot self-administrate,[71] such as being physically incapable of doing so.[72] The process at this stage differs in each State. In Victoria, the patient must apply for a self-administration or practitioner administration permit to the Secretary of the Department of

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[64] *Victorian VAD Act* s 34(1); *Western Australian VAD Act* s 42(1).

[65] *Victorian VAD Act* ss 34-36; *Western Australian VAD Act* s 42-44.

[66] *Victorian VAD Act* ss 37-38; *Western Australian VAD Act* ss 47-48.

[67] *Victorian VAD Act* s 41(1)(a); *Western Australian VAD Act* s 51.

[68] *Victorian VAD Act* s 41(1); *Western Australian VAD Act* s 51.

[69] *Victorian VAD Act* s 41(2); *Western Australian VAD Act* s 51(4).

[70] *Victorian VAD Act* s 42; *Western Australian VAD Act* s 52.

[71] *Victorian VAD Act* s 48(3); *Western Australian VAD Act* s 56(2).

[72] *Victorian VAD Act* s 48(3)(a); *Western Australian VAD Act* s 56(2)(a).

Health and Human Services.[73] The Secretary must then notify the Victorian VAD Board of their decision to grant the permit.[74]

The WA Act does not require such an application for a permit. The patient's decision for self-administration or practitioner administration of the VAD substance is made in consultation with the coordinating medical practitioner.[75] Once the administration decision has been made, the coordinating practitioner must record that decision in the patient's medical records[76] and prescribe a sufficient dose for the VAD substance to cause death for the patient.[77] The coordinating medical practitioner must then notify and provide the Western Australian VAD Board with a copy of the administration decision and prescription form.[78] Finally, once all the procedural steps are completed in accordance with the legislative requirements, the patient is free to ingest the drug.

6 *Continued participation in the VAD process*

The outline of the VAD framework indicates that each of the medical practitioners and the patient is actively involved in the process. The process can be described as a collaborative effort between the patient and medical practitioner to progress the VAD procedure. For example, the patient leads and progresses the process by making the first request and further requests in light of the medical practitioners' information on specific matters.[79] Similarly, the medical practitioners lead and progress the process by assessing the patient's eligibility, making referrals, and informing the patients about specific matters required by the VAD Acts.[80] There is no stage of the VAD process where the medical practitioner decides for the patient and vice versa. If any of the medical practitioners and patients do not want to participate in the VAD process actively, the VAD Acts have provided them with some rights.

The VAD Acts state that the patient has no obligation to continue the VAD process after making the first request[81] and after the final review has been completed.[82] There are no

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[73] *Victorian VAD Act* s 45-46.
[74] Ibid s 49(4)(b).
[75] *Western Australian VAD Act* s56(1).
[76] Ibid s 56(5).
[77] Ibid ss 58(2), 59(2).
[78] Ibid s 60(1).
[79] *Victorian VAD Act* s 19(1); *Western Australian VAD Act* s 27(1).
[80] *Victorian VAD Act* s 19(1); *Western Australian VAD Act* s 27(1).
[81] *Victorian VAD Act* s 12; *Western Australian VAD Act* s 19.
[82] *Victorian VAD Act* s 44; *Western Australian VAD Act* 53.

formal requirements to terminate the patient's participation.[83] The patient can simply decide not to continue by their words or actions (for example, going home and not returning to the medical practitioner). Terminating their participation before the final review does not preclude the patient from making a new first request.[84] In the event that the patient terminates their participation after the final review, they do not need to make a new first request. However, they can choose to resume their participation at any given time after completing the final review.[85] At any time when the patient obtains, possesses, or stores the VAD substance and briefly expresses a desire not to continue with the VAD process, their expression does not completely terminate the VAD process that prevents them from taking the VAD substance. For example, suppose that a patient has obtained the VAD substance and expresses that they do not wish to take the substance until the following day or has been visited by a family member or friend. This does not terminate their participation. The patient will need to safely and securely store the VAD substance.[86] The patient may resume the VAD process on the following day, or any point in time, by retrieving and ingesting the VAD substance.

Similarly, the VAD Acts affords medical practitioners a right to refuse participation at any given stage in the VAD process by making a conscientious objection.[87] The notion of conscience is widely understood to cover, for example, the religious, moral or secular beliefs that a person holds that determines whether a particular activity is wrong.[88] A medical practitioner's right to exercise conscientious objection captures their decision to withdraw from providing services and care to a person based on their religious, moral or secular beliefs.[89] For example, a medical practitioner who values human life's sanctity may have a conscientious objection whether that value was based upon religious or secular values. Further, a medical practitioner can refuse participation if the medical practitioner believes

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[83] *Victorian VAD Act* s 12(1)-(2); *Western Australian VAD Act* s 19(1)-(2).
[84] *Victorian VAD Act* s 12(3); *Western Australian VAD Act* s 19(3).
[85] *Victorian VAD Act* s 44; *Western Australian VAD Act* s 53.
[86] *Victorian VAD Act* s 61; *Western Australian VAD Act* s 72(2)(b).
[87] *Victorian VAD Act* s 7; *Western Australian VAD Act* s 9; Medical Code (n 15) [2.4.6].
[88] Andrew Grubb, *Principles of Medical Law* (Oxford University Press, 2nd ed, 2004) 769.
[89] Andrew Lu, 'A new guidance for doctors on end of life treatment and care' (2010) 18(7) *Health Law Bulletin* 100; Australian Medical Association, *AMA Position Statement: Conscientious Objection* (2013) <https://ama.com.au/sites/default/files/documents/AMA_position_statement_on_conscientious_objection_2013.pdf>.

they cannot perform the duties of a coordinating or consulting practitioner due to unavailability.[90]

In summary, outlining the VAD procedural framework and the participation is relevant to the Thesis. Those two aspects not only illustrate the doctor-patient relationship but carries the essence of some of the VAD Acts' principles, such as respecting autonomy,[91] supporting a person to make informed decisions,[92] and be encouraged to discuss death and dying openly.[93] These links will be made expressly in Chapter IV below. However, the Acts' principles are further discussed in Chapter III in light of autonomy and the doctor-patient relationship.

C *Prohibition on Registered Health Practitioners*

The eligibility criteria determine whether a person can legally access VAD. However, the Victorian and Western Australian VAD Acts have included a general prohibition provision that registered health practitioners must not, in the course of providing health services or professional care services to a person must not, in the course of providing those services to the person, initiate discussions or substantially suggest VAD to a person.[94] This prohibition provision, to an extent, can affect a person's ability to access VAD – because some people who may be interested in accessing VAD may not be aware of an end-of-life option that is legally available to them. The only circumstances that the Acts permit a registered health practitioner to engage in VAD discussions are if the person requests information about VAD.[95]

There is, nonetheless, a notable difference between the two Acts. An extract of the Victorian and Western Australian prohibition provisions is provided below to indicate the differences. Section 8 of the Victorian VAD Act states ('Victorian prohibition provision'):

> (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person-
>
> (a) initiate discussion with that person that is in substance about voluntary assisted dying; or

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[90] *Victorian VAD Act* (n 4) ss 14(1)(b)(ii), 23(1)(b)(ii); *Western Australian VAD Act* (n 5) ss 20(2)(b), 31(2)(b).

[91] *Victorian VAD Act* (n 4) s 5(1)(b); *Western Australian VAD Act* (n 5) s 4(1)(b).

[92] *Victorian VAD Act* (n 4) s 5(1)(c); *Western Australian VAD Act* (n 5) s 4(1)(c).

[93] *Victorian VAD Act* (n 4) s 5(1)(f); *Western Australian VAD Act* (n 5) s 4(1)(f).

[94] *Victorian VAD Act* (n 4) s 8; *Western Australian VAD Act* (n 5) s 10.

[95] *Victorian VAD Act* (n 4) s 8(2); *Western Australian VAD Act* (n 5) s 10(4).

> (b) in substance, suggest voluntary assisted dying to that person.
>
> (2) Nothing in subsection (1) prevents a registered health practitioner providing information about voluntary assisted dying to a person at that person's request.

Whereas section 10 of the Western Australia VAD Act states ('Western Australian prohibition provision'):

> (2) A [registered health practitioner] who provides health services or professional care services to a person must not, in the course of providing the services to the person-
>
> (a) initiate discussion with the person that is in substance about voluntary assisted dying; or
>
> (b) in substance, suggest voluntary assisted dying to the person.
>
> (3) Nothing in subsection (2) prevents a medical practitioner or nurse practitioner from doing something referred to in subsection 2(a) or (b) if, at the time it is done, the medical practitioner or nurse practitioner also informs the person about the following-
>
> (a) the treatment options available to the person and the likely outcome of that treatment; and
>
> (b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.
>
> (4) Nothing in subsection (2) prevents a [registered health practitioner] from providing information about voluntary assisted dying to a person at the person's request.

The difference is that section 10(3) of the Western Australian prohibition provision provides an exemption to medical practitioners to disclose VAD information if they also disclose other alternative treatments and end-of-life options. This difference between the Victorian and Western Australian prohibition provisions is the subject matter of the Thesis' comparative analysis. The purpose of this section is to analyse and determine the scope of the prohibition provisions.[96] The VAD Acts have used quite a vague language in the prohibition provision, such as what constitutes initiating discussions that are in substance about VAD and when a person can be taken to have requested information about VAD.

There is limited literature surrounding the current Australian VAD laws, even more so regarding the prohibition provisions. Savulescu formed the view that it is difficult to apply

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[96] The reasoning and policy intent from the State's Parliamentary and Ministerial Panel that assisted in forming the VAD legislation will be furthered discussed in Chapter IV because it does not assisted with the present analysis.

the prohibition provision objectively.[97] By way of applying the prohibition provision in hypothetical clinical scenarios, Savulescu concluded that 'there is a significant degree of uncertainty in judging whether patients have actually introduced the topic of [VAD] sufficiently for the health practitioner to be able to discuss the specifics of the process'.[98] Moreover, White and colleagues also identified the issue with the prohibition provision. They formed the view that 'a person asking for all possible end-of-life options to inform their treatment decisions cannot be told about VAD unless they know to ask about it first and do so'.[99]

Building on Savulecu's assessment, the VAD Acts do not explain what constitutes initiating a discussion that 'is in substance' about VAD.[100] The following cases that are discussed are not VAD decisions but will support the Thesis' analysis by way of analogy. In *Perrett v Attorney-General (Cth)* ('Perrett'),[101] Dowsett J was required to interpret the meaning of the term 'the same in substance' as provided by section 48 of the *Legislative Instruments Act 2003* (Cth), where the applicants submitted that the term 'the same in substance' should be interpreted and treated in the same manner as 'substantially similar'.[102] In relation to the definition of the expression 'in substance', his Honour referred to the Oxford English Dictionary,[103] Macquarie Dictionary,[104] and the Collins Australian Dictionary.[105] When referring to the Oxford English Dictionary, his Honour found that it defined 'in substance' as meaning 'in reality', and sought its definition of 'in reality' to mean 'really, actually, in fact'. Then his Honour relevantly provided the definition of 'substantial' to mean 'relating to or proceeding from the essence of a thing'.[106]

Further, in *Pfizer Inc v Commissioner of Patents*[107] ('Pfizer') the issue before Bennett J was the construction of section 70(2)(a) in the Patents Act 1990 (Cth) regarding an application for an extension of term of a patent. Relevantly, section 70(2)(a) provides that at least one or

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[97] Julian Savulescu, 'The Voluntary Assisted Dying Law in Victoria – A Good First Step But Many Problems Remain' (2020) 27(3) *Journal of Law and Medicine* 535, 538.
[98] Ibid 539.
[99] Ben White, et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 440.
[100] *Discussing Voluntary Assisted Dying* (n 13) 457.
[101] *Perrett v Attorney-General (Cth)* [2015] FCA 834.
[102] Ibid [25].
[103] Ibid [23].
[104] Ibid.
[105] Ibid [26].
[106] Ibid [23].
[107] *Pfizer Inc v Commissioner of Patents* [2005] FCA 137.

more pharmaceutical substance per se must “in substance be disclosed”. In analysing the scope and application of the ‘in substance disclosed’ test, her Honour referred to a breadth of legal authorities.[108] Bennett J stated that ‘to my mind the requirement for “in substance” disclosure is a lesser requirement than for a “real and reasonably clear disclosure” or description. Section 70(2)(a) does not require express disclosure. If it did, there would be no need for the words “in substance”. It seems to me that the additional words cannot import a higher test than “real and reasonably clear disclosure”.’[109] and ultimately deciding that section 70(2)(a) does not import a higher test of disclosure.[110]

Applying the above discussion of Perrett and Pfizer to the prohibition provision, the inclusion of the term ‘in substance’ suggest that health practitioners do not need to employ the actual words ‘voluntary assisted dying’ to contravene the prohibition provision. By adopting the definition provided by Dowsett J taken from the Oxford English Dictionary, a health practitioner can contravene the prohibition provision if in fact or reality they initiated discussions about VAD to a person. Moreover, Bennett J in Pfizer determined that ‘in substance’ does not import a higher test than ‘real and reasonably clear disclosure’ and if it did, then the expression ‘in substance’ is redundant. Initiating VAD discussions with a patient is essentially disclosure of VAD to the patient, so, a health practitioner does not need to be real and reasonably clear in their discussions about VAD the patient. Therefore, initiating a discussion that is in substance about VAD is likely to encompass a health practitioner using language to allude or inform the patient about the VAD Acts’ lawful provisions, eligibility criteria, and the procedural framework to access VAD.

Further, the VAD Acts have not set parameters as to when a person has requested information about VAD. This particular subsection of the prohibition provision does not include the words ‘in substance’.[111] By not including the expression ‘in substance’ suggests that a patient’s request for VAD information must be more specific and clearly identify that they

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[108] Ibid [57]-[74].

[109] Ibid [75].

[110] Ibid [76].

[111] *Victorian VAD Act* s 8(2); *Western Australian VAD Act* s 10(4).

are seeking information about VAD. The Victorian Department of Health and Human Services, in its Guidance on the Victorian Act, states:[112]

> [Unless] a patient specifically asks about VAD, the conversations that health practitioners currently have with patients about end-of-life should not change after the VAD Act commences. Broad questions such as 'what are my options at the end of my life?' do not constitute requests for information about VAD. Requests for information must be specific and explicit.

Although the guidance provided by the Victorian Department is not a legally enforceable instrument, the commentary would assist all health practitioners to navigate the prohibition provision in practice.

Notwithstanding Western Australian's exemption for medical practitioners, it seems apparent that the prohibition provisions in the VAD Acts is quite narrow in its application. Until the parameter of the prohibition provision has been judicially tested or Parliament has clarified it, there is no certainty as to what constitutes initiating a discussion in substance about VAD and when a person can be taken to have requested information about VAD. As a result, based on the analysis above, the Thesis will assume the scope of the prohibition provision to be that when a person is requesting information about VAD, they must use clear and unambiguous language by adopting the technical language 'voluntary assisted dying' and not its synonyms such as 'euthanasia' or be given VAD information by requesting alterative end-of-life options.

Health practitioners must exercise great caution when deciding when to discuss VAD with a person or to have taken the person to request VAD information. The Victorian and Western Australian VAD Acts have a penalty for health practitioners that contravenes the general prohibition provision, and such contravention will be guilty of unprofessional conduct.[113] The potential implication of an adverse finding contravening the prohibition provision may result in, inter alia, suspension or restricted practice.[114] However, the most dire consequence for a health practitioner is if they 'by dishonesty or undue influence, induces another person to

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[112] Victorian Government Department of Health and Human Services, 'Health Practitioner information', *Voluntary assisted dying for health practitioners* (23 May 2021) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information>.

[113] *Victorian VAD Act* (n 4) s 8(3); *Western Australian VAD Act* (n 5)

[114] Western Australian National Health Law (n 26) s 196(1); Victorian National Health Law (n 26) s 196(2).

make a request for access for voluntary assisted dying'.[115] A health practitioner guilty of such an offence can face up to a penalty of up to five years' imprisonment in Victoria[116] and seven years of imprisonment in Western Australia.[117] Although the Western Australian exemption provisions provide some protection to medical and nurse practitioners, the penalties outlined in the legislation serves as a warning that all health practitioners must exercise great caution. All health practitioners must be careful when to discuss VAD with a person, and WA medical and nurse practitioners must ensure to disclosure palliative care and alternative options when initiating discussions about VAD to a person. The severity of the penalty for contravening the prohibition provision serves as a cautionary warning to all health practitioners in clinical practice.

D *Summary*

In summary, the VAD Acts have implemented strict requirements when a person can be eligible to access VAD. Further, the VAD procedural framework illustrates that the doctor-patient relationship appears to be one of a collaborative nature rather than, given at any stage, the medical practitioner or patient sit idly for a decision to be made for them to progress the process. However, this Chapter has identified the issues in applying the prohibition provisions in practice. Despite those difficulties, there is nonetheless a difference between the Victorian and Western Australian prohibition provisions. This then poses the question, which of the two prohibition provisions is better. To assess which prohibition provision is better, this Thesis proposes to understand the VAD Acts, and more specifically, the prohibition provisions through the lens of autonomy and the doctor-patient relationship. The concept of autonomy and the doctor-patient relationship will be discussed in the next Chapter.

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[115] *Victorian VAD Act* (n 4) s 85; *Western Australian VAD Act* (n 5) s 100.

[116] *Victorian VAD Act* (n 4) s 85.

[117] *Western Australian VAD Act* (n 5) s 100.

III AUTONOMY AND THE DOCTOR-PATIENT RELATIONSHIP

Chapter II outlined some of the core aspects of the Victorian and WA *Voluntary Assisted Dying Acts* ('the VAD Acts'). This Chapter explores the concept of autonomy and the doctor-patient relationship to understand the VAD Acts. To begin with, the preliminary issue of this Chapter is the definition of autonomy. Given the potential range of definitions available, autonomy will be defined as it is to be used in this Thesis. The second issue concerns what model of the doctor-patient relationship should be adopted, as it is a fundamental aspect to all healthcare systems guiding how the patient is diagnosed, treated, and cared for. Each analysis will be discussed in light of the common law, Medical Code and the VAD Acts. The conclusion of this Chapter serves particular importance because it will provide the final framework of autonomy and the doctor-patient relationship to analyse and compare the Victorian and WA prohibition provision in the next Chapter—a critical aspect of the Thesis.

A *Autonomy*

There are a variety of understandings of autonomy, even in the limited area of medical care.[118] 'Autonomy' means self-rule, derived from the Greek works *auto*, meaning self; and *nomos* meaning rule or law.[119] Autonomy is widely acknowledged to play a central role in medical law.[120] Current literature regarding bioethical debates emphasises the paramount importance of respecting personal autonomy.[121] In fact, due to the enormous advocacy for respecting personal autonomy, academics have commented that this principle is seen as 'a trump card beating all other principles'.[122] The traditional notion of personal autonomy

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[118] A specific example of psychological autonomy, see Jay Katz, *The Silent World of Doctor and Patient* (Free Press, 1984) 104. Specific examples of relationship autonomy, see J Christman, 'Relational autonomy liberal individualism and the social constitution of selves' (2004) 117(1) *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 143; Alfred Tauber, 'Sick Autonomy' (2003) 46(4) *Perspectives in Biology and Medicine* 484. A discussion on the criticism of relationship autonomy, see Natalie Stoljar, 'Informed consent and relational conceptions of autonomy' (2011) 36(4) *Journal of Medicine and Philosophy* 375.

[119] Ben White, Fiona McDonald and Lindy Willmott, *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 30.

[120] C Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Oxford, 2009) chapter 1.

[121] See Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013) ('Principles of Biomedical Ethics'); Gerald Dworkin, 'Autonomy and Behaviour Control' (1976) 6 *Hastings Center Report* 23; Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press, 1988).

[122] See Margaret Brazier, 'Do No Harm – Do Patients Have Responsibilities Too?' (2006) 65 *Cambridge Law Journal* 397, 400; Alexander McCall Smith, 'Beyond autonomy' (1997) 14 *Journal of Contemporary Health Law and Policy* 23 ('McCall Smith Beyond Autonomy'); C Foster, 'Autonomy in the medico-legal courtroom: A principle fit for purpose?' (2014) 22 *Medical Law Review* 48.

embodies a sense of individualism as first developed in John Stuart Mill's 1869 essay *On Liberty*. The idea was re-expressed by Isaiah Berlin as follows:

> I wish my life and decisions to depend on myself, not on external forces of whatever kind, I wish to be the instrument of my own, not of other men's, act of will. I wish to be a subject, not an object; to be moved by reason, by conscious purpose, which are my own, not by causes which affect me, as it were, from outside.[123]

As an example of a more contemporary understanding, Sheila McLean has noted that the law has an ongoing strong focus on the individual's decision-making capacity and their individual right to exercise decision-making.[124]

Since Berlin's expression, the notion of personal autonomy has developed to be understood and interpreted differently.[125] Mackenzie and Rogers' definition of autonomy can be seen as a deconstruction of Berlin's expression into three distinct elements. Mackenzie and Rogers argued that a person must meet three conditions necessary for autonomy: 'freedom conditions', 'competence conditions' and 'authenticity conditions'.[126] To briefly summarise Mackenzie and Rogers' definitions, the freedom conditions is the person's ability to determine their beliefs, values, goals and wants free from the threat of external factors (such as coercion and undue influence).[127] The competence conditions is the ability to make and enact decisions that express one's beliefs, values and commitments free from threats of internal factors (such as a decline in cognitive function).[128] Finally, the authenticity conditions means that a person's actions must reflect their own beliefs, values and commitments.[129] Mackenzie and Rogers make the point that if the three conditions are not fulfilled, then a person cannot be said to have chosen a course of action for themselves because others have imposed values upon them or they are not able to use their values to

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[123] Isaiah Berlin, 'Two Concepts of Liberty', in Isaiah Berlin ed Henry Hardy (eds) *Liberty* (2002, Oxford University Press) 166-217.

[124] Sheila McLean, *Autonomy, Consent and the Law* (Routledge Cavendish, 2010) ch 3, 67-97.

[125] See McCall Smith Beyond Autonomy (n 122) 30; Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (Harper Collins, 1993) 224; B Secker, 'The appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics' (1999) 24(1) *Journal of Medicine and Philosophy* 44.

[126] C Makenzie and W Rogers, 'Autonomy, vulnerability and capacity: a philosophical appraisal of the Mental Capacity Act' (2013) *International Journal of the Law in Context* 37, 42 (Mackenzie and Rogers Characteristics of Autonomy').

[127] Ibid.

[128] Ibid.

[129] Ibid 42-43.

make decisions for themselves.[130] This Thesis will now look at the expression of autonomy in law. To begin with, the common law will be considered, then turning to statute.

1 *The expression of autonomy in common law*

The expression of autonomy in the legal sphere can be found within the common law doctrine of consent. The doctrine of consent has been judicially recognised to rely on the principles of autonomy and bodily inviolability.[131] Valid consent requires that the:

(1) person has the capacity to consent;[132]
(2) person can understand the treatment in broad terms;[133]
(3) person's consent covers the act performed;[134] and
(4) the person's decision is made voluntarily.[135]

In law, the doctrine of consent can be applied in the tort of trespass and the tort of negligence. Therefore, there is value to briefly distinguish between the applications.

The general rule of the doctrine in the tort of trespass is that unless a medical practitioner obtains consent to medical treatment, then touching of a patient may constitute battery.[136] There are only limited circumstances where obtaining consent is exempted. Those exceptions are authorised by statute (including compulsory blood and urine test in motor vehicle accidents[137] and tests to determine paternity).[138] Notably, the Courts have not defined what constitutes an emergency, but rather relies on the question whether the patient's injury is life threatening, and if the procedure was necessary and not merely convenient.[139]

The doctrine of consent in the tort of negligence is derived from the medical practitioner's provision of information (duty to disclose) as to the nature and consequences of the treatment, and the risks and complications involved in the procedure.[140] A medical

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[130] Ibid.
[131] *Secretary, Department of Health and Community Services v JWS* (1992) 106 ALR 385, 391, 403 ('*Marion's case*').
[132] *Hunter and New England Area Health Services v A* [2009] NSWSC 761, [24] ('*Hunter*').
[133] *Marion's case* (n 131).
[134] *Criminal Code 1913* (WA) s 319; *Dean v Phung* [2012] NSWCA 223.
[135] *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 ('*Re T Adult*').
[136] *Marion's case* (n 131) 311 (McHugh J).
[137] *Road Traffic Act 1974* (WA), ss 66B, 66D, 66E.
[138] *Family Court Act 1997* (WA), s 195; *Family Law Act 1975* (Cth) ss 69W-69XA.
[139] *Rogers v Whitaker* (1992) 109 ALR 625, 636 ('*Rogers case*');
[140] Ibid.

practitioner has a duty to warn a patient of a material risk inherent in a proposed treatment.[141] A risk is material if:[142]

(1) a reasonable person, in the patient's position, if warned of the risk, would be likely to attach significance to it;
(2) the medical practitioner is aware that the particular patient would attach significance to it; or
(3) the medical practitioner should reasonably have been aware that the particular patient would attach significance to it.

In circumstances where there has been a breach to disclose of a material risk, a claim in negligence will not succeed unless the patient is also able to establish that, had the patient known of the relevant risk, they would not have had the treatment in question,[143] or would have taken steps which would have reduced the risk.[144]

The expression of autonomy in the legal sphere can be summarised with the words of McHugh J in the High Court case of *Secretary, Department of Health and Community Services* ('*Marion's case*').[145] His Honour said that:

> The common law respects and preserves the autonomy of adult persons of sound mind with respect to their bodies. By doing so, the common law accepts that a person has rights of control and determination in respect of his or her body which other persons must respect.[146]

This statement provides general evidential support to McLean's position that the law has an ongoing strong focus on the individual's decision-making capacity and their individual right to exercise decision-making. A doctrine of law that strongly expresses autonomy is the refusal of life-sustaining treatment in medical law ('doctrine of refusal of treatment').

The doctrine of refusal of treatment provides that an adult with the requisite capacity[147] may choose not to receive medical treatment, even if that treatment is needed to stay alive.[148] The

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[141] Ibid 634.
[142] Ibid.
[143] *Chappel v Hart* (1998) 156 ALR 517, 526 (McHugh J).
[144] Ibid .
[145] *Marion's case* (n 131).
[146] Ibid 452 (McHugh J).
[147] *Re B (Adult: Refusal of Medical Treatment*) [2002] 2 All ER 449, 472.

reasons for such refusal can be “rational, irrational, unknown or even non-existent”.[149] This doctrine has been judicially recognised to rely on the principles of autonomy and bodily inviolability,[150] and has been repeatedly described as conferring on an adult the right to choose how the adult lives their life.[151] A couple of significant cases will be discussed below to demonstrate this point and conclude that a competent adult exercising autonomy should not be interfered with.

The United Kingdom Courts have held that it is not appropriate to interfere with a person exercising autonomy simply because the decision is contrary to medical advice, not in the best interests of the adult, based on spurious reasoning or even based on no apparent reasoning.[152] Donaldson LJ in *Re T (Adult: Refusal of Medical Treatment*) (‘*Re T*’) stated ‘this right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent’.[153] This position has been cited with approval in Australian cases such as *New England Area Health Services v A*[154] and *Brightwater Care Group v Rossiter and Hunter* (‘*Brightwater*’).[155]

Brightwater is an illustration of a competent adult’s decision to withdraw life-sustaining treatment. Mr Rossiter was a quadriplegic man who depended on others for the provision of the necessaries of life by receiving nutrition and hydration through a percutaneous endoscopic gastrostomy tube.[156] Martin CJ observed that Rossiter had on many occasions ‘clearly and unequivocally indicated’ that he wished to die but that he lacked ‘the physical capacity to bring about his own death’.[157] The Western Australia Supreme Court ultimately granted declarations for the withdrawal of life-sustaining treatment. This decision aligns with

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[148] Ibid; *He v A Hospital NHS Trust* [2003] 2 FLR 408, 414 where Munby J agrees with the assessment of Andrew Grubb in ‘Competent Adult Patient: Right to Refuse Life-sustaining Treatment’ (2002) 10(2) *Medical Law Review* 201, 203 that “English law could not be clearer” on this point.

[149] *Re T Adult* (n 135) 102.

[150] *Marion’s case* (n 131) 391, 403.

[151] *Rogers case* (n 139); *F v R* (1983) 33 SASR 189, 192-193; *Airedale National Health Service Trust v Bland* [1993] AC 789, 816 (Butler-Sloss LJ), 891 (Hoffmann LJ), 891 (Lord Mustill) (‘*Airedale case*’); *Re T (Adult: Refusal of Medical Treamtnet)* [1993] Fam 95, 102; *Brightwater Care Group v Rossiter* [2009] WASC 229 (‘*Brightwater case*’) [24]-[25].

[152] Katherine Curnow, ‘A right to choose how to live: The Australian common law position on refusals of care’ (2014) 22 *Journal of Law and Medicine* 398, 402.

[153] *Re T Adult case* (n 135) 102.

[154] *Hunter case* (n 132) [24].

[155] *Brightwater case* (n 151).

[156] Ibid [6]-[8].

[157] Ibid [11].

the Australian common law. That is, when there is a conflict between a competent adult's exercise of the right of self-determination (autonomy)[158] and the State's interest in preserving life, the right of the individual must prevail.[159] However, the respect for autonomy in the doctrine of refusal of treatment is limited. The case of *Re T*[160] best illustrates the doctrine of refusal.

The appeal brought in *Re T* hinged on the question about the 'right to choose how to live'.[161] Ms T had previously been a Jehovah's Witness. At the time, she was 34 weeks pregnant and had been involved in a road traffic accident, then admitted to hospital and was diagnosed with pneumonia.[162] During the care of Ms T, she indicated on several occasions she did not want a blood transfusion.[163] However, Ms T's refusals were alleged to have arisen in response to the influence of her mother, who was a practising Jehovah's Witness and present at times immediately before Ms T had refused blood.[164] After giving birth to a stillborn child, Ms T's condition worsened, and she became unconscious.[165] In discussing the potential for the mother to have exerted undue influence, Donaldson LJ stated:

> A special problem arises if at the time the decision is made the patient has been subjected to the influence of some third party. This is by no means to say that the patient is not entitled to receive and indeed invite advice and assistance from others in reaching a decision, particular from members of the family. But the doctors have to consider whether the decision is really that of the patient.[166]

The Court of Appeal ultimately found that Ms T's refusal was invalid because of incapacity[167] and the mother's undue influence.[168] Therefore, the extent that the right to refuse treatment is respected is that a person must have decision-making capacity and be free from undue influence.

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[158] *Airedale case* (n 151) 826.
[159] *Hunter case* (n 132) [17].
[160] *Re T Adult case* (n 135).
[161] Ibid 102
[162] Ibid 104-106.
[163] Ibid 108.
[164] Ibid.
[165] Ibid 113.
[166] Ibid 113.
[167] Ibid.
[168] Ibid 113-114.

2 *The expression of autonomy in the Medical Code and statute*

The Medical Code sets out principles that characterise good medical practice and explicitly state the standards of ethical and professional conduct expected of doctors by their professional peers and the community. Further, the Australian Medical Association *Code of Ethics*[169] complements the Medical Code. Although the Medical Code is not legislative instrument, it can be legally enforced through the Health Practitioner Regulation National Law.[170] The Medical Code expresses respect for autonomy by stating that providing good patient care includes 'recognising and respecting patients' rights to make their own decisions'.[171]

The VAD Acts represents autonomy generally to the Australian community through the name of its legislation.[172] On a more detailed level, the VAD Acts expresses the notion of autonomy through its explicit principles.[173] Furthermore, the VAD Acts enables a terminally ill patient to exercise autonomy to its highest degree at the final stage in the VAD procedure.[174]

The focus on autonomy is evident in the naming of the VAD Acts. The term 'euthanasia' was not specifically incorporated. As such, it is helpful to consider the term 'euthanasia' and its meaning. Euthanasia is often understood to be either active or passive, and Bagaric draws this distinction.[175] To summarise, active euthanasia is the act of giving drugs with the intention that death will follow.[176] Conversely, passive euthanasia is the withdrawal or discontinuation of life-sustaining nutrients, medication, or other medical treatments, leading to death.[177] Regardless of whether euthanasia is passive or active, the Victorian and WA Ministerial Panel was of the view that the term carries a negative connotation because of its history abuse

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[169] Australian Medical Association, *Code of Ethics* (17 March 2017) <https://ama.com.au/articles/code-ethics-2004-editorially-revised-2006-revised-2016>.

[170] Western Australian National Health Law (n 26); Victorian National Health Law (n 26); *Health Practitioner Regulation National Law Act 2009* (QLD); *Health Practitioner Regulation National Law (NSW) No 86a* (NSW); *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (TAS); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA).

[171] Medical Code (n 13) 6, [3.1.5].

[172] Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 31 July 2017) 7 ('Victorian Ministerial Final Report'); Western Australian Ministerial Final Report (n 45) 9.

[173] *Victorian VAD Act* (n 4) s 5; *Western Australian VAD Act* (n 5) s 4.

[174] *Victorian VAD Act* (n 4) s 47; *Western Australian VAD Act* (n 5) s 58.

[175] Mirko Bagaric, 'Active and passive euthanasic: is there a moral distinction and should there be a legal difference?' (1997) 5 *Journal of Law and Medicine* 153.

[176] Ibid 145.

[177] Ibid 146.

in involuntary euthanasia.[178] As a result, the term ‘voluntary’ was adopted rather than euthanasia or suicide.[179] The Victorian Ministerial Panel stated that the term ‘voluntary’ is to be an emphatic statement of a person taking responsibility for their decision, and the WA Ministerial Panel has stressed the ‘voluntary nature of the choice of the person to make [the decision to access VAD]’.[180] Therefore, Parliament adopted the term ‘voluntary’ and affirmed that VAD ‘involves a person’s choice about the manner of their death when faced with inevitable and imminent death’.[181] The name of the VAD Acts in itself has the capabilities to reach the wider community to represent autonomy.

The VAD Acts’ clearest written expression of autonomy is the Acts’ principles that provide concrete policy goals that underpin the VAD laws.[182] The Victorian and WA Parliament intended that the principles are to recognise the ‘importance of giving people genuine choice, while also recognising the need to protect individuals who may be subject to abuse’.[183] The Victorian Minister for Health, Jill Hennessy, summarised the principles to recognise three values: ‘the value of every human life, respect for autonomy and a person’s preferences, choices and values, and the provision of high-quality care’.[184] The VAD Acts explicitly states the following principles:

- A person has the right to be supported in making informed decisions.[185]
- A person is entitled to genuine choices about the person’s care, treatment and end-of-life.[186]
- A person should be encouraged to openly discuss about dying, death and the person’s preferences and values regarding their care, treatment and end-of0life should be encouraged and promoted.[187]
- A person should be supported in conversations with health practitioners and family about treatment and care preferences.[188]

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[178] Victorian Ministerial Final Report (n 172) 7; Western Australian Ministerial Final Report (n 45) 9.

[179] *Western Australian VAD Act* (n 5) s 12.

[180] Western Australian Ministerial Final Report (n 45) 8.

[181] *Parliamentary Debates,* Legislative Council, 26 September 2019, 3 (Hon Stephen Dawson, Minister for Environment); Western Australia, *Parliamentary Debates*, Legislative Assembly, 7 August 2019, 1 (Roger Cook, Minister for Health); My Life, My Choice (n 49) 225.

[182] *Victorian VAD Act* (n 4) s 5; *Western Australian VAD Act* (n 5) s 4.

[183] Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 2; Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 1.

[184] Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2951 (Jill Hennessy) (‘*Victorian Legislative Assembly Debate*’).

[185] *Victorian VAD Act* (n 4) s 5(c); *Western Australian VAD Act* (n 5) s 4(c).

[186] *Victorian VAD Act* (n 4) s 5(h); *Western Australian VAD Act* (n 5) s 4(h).

[187] *Victorian VAD Act* (n 4) s 5(f); *Western Australian VAD Act* (n 5) s 4(f).

The principles above are aligned with the notion of autonomy.

Now turning to the procedural framework of the VAD Acts, in the absence of coercion and undue influence, the decision to access and progress with VAD is to be voluntarily initiated by the individual. Moreover, regarding the VAD administration process, the VAD substance must be self-administrated unless the person is physically incapable of doing so.[189] The self-administration framework ensures that the person's decisions remain consistent throughout the process. The self-administration enables a patient to exercise greater control over the manner and timing of their death. Throughout the VAD process, the VAD Acts have a preference for self-administration over practitioner-administration. This preference demonstrates that the patient's actions are autonomous and consistent with the key principles of autonomy.[190] Arguably, a patient that self-administer the VAD substance is the highest form of exercising personal autonomy.

In summary, the discussion above shows the importance of respecting personal autonomy and the freedom to 'choose to end their life according to their own preferences'[191] in the VAD laws. However, the respect for autonomy in the VAD laws is not respected to its full extent. The Victorian Expert Panel has noted that respecting autonomy does not mean allowing people 'to do whatever they want' or to 'choose whether to live or die'.[192] Instead, respect for autonomy is aimed towards individuals who have the choice over the 'timing and manner' of a death that is otherwise inevitable.[193] Therefore, the VAD laws does recognise and respects autonomy but in a narrower sense - specifically, to those who meet the eligibility criteria.

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[188] *Victorian VAD Act* (n 4) s 5(g); *Western Australian VAD Act* (n 5) s 4(g).
[189] *Victorian VAD Act* (n 4) s 47; *Western Australian VAD Act* (n 5) s 58.
[190] My Life, My Choice (n 49) 206.
[191] *Victorian Legislative Assembly Debate* (n 184) 2945 (Jill Hennessy).
[192] Victorian Ministerial Final Report (n 172) 44.
[193] Ibid.

B *The Doctor-Patient Relationship*

The doctor-patient relationship is fundamental to the Australian healthcare system. The relationship is continuous and shapes how the patient is diagnosed, treated, and cared for. Myfanwy Morgan has suggested four models of the doctor-patient relationship:[194]

- A paternalistic relationship – the physician controls the relationship and decides what is best for the patient.
- A relationship of mutuality (shared decision-making) – the doctor and patient are equal partners engaged in sharing information and ideas designed to produce the best treatment for the patient.
- A consumerist relationship – the patient is the active and dominant party, demanding treatment and assistance from a doctor whose primary role is to meet the requests of the patient.
- A relationship of default – in this model, neither party takes a leading role. This normally leads to a non-productive encounter.

An argument can be made that a consumerist relationship can fit within the VAD context (i.e., a person demanding VAD). However, it may be morbid to classify a lethal drug substance causing death as a commercial commodity in comparison to a person demanding, for example, Botox treatment within the cosmetic surgery context. More importantly, given the stringent eligibility criteria to access VAD, not all patients can demand to participate in the VAD process. Therefore, the consumerist model does not fit well within the VAD process. With regards to the relationship of default, the VAD process requires the medical practitioners and patient to be active participants. Additionally, the VAD process has a specific endpoint. Accordingly, the relationship of default model does not apply.

Due to the nature of the consumerist relationship and relationship of default model within the VAD context, this Thesis will exclusively consider the relationship of paternalism and a relationship of mutuality. The two models will be further discussed in light of some of the core stages of healthcare decision-making. Those care stages are (1) information exchange, (2) deliberation and (3) decision on the treatment to implement.[195]

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[194] Myfanwy Morgan, 'The Doctor-Patient Relationship' in Graham Scambler (ed), *Sociology as applied in Medicine* (Elsevier Health Sciences, 2009) 55.

[195] *The Different Faces of Autonomy* (Kluwer Academic Publishers, 2002) ('The Different Faces of Autonomy') 89; Cathy Charles et al, 'Shared Treatment Decision Making: What Does it Mean to Physicians?' (2003) 21(5)

1 *The paternalistic model*

Paternalism is a heavily debated subject[196] and is notoriously difficult to define.[197] A specific, universally accepted definition is not needed here. Generally, paternalism has been defined as the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appealing to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden.[198]

The paternalistic model within the doctor-patient relationship holds the position that doctors always know what is best for their patients.[199] It is not controversial to say that patients are generally not in the position to diagnose their condition, know the risk of medication or what medical treatments are available.[200]These matters are for doctors to evaluate and determine because of their professional expertise. Further, the paternalistic model is based on the beneficence of doctors that is emphasised in the Hippocratic Oath.[201] A respected expression appears in the Hippocratic work *Epidemics*: 'As to disease, make a habit of two things—to help, or at least to do no harm'.[202] Doctors may see themselves being bound by the ethical duty of beneficence to exercise his or her authority in the best interests of the patient regardless of the patient's own preferences (though the Oath predates twentieth-century understandings of autonomy).[203]

Journal of Clinical Oncology 932-936; See Gregory Makoul and Marla Clayman, 'An Integrative model of shared decision making in medical encounters' (2006) 60(3) *Patient Education and Counselling* 301, 304, 306, where the authors have collated literature on shared decision-making models – they identify and analyse the common themes of different shared decision-making models.

[196] For a summary of this debate, see The Different Faces of Autonomy (n 195).

[197] Tom Beauchamp and Laurence McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* (Prentice Hall, 1984) 84; Donald VanDeVeer, *Paternalistic Intervention: The Moral Bounds on Benevolence* (Princeton University Press, 1986) 16-40; John Kleinig, *Paternalism* (Rowman & Allanheld, 1983) 6-14.

[198] Principles of Biomedical Ethics (n 121) 215; Warren Reich and Tom Beauchamp, *Encyclopaedia of Bioethics* (New York: Free Press, 1978) 1194-1201; Cathy Charles, Amiram Gafni and Tim Whelan, 'Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model' (1999) 49(5) *Social Science & Medicine* 651, 661 ('Revisiting Shared Decision-Making').

[199] Eduardo Lazcano-Ponce, et al, 'Communication patterns in the doctor-patient relationship: evaluating determinants associated with low paternalism in Mexico' (2020) 21(1) *BMC Medical Ethics* 1, 2 ('Communication Patterns'); M.S Komrad, 'A defence of medical paternalism: maximising patients' autonomy' (1983) 9(1) *Journal of Medical Ethics* 38, 44.

[200] Madison Kilbride and Steven Joffe, 'The New Age of Patient Autonomy' (2018) 320(19) *Journal of American Medical Association* 1973.

[201] William Henry Samuel Jones, *Hippocrates* (Harvard University Press, 1923); Steven Miles, *The Hippocratic Oath and the Ethics of Medicine* (Oxford University Press, 2004).

[202] W.H.S. Jones, et al, 'Epidemics', *Hippocrates* (Harvard University Press, 1923) vol 1, 165.

[203] Kerry Breen, Vernon Plueckhahn and Stephen Cordner, *Ethics, Law & Medical Practice* (Allen & Unwin, 1997) 8; Erik Falkum and Reidun Forde, 'Paternalism, patient autonomy, and moral deliberations in the

There are two distinguishing features in the paternalistic model. The patient's decision-making is reduced by what the doctor determines is in the patient's best interests; or to some extent, determined by what information the doctor permits to be filtered through to the patient.[204] Secondly, the paternalistic model does not recognise that the doctor, to an extent, relies on the patient to cooperate and assist in the patient's health management because the model focuses on the doctor's expertise. For example, a doctor requires the patient to answer honestly and openly when answering medical history questions and to report ongoing and any further symptoms. Ultimately, the paternalistic model places a high responsibility on the doctor's shoulders regarding the patient's health; and further does not recognise that the patient may have any responsibility for their own health.[205]

2 *The shared decision-making model (relationship of mutuality)*

The right to autonomy as self-determination has grown to become a central feature in medical ethics. This right has been granted through the doctrine of consent[206] and the doctrine of refusal of treatment. As a result, autonomy has a unique role in shared decision-making. At its core, accepting that individual self-determination is a desirable goal and that doctors need to support patients to achieve this goal (wherever feasible) is a condition of shared decision-making.[207] The shared decision-making model recognises the need for doctors to support personal autonomy by building good relationships, respecting both individual competence and preferences.[208]

Towle and Godolphin have created a suggestion of steps for shared decision-making to take place within the doctor-patient relationship.[209] Those steps can be categorised into three core

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physician-patient relationship: Attitudes among Norwegian physicians' (2001) 52(2) *Social Science & Medicine* 239.

[204] R Magnusson and H Opie, 'Patient Access to Medical Records: Fiduciary Duties and Other Issues – A Classroom Interactive' (1998) 17 *University of Tasmania Law Review* 99, 129.

[205] Robert Harper, 'The application of contributory negligence principles to the doctor/patient relationship' (2001) 9 *Torts Law Journal* 180, 182.

[206] Ben White, Fiona McDonald and Lindy Willmot, *Health Law in Australia* (Thomson Reuters, 3rd, 2018) 138, [5.10].

[207] Glyn Elwyn et al., 'Shared Decision Making: A Model for Clinical Practice' (2012) 27(10) *Journal of General Internal Medicine* 1361.

[208] Ibid.

[209] Angela Towle and William Godolphin, 'Framework for teaching and learning informed shared decision making' (1999) 319(7212) *British Medical Journal* 766, 767 ('Framework for Informed Shared Decision Making'); Glyn Elwyn et al., 'Towards a Feasible Model for Shared Decision Making: Focus Group Study with General Practice Registrars' (1999) 319(7212) *British Medical Journal* 753.

stages of healthcare decision-making: (1) information exchange, (2) deliberation and (3) decision on the treatment to implement. Not only do these steps occur in the shared decision-making model, but it can also be used to understand the paternalism model. The following section will not consider the two models through the lends of the three core steps.

3 *Differences between the models regarding information exchange*

Information exchange refers to the type and amount of information exchanged between a doctor and a patient. The type of information that a doctor communicates to the patient may include: the history and severity of the disease, the benefits and risk (side effects) of various treatment alternatives, a description of the treatment procedure(s) to be used, and community resources and information that the patient could access about their disease.[210] This information communicated by the doctor can be categorised as technical knowledge that the patient may not have. The information communicated by the patient may include: aspects of the patient's health history, their lifestyle, social context (i.e. work and family responsibilities and relationships), their beliefs and fears their disease, and knowledge of various treatment options ascertained from other information sources.[211]

In addition to the type of information exchange, the doctor and patient may exchange preferences and values regarding treatment and each other's role in the decision-making process.[212] The flow of information can occur in one of two ways. The first way is when the doctor gives information to the patient; whereas the other way is when the doctor and patient collaboratively exchange information.

In the paternalistic model, the direction of the information goes one way. At a minimum, the doctor must provide the patient with the legally required information on treatment options. Generally, the patient is placed as a passive recipient in the information exchange—the information that the patient receives is dependent on the type and amount the doctor passes on. There may be some cases where the patient does pass some information to the doctor. However, information exchange from patient to doctor is not a prerequisite in this model to fulfil the task because the doctor in this model is assumed to know what is best and will choose the best treatment decision for the patient.

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[210] Revisiting Shared Decision-Making (n 198) 654.

[211] Ibid.

[212] Ibid.

On the other hand, in the shared decision-making model, the information exchange is two ways.[213] At a minimum, the doctor must inform the patient of all information that is relevant to making the decision. This may include information about available treatment options, the benefits and risks of each and potential effects of the patient's psychological and social wellbeing.[214] In response, the patient then provides information to the doctor on any issues raised. This may include their values, preferences, lifestyle, beliefs and knowledge about their medical condition and its treatment.[215] The patient's sharing of such information is important because research has suggested that when doctors infer patient preferences for information and participation in treatment decisions, they often fail to get them right.[216]

4 *Differences between the models regarding deliberation*

The deliberation stage of decision-making refers to the process of expressing and discussing treatment preferences.[217] In the paternalistic model, the deliberation process is dominated by the doctor. In this approach, the doctor weighs the benefits and risks of each option, either alone or deliberating with other doctors. The treating doctor may then verbally communicate to the patient about the final treatment decision. Additionally, the treating doctor may not reveal to the patient the knowledge and values considered in the decision-making process and how these factors were weighed. The costs of having the patient be a passive participant in the deliberation process allow the doctor to make relatively quick decisions without having the restrictions of the patient's input.

In the shared decision-making process, the defining characteristic is the interactional nature.[218] The interactional nature allows the patient to have input in the decision-making process. In order for the shared decision-making model to work, doctors and patients have to

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[213] Charles, Cathy, Amiram Gafni and Tim Whelan, 'Shared decision-making in the medical encounter: what does it mean? (Or, it takes at least two to tango)' (1997) 44(5) *Social Science & Medicine* 681, 682, 685-686 ('Shared Decision Making').

[214] Revisiting Shared Decision-Making (n 198) 654.

[215] Ibid.

[216] William Strull, Bernard Lo and Gerald Charles, 'Do Patients Want to Participate in Medical Decision Making?' (1984) 252(21) *Journal of the American Medical Association* 2990-2994; Howard Waitzkin, 'Doctor-Patient Communication: Clinical Implications of Social Scientific Research' (1984) 252(17) *Journal of the American Medical Association* 2441-2446.

[217] Revisiting Shared Decision Making (n 198) 656.

[218] Shared Decision Making (n 213) 687.

perceive that there are treatment choices – otherwise, there is nothing to decide.[219] In addition to the information exchange, each person needs to be willing to engage in the decision-making process by expressing treatment preferences. The process is likely to be consensual given that during the earlier stages, both parties at least have shared treatment preferences; otherwise, if their views differentiate, then a process of negotiation is likely to occur.[220] However, negotiating as equal partners can be difficult because of the inherent power imbalance. Therefore, doctors who want to practice in the shared decision-making model should create and foster a safe environment for the patient to feel comfortable in exploring information and expressing opinions.[221] Additionally, the shared decision-making model assumes that both parties are invested in the treatment decisions.[222]

5 *Differences between the models regarding treatment implementation decisions*

The final step in the decision-making process is the choice to implement a treatment.[223] In the paternalistic model, subject to the doctrine of consent,[224] the decision-maker on the implemented treatment is the doctor. In the shared decision-making model, through the deliberation process, both parties work towards an agreement, and they have an investment in the ultimate decision being made.[225] At this point, it may seem appropriate to ask "which doctor-patient relationship model" does Australia align with, or at least favour. This question will now be addressed below in light of the Medical Code and Australian medical negligence law.

C *The Doctor-Patient Relationship Implicit in Australian Law*

As previously discussed, consent in the tort of trespass is treated as a defence to wrongful touching. In contrast, consent in the tort of negligence is a positive duty. This Thesis focuses

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[219] Cathy Charles et al, 'Doing nothing is no choice: lay constructions of treatment decision-making among women with early-stage breast cancer' (1998) 20(1) *Sociology of Health & Illness* 71, 77, 85-86.
[220] Revisiting Shared Decision-Making (n 198) 656.
[221] Edward Guadagnoli and Patricia Ward, 'Patient participation in decision-making' (1998) 47(3) *Social Science & Medicine* 329, 336.
[222] Revisiting Shared Decision-Making (n 198) 656.
[223] Ibid 658.
[224] In law, consent is treated differently depending whether the cause of action is a defence to the tort of trespass, or a duty in a negligence claim. For a discussion on the dual concept of consent, see Cameron Stewart, 'Cracks in the Lintel of Consent' in Ian Freckleton and Kerry Peterson (eds), *Tensions & Traumas in Health Law* (The Federation press, 2017), 214.
[225] Revisiting Shared Decision-Making (n 198) 656.

on medical practitioners upholding and respecting personal autonomy. On that account, this Part of the Chapter will focus on the tort of negligence as opposed to the tort of trespass.

In medical law, the three essential elements of a negligence claim are duty, breach, and damage. The duty that doctors owe patients in their care is to exercise care and skill in the provision of services, including examination, diagnosis and treatment of their patients and the provision of information or advice.[226] That duty is a ‘single comprehensive duty’.[227] The development of the Australian medical negligence law indicates a preference for the shared decision-making model than the paternalistic model. The evidence to support that suggestion is to first consider the nature of the doctor-patient relationship in the English case of *Bolam v Friern Hospital Management Committee* (‘*Bolam*’).[228]

1 *The doctor-patient relationship in Bolam*

In *Bolam*, Mr Bolam suffered from depression and voluntarily admitted himself to a mental hospital. Friern Hospital treated Mr Bolam’s depression with electro-convulsive therapy (‘ETC’).[229] In the course of receiving ECT, Mr Bolam experienced violent convulsive movements and consequently suffered fractures of the pelvis on each side.[230] Mr Bolam sued in negligence and his case depended upon three points, of which only one of them is relevant to the current discussion. Mr Bolam alleged that Friern Hospital was negligent in failing to warn him of the risks involved in the treatment so that he could have a chance to decide whether he wanted to take those risks.[231] Friern Hospital denied liability on the basis that it was common practice not to warn patients of the treatment risks.[232] Ultimately, McNair J held that the defendants were not negligent and established the *Bolam* principle.[233] The principle was described by Lord Scarman in *Sidaway v Governors of Bethlem Royal Hospital* in the following terms:

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different

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[226] *Sidaway v Governors of Bethlehem Royal Hospital* [1985] AC 871, 893 (Lord Diplock).
[227] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[228] Ibid.
[229] Ibid 583.
[230] Ibid.
[231] Ibid 588.
[232] Ibid 589-593.
[233] Ibid 587.

> practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.[234]

Though it was not part of the judgment, the *Bolam* principle can be seen to be founded on a particular idea of the doctor-patient relationship.

In *Bolam*, it appears that Mr Bolam had a passive role in the decision of his treatment. The answer to whether the defendants were negligent in failing to warn Mr Bolam of the risk rested on medical practice and judgment rather than whether Mr Bolam, if informed of the risk, would have taken on that risk. One of the foci in the trial was the two opposing opinions of medical practice between Dr Randall (plaintiff's witness) and Dr Bastarrechea (defendant's witness). In evidence, Dr Randall said, 'I think it is not right to give no warning of the risks to a patient who can understand the import of the warning';[235] whereas Dr Bastarrchea stated 'I do not warn as to technique … If they do not ask me anything, I do not say anything about the risk'.[236] Further, the question as to what Mr Bolam would have done if informed of the risk was never put to him,[237] and his answer was speculated.[238]

2 *The doctor-patient relationship in Rogers*

In the 1980s, Australia started to reject the *Bolam* principle.[239] The law was finally settled in *Rogers v Whitaker* ('*Rogers*')[240] and arguably favours a shared decision-making model in the doctor-patient relationship. In *Rogers*, Ms Whitaker consulted with Mr Rogers, an ophthalmic surgeon, and informed him that she had been almost totally blind in her right eye since a childhood injury. Mr Rogers advised her that an operation would not only improve the appearance of her right eye but also restore significant sight in it. Ms Whitaker agreed to that surgery. After the operation, there was no improvement in her right eye, and she developed inflammation in her left eye that led to the loss of sight in that eye. The evidence in this case established a 1 in 14,000 chance of this outcome.[241] Ms Whitaker successfully sued for damages for negligence in the provision of information about the risks of the procedure, even

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[234] Ibid 881.

[235] Ibid 589.

[236] Ibid.

[237] Ibid 590.

[238] Ibid 591.

[239] See *Albrighton v Royal Prince Hospital* [1980] 2 NSWLR 542; *F v R* (1983) 33 SASR 189; *Gover v State of South Australia v Perriam* (1985) 39 SASR 543; *Battersby v Tottman and State of South Australia* (1985) 37 SASR 524.

[240] *Rogers case* (n 139).

[241] Ibid 626-627.

though there was no negligence in the carrying out of the procedure. Mr Rogers was held to be negligent because he did not warn Ms Whitaker of the risk that, following the surgery, she might develop sympathetic ophthalmia, which could lead to the loss of sight in her left eye.[242] In coming to the decision, the majority held that:

> The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[243]

The Court acknowledged that a risk would be material if a patient would likely 'attach significance' to the warned risk. This introduces an element that requires the patient's participation—an element that the *Bolam* principle does not have. The decision in *Rogers* is symbolic of the doctor-patient relationship shifting from the paternalistic model to a shared-decision making model.

The approach in *Rogers* was followed in *Rosenberg v Percival* ('*Rosenberg*').[244] However, *Rosenberg* considered and clarified the meaning of 'material risk' enunciated in *Rogers*. The test provides that there is an obligation to warn of risks which a reasonable person in the plaintiff's position would consider material (this is an objective test), and that the obligation to provide the information extends to risks which the particular patient, if warned of the risk, would be likely to attach significance to (this is a subjective test).[245]

In summary, the Australian common law position regarding the doctor-patient relationship favours the shared decision-making model rather than the paternalistic model. As illustrated, the *Bolam* principle does not mandate the disclosure of risk. However, *Rogers* and *Rosenberg* require doctors to disclose to the patient of a material risk concerning a proposed treatment or procedure, a condition that satisfies the two-way information exchange in the shared decision-making model.[246] Further, the law requires the patient's consent to proceed with a proposed treatment, a requirement that incorporates the patient's autonomous choice. Again,

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[242] Ibid 627.
[243] Ibid 633-634.
[244] *Rosenberg v Percival* (2001) 178 ALR 577.
[245] Ibid 594.
[246] Revisiting Shared Decision-Making (n 198) 654.

this part of the law conforms with the decision to implement a treatment aspect of the shared decision-making model rather than the paternalistic model.[247] The discussion in the next section proposes that the Medical Code and VAD Acts also conforms with the shared decision-making model.

3 *The Medical Code and VAD Acts*

The Medical Code establishes a set of standards that brings together, into a single Australian code, a useful and practical guide for medical practice.[248] The Medical Code provides guidance on, *inter alia*, on how to provide good patient care and effective communication care which includes:

- assessing the patient, taking into account the history and patient's views;[249]
- formulating and implementing a suitable management plan;[250]
- recognising and respecting patients' rights to make their own decisions;[251]
- discussing and providing treatment options based on the best available information;[252]
- encouraging patients to take interest in, and responsibility for, the management of their health and supporting them in this;[253] and
- responding to patients' questions and keeping them informed about their clinical progress.[254]

The last four points closely align with the three core steps in the shared decision-making model, while the first two acknowledge the practitioners' expertise. Additionally, the Medical Code recognises that the doctor-patient relationship is based on respect, openness, trust and good communication and provides guidance on how to work with patients.[255] Therefore, the Medical Code strongly embodies the shared decision-making model.

More specifically, the Medical Code encourages information to be exchanged two ways, such as, among other things, providing treatment options based on the best available information[256]

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[247] Ibid 656.

[248] Medical Code (n 13) 3, [1.1].

[249] Ibid 6, [3.1.1]; 6, [3.2.6].

[250] Ibid 6, [3.1.2].

[251] Ibid 6, [3.1.5]

[252] Ibid 6, [3.2.6]; Ibid 8, [4.3.4].

[253] Ibid 6, [3.2.13]; Ibid 8, [4.3.2].

[254] Ibid 8, [4.3.6].

[255] Ibid 8, [4.1].

[256] Ibid 6, [3.2.6].

and encouraging patients to tell doctors about their condition and how they are currently managing it.[257] In the deliberation stage, the Medical Code outlines guidelines that facilitate the interactional nature that allows the patient to have input in the decision-making process. For instance, the Medical Code provides that the medical practitioners help formulate a suitable management plan[258] and the patients have the opportunity to provide their views, concerns and preferences.[259] Lastly, the final stage of the decision of implementing a treatment in the Medical Code does not reflect a paternalistic model. The Medical Code explicitly states under the subheading 'shared decision-making' that 'making decisions about healthcare is the shared responsibility of the doctor and the patient',[260] and further describes the doctor-patient relationship to be a partnership.[261]

Moreover, The VAD Acts mandates that medical practitioners must have regard to the following express principles:[262]

- a person has the right to be supported in making informed decisions;[263]
- a therapeutic relationship between a person and the doctor should be supported and maintained;[264]
- a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding their care, treatment and end-of-life should be encouraged and promoted;[265] and
- a person should be supported in conversation with the person's doctor.[266]

The VAD Acts' principles that require medical practitioners to cast their mind when performing a function or duty under the VAD Acts are similar to the Medical Code that guides medical practice. Therefore, that suggests that the shared decision-making model is favourable within the VAD laws.

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[257] Ibid 8, [4.3.2].
[258] Ibid 6, [3.1.2].
[259] Ibid 8, [4.3.1].
[260] Ibid 6, [3.3].
[261] Ibid 8, [4.2].
[262] *Victorian VAD Act* (n 4) s 5(1); *Western Australian VAD Act* (n 5) s 4(1)(c).
[263] *Victorian VAD Act* (n 4) s 5(1)(c); *Western Australian VAD Act* (n 5) s 4(1).
[264] *Victorian VAD Act* (n 4) s 5(1)(e); *Western Australian VAD Act* (n 5) s 4(1)(e).
[265] *Victorian VAD Act* (n 4) s 5(1)(f); *Western Australian VAD Act* (n 5) s 4(1)(f).
[266] *Victorian VAD Act* (n 4) s 5(1)(g); *Western Australian VAD Act* (n 5) s 4(1)(g).

D *Conclusion*

In summary, this Chapter has explored the definition of autonomy and the doctor-patient relationship models. The Thesis will adopt a definition based on Mackenzie and Rogers' three conditions of autonomy, that is freedom, competency and authenticity. The Thesis' definition of autonomy has been narrowed down through its discussion on how law expresses autonomy. In terms to the extent to which autonomy is respected within the VAD Acts, respect for autonomy is limited to people who are eligible to access VAD. On the topic of the doctor-patient relationship, the paternalistic model and the shared decision-model were thoroughly discussed. This Chapter established that the shared decision-making model is the appropriate model to adopt. Such justification was demonstrated how the Medical Code, VAD Acts, and the common law favours a shared decision-making model instead of the paternalistic model. Therefore, this Chapter has provided the framework as to how the comparative analysis will be conducted.

IV COMPARATIVE ANALYSIS OF THE VICTORIAN AND WESTERN AUSTRALIAN PROHIBITION PROVISION

Chapter II outlined the eligibility criteria and procedural structure in order for a patient to access voluntary assisted dying under the Victorian and Western Australian Voluntary Assisted Dying Acts ('the VAD Acts'). But more importantly, Chapter II determined the scope to understand the application of Victorian and WA prohibition provisions. Then, Chapter III explored the concept of autonomy and the doctor-patient relationship, serving particular importance for this Chapter; it provided the framework and approach as to how the Victorian and WA prohibition provisions can be understood – forming the basis for the comparative analysis. The primary issue of this Thesis is that the Victorian prohibition affords no flexibility to medical practitioners to engage an open and honest discussion with a terminally ill patient about VAD, ultimately undermining the respect for autonomy and the doctor-patient relationship. Additionally, the Victorian prohibition provision places an unfair burden and expectation on patients to ask for VAD when they may not know that VAD is a legally available option. This Chapter argues that the WA prohibition provision is better than the Victorian model when viewed through the lens of autonomy and the doctor-patient relationship.

A *The Prohibition Provisions*

Notwithstanding that a person can request VAD information, the prohibition provisions impose a general prohibition on all registered health practitioners. It prohibits health practitioners, in the course of providing professional services, from initiating discussions with a person that is in substance about VAD, or in substance, suggest VAD to a person.[267] However, the WA prohibition provision provides an exemption to medical and nurse practitioners. The exemption allows medical and nurse practitioners to disclose VAD information, if at the same time, they also inform the person about palliative care and alternative treatment options.[268] The rationale and policy intentions of the Victorian and WA prohibition will be discussed first before conducting the comparative analysis.

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[267] *Victorian VAD Act* (n 4) s 8(1); *Western Australian VAD Act* (n 5) s 10(2).
[268] *Western Australian VAD Act* (n 5) s 10(3).

The Victorian Parliamentary Committee was silent and did not make any specific comments on the Victorian prohibition provision.[269] Whereas the Victorian explanatory memorandum states that the intentions for section 8(2) was not that 'every single subsequent discussion be initiated by the patient. The intention of this provision is to protect individuals who may be open to suggestion or coercion by registered health practitioners, not to discourage open discussions driven by the individual'.[270]

With regards to WA, the WA Ministerial Panel's Report discussed the prohibition provision under the heading 'Raising the subject of voluntary assisted dying'.[271] The Report began by noting that it is 'known that up to 60% of Australians have low levels of individual health literacy.[272] When the WA Ministerial Panel provided the statistic that 60% of Australians have low levels of individual health literacy that was obtained from the Health Care Commissioner's report on health literacy.[273] When defining health literacy, the WA Ministerial Panel offered a short definition—that is, 'people may not have the knowledge or confidence to start discussions about specific treatments or options that have not already been raised by their health practitioners'.[274] Notwithstanding the various definitions of health literacy,[275] the Health Care Commissioner has defined individual health literacy as 'the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action'.[276] Given that the Health Care Commissioner's definition provides a clearer understanding of what health literacy means, this Thesis will adopt that definition.

The WA Ministerial Panel Report's consultation findings indicated that 'people were clear that they expect to be made aware of all the clinically suitable, legally available options to enable them to make fully informed decisions at end-of-life'.[277] In a similar vein, the WA Ministerial Panel believed 'that health practitioners have a professional obligation to ensure

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[269] Victorian Ministerial Final Report (n 172) 92.

[270] Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 2-3.

[271] Western Australian Ministerial Final Report (n 45) 30-31.

[272] The Western Australian Parliamentary Committee cited Australian Commission on Safety and Quality in Health Care, *Health Literacy: taking action to improve safety and quality* (August 2014) 2 <https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf> ('Health Care Commission Report').

[273] Ibid.

[274] Western Australian Ministerial Final Report (n 45) 30.

[275] Ibid 9.

[276] Ibid 10.

[277] Ibid.

that their patients are fully informed about their choices at end-of-life, including [VAD]'.[278] On the topic of policy intent, the WA Ministerial Panel stated that it was to:

> 'ensure that people are able to make fully informed decisions at end-of-life; and to ensure that access to VAD is not impeded by a health practitioner not discussing what would be a legal option at end-of-life for some people'.[279]

Ultimately, the WA Panel recommended that health practitioners can appropriately raise the topic of VAD. Again, the WA Panel was silent on whether the prohibition provision should be extended or exempted to medical practitioners. The inference here would be that the WA Panel's view was that the WA prohibition provision should be exempted to medical practitioners because of its final recommendation that health practitioners can initiate VAD discussions.

Further, the WA Parliamentary Committee was of the view that:

> assisted dying should be considered as one of many clinical options available to patients for responding to terminal illness. Achieving the best possible clinical outcomes for a patient will require health professionals to discuss the full range of responses to challenges encountered by many at the end-of-life.[280]

The WA Parliamentary Committee shared the same point of view as the WA Ministerial Panel. In the end, the Committee specially recommended not to adopt the Victorian position. [281] Lastly, the WA explanatory memorandum is silent on the prohibition provision.[282]

Evidently, the approach taken by the Victorian and WA Ministerial Panels were different. On the one hand, the nature of the Victorian approach is protective, ensuring that an individual is not coerced or unduly influenced to access VAD. In comparison, the nature of the WA approach can be described as focusing on the person (i.e., person-centred), ensuring that people are able to make an informed decision at end-of-life. The question now posed is how the Victorian and Western Australian prohibition provision would compare to each other if they were analysed through the same lens.

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[278] Ibid 31.
[279] Ibid.
[280] Western Australian Ministerial Final Report (n 45) 200.
[281] Ibid 199-200.
[282] Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA).

B *Comparative Analysis*

The comparative analysis Part of this Thesis will discuss, in turn, the prohibition provisions in light of the conceptual frameworks discussed in Chapter III. For each concept, the Victorian provision, and then the WA provision, will be analysed in terms of autonomy and the doctor-patient relationship. The Chapter will conclude with the assessment that the latter provision is the more favourable model.

1 *Respecting autonomy*

The discussion in Chapter II established the concept of autonomy and to what extent autonomy is respected. In the context of VAD, subject to meeting the eligibility criteria, respect for autonomy effectively gives a terminally ill patient the choice to end their life according to a preference for death. The analysis in this section will that the Victorian prohibition provision prevents medical practitioners from respecting a patient's autonomous choice; specifically, a choice that reflects their preference for death. In contrast, the analysis on the WA prohibition provision will conclude that the WA model provides great flexibility to respect a patient's autonomy irrespective of their treatment preferences.

According to Mackenzie and Rogers, a person must meet three conditions of 'freedom', 'competence' and 'authenticity' to exercise autonomy.[283] Mackenzie and Rogers' definition of autonomy can be applied to the VAD Acts. To access VAD, a patient must be acting free from coercion[284] (freedom condition), have decision-making capacity in relation to VAD[285] (competency condition), and be acting voluntarily[286] (authenticity condition). Arguably, a patient who exercises their autonomous choice, who satisfies Mackenzie and Rogers' three conditions or the eligibility criteria, should have their decisions to access VAD respected.

The Australian common law has a strong focus for respecting autonomy that can be founded in the doctrine to refuse life-sustaining medical treatment. That doctrine provides that a person has the choice to withdraw from life-sustaining medical treatment despite resulting in inevitable death.[287] In *Brightwater*, Martin CJ stated:

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[283] Mackenzie and Rogers Characteristics of Autonomy (n 126).

[284] *Victorian VAD Act* (n 4) s 20(1)(c); *Western Australian VAD Act* (n 5) s 16(1)(e).

[285] *Victorian VAD Act* (n 4) s 9(1)(c); *Western Australian VAD Act* (n 5) s 16(d).

[286] *Vicortian VAD Act* (n 4) s 20(1)(c); *Western Australian VAD Act* (n 5) s 16(1)(e).

[287] The case-law in this area were discussed in Chapter III.

> ‘it follows that, at common law, the answers to the questions posed by this case are clear and straightforward. They are to the effect that Mr Rossiter has the right to determine whether or not he will continue to receive the services and treatment provided by Brightwater and, at common law, Brightwater would be acting unlawfully by continuing to provide treatment contrary to Mr Rossiter’s wishes’.[288]

The Court considered that Mr Rossiter had a clear and unequivocal desire to die,[289] and had the right to withdraw from life-sustaining medical treatment. This right to self-determination in Australia is well established. [290]

In relation to the Medical Code, it expects that doctors should provide good patient care by ‘recognising and respecting patients’ right to make their own decisions’.[291] Similarly, the VAD Acts explicitly states that a patient’s autonomy should be respected.[292] In addition, the VAD Acts’ principles include that making informed decisions are to be supported,[293] genuine choices are to be promoted,[294] encouraging open discussions about dying, death and people’s preferences,[295] and supporting conversations about treatment and care preferences.[296] Evidently, respect for personal autonomy is explicitly acknowledged in written instruments connected to the services of healthcare; and more importantly, the regulation, accessibility and administration of VAD.

a) Victorian Analysis

Two significant issues may arise when applying the notion of respecting personal autonomy to the Victorian prohibition provision. One aspect is that the provision discourages or prevents medical practitioners from respecting a patient’s exercise of autonomy according to their preference to access VAD. Suppose that a terminally ill patient may prefer death over prolonging their life in palliative care. Despite that the medical practitioner knowing of the patient’s preference, the medical practitioner cannot disclose VAD information without

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[288] *Brightwater case* (n 151) [32].
[289] Ibid [3].
[290] Ibid [24], [48]; *H Ltd v J* (2010) 107 SASR 352, 364-9, [33]-[46] (Kourakis J); *Hunters case* (n 132) [5] (McDougall J).
[291] Medical Code (n 13) 6, [3.1.5].
[292] *Victorian VAD Act* (n 4) s 5(b); *Western Australian VAD Act* (n 5) s 4(b).
[293] *Victorian VAD Act* (n 4) s 5(c); *Western Australian VAD Act* (n 5) s 4(c).
[294] *Victorian VAD Act* (n 4) s 5(h); *Western Australian VAD Act* (n 5) s 4(h).
[295] *Victorian VAD Act* (n 4) s 5(f); *Western Australian VAD Act* (n 5) s 4(f).
[296] *Victorian VAD Act* (n 4) s 5(g); *Western Australian VAD Act* (n 5) s 4(g).

contravening the prohibition provision unless the patient has specifically requested such information. This will pose a major issue to patients who may not have the knowledge that VAD is a legally available option.

Another issue that may arise is circumstances where the patient does not have the confidence or skills to properly communicate that they are seeking information or access to VAD. An example of this problem may become evident when a patient does not speak English as a first language, speak the same language as the medical practitioner or have limited communication capabilities. Applying the Victorian Department of Health and Human Services guidance on the Victorian Act, as noted in Chapter II, broad questions do not constitute request for VAD information—which may also include comments alluding to VAD. Again, the medical practitioner cannot disclose VAD information in this situation.

Given that the medical practitioner does not disclose VAD information, each of the two issues have a common outcome. The patient may choose an end-of-life option (such as palliative care) that is contrary to the patient's preference for death. It is difficult to see how a Victorian patient who satisfies Mackenzie and Rogers' three conditions of freedom, competency and authenticity in their preference for death and meets the eligibility criteria cannot access VAD based on the lack of communication. This essentially disrespects a patient's exercise of autonomy. For example, despite a patient expressing a preference for death and not learning of a legally available option to that enables them to exercise that preference, then the patient may choose an end-of-life option that does not satisfy the authenticity condition.

The Victorian prohibition provision places an unfair expectation on a Victorian, with low levels of health literacy, to ask for a legally available treatment that they may not know about. Moreover, according to the scope of the prohibition provision discussed above, the Victorian model places a burden on patients to somehow identify that VAD is an available option to them without the initial assistance from their medical practitioner to initiate the first question to access VAD. Similarly, on the point of communication limitation barriers, patients will need to somehow find help from a third party and strike the balance of seeking enough assistance that does not raise suspicion that the patient has been coerced or influence into seeking VAD.

With respect to the explicit VAD Acts' principles relating to autonomy, there are some tensions with how the principles interacts with the Victorian prohibition provision. The tension becomes evident by drawing on three of the VAD Acts' principles. That is, a patient should be encouraged to openly discuss death and dying,[297] a patient is entitled to genuine choices,[298] and a person has the right to be supported in making informed decisions.[299]

In discussing death and dying, medical practitioners may openly discuss that topic with their patient in a general manner. However, medical practitioners cannot explicitly discuss VAD until the patient has clearly requested VAD information.[300] Given that VAD is directly connected to death, the limitation imposed on medical practitioners restricts their ability to openly discuss death and dying to its fullest extent.

There is an overlap between the VAD Acts' principles relating to a patient's entitlement to genuine choices and a right to make informed decisions. Due to the nature of those two principles being similar, they will be addressed together. Suppose that a patient has expressed a preference for death and not been made aware that they are eligible to access VAD. The patient has discussed end-of-life options, except for VAD, with their medical practitioner then chooses an end-of-life option that is contrary to their preference for death. Arguably, without the patient having all the available information and option presented to them, they have not made an informed decision, or have chosen a genuine choice. In this case, without contravening the prohibition, the view cannot be taken that the medical practitioner has supported the patient to make a genuine choice and an informed decision. Therefore, it is difficult to see how a Victorian medical practitioner can thoroughly achieve the VAD Acts' principles without transgressing the prohibition provision.

In summary, based on Mackenzie and Rogers' three conditions on autonomy, the Victorian prohibition provision, to an extent, does not respect a person's autonomy. Moreover, although an Australian that has low levels of health literacy can present two separate issues, the final decision on an end-of-life option is, in essence, the same—that is, a choice contrary to the patient's preference for VAD. Finally, it is difficult to see how a Victorian medical

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[297] *Victorian VAD Act* (n 4) s 5(f); *Western Australian VAD Act* (n 5) s 4(f).

[298] *Victorian VAD Act* (n 4) s 5(h); *Western Australian VAD Act* (n 5) s 4(h).

[299] *Victorian VAD Act* (n 4) s 5(c), (h); *Western Australian VAD Act* (n 5) s 4(c), (h).

[300] *Victorian VAD Act* (n 4) s 5(f); *Western Australian VAD Act* (n 5) s 4(f).

practitioner can thoroughly achieve the VAD Acts' principles without transgressing the prohibition provision.

b) Western Australian Analysis

The WA prohibition provision allows medical practitioners to initiate VAD discussions with a patient, subject to the disclosure requirements being met. [301] This exemption given to medical practitioners provides a feature of flexibility to respect a patient's autonomy. Given this feature, the exemption provision removes the issues presented above with Victorian prohibition provision. Regardless of a patient's level of health literacy or their background, it is reasonable to assume that most, if not all, terminally ill patients and are coming to their end-of-life have a regular medical practitioner that monitors and consults with the patient.[302] Through regular dialogue and conversation between the medical practitioner and patient, a medical practitioner can assess and determine whether a patient has a genuine preference for death. Presume that a patient has a legitimate preference for death, does not know about VAD or does not have the confidence to initiate the VAD discussion. In that case, a medical practitioner can appropriately provide information or initiate discussions relating to VAD and alternative treatments.

On the other hand, if through dialogue and conversation it appears to the medical practitioner that the patient does not have a genuine preference for death, then there may be no need for a medical practitioner to disclose VAD to the patient. Although, a distinct issue arises from this—the medical practitioner must determine whether the patient's preference is genuine. This issue is further discussed and analysed in the next section on the doctor-patient relationship. Nevertheless, in any of the two events, the WA prohibition provision affords the opportunity for medical practitioners to respect a patient's autonomy. Additionally, the WA model enables a patient to fulfil Mackenzie and Rogers' three conditions of freedom, competency, and authenticity.

The argument and analysis above can be applied to the VAD Acts' principles. The WA prohibition provision enables a medical practitioner to support a patient to make informed decisions, promote genuine choices, and encourage open discussions about dying and

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[301] *Western Australian VAD Act* (n 5) s 10(3).

[302] This assumption will be further discussed in the doctor-patient relationship comparative analysis section.

death.[303] Regardless of the patient's health literacy levels, educational background or language skills, the WA prohibition provision provides enough flexibility to respect a patient's autonomy. That is, if a patient expresses a preference for death, then the medical practitioner may appropriately raise VAD discussions. If the patient expresses a preference to prolong their life, then disclosure of VAD may not be necessary. Ultimately, the WA prohibition provision provides greater flexibility than the Victorian prohibition provision, such as respecting a person's autonomy and abiding by the VAD Acts' principles. Further, the WA prohibition provision does not place a burden or expectation on a patient to ask for a treatment option that they are unaware of because medical practitioners can appropriately raise VAD discussions should those discussions align with the patient's preference.

In conclusion, the Victorian prohibition provision effectively creates a barrier for the patient to satisfy Mackenzie and Rogers' three conditions of autonomy and can only be fulfilled in limited circumstances. In contrast, the WA prohibition provision provides a feature of flexibility for the patient to achieve autonomy. Evidently, suppose the average Australian has low levels of health literacy and does not know that VAD is an available option to them. In that case, the Victorian prohibition can only respect a person's autonomy to its fullest extent if the patient's preference is to prolong their life. On the other hand, the scope of the WA prohibition provision is wider for medical practitioners that allows them to respect a patient's autonomy irrespective of the patient's preference (whether that be death or the prolongment of life). Therefore, the comparative analysis reveals that the WA prohibition provision respects autonomy more than the Victorian prohibition provision.

2 *The doctor-patient relationship*

The discussion in Chapter III on the doctor-patient relationship concluded that the Australian common law, Medical Code and the VAD Acts conform to the shared decision-making model (a relationship of mutuality). Based on that conclusion, the appropriate doctor-patient relationship model to apply within the VAD context, specifically, the prohibition provision, is the shared decision-making model rather than the paternalistic one. The analysis in this section will argue that the Victorian prohibition provision does not conform to the shared decision-making model. The non-compliance will cause difficulty for medical practitioners to adhere to the fundamental tenets of medical practice (the Medical Code) and the VAD Acts'

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[303] *Victorian VAD Act* (n 4) s 5(1)(c), (h), (f); *Western Australian VAD Act* (n 5) s 4(1)(c), (h), (f).

principles, which ultimately undermines the doctor-patient relationship. In comparison, the WA prohibition provision can conform to the shared decision-making model and allow medical practitioners to follow the Medical Code and the VAD Acts' principles accordingly, which supports the doctor-patient relationship.

In the doctor-patient relationship, the shared decision-making model recognises the need to support personal autonomy by building good relationships, respecting both individual competence and preferences that are recognised in Towle and Godolphin's steps for shared decision-making.[304] The nature of the shared decision-making is collaborative and interactional. Moreover, the three core stages of healthcare decision-making are (1) information exchange, (2) deliberation, and (3) decision on the treatment to implement. In summary, information exchange refers to the type and amount of information exchanged between a doctor and patient; the deliberation stage of decision-making refers to the process of expressing and discussing treatment preferences; and finally, the treatment to implement is decided.

The Medical Code standardises and guides medical practitioners in Australian medical practice.[305] The Medical Code provides guidance on how to provide good patient care, which includes, *inter alia*, provide treatment options based on the best available information,[306] encouraging patients to take an interest, and responsibility for, the management of their health and supporting them in this,[307] and communicating effectively with patients.[308] The Medical Code defines effective communication to include discussing with the patients of their condition and the available management options,[309] and responding to patients' questions.[310] In relation to the VAD Acts' principles, it includes supporting a patient to make informed decisions,[311] and that a therapeutic relationship between a patient and medical practitioner should be supported and maintained.[312]

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[304] Framework for Informed Shared Decision Making (n 209) 767.
[305] Medical Code (n 13) 3, [1.1].
[306] Ibid 6, [3.2.5].
[307] Ibid 6, [3.2.13].
[308] Ibid 6, [3.2.5].
[309] Ibid 8, [4.3.2].
[310] Ibid 6, [3.2.1].
[311] *Victorian VAD Act* (n 4) s 5(1)(c); *Western Australian VAD Act* (n 5) s 4(1)(c).
[312] *Victorian VAD Act* (n 4) s 5(1)(e); *Western Australian VAD Act* (n 5) s 4(1)(e).

a) Victorian Analysis

The Victorian prohibition provision diminishes the doctor-patient relationship and prevents patients from receiving good patient care according to their preference. Let us assume that a patient, who has low levels of health literacy, is eligible for VAD and has established a good relationship with their treating medical practitioner through Towle and Godolphin's steps for shared decision-making.[313] Additionally, the patient has expressed a preference for death over the prolongment of their life. Based on that premise, the Victorian prohibition provision taints the initial core stage of healthcare decision-making. It causes detriment through to the final stage of the decision to implement a treatment. That is, in the information exchange stage of the shared decision-making model, the medical practitioner is unable to part VAD information onto the patient despite the patient expressing a preference for death. Following that, in the deliberation stage, in one instance, a process of negotiation is likely to occur. If the patient is adamant about not considering palliative care and its alternative, then the healthcare decision-making process will likely come to an end.

On the other hand, the patient may consider an end-of-life option that is less desirable to them. Eventually, the patient may choose to implement a treatment that does not reflect their genuine treatment preference. Throughout this process, the medical practitioner knowing knows, but cannot reveal, that there is a suitable treatment option (that being VAD) that aligns according to the patient's treatment preference.

With respect to the Medical Code and VAD Acts' principles, the Victorian prohibition provision makes it hard for medical practitioners to adhere to the fundamental tenets of medical practice if medical practitioners are unable to introduce the topic of VAD appropriately. The Medical Code expects medical practitioners to provide treatment options based on the best available information.[314] A Victorian medical practitioner may have difficulty following this practice with a patient who has low levels of health literacy without contravening the prohibition provision. Additionally, there is an expectation to encourage patients to take an interest in, and responsibility for, the management of their health and supporting them in this.[315] Without the medical practitioner having the ability to disclose VAD to a patient, according to the patient's preference for death, may achieve the opposite.

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[313] Framework for Informed Shared Decision Making (n 209) 767.

[314] Medical Code (n 13) 6, [3.2.6].

[315] Ibid 6, [3.2.13].

That is, a patient may be discouraged from taking an interest in their health because a legally available option has not been made known to them despite the patient's preference for death. Lastly, the Medical Code expects medical practitioners to communicate effectively, which includes discussing with the patients of their available management options and responding to their questions. The scope of the Victorian prohibition provision does not allow medical practitioners to disclose VAD by the person simply asking, 'what are my other options'. The issue here for medical practitioners to effectively communicate and respond to that question is that they would need to craft an answer that is true, not misleading and satisfactory to the patient without contravening the prohibition provision.

Similarly, a Victorian medical practitioner will have difficulty abiding by the VAD Acts' principles. Without disclosing VAD information in a way that does not contravene the prohibition provision to a patient with low levels of health literacy, the medical practitioner will have troubles to maintain and support a therapeutic relationship,[316] encourage open discussions about death, dying, and the patient's preferences and values regarding their care, treatment and end-of-life,[317] and be supported to have a conversation with the patient.[318] In the event that the medical practitioner provides an unsatisfactory answer to the question 'what are my other options?', then it may create an unfavourable tension between the medical practitioner and patient. To that extent, the Victorian prohibition provision hinders the maintenance and support of a therapeutic relationship and a conversation to progress. In addition, the VAD Acts requires that medical practitioners support patients to make an informed decision[319] and promote genuine choices.[320] Because of the restrictive nature that the prohibition provision imposes on Victorian medical practitioners, this may cause a moral dilemma – for instance, does the medical practitioner transgress the prohibition provision and disclose VAD information to support a patient to make an informed decision or stay silent and demote genuine choices.

In summary, the analysis of the Victorian prohibition provision against the shared decision-making model, Medical Code, and VAD Acts' principles has revealed that the Victorian prohibition provision can be problematic for the doctor-patient relationship. In relation to the

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[316] *Victorian VAD Act* (n 4) s 5(e); *Western Australian VAD Act* (n 5) s 4(e).
[317] *Victorian VAD Act* (n 4) s 5(1)(f); *Western Australian VAD Act* (n 5) s 4(1)(f).
[318] *Victorian VAD Act* (n 4) s 5(1)(g); *Western Australian VAD Act* (n 5) s 4(1)(g).
[319] *Victorian VAD Act* (n 4) s 5(1)(c); *Western Australian VAD Act* (n 5) s 4(1)(c).
[320] *Victorian VAD Act* (n 4) s 5(1)(h); *Western Australian VAD Act* (n 5) s 4(1)(h).

three core steps of healthcare decision-making in the shared decision-making model, the Victorian prohibition provision taints the initial information exchange stage. This may cause two unfavourable outcomes for the patient. One outcome is where the patient terminates the process at the deliberation stage. The other is where the patient chooses to implement a treatment decision that is less desirable or contrary to their preference. The analysis has also demonstrated the difficulties medical practitioners can face with following the Medical Code and the VAD Acts' principles without contravening the prohibition provision. Therefore, the Victorian prohibition provision undermines the doctor-patient relationship and inhibits a patient from receiving good patient care.

b) Western Australian Analysis

Now turning to the WA analysis, given that its prohibition provision provides an exemption for medical practitioners,[321] it is important to note that two types of doctor-patient relationship affect the WA analysis. That is, a patient with a long-standing relationship with their doctor ('long-standing relationship'); and a patient who does not have a pre-existing relationship with a doctor ('non-existent relationship'). Applying the two types of the doctor-patient relationship on the Victorian prohibition provision does not affect its analysis because there is no flexibility afforded to Victorian medical practitioners to disclose VAD information unless a Victorian patient requests such information.[322] This analysis of the WA prohibition provision proposes that it will achieve the opposite outcome of its Victorian counterpart and that a patient's level of health literacy is not detrimental to the patient's care.

Based on Towle and Godolphin's steps for shared decision-making, a WA medical practitioner can establish a good relationship with a patient and explore their treatment preferences. If there is a long-standing relationship and the medical practitioner has established that the patient has a preference for death, then in the information exchange stage, the medical practitioner may disclose VAD. However, if the patient has indicated a preference for an alternative end-of-life option to prolong their life, the medical practitioner may not need to disclose VAD. Given that the medical practitioner has a long-standing relationship with their patient, the medical practitioner is better positioned to determine whether the patient's preference for death is a genuine choice.

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[321] *Western Australian VAD Act* (n 5) s 10(3).

[322] *Victorian VAD Act* (n 4) s 8(2).

In normal circumstances, a terminally ill patient will have a treating medical practitioner with a long-standing relationship. However, there are situations where a non-existent relationship can arise. For example, a treating medical practitioner may exercise their right to conscientiously object to participate in the VAD process.[323] If the medical practitioner has conscientiously objected, then the medical practitioner may refer the patient to another medical practitioner that is willing and able to participate in the VAD process, or the patient can consult with another medical practitioner with a long-standing relationship. In the event that the two scenarios fail, the patient must seek assistance from a medical practitioner with a non-existent relationship to continue the VAD process. This specific situation is not problematic to a patient's ability to seek and access VAD. That is because the patient would have knowledge of VAD and raised those discussions for the medical practitioner to conscientiously object.

In contrast to the example above, there will be situations when the patient does not know that VAD is a legally available option in order to raise VAD discussions. The lack of knowledge will cause complications for patients who have a non-existent relationship with a medical practitioner. The following scenarios are examples of those complications, which can impact a terminally ill patient's ability to access VAD. In one unfortunate scenario, the treating medical practitioner may die whilst treating the patient or is no longer available for some other reason. In another scenario, the patient may be required to relocate to another facility or residential area. The relocation may become impractical for the patient to continue treatment with the treating medical practitioner because of the distance. In both scenarios, the patient will be required to engage with another medical practitioner, that may have a non-existent relationship.

For the last scenario, the patient could be approaching the timeframe to become eligible to access VAD such as, having an illness that will likely cause death in six months[324] (12 months for neurodegenerative diseases).[325] The treating medical practitioner, with a long-standing relationship, may have already established that the patient has a preference for death. Following that assessment, the treating medical practitioner may feel obligated to inform the patient that the patient may be eligible for VAD soon. However, before the

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[323] *Western Australian VAD Act* (n 5) s 9.
[324] *Western Australian VAD Act* (n 5) ss 16(1)(c)(i)-(ii).
[325] *Western Australian VAD Act* (n 5) ss 16(1)(c)(i)-(ii).

treating medical practitioner can exercise their right to conscientiously object (because VAD has not been yet raised), the medical practitioner may submit an internal request at their facility to cease treating their patient. Alternatively, the treating medical practitioner may recommend the patient to engage another medical practitioner. The treating medical practitioner would do this because the treating medical practitioner may want to avoid discussions about VAD before VAD has actually been raised. The treating medical practitioner's decision to do so can be based on their value for the sanctity of life, and VAD discussions may be personally uncomfortable. This will result in the patient engaging with another medical practitioner who may have a non-existent relationship.

A problem that follows is if the treating medical practitioner/facility neglects or refuses to disclose to the new treating medical practitioner/facility of the terminally ill patient's potential preference for death. A consequential issue will relate to time constraints when the patient has engaged with a medical practitioner with a non-existent relationship (this issue is also applicable to the two earlier examples, where the treating medical practitioner becomes unavailable, or the patient relocates). The following time factors are relevant to consider:

(1) the time that it takes for the patient's medical file to transfer to the new treating facility successfully;
(2) the time that it takes for the new treating medical practitioner to review and consider the patient's medical file;
(3) the time required for the new treating medical practitioner to establish a good relationship with the patient; and
(4) the time required to determine the patient's genuine treatment preferences, specifically for death.

During that time and before establishing the patient's preference for death, the patient may lose decision-making capacity in relation to VAD. If the patient loses this decision-making capacity, the patient will become ineligible for VAD.[326] This problem can adversely affect the patient's preference for death and access to VAD. The impact of this problem on the doctor-patient relationship, Medical Code and VAD Acts' principles will be further discussed separately below.

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[326] *Victorian VAD Act* (n 4) s 9(1)(c); *Western Australian VAD Act* (n 5) s 16(d).

If timing is not an issue, then the fact as to whether the past treating medical practitioner has disclosed the patient's potential preference for death becomes insignificant. The issue for the new treating medical practitioner is to determine the patient's genuine treatment preferences. The treating medical practitioner can address this issue by adopting a practice based on the shared decision-making model. Throughout the patient's treatment, the treating medical practitioner can further explore and assess the patient's treatment preferences. Upon that assessment, the treating medical practitioner may appropriately disclose VAD information should the patient reveal a genuine preference for death.

Regarding the Medical Code and VAD Acts', the WA prohibition provision is more favourable than the Victorian model. That is because the WA prohibition provision's scope allows medical practitioners greater flexibility to adhere to the Medical Code and VAD Acts' principles. In a long-standing doctor-patient relationship, a WA medical practitioner can provide good patient care according to the patient's treatment preferences. Albeit a longer process than a long-standing doctor-patient relationship, a treating medical practitioner who has a non-existent relationship can collaborate with the patient, establish the patient's treatment preferences and work towards achieving good patient care. In any event, a WA medical practitioner can effectively communicate with the patient,[327] encourage patients to take an interest in their health,[328] provide all end-of-life treatment options,[329] and formulate and implement a suitable plan.[330] Additionally, should a patient ask any questions, the medical practitioner will have less difficulty than its Victorian counterpart and can provide an answer that is full and true.[331]

Similarly, the wider scope of the WA prohibition provision affords medical practitioners to approach medical practice that is consistent with the VAD Acts' principles. In a long-standing doctor-patient relationship, it is easier to determine whether the patient has a genuine preference for death and disclose VAD information accordingly. Whereas, in a non-existent doctor-patient relationship, further fact-finding and discussions with the patient is required to determine the patient's genuine preference and whether disclosure of VAD is appropriate. In any of the two types of doctor-patient relationships, the WA prohibition

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[327] Medical Code (n 13) 6, [3.2.5].
[328] Ibid 6, [3.2.13].
[329] Ibid 6, [3.2.6].
[330] Ibid 6, [3.1.2].
[331] Ibid 8, [4.3.6].

provision enables medical practitioners to achieve the following VAD Acts' principles with the patient by:

- maintaining and supporting a therapeutic relationship;[332]
- encouraging open discussions about death and dying;[333] and
- promoting genuine choices.[334]

The most significant principle that medical practitioners can achieve is to support patients to make informed decisions.[335]

This Chapter earlier noted that the non-existent relationship can impact the doctor-patient relationship, Medical Code and VAD Acts' principles. An aspect that can have a negative impact on the patient is the new treating medical practitioner's timing of VAD disclosure. Given the nature of the terminal disease, losing decision-making capacity in relation to VAD is uncertain. But firstly, it is important to note that if a person loses decision-making capacity in one aspect of their life, it does not preclude them from having decision-making capacity in another aspect of their life. For example, in *Re LP*, the WA State Administrative Tribunal found that Mrs LP had decision-making capacity in relation to her own health and safety and was not required a guardianship order.[336] Conversely, the Tribunal found that Mrs LP did not have decision-making capacity in relation to her financial affairs[337] and appointed the Public Trustee as the plenary administrator of Mrs LP's estate.[338] The point being made here is that a terminally ill patient that loses decision-making capacity in relation to VAD may have cognitive function to comprehend their surroundings—losing decision-making capacity in relation to VAD does not necessarily mean to be in a 'vegetative' state.

The uncertainty of the time when a patient will lose decision-making capacity in relation to VAD may place unnecessary stress on the treating medical practitioner to gather enough information to get a sense of the patient's treatment preferences. During this time, the patient can lose the decision-making capacity in relation to VAD at any time. Following on from that, the medical practitioner, upon the patient confirming their preference for death, may fear

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[332] *Victorian VAD Act* (n 4) s 5(1)(e); *Western Australian VAD Act* (n 5) s 4(1)(e).
[333] *Victorian VAD Act* (n 4) s 5(1)(f); *Western Australian VAD Act* (n 5) s 4(1)(f).
[334] *Victorian VAD Act* (n 4) s 5(1)(h); *Western Australian VAD Act* (n 5) s 4(1)(h).
[335] *Victorian VAD Act* (n 4) s 5(1)(c); *Western Australian VAD Act* (n 5) s 4(1)(c).
[336] *Re LP* [2020] WASAT 25, [182]-[189], [204]-[209].
[337] Ibid [190]-[203], [210]-[226].
[338] Ibid [227]-[228].

receiving criticism for not disclosing VAD prior to the patient losing decision-making capacity to VAD. Should the medical practitioner not have the ability to overcome that fear, then they may choose not to disclose VAD to the patient. In this situation, it cannot be said that the treating medical practitioner has abided by the Medical Code and VAD Acts' principle. Whether the decision was based on the preservation of reputation, self-confidence or self-esteem, the treating medical practitioner has made a decision that is nonetheless self-serving and undermines the doctor-patient relationship. The medical practitioner's decision would not be based on working collaboratively with the patient or following the VAD Act's explicit principles. Alternatively, the treating medical practitioner may decide to conform with the basic idea of the Hippocratic Oath, 'to help, or at least to do no harm'. WA medical practitioners would not contravene the WA prohibition provision for not disclosing VAD simply on the basis that the medical practitioner has suspected or confirmed the patient's preference for death. As a result, the WA model is flexible enough to enable specific medical practitioners to undermine the doctor-patient relationship, and not adhere to the Medical Code and VAD Acts' principles.

Except for specific types of medical practitioners, the analysis of the WA prohibition provision has revealed to have the essence of the collaborative and interactional nature of the shared decision-making model. In relation to the three core steps of healthcare decision-making, a WA medical practitioner can reassess and determine whether disclosing VAD is appropriate at any stage to meet the patient's needs and treatment preferences. Moreover, the WA prohibition provision affords enough flexibility for a medical practitioner to follow and adhere to the Medical Code and the VAD Acts' principles. The analysis has also revealed that a patient's level of health literacy is not problematic or a significant issue, as demonstrated in the Victorian analysis. The primary issue that arose in the WA's shared decision-making model, Medical Code and VAD Acts' analysis is determining the patient's genuine treatment preferences and the appropriate time to disclose VAD information. The WA prohibition provision imposes an issue that requires the medical practitioner and patient to work towards a solution collaboratively. In comparison, the Victorian prohibition provision places a burden and unfair expectation on patients to ask for a treatment they may not know exists or is legally available to them.

C *Conclusion*

In conclusion, the WA model is more favourable than the Victorian when comparing the two prohibition provisions through the lends of autonomy and the doctor-patient relationship. Throughout the Victorian and WA analysis, each prohibition provision revealed to have two separate and distinct issues. In relation to the Victorian prohibition provision, the disclosure of VAD is contingent on a VAD eligible patient’s knowledge and confidence to ask for VAD. This contingency is a barrier to access VAD for those who fall within the 60% of Australians who have low levels of literacy. However, the patient’s level of health literacy is not problematic for the WA prohibition provision. The issue in the WA prohibition provision mainly concerns the determination of the patient’s genuine treatment preferences and assessing whether the disclosure of VAD information is appropriate. Ultimately, the Victorian prohibition provision undermines the respect for a person’s autonomy and the doctor-patient relationship. The WA prohibition provision has the flexibility to achieve respect for a person’s autonomy and supports the doctor-patient relationship.

V CONCLUSION

This Thesis has provided a comprehensive overview of the Voluntary Assisted Dying Acts ('the VAD Acts') of the eligibility criteria to access voluntary assisted dying ('VAD'), the procedural framework to access VAD, and the provision related to the disclosure of VAD information to a person that has been described in the Thesis as the prohibition provision. One of the Thesis' key determinations was the scope and application of the prohibition provision. Given that the VAD laws are new in Australia, the prohibition provision has yet to be judicially tested and there is little guidance given by legislative instruments. Therefore, the scope and application of the prohibition provision is unknown. Nevertheless, the uncertainty of the scope and application of the prohibition provision is a cautionary warning to all health practitioners to ensure that they do not transgress the prohibition provision, otherwise dire consequences will follow.

However, the focus of this Thesis was to comparatively analyse the Victorian and WA prohibition provision and determine which model was better. The understanding of the Victorian and WA prohibition provision was not predicated on what is morally right or wrong; but rather defining the parameters of autonomy and the doctor-patient relationship that aligns with Australian medical practices and the essence of the VAD Acts. The criticism here is that the Victorian model imposes a strict prohibition that undermines the doctor-patient relationship and prevents medical practitioners from providing good patient care and respecting a person's autonomy. Ultimately, the analysis found that the WA prohibition provision provides a wide enough scope and flexibility to support the doctor-patient relationship and for medical practitioners to adjust their approach to achieve good patient care and respect a person's autonomy.

A *Issues for the Future*

In the near or far future, Parliament may consider various reform proposals to the VAD Acts. There are two aspects of reform that may be considered. One aspect is to enable minors (who are terminally ill and have yet to each 18 years of age) to access VAD. A reason for Parliament to consider this reform is to follow in the footsteps of some of the liberal

European laws that allow minors to access a similar VAD scheme.[339] Another aspect is to allow competent adults to plan for VAD in advance. This amendment to the VAD Acts may be considered driven by community demand and expectations. There are many issues that can arise if such reforms were considered. This section does not engage to provide a full and detailed explanation of those issues but rather identify some issues that could appear.

1 *Minors accessing VAD*

The VAD Acts require that a person must have decision-making capacity in relation to VAD to access VAD.[340] The issue here is the determination of whether a minor can validly consent to VAD. The legislative framework for minors to consent to medical treatment is a complex area;[341] but generally, the legal test to determine whether a minor has the competency to validly consent to VAD would be if the minor has achieved a sufficient understanding and intelligence to enable them to understand fully what is being proposed.[342] To the extent that the minor lacks competency to consent to medical treatment, then the right to consent to the minor's medical treatment is vested in the guardian's parental responsibility, given that the treatment is in the child's best interest.[343] This aspect of the minor's consent will be in conflict with the VAD Acts' requirement to be acting voluntarily.[344] That is, if a parental guardian has consented for a minor to access VAD, then it cannot be said that the minor has acted voluntarily. On the other hand, should a minor have the competency to consent to VAD, Parliament must address the issue of the *parens patriae* jurisdiction. The *parens patriae* jurisdiction can make decisions for minors that are deemed mature and competent.[345] Again, it cannot be said that a minor has voluntarily accessed VAD if the Court has made the decision for them.

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[339] *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands) Ch II, art 2(4); Jurriaan De Haan, 'The New Dutch Law on Euthanasia' (2002) 10(1) *Medical Law Review* 57, 64; Kumar Amarasekara and Mirko Bagaric, 'The Legislation on Euthanasia in the Netherlands: Lessons to be Learn' (2001) 27(2) *Monash University Law Review* 179, 186-187; see Giulia Cuman and Chris Gastmans, 'Minors and euthanasia: a systematic review of argument-based ethics literature' (2017) 176(7) *European Journal of Pediatrics* 837, 838 for commentary on the Belgian Act allowing minors to access the euthanasia scheme.

[340] *Victorian VAD Act* (n 4) s 9(1)(c); *Western Australian VAD Act* (n 5) s 16(1)(d).

[341] See *Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218 ('*Marions case*'); *Gillick v West Norfold & Wisbech Area Health Authority* [1986] AC 112; *Minister for Health v AS* [2004] WASC 286; *X v Sydney Children's Hospital Network* [2013] NSWCA 320 ('*Sydney Children's Hospital Appeal')*; *Mercy Hospital Victoria v D1* [2018] VSC 519; *Women's and Children's Health Network Inc v LC, JC, and KC* [2012] SASC 104; *Re Alex* [2004] FamCA 297; *Re Imogen (No 6)* [2020] FamCA 761

[342] *Marion's case* (n 131) 273 (Mason CJ, Dawson, Toohey and Gaudron JJ).

[343] *Marion's case* (n 7) 235; *Family Law Act 1975* (Cth) s 61B.

[344] *Victorian VAD Act* (n 4) s 20(1)(c); *Western Australian VAD Act* (n 5) s 16(1)(e).

[345] See *Sydney Children's Hospital Appeal* (n 341) where the applicants unsuccessfully argued that the *parens patriae* jurisdiction only operated in cases of incompetence.

In relation to the disclosure of VAD information to minors, there are two key issues that can arise regarding coercion and influence. For instance, an issue for medical practitioners is when and how they can appropriately disclose VAD information to a minor. Parliament would need to consider whether a medical practitioner can disclose VAD information to a minor with or without the presence of a parental guardian. A further consideration is how this can be done without a parental guardian making a formal complaint that the minor has been coerced and influenced by the medical practitioner to access VAD. Another issue that Parliament would need to consider are circumstances where the minor has requested VAD information from a medical practitioner. The issue would be whether the VAD laws need a regime to ascertain how the minor obtained knowledge to ask for VAD information, and to ensure that the minor has not been coerced and influenced by a third-party.

2 *Competent adults planning in advance to access VAD*

Many people may be concerned with losing decision-making capacity regarding their health care preferences in the future.[346] An Advance Health Directive ('AHD') can provide competent adults with a way to ensure their autonomous choice are honours at a future time when they are unable to express their wishes. They are:

> founded on respect for personal autonomy and are intended to ensure a person's preference can be honoured during any period of temporary or permanent impaired decision-making capacity, not only at end-of-life.[347]

The *Guardianship and Administration Act 1990* (WA) ('GAA') enables a person to create a legally binding statutory AHD and health practitioner must comply with the treatment in accordance with the decision in the AHD.[348]

The maker of a statutory AHD:

(1) must have full legal capacity;[349]

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[346] My Life, My Choice (n 49) 25.

[347] The Clinical, Technical and Ethical Principal Committee of the Australian Health ministers' Advisory Council, *A National Framework for Advance Care Directives* (Web Page, September 2011) 4 <https://www.dementia.org.au/sites/default/files/start2talk/5.0.4.1%20AHMAC%20framework.pdf>.

[348] *Guardianship and Administration Act 1990* (WA) s 110ZJ(2).

[349] Ibid s 110P.

(2) must understand the nature and consequence of the treatment they are consenting to or refusing;[350]

(3) must use the form prescribed under the GAA, and have the document properly witnessed;[351] and

(4) is encouraged to seek legal and medical advice (but this is not mandatory).[352]

Additionally, the statutory AHD must be made voluntarily, and without inducement or coercion by another person.[353] A treatment decisions in a statutory AHD operates when the maker of the AHD has lost decision-making capacity. The treatment decision then operates as if the decision was made by the person at that time and as if the person had full legal capacity.[354] However, since the introduction of the WA VAD Act, the GAA has been amended. The amendment provides that nothing in the GAA authorises the making of a treatment decision, whether in an AHD or otherwise, in relation to VAD.[355]

If Parliament were to allow people to plan for VAD in advance, there are a few issues to consider. A significant issue is whether an AHD would reflect the person's current treatment preference for VAD. An AHD does not operate if circumstances exist or have arisen that would have caused a reasonable person in the maker's position to have changed his or her mind about the treatment decision.[356] Suppose that a person made an AHD to plan for VAD in advance five years prior to losing decision-making capacity. The risk here is that the longer the time between the executed AHD and until the AHD comes into operation, it will be more difficult to determine whether the AHD reflects the person's current treatment preferences. Suppose that a person who executed an AHD may at the time value pro-choice. Over the years, the person may have shifted their values and support pro-life. Arguably, a reasonable person in the maker's position, who made an AHD for VAD, would likely no longer want to access VAD.

Parliament would need to consider a timeframe for the AHD to validly access VAD. For example, the timeframe could be one year from the AHD's date of execution until the date the person has lost capacity and is seeking to access VAD. One of the inconveniences of this

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[350] Ibid 110R(2).

[351] Ibid s 110Q(1)(a).

[352] Ibid s 110(1)(b).

[353] Ibid s 110R(1).

[354] Ibid s 110S.

[355] Ibid s 3B.

[356] Ibid s 110S(3)(b).

proposed timeframe is that a person would need to continuously update their AHD on a yearly basis. However, a benefit of an AHD would be for patients who have been diagnosed with a terminal illness who are not eligible to access VAD yet because their disease will not likely cause death within the next six months. An AHD can address the fear of losing decision-making capacity upon being diagnosed of a terminal illness and before satisfying the VAD Acts' time threshold. Nevertheless, Parliament would need implement an appropriate timeframe that would strike the balance between honouring the person's autonomous choice for VAD and to reduce doubt of the person's wishes to still access VAD. An additional condition that Parliament may consider is that the person must be diagnosed with a terminal illness in order to make an AHD concerning VAD.

B *Other Matters of Consideration*

There are other matters that this Thesis did not engage with and could have been considered such as consideration of the Tasmanian, South Australian and Queensland VAD laws. At the research phase of this Thesis, only the Victorian and WA VAD Acts had passed through Parliament. Since then, the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) received royal assent on 22 April 2021,[357] the *Voluntary Assisted Dying Act 2021* (SA) will come into operation on a day to be fixed by proclamation,[358] and the *Voluntary Assisted Dying Bill 2021* (QLD) will commence on 1 January 2023.[359]

It is interesting to note that the SA VAD Act's prohibition provision follows the Victorian model by not implementing an exemption for medical practitioners to disclose VAD information.[360] In contrast, the Tasmanian and Queensland VAD Act's prohibition provision follows the WA model by implementing an exemption for medical practitioners to disclose VAD information, if at the time of doing so, the medical practitioner also discloses information about palliative care and other treatment options available.[361] There will be benefits and values to investigate the approach and development to the Tasmanian and SA prohibition provision.

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[357] *Tasmanian VAD Act* (n 6).

[358] *South Australian VAD Act* (n 7) s 2

[359] *Queensland VAD Act* (n 8) s 2(2).

[360] *South Australian VAD Bill* (n 7) s 12.

[361] *Tasmanian VAD Act* (n 6) s 17; *Queensland VAD Act* (n 8) s 7(2).

C *Final Comments*

Notwithstanding the moral and ethical debates to choose death at the end-of-life, the Australian States' Parliaments have taken a protective approach in the VAD laws. This protective approach can be seen in the stringent eligibility criteria. Nonetheless, it is a significant law that enables terminally ill persons to choose the manner and timing of their death. With respect to the prohibition provision, this Thesis has argued that the WA model is better by establishing that the Victorian prohibition provision undermines autonomy and the doctor-patient relationship. However, only time will tell and determine which of the two models are in fact better in medical practice and the legal sphere.

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