

Queensland Voluntary Assisted Dying Handbook

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Version 2.0



Queensland
Government

Disclaimer: The information within the *Queensland Voluntary Assisted Dying Handbook Version 2.0* is intended as a guide to good clinical practice. The law and service delivery environment is constantly evolving, so while every attempt has been made to ensure the content is accurate, it cannot be guaranteed. The information within this document should not be relied upon as a substitute for other professional or legal advice.

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Introduction

Voluntary assisted dying is available in Queensland from 1 January 2023. It gives eligible people diagnosed with a life-limiting condition, who are suffering intolerably and dying, an additional end-of-life choice by allowing them to choose the timing and circumstances of their death.

The Queensland Voluntary Assisted Dying Handbook (QVAD Handbook) assists healthcare workers, health services and others understand their roles and responsibilities and support compliance with the [Voluntary Assisted Dying Act 2021](#) (the Act).

Acknowledgment of Country

Queensland Health acknowledges the Traditional and Cultural Custodians of the lands, waters, and seas across Queensland, pays respect to Elders past and present, and recognises the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination, and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

Acknowledgment of co-design

Queensland Health acknowledges the significant contributions of all stakeholders who have supported the implementation of voluntary assisted dying as part of the Implementation Taskforce, committees, working groups, and forums. This includes doctors, nurses, pharmacists, allied health professionals, consumers, and content experts from across Queensland. The authors extend their sincere thanks to these contributors for generously providing their advice and feedback.

Your honesty and courage in sharing your experiences, hopes, and insights has been invaluable in ensuring the best outcomes for Queenslanders. Thank you for helping to ensure voluntary assisted dying in Queensland is high quality, safe, accessible, and compassionate.

Acknowledgement statement

Queensland Health acknowledges that some of the material in these guidelines has been extracted or adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, Queensland University of Technology. That material is reproduced here with permission under license from Queensland University of Technology.

With permission, the QVAD Handbook is also adapted from resources created by the:

- End of Life Care Program, Western Australian Department of Health
- Victorian Department of Health and Human Services.

Intended audience

The QVAD Handbook is intended for:

- medical practitioners, nurse practitioners, and registered nurses who participate in voluntary assisted dying as coordinating, consulting, or administering practitioners
- Queensland Hospital and Health Services and private entities developing policies, processes, and procedures to support access to the voluntary assisted dying scheme.

It may also be used by:

- other healthcare workers who provide care and support for people who may seek information about or access to voluntary assisted dying
- healthcare workers who conscientiously object to participating in the voluntary assisted dying process.

Information in the QVAD Handbook can be applied to a range of settings, including:

- Queensland Health Hospital and Health Services
- private hospitals
- residential aged care facilities
- hospices
- hostels or other facilities where accommodation, nursing or personal care is provided (for example, disability accommodation services)
- primary care
- community-based services
- a person's home.

In scope

The QVAD Handbook aims to provide context to the Act and provides guidance on navigating the voluntary assisted dying process from the practitioner perspective. It covers topics including:

- the regulatory framework for voluntary assisted dying in Queensland, including offences, protections, and oversight mechanisms
- restrictions on communication
- conscientious objection
- the role of Hospital and Health Services and private entities
- the stages of voluntary assisted dying:
 - » preparing for participation
 - » receiving a request from a person
 - » assessment processes
 - » administration of a voluntary assisted dying substance
 - » after the person dies.

The QVAD Handbook also provides information on the roles of the:

- Voluntary Assisted Dying Review Board (Review Board)
- Queensland Voluntary Assisted Dying Review Board Information Management System (QVAD Review Board IMS)
- Queensland Voluntary Assisted Dying Support Service (QVAD-Support)
- Queensland Voluntary Assisted Dying Pharmacy Service (QVAD-Pharmacy)
- Queensland Civil and Administrative Tribunal (QCAT).

The information contained in the QVAD Handbook is general in nature and does not restate the requirements of the Act in full. It is not intended to replace clinical judgement or act as legal advice. It is expected healthcare workers assisting a person to access voluntary assisted dying will draw on their existing clinical knowledge and expertise as they would in providing any other end-of-life care.

Queensland voluntary assisted dying mandatory training is required for a medical practitioner, nurse practitioner, or registered nurse who undertakes a role designated by the Act. The QVAD Handbook complements the content of the mandatory training and is intended to be used as reference for any practitioner providing voluntary assisted dying services under the Act.

Out of scope

The following matters related to voluntary assisted dying are briefly touched on in the QVAD Handbook; however, in-depth guidance is considered out of scope as it is covered in other resources:

- QVAD Review Board IMS user guide and work instructions
- specific requirements of private entities
- safety and quality guidance
- information about the protocols for prescription and administration of a voluntary assisted dying substance
- information targeted towards consumers.

Other matters out of scope for the QVAD Handbook include:

- professional obligations under specific codes of conduct
- a healthcare worker's professional standards
- obligations under common law and other legislation
- any organisational policies and procedures at facilities and services where voluntary assisted dying may be engaged with or provided.

Section I: Overview of voluntary assisted dying in Queensland

Chapter 1: Voluntary assisted dying in Queensland

Overview

Voluntary assisted dying in Queensland gives eligible people diagnosed with a life-limiting condition, who are suffering intolerably and dying, an additional end-of-life choice by allowing them to choose the timing and circumstances of their death.

It involves the administration of a substance prescribed by a medical practitioner, with the purpose of bringing about the person's death. It is instigated by the person's voluntary request and follows a process of requests and assessments.¹

The phrase 'voluntary assisted dying' emphasises:²

- the decisions to request, access and to continue with the process must be **voluntary** and without coercion
- that the process is **assisted** by medical practitioners, nurse practitioners and registered nurses; and
- to be eligible the person must be **suffering and dying**.

Refer to [Chapter 2: The regulatory framework for voluntary assisted dying](#) of this Handbook for more information about the legal context in Queensland.

Principles of voluntary assisted dying

Eight principles underpin the Act. These principles are based on Queensland's legal and human rights framework, relevant professional ethics, and standards for healthcare workers. They guide how healthcare workers in Queensland interact with voluntary assisted dying.

1. **Value of human life:** human life is of fundamental importance.
2. **Dignity:** every person has inherent dignity and should be treated equally and with compassion and respect.
3. **Autonomy:** a person's autonomy, including autonomy in relation to end-of-life choices, should be respected.
4. **High quality care and treatment:** every person approaching the end-of-life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life.
5. **Accessibility:** access to voluntary assisted dying and other end-of-life choices should be available regardless of where a person lives in Queensland.
6. **Informed decision-making:** a person should be supported in making informed decisions about end-of-life choices.

1. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. [www.qlrc.qld.gov.au/data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf](http://www qlrc.qld.gov.au/data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf)

2. Ibid.

7. **Protecting those who are vulnerable:** a person who is vulnerable should be protected from coercion and exploitation.
8. **Respect for diversity:** a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

The process

There are three phases in the voluntary assisted dying process and each phase has specific steps. A person who has requested access to voluntary assisted dying has the right to stop the process at any time.

- [Phase 1: Request and assessment](#)
 - » first request
 - » first assessment
 - consulting assessment
 - second request
 - » final request
 - » final review
- [Phase 2: Administration of the voluntary assisted dying substance](#)
 - » administration decision
 - » appointing the contact person
 - » prescription of the voluntary assisted dying substance
 - » supply of the voluntary assisted dying substance
 - » administration and death
- [Phase 3: After the person dies](#)
 - » disposal of the substance
 - » death notification.

The voluntary assisted dying process is depicted in [Figure 1](#).

The voluntary assisted dying process: an overview:

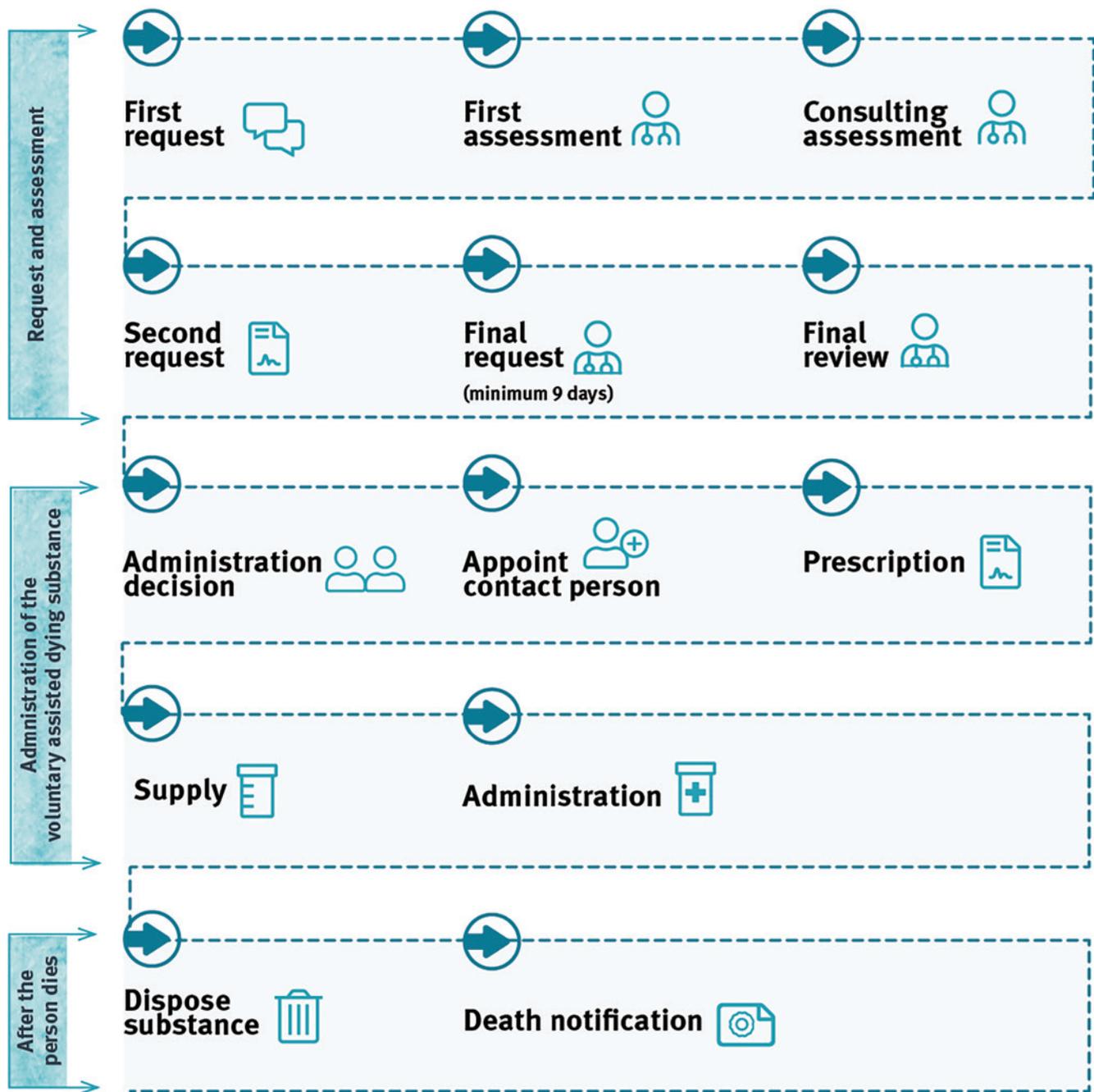


Figure 1: The voluntary assisted dying process.

The Voluntary Assisted Dying Review Board (Review Board) reviews each completed request for voluntary assisted dying for compliance with the process and legislation. For more information about the Review Board refer to [Chapter 3: Oversight](#).

Refer to [Section II](#) of this Handbook for detailed guidance about the voluntary assisted dying process.

Eligibility criteria for a person to access voluntary assisted dying

There are strict eligibility criteria to access voluntary assisted dying. The Act requires that a person must meet all the following criteria to be eligible for voluntary assisted dying.

A person must:

- be diagnosed with a disease, illness or medical condition that:
 - » is advanced, progressive and will cause death
 - » is expected to cause death within 12 months
 - » is causing suffering that the person considers to be intolerable
- have decision-making capacity in relation to voluntary assisted dying
- be acting voluntarily and without coercion
- be at least 18 years of age
- be an Australian citizen, permanent resident, or have been ordinarily resident in Australia for at least three years immediately before making their first request (or granted an Australian residency exemption by Queensland Health)
- have been ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request (or granted an Australian residency exemption by Queensland Health).

Assessment of whether a person satisfies the eligibility criteria occurs at numerous stages of the voluntary assisted dying process:

- in the [first assessment](#) and [consulting assessment](#), two appropriately qualified and authorised medical practitioners must independently assess whether the person meets all the eligibility criteria
- at the [final review](#), the coordinating practitioner must certify they are satisfied the person has decision-making capacity and is acting voluntarily and without coercion
- if a person has chosen practitioner [administration](#), the administering practitioner (who must be an appropriately qualified and authorised medical practitioner, nurse practitioner or registered nurse) must certify that they believe the person has decision-making capacity and is acting voluntarily at the time a voluntary assisted dying substance is administered.

Administration methods

A person who accesses voluntary assisted dying must make an administration decision. The Act allows for a voluntary assisted dying substance to be administered in one of two ways:

1. **Self-administration:** the person administers the voluntary assisted dying substance themselves. This is the **default method of administration**.
2. **Practitioner administration:** the voluntary assisted dying substance is administered to the person by the administering practitioner. A practitioner administration decision may only be made if the coordinating practitioner for the person advises self-administration is inappropriate, having regard to any of the following:
 - » the ability of the person to self-administer the substance
 - » the person's concerns about self-administering the substance
 - » the method for administering the substance that is suitable for the person.

If a person chooses practitioner administration, the coordinating practitioner is the default administering practitioner. However, the role can also be transferred to another eligible medical practitioner, nurse practitioner, or registered nurse if the original administering practitioner is unable or unwilling to administer the substance to the person.

For more information, refer to [Chapter 17: Administration decision](#).

Key roles in the process

Voluntary assisted dying is a multidisciplinary model of service delivery. The Act identifies specific roles and responsibilities for medical practitioners, nurse practitioners, registered nurses, and other registered health practitioners including pharmacists. In addition, there are a range of other key roles in voluntary assisted dying in Queensland. These are summarised in [Table 1](#).

The operational structure for delivery of voluntary assisted dying in Queensland is depicted in [Appendix A](#).

Summary: Key roles in delivery of voluntary assisted dying

Table 1: Key roles in delivery of voluntary assisted dying

Role	Functions	Who can act in this role	More information	
Authorised voluntary assisted dying practitioners	Coordinating practitioner	<ul style="list-style-type: none"> Coordinates the voluntary assisted dying process Primary voluntary assisted dying clinical contact for the person Receives the first, second, and final requests from the person Conducts the first eligibility assessment Undertakes the final review Prescribes the voluntary assisted dying substance As a default, acts as administering practitioner (if practitioner administration) 	Eligible medical practitioner who has been authorised by the Chief Medical Officer prior to conducting the first assessment	Appendix B provides a detailed list of the tasks and actions required of the coordinating practitioner
	Consulting practitioner	<ul style="list-style-type: none"> Conducts the second eligibility assessment 	Eligible medical practitioner who has been authorised by the Chief Medical Officer prior to conducting the consulting assessment	Appendix C provides a detailed list of the tasks and actions required of the consulting practitioner
	Administering practitioner	<ul style="list-style-type: none"> Only involved in practitioner administration (not self-administration) Administers the voluntary assisted dying substance in the presence of a witness Disposes of any unused or remaining voluntary assisted dying substance 	As a default, this will be the coordinating practitioner, but the role can be transferred to another eligible medical practitioner, nurse practitioner, or registered nurse who has been authorised by the Chief Medical Officer	Appendix D provides a detailed list of the tasks and actions required of the administering practitioner

Role	Functions	Who can act in this role	More information
Authorised supplier/ Queensland Voluntary Assisted Dying Pharmacy Service (QVAD-Pharmacy)	<ul style="list-style-type: none"> Receives the prescription for the voluntary assisted dying substance Prepares and supplies the voluntary assisted dying substance Provides written information about the voluntary assisted dying substance and related requirements to a person who has made a self-administration decision 	Pharmacists employed by QVAD-Pharmacy	<p>Chapter 20: Supply</p> <p>Chapter 25: Queensland Voluntary Assisted Dying Support and Pharmacy Service</p>
Authorised disposer	<ul style="list-style-type: none"> Disposes of unused or remaining voluntary assisted dying substance 	Pharmacists who hold general registration and are employed by QVAD-Pharmacy, a public or private hospital, or a community pharmacy	<p>Chapter 23: Disposal of the voluntary assisted dying substance</p> <p>Other information on the Queensland Health website:</p> <ul style="list-style-type: none"> <i>Disposing of Voluntary Assisted Dying Substances: Guidance for Administering Practitioners</i> <i>Disposing of Voluntary Assisted Dying Substances: Guidance for Pharmacists</i>

Role	Functions	Who can act in this role	More information
<p>Referral for determination</p>	<ul style="list-style-type: none"> If the coordinating and/or consulting practitioner is unable to determine whether a person has an eligible condition (i.e. that the disease, illness, or medical condition is advanced, progressive and will cause death; is expected to cause death within 12 months; and is causing suffering that the person considers intolerable) or decision-making capacity in relation to voluntary assisted dying, a registered health practitioner can accept a referral to assist in determining the matter If the coordinating and/or consulting practitioner is unable to determine whether a person is acting voluntarily and without coercion, another person with appropriate skills and training can accept a referral to assist in determining the matter 	<p>Any registered health practitioner with appropriate skills and training to determine whether a person has an eligible disease or prognosis or decision-making capacity</p> <p>Another person with appropriate skills and training to determine whether a person is acting voluntarily and without coercion</p>	<p>Chapter 11: The first assessment</p> <p>Other resources on the Queensland Health website:</p> <ul style="list-style-type: none"> <i>Referral for Determination Form</i> <i>Determination Assessment Report</i>
<p>Contact person</p>	<p>For self-administration:</p> <ul style="list-style-type: none"> May receive the voluntary assisted dying substance from an authorised supplier and supply it to the person accessing voluntary assisted dying Required to give any unused or remaining substance to an authorised disposer Informs the coordinating practitioner if the person dies (as a result of self-administering the voluntary assisted dying substance, or from another cause) Provides information to the Review Board if requested <p>For practitioner administration:</p> <ul style="list-style-type: none"> Informs the coordinating practitioner if the person dies without accessing voluntary assisted dying Provides information to the Review Board if requested 	<p>Any person who consents to being appointed and is at least 18 years of age</p>	<p>Chapter 18: Appointing the contact person</p>

Role	Functions	Who can act in this role	More information
Queensland Voluntary Assisted Dying Support Service (QVAD-Support)	<ul style="list-style-type: none"> • The statewide service staffed by multidisciplinary care coordinators who provide support to anyone involved with voluntary assisted dying in Queensland. This includes: <ul style="list-style-type: none"> » assistance connecting people with coordinating, consulting, and administering practitioners » support for people, carers, and families as they navigate the voluntary assisted dying process » connections with local services and providers to facilitate coordination of care across public and private hospitals, primary care, aged care facilities, hospices, and community-based services » information for people wishing to access the scheme, carers and family members, healthcare workers, and service providers. • Manages the regional access support scheme (QVAD-Access) • Delivers healthcare worker education to support capacity building and awareness about voluntary assisted dying, as required • Links practitioners with the QVAD Community of Practice 	<p>Employees of QVAD-Support (referred to as care coordinators)</p>	<p>Chapter 25: Queensland Voluntary Assisted Dying Support and Pharmacy Service</p> <p>Chapter 26: Support for healthcare workers</p>

Role	Functions	Who can act in this role	More information
Voluntary Assisted Dying Review Board (Review Board)	<ul style="list-style-type: none"> • Monitors the operation of the Act • Reviews each completed request to ensure practitioners and other persons involved have complied with the Act • Refers identified issues to relevant entities such as the Commissioner of Police, the Queensland Health Ombudsman, and the Director-General of Queensland Health • Provides advice and reports to the Minister for Health and Ambulance Services and Director-General of Queensland Health as required • Provides an annual report to the Minister to be tabled in Parliament by the Minister about the operation of the Act, the performance of the board's functions including the number of completed requests reviewed, and recommendations for systemic improvements • Receives the forms associated with each step of the voluntary assisted dying process • Keeps records of information about voluntary assisted dying as required by the Act 	<p>The Review Board consists of between five to nine members appointed by the Minister. The Minister must appoint one person to be chairperson.</p> <p>Board members must have expertise in medicine, nursing, pharmacy, psychology, social work, ethics, law, or other relevant areas; or have experience, knowledge or skills likely to make a valuable contribution to the work of the Review Board.</p>	Chapter 3: Oversight
Office of the Voluntary Assisted Dying Review Board	<ul style="list-style-type: none"> • Provides secretariat support to the Review Board • Administers the QVAD Review Board IMS 	Queensland Health employees of the Office of the Voluntary Assisted Dying Review Board	Chapter 3: Oversight
Voluntary Assisted Dying Unit (VAD Unit)	<ul style="list-style-type: none"> • Coordinates the practitioner authorisation process • Coordinates exemptions from the residency and interpreter requirements 	Queensland Health employees of the VAD Unit	Chapter 3: Oversight

Voluntary assisted dying terminology

‘Voluntary assisted dying’ is the preferred terminology in Queensland.

Other terms used to describe voluntary assisted dying such as ‘euthanasia’, ‘physician-assisted suicide’, and ‘medical assistance in dying’ (although still used in other international jurisdictions) are potentially stigmatising and can be used pejoratively.

Glossary

The terms in Table 2 are related to the voluntary assisted dying process in Queensland and can be used as a reference when reading the QVAD Handbook. For exact definitions you may need to refer to the Act or other legislation as this glossary is a general guide only.

Table 2: Glossary

Term	Definition
Accredited interpreter	For the purposes of voluntary assisted dying, this is an interpreter who holds a credential issued under the National Accreditation Authority for Translators and Interpreters (NAATI) certification scheme.
Administering practitioner	The medical practitioner, nurse practitioner or registered nurse who is authorised to administer the voluntary assisted dying substance to a person. If the person chooses practitioner administration, the coordinating practitioner is the administering practitioner by default, but can transfer this role to another authorised practitioner.
Administration decision	The decision a person makes in consultation with and on the advice of their coordinating practitioner to either self-administer the voluntary assisted dying substance or have it administered by an administering practitioner.
Advance health directive	A legal document that allows people to make decisions about future healthcare and treatment, in line with their values and wishes, in the event they are unable to do so (for example, if the person loses decision-making capacity). Advance health directives cannot be used for voluntary assisted dying.
Agent	Someone authorised by the Act, in certain circumstances, to act on the person’s behalf.
Allied health professional	A qualified person who specialises in a health profession other than medicine, dentistry, nursing, or midwifery. For example, a physiotherapist, speech pathologist, psychologist, social worker, or pharmacist. Allied health professionals are often part of a multidisciplinary healthcare team.
Authorised disposer	A pharmacist who is authorised to dispose of the voluntary assisted dying substance.
Authorised supplier	A registered health practitioner (generally a pharmacist) who is authorised to supply the voluntary assisted dying substance. In Queensland, authorised suppliers are part of QVAD-Pharmacy.

Term	Definition
Authorised voluntary assisted dying practitioner	A medical practitioner, nurse practitioner or registered nurse who is authorised to participate in the voluntary assisted dying process as a coordinating, consulting, or administering practitioner. An authorised voluntary assisted dying practitioner has been verified as eligible to participate by Queensland Health and has completed mandatory training.
Care coordinator	A healthcare worker employed by QVAD-Support who can provide information and assistance regarding voluntary assisted dying.
Carer	A person who provides personal care, support and assistance to another person who needs it because that other person has a disability, or has a medical condition (terminal or chronic illness), or has a mental illness, or is frail and aged.
Carriage service	An electronic means of communication, including telehealth, telephone, fax, email, internet, and videoconference.
Cause of death certificate	<p>A legal document completed by a medical practitioner that certifies the probable cause of death of a person.</p> <p>The medical practitioner certifying the death of a person who has died following self-administration or practitioner administration of a voluntary assisted dying substance must write on the cause of death certificate that the person's underlying illness, disease, or medical condition was the cause of death. It must not mention voluntary assisted dying.</p>
Chief executive	The Director-General of Queensland Health.
Coercion	Includes intimidation or a threat or promise, including by an improper use of a position of trust or influence. Under the Act, a person's choice to access voluntary assisted dying must be free from coercion.
Conscientious objection	Refusal by a healthcare worker to provide, or participate in, a lawful treatment or procedure because it conflicts with their personal beliefs, values, or moral concerns.
Consulting assessment	The independent assessment conducted by the consulting practitioner to determine if a person meets the eligibility criteria for voluntary assisted dying. This occurs after a person has been assessed as eligible by the coordinating practitioner during the first assessment.
Consulting practitioner	A medical practitioner who independently completes a consulting assessment for the person. This person is always different to the coordinating practitioner.
Contact person	The person appointed by a person accessing voluntary assisted dying to carry out specific activities under the Act and act as a point of contact for the Review Board.
Coordinating practitioner	The medical practitioner who accepts a person's first request and supports the person through the voluntary assisted dying process. This role can be transferred to the consulting practitioner at the request of either the person, or the coordinating practitioner.

Term	Definition
Deciding practitioner	The practitioner responsible for making a decision about the transfer of a person. This is normally the person's coordinating practitioner. However, it may be a different medical practitioner if chosen and agreed to by the person accessing voluntary assisted dying and the relevant entity.
Decision-making capacity	A person's ability to make decisions about their life. For the purposes of the Act, the decision for which the person must have decision-making capacity is the request for access to, and a decision to access, voluntary assisted dying.
Eligibility criteria	The set of requirements that a person must meet to access voluntary assisted dying.
End-of-life	The time leading up to a person's death, when it is expected that they are likely to die soon from an illness, disease, or medical condition. To be eligible for voluntary assisted dying a person must be expected to die within the next 12 months.
Enduring request	Lasting over a period of time. The Act requires a request for voluntary assisted dying to be made at three different points in time (first request, second request and final request) to ensure the request is enduring.
Facility	For Part 6, Division 2 of the Act relating to non-participation in voluntary assisted dying by entities, a facility is: <ul style="list-style-type: none"> a) a private hospital; or b) a hospice; or c) a public sector hospital; or d) a nursing home, hostel, or other facility at which accommodation, nursing or personal care is provided to persons who, because of infirmity, illness, disease, incapacity, or disability, have a need for nursing or personal care; or e) a residential aged care facility.
Family member	Under the Act, a family member cannot undertake certain roles relating to voluntary assisted dying. This includes being the person's coordinating/consulting/administering practitioner; a person referred to for an assessment of voluntariness under the Act; or an interpreter. <p>In this context, family member means the person's:</p> <ul style="list-style-type: none"> • spouse; or • parent, grandparent, sibling, child, or grandchild; or • a person who, under Aboriginal tradition or Torres Strait Island custom, is regarded as the person's parent, grandparent, sibling, child, or grandchild.
Final request	The final request for access to voluntary assisted dying that a person makes to the coordinating practitioner after completing the second request. This is the last of three requests a person must make to access voluntary assisted dying.

Term	Definition
Final review	The review the coordinating practitioner must complete after receiving the final request. The final review confirms the request and assessment process has been completed in accordance with the Act, and that the person has decision-making capacity in relation to voluntary assisted dying and is acting voluntarily and without coercion.
First assessment	The assessment completed by the coordinating practitioner to determine if a person meets the eligibility criteria for access to voluntary assisted dying. If assessed as eligible, the next step is the consulting assessment.
First request	The clear and unambiguous request a person makes to a medical practitioner for access to voluntary assisted dying. This is the first of three requests a person must make to access voluntary assisted dying and should ordinarily be made during a medical consultation.
First request accepted: Approved Queensland Health information	Specific information given to a person by a medical practitioner who accepts that person's first request for voluntary assisted dying. This information is approved by the Director-General of Queensland Health.
First responder	A person whose job means that they are likely to be called to attend to an emergency. For example, ambulance officers, police, or firefighters.
Health professional	A qualified person from the medical, nursing, or allied health professions.
Healthcare worker	A person who works in a healthcare setting such as a hospital, general practice, or residential care facility. This includes health professionals and any other person who provides or supports delivery of health services or professional care services.
Medical consultation	An appointment or meeting with a medical practitioner to seek medical advice or treatment. This may be conducted in a physical (face-to-face) or virtual (via telehealth or videoconferencing) setting.
Medical practitioner	A person registered under the Health Practitioner Regulation National Law to practise in the medical profession, other than as a student, in Australia. Also known as a doctor.
National Accreditation Authority for Translators and Interpreters (NAATI)	The national standards and accreditation body for translators and interpreters in Australia. Interpreters must be NAATI accredited to provide services to persons seeking voluntary assisted dying.
Nurse practitioner	A person who is a registered nurse and endorsed under the Health Practitioner Regulation National Law as being qualified to practise as a nurse practitioner in Australia.
Office of the Health Ombudsman (OHO)	Queensland's independent health service complaints agency responsible for managing health service complaints received from individuals and organisations.
Office of the Voluntary Assisted Dying Review Board	The office within Queensland Health which provides secretariat support to the Review Board and administers the QVAD Review Board IMS.

Term	Definition
Palliative care	The care provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting; and is directed at preventing, identifying, assessing, relieving, or treating the person's pain, discomfort or suffering in order to improve their comfort and quality of life.
Penalty unit	<p>The fine amount for an offence under Queensland legislation and the laws of local governments is identified as a penalty unit. The dollar value of a penalty unit is subject to annual review.</p> <p>The current penalty unit value in Queensland is available on the Queensland Government website.</p>
Practitioner administration	The process whereby a person is administered the voluntary assisted dying substance by an administering practitioner.
Queensland Civil and Administrative Tribunal (QCAT)	Independent body that makes and reviews a range of decisions related to administrative, commercial, and personal matters in Queensland. QCAT can review certain decisions related to the voluntary assisted dying assessment process.
Queensland Voluntary Assisted Dying Review Board Information Management System (QVAD Review Board IMS)	<p>The online record-keeping system for the management of voluntary assisted dying in Queensland. Authorised voluntary assisted dying practitioners can use QVAD Review Board IMS to complete and submit forms to the Review Board as required by the Act.</p> <p>Available at: https://qvad-ims.health.qld.gov.au/</p>
Queensland Voluntary Assisted Dying Pharmacy Service (QVAD-Pharmacy)	The statewide pharmacy service hosted by Metro South Health. Staff within QVAD-Pharmacy are the authorised suppliers of the voluntary assisted dying substance in Queensland.
Queensland Voluntary Assisted Dying Review Board (Review Board)	The independent oversight body established to monitor the operation of and ensure compliance with the Act.
Queensland Voluntary Assisted Dying Support Service (QVAD-Support)	<p>The statewide support service hosted by Metro South Health. QVAD-Support care coordinators provide support to anyone involved with voluntary assisted dying in Queensland, including:</p> <ul style="list-style-type: none"> • people wanting information about or access to voluntary assisted dying • carers and family members of people wanting to access voluntary assisted dying • healthcare workers • facilities and entities.
Registered health practitioner	A person (other than a student) who is listed as a health professional with the Australian Health Practitioner Regulatory Agency (Ahpra) under the Health Practitioner Regulation National Law (Queensland).

Term	Definition
Request and assessment process	The phase of the voluntary assisted dying process that involves the first request, first assessment, consulting assessment, second request, final request, and final review.
Second request	The written request for access to voluntary assisted dying that a person makes after being assessed as eligible by the coordinating practitioner and the consulting practitioner. This is the second of three requests a person must make to access voluntary assisted dying.
Self-administer/ self-administration	The process whereby a person administers the voluntary assisted dying substance themselves.
Telehealth	The use of communication technology to provide healthcare remotely.
Voluntary	When a person acts of their own free will.
Voluntary assisted dying (VAD)	The administration of a voluntary assisted dying substance and steps reasonably related to that administration.
<i>Voluntary Assisted Dying Act 2021 (the Act)</i>	The legislation that regulates voluntary assisted dying in Queensland.
Voluntary assisted dying substance	The approved Schedule 4 substance or Schedule 8 substance, or a combination of those substances, for use under the Act for the purpose of causing a person's death. The substances are approved as voluntary assisted substances by the Director-General of Queensland Health.
VAD Unit	Coordinates the practitioner authorisation process, and provides ongoing policy support. Located within the Department of Health.

Key contact details

- QVAD-Support: QVADSupport@health.qld.gov.au
- QVAD-Pharmacy: QVADPharmacy@health.qld.gov.au
- VAD Unit: VAD@health.qld.gov.au
- Review Board: VADReviewBoard@health.qld.gov.au

Other sources of information about voluntary assisted dying:

- [Voluntary Assisted Dying in Queensland | Queensland Health](#)
- [Voluntary Assisted Dying | Queensland Health Intranet](#) (only accessible to Queensland Health staff).

Chapter 2: The regulatory framework for voluntary assisted dying

The [Voluntary Assisted Dying Act 2021](#) (the Act) sets the framework for a voluntary assisted dying scheme in Queensland. This chapter³ provides an overview of:

- the background to legalising voluntary assisted dying in Queensland
- consumer safeguards
- protections from liability for people involved in voluntary assisted dying who act in accordance with the Act
- approaches to enforcing compliance with the Act, including offences and misconduct.

Background to legalising voluntary assisted dying in Queensland

The Act was passed by the Queensland Parliament on 16 September 2021. This followed almost three years of public debate, consideration, and consultation, including a review by the independent Queensland Law Reform Commission and two inquiries by Parliamentary Committees as summarised in Table 3.

The Act will be reviewed three years after its commencement.

Table 3: Background to legalising voluntary assisted dying in Queensland

Timeline	Event
November 2018 – March 2020	The former Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee undertook an inquiry into aged care, end-of-life and palliative care, and voluntary assisted dying. The Committee conducted 34 public hearings across Queensland and received over 4,700 written submissions. Report No. 34, 56th Parliament–Voluntary assisted dying made 21 recommendations for a voluntary assisted dying scheme in Queensland.
May 2020	The Queensland Government asked the Queensland Law Reform Commission to develop a legislative scheme for voluntary assisted dying in Queensland.
May 2020 – May 2021	The Queensland Law Reform Commission undertook a review to develop a legislative scheme for voluntary assisted dying.
18 May 2021	The Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence tabled the Queensland Law Reform Commission’s final report, Report No. 79: A legal framework for voluntary assisted dying and draft Voluntary Assisted Dying Bill 2021 (the Bill) in the Queensland Legislative Assembly.
25 May 2021	The Queensland Premier introduced the Bill into the Legislative Assembly and referred it to the Health and Environment Committee (the Committee) for a 12-week inquiry.

³ Material in this chapter is extracted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, Queensland University of Technology.

Timeline	Event
July 2021	As part of the inquiry, the Committee held a week of public hearings in Townsville, Rockhampton and Brisbane and received over 6000 written submissions on the Bill.
20 August 2021	The Committee tabled Report No. 10, 57th Parliament–Voluntary Assisted Dying Bill 2021 , recommending that the Bill be passed.
14–16 September 2021	During this parliamentary sitting period, the Voluntary Assisted Dying Bill 2021 was debated and passed.
1 January 2023	The Act commences.

Voluntary assisted dying is not suicide

The Act states that a person who accesses voluntary assisted dying and dies because of the self-administration or administration of a substance does not die by suicide. The person is considered to have died from the disease, illness, or medical condition that made them eligible to access voluntary assisted dying.

The medical practitioner completing the cause of death certificate must state the cause of death was the disease, illness, or medical condition from which the person suffered and not include any reference to voluntary assisted dying; for more information, refer to [Chapter 22: Death certification, notification, and bereavement care](#).

Safeguards for consumers

Safeguards built into the scheme ensure only an eligible person can access voluntary assisted dying and protect vulnerable people from coercion, abuse, and exploitation.

Safeguards include:

- strict eligibility criteria
- qualification and training requirements to be an authorised voluntary assisted dying practitioner
- prohibiting healthcare workers (excluding medical practitioners and nurse practitioners in certain circumstances⁴) from initiating discussions about voluntary assisted dying
- a staged request and assessment process
- an administration decision must be made in consultation with, and on the advice of, the coordinating practitioner
- specific requirements for managing the voluntary assisted dying substance
- independent oversight by a review board
- applicable offences where there is non-compliance with the law.

4. Medical and nurse practitioners can initiate discussions only if, at the same time, the practitioner also informs the person about the 1) treatment options available to the person and the likely outcomes of that treatment, and 2) palliative care treatment and support options available to the person and the likely outcomes of that care.

Privacy and confidentiality

The Act protects the privacy of people accessing voluntary assisted dying, as well as the healthcare workers involved in providing these services. It is an offence to unlawfully record or disclose personal information about a person accessing voluntary assisted dying, or a practitioner involved in voluntary assisted dying.

People may be aware that a person is accessing or has accessed voluntary assisted dying due to:

- their role in the process (for example, authorised voluntary assisted dying practitioner, QVAD-Support or QVAD-Pharmacy staff member)
- a request from the person's coordinating and/or consulting practitioner for background clinical information about the person to inform a first and/or consulting assessment
- providing treatment and care to the person for their underlying condition (for example, as their general practitioner, other treating specialist, multidisciplinary team in hospital)
- supporting the person's carers, family, or friends after their death (for example, funeral director, community nurse).

If a person obtains personal information obtained while exercising a function or power under the Act, it is an offence to record that information, or to disclose it to anyone (unless one of the below exceptions applies). **'Personal information'** means information that is not publicly available, that is about an individual who is identified (or whose identity can reasonably be ascertained) from the information.

It is not an offence to make a record or disclose personal information:

- for a purpose under the Act, for example, where information is recorded in an approved form for the Review Board in accordance with requirements under the Act
- if the person to whom the personal information relates gives consent
- if a court or tribunal requires a person to produce documents or give evidence
- if a person is authorised or required by law to record or disclose the information.

These offences are in addition to the obligations of non-disclosure of personal information imposed on health practitioners under other laws, such as the *Information Privacy Act 2009* (Qld), the *Privacy Act 1988* (Cth), and the *Hospital and Health Boards Act 2011* (Qld) (for services provided in the public health system). Codes of conduct also contain provisions regarding privacy of personal information.

The person's privacy must always be respected. Personal information should only be shared as necessary with members of the person's healthcare team. Making a record in a public or private health facility is permitted by the Act as this is authorised under other laws (the *Hospital and Health Boards Act 2011*, if making such a record is for the person's care and treatment, and the Information management standard made under the *Private Health Facilities Act 1999*, which requires the keeping of medical records in private health facilities).

Outside of these settings, a healthcare worker should seek the person's consent before sharing information about any aspect of their involvement in voluntary assisted dying.

Legal protections under the Act

Protections from liability are included in [Part 10](#) of the Act to provide clarity and certainty for people who may act under, or interact with, the legislation. This ensures a person who assists another person to access voluntary assisted dying under the legislation will not be guilty of a criminal offence, including the offences of **‘unlawful killing’** and **‘aiding suicide’** under the *Criminal Code Act 1899* (Qld).

The Act contains protections for:

- assisting a person to access voluntary assisted dying
- being present when a person accesses voluntary assisted dying
- performing roles and functions under the Act without negligence
- not administering life-sustaining treatment to a person who has accessed voluntary assisted dying.

These protections generally apply when a person is acting **‘in good faith’**: that is, they are acting in a way which they honestly believe falls within the general purpose of the Act. They are designed to protect healthcare workers and others from criminal liability or civil actions (for example, for breach of the duty of care), which would otherwise arise if a person assisted someone to die.

Commonwealth Criminal Code guidance



Note that these protections in the Act only protect healthcare workers from criminal liability under the law in Queensland. They cannot protect a healthcare worker from criminal liability under the *Criminal Code Act 1995* (Cth) (Commonwealth Criminal Code).

In each relevant chapter of the QVAD Handbook, guidance is provided on which discussions should be conducted in face-to-face, rather than over the telephone, videoconference, or telehealth, as required by the Commonwealth Criminal Code.

Refer to [Chapter 5: Restrictions on communication about voluntary assisted dying](#).

Assisting a person to access voluntary assisted dying

The Act protects any person (including a healthcare worker, friend, family member, or carer) from criminal liability if they assist another person who they believe is seeking voluntary assisted dying.

There are two conditions to establish this protection. First, the person must be assisting the other person to access voluntary assisted dying **‘in good faith’**—they must honestly believe the other person is requesting access to, or accessing, voluntary assisted dying, in accordance with the Act.

Second, the person must have **‘reasonable grounds’** to believe the other person is requesting access to, or accessing, voluntary assisted dying in accordance with the Act. This is an objective standard and means that a reasonable person in the same circumstances would consider there was a reasonable basis for the decision.

If these two conditions are met, any conduct to assist a person will not result in criminal liability.

Being present when a person accesses voluntary assisted dying

The Act protects a person (including a healthcare worker, friend, family member or carer) who is present when another person self-administers or is administered a voluntary assisted dying substance.

Being present when a person dies by voluntary assisted dying is not considered assisting a suicide.

Acts done in accordance with the Act

The Act protects persons from civil and criminal liability for acts done or omissions made in accordance with, or for a purpose of, the Act: that is, for conduct which is lawful under the Act.

This protection applies to a person acting **‘in good faith and without negligence’**, who does an act or omission in accordance with, or for the purposes of, the Act.

Life-sustaining treatment

The Act provides protection from civil and criminal liability for registered health practitioners, ambulance officers, and student health practitioners who, while acting in good faith, do not administer life-sustaining treatment where:

- the person has not requested it
- the registered health practitioner, ambulance officer, or student health practitioner believes on reasonable grounds the person is dying after administration of the voluntary assisted dying substance (either self-administered or practitioner administered in accordance with the Act).

The Act protects registered health practitioners (including medical practitioners, nurse practitioners, and registered nurses), ambulance officers, and student health practitioners from civil or criminal liability if they do not provide life-sustaining treatment to a person who they believe is dying after lawfully accessing voluntary assisted dying.

This protection applies if the registered health practitioner, ambulance officer or student health practitioner is acting **‘in good faith’**: that is, they honestly believe the person is dying after self-administering or being administered a voluntary assisted dying substance.

The registered health practitioner, ambulance officer or student health practitioner must also have **‘reasonable grounds’** to believe that the person is dying after administration of a voluntary assisted dying substance. This is an objective standard and means that a reasonable person in the same circumstances would consider there was a reasonable basis for the decision.

Importantly, if a person asks for life-sustaining treatment, the registered health practitioner, ambulance officer or student health practitioner must provide it, or they will be liable for breaching their duty to the person. In the very unlikely event that a person changes their mind and asks for life-sustaining treatment after ingesting or being administered a voluntary assisted dying substance, that treatment must be provided to the person, despite the existence of this protection from liability.

Note, that if a registered health practitioner, ambulance officer or student health practitioner does not know that a person had administered a voluntary assisted dying substance and resuscitates the person or provides life-sustaining treatment, they will not be liable if this was reasonable in the circumstances.

Protections do not affect health service complaints or voluntary or mandatory notifications under the Health Practitioner Regulation National Law

These protections from liability do not prevent complaints or notifications being made about a practitioner's performance or conduct or a breach of about professional misconduct, unprofessional conduct, breaches of professional ethics or standards (refer to [Consequences of non-compliance with the Act](#)).

All steps in the process must occur in Queensland

For the protections from liability under the Act to apply, all steps in the voluntary assisted dying process must occur with both the practitioner and the person accessing voluntary assisted dying located in Queensland at the time the steps are undertaken.

As outlined in [Chapter 5: Restrictions on communication about voluntary assisted dying](#), some early steps in the process (such as providing general information about voluntary assisted dying, accepting a request or conducting an eligibility assessment) may occur via telehealth (where clinically appropriate) in Queensland, as long as the healthcare worker does not:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** practitioner administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on practitioner administration or self-administration of a voluntary assisted dying substance.

Despite this, no steps in the process (i.e. in the request, assessment, administration and after death phases) should take place via telehealth with either the practitioner or the person accessing voluntary assisted dying (or both) located outside Queensland.

This extends to any interpreters who are involved in interpreting or translating relevant material.

Criminal offences under the Act

Healthcare workers and others participating in voluntary assisted dying should be aware of the offences in the Act. Penalties include monetary fines and imprisonment. These offences and relevant penalties are summarised in [Table 4](#), and cover:

- unauthorised administration of the voluntary assisted dying substance
- inducing another person to request, or revoke a request for, voluntary assisted dying
- inducing self-administration of the voluntary assisted dying substance
- giving the Review Board false or misleading information
- making a false or misleading statement
- falsifying documents
- recording or disclosing personal information if outside the functions of the Act.

Summary: Offences and penalties under the Act

Table 4: Offences and penalties under the Act

Offence	Details	Maximum penalty
Unauthorised administration of voluntary assisted dying substance	A person must not administer a voluntary assisted dying substance to another person unless the person is authorised to do so	14 years imprisonment
Inducing a person to request, or revoke request for, voluntary assisted dying	A person must not, dishonestly or by coercion, induce another person to make, or revoke, a request for access to voluntary assisted dying.	7 years imprisonment
Inducing self-administration of voluntary assisted dying substance	A person must not, dishonestly or by coercion, induce another person to self-administer a voluntary assisted dying substance.	7 years imprisonment
Giving the Review Board false or misleading information	A person must not, in relation to the administration of the Act, give the Review Board information the person knows to be false or misleading in a material particular.	5 years imprisonment
Making false or misleading statement	A person must not make a statement in a form or other document required to be made under this Act that the person knows to be false or misleading in a material particular.	5 years imprisonment
Falsifying documents	A person must not falsify a form or other document required to be made under the Act.	5 years imprisonment
Personal information not to be recorded or disclosed	<p>A person who obtains personal information in the course of, or because of, the exercise of a function or power under the Act must not:</p> <ul style="list-style-type: none"> • make a record of the personal information; or • disclose the personal information to a person. <p>However, this does not apply if the record is made, or the personal information is disclosed:</p> <ul style="list-style-type: none"> • for a purpose under this Act; or • with the consent of the person to whom the personal information relates; or • in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal; or • as authorised or required by law. 	100 penalty units

Offence	Details	Maximum penalty
Failure to submit approved form to the Review Board	Authorised voluntary assisted dying practitioners are required to submit approved forms to the Review Board throughout the process. These forms must be submitted within two business days of completing a step in the process (for example, after completing a first assessment). The forms may be submitted through the QVAD Review Board IMS .	100 penalty units
Coordinating practitioner must give copy of QCAT's decision to the Review Board	If QCAT undertakes a review of a reviewable decision about a person and the coordinating practitioner for the person receives a final decision of QCAT, the coordinating practitioner must give a copy of the final decision to the Review Board within two business days after receiving it.	100 penalty units
Contact person to give voluntary assisted dying substance to authorised disposer	A person can revoke a self-administration decision after an authorised supplier has supplied a voluntary assisted dying substance. In this circumstance, the contact person for the person must, as soon as practicable and in any event within 14 days after the day on which the decision is revoked, give the voluntary assisted dying substance to an authorised disposer.	100 penalty units
	If a person has made a self-administration decision and died after supply of a voluntary assisted dying substance, the contact person for the person must, as soon as practicable and in any event within 14 days after the day on which the person dies, give any unused or remaining substance to an authorised disposer.	100 penalty units

Consequences of non-compliance with the Act

Registered health practitioners may be subject to serious professional consequences if they participate in voluntary assisted dying and are non-compliant with:

- the Act
- registration and accreditation standards
- professional standards (including codes of ethics, codes of conduct and competency standards)
- policies and guidelines.⁵

5. See Health Practitioner Regulation National Law (Queensland) pt 5 div 3, pt 6.

Unregistered health practitioners (healthcare workers, including those not required to be registered under the Health Practitioner Regulation National Law [including deregistered health practitioners]), are subject to the [National Code of Conduct for Health Care Workers \(Queensland\)](#). The code sets minimum standards of conduct for healthcare workers, including that health services are to be provided in a safe and ethical manner.

The legal protections under the Act which provide protection from civil or criminal liability do not prevent:

- a mandatory or voluntary notification being made about a registered health practitioner to the Office of the Health Ombudsman or the Australian Health Practitioner Regulation Agency under the [Health Practitioner Regulation National Law](#); or
- a health service complaint being made to the Office of the Health Ombudsman under the Health Ombudsman Act; or
- the Review Board referring an issue to the Health Ombudsman.

The Act also provides that in considering a relevant person's professional conduct or performance under another Act, such as the *Health Ombudsman Act 2013*, regard may be had to whether the person contravened a section of the Act.

Complaints

Health service complaints may be made to the Office of the Health Ombudsman about health service facilities, registered health practitioners and health service providers who are not required to be registered. Mandatory and voluntary notifications can also be made to the Office of the Health Ombudsman about registered health practitioners under the Health Practitioner Regulation National Law.

This may include complaints about practitioners and health service facilities failing to meet their obligations under the Act as well as concerns about the performance, conduct or health of practitioners who provide a health service.

Chapter 3: Oversight

Voluntary Assisted Dying Review Board (Review Board)

The Review Board is an independent oversight body established to undertake monitoring and compliance with the Act as required by [Part 8](#) of the Act. The Review Board acts in the public interest.

Review Board functions

The Review Board functions include:

- promoting compliance and monitoring the operation of the Act
- retrospectively reviewing each completed voluntary assisted dying request to confirm compliance with the Act, including compliance by the coordinating practitioner, consulting practitioner, administering practitioner, authorised supplier and disposer, and contact person
- referring matters (as required) to:
 - » Commissioner of Police
 - » the Registrar-General of Births, Deaths and Marriages
 - » the State Coroner
 - » the Queensland Health Ombudsman (who can then refer matters to the Australian Health Practitioner Regulation Agency (Ahpra))
 - » the Director-General of Queensland Health
- recording and storing information about requests for, and provision of, voluntary assisted dying via forms submitted to [QVAD Review Board IMS](#)
- analysing information and researching matters related to the operation of the Act
- providing information, reports (including an annual report), and advice to the Minister for Health and Ambulance Services or Director-General of Queensland Health about the operation of the Act, the Review Board's functions, or the improvement of processes and safeguards of voluntary assisted dying
- promoting continuous improvement in the compassionate, safe, and practical operation of the Act
- consulting and engaging with the community about voluntary assisted dying and the Act
- any other function given to the Board under the Act.

The Review Board does not have the power to:

- overrule voluntary assisted dying eligibility assessments
- address disputes about whether a patient is eligible for voluntary assisted dying
- investigate complaints or breaches of the Act.

The Review Board is supported by the Office of the Voluntary Assisted Dying Review Board, situated within the Department of Health.

Review Board membership

The Review Board consists of at least five, but not more than nine members, appointed by the Minister for Health and Ambulance Services.

Members must have expertise in medicine, nursing, pharmacy, psychology, social work, ethics, law, or other relevant experience, knowledge, or skills. The membership should reflect Queensland's social, cultural, and geographic diversity, and cannot include a majority who are public service employees.

More information about the Review Board is available on the [Queensland Health website](#).

Ministerial Review

The Minister for Health and Ambulance Services must conduct a review of the operation and effectiveness of the Act after the Act has been in operation for three years. This review is separate to the annual reports prepared by the Review Board and includes a review of the eligibility criteria for persons seeking to access voluntary assisted dying.

Queensland Civil and Administrative Tribunal (QCAT)

QCAT is an independent tribunal that resolves disputes on a range of matters.

QCAT has jurisdiction to review decisions made by a coordinating practitioner or consulting practitioner about some of the eligibility criteria for voluntary assisted dying, as summarised in Table 5. QCAT cannot review decisions about disease-related eligibility criteria (i.e. diagnosis and prognosis), as they are clinical judgement matters best determined by a medical practitioner.

Summary: QCAT reviewable decisions

Table 5: QCAT reviewable decisions

Decision-maker	Step in the process	Reviewable decision
Coordinating practitioner	First assessment	<ul style="list-style-type: none">• Residency in Australia for at least three years immediately before the person makes the first request• Residency in Queensland for at least 12 months immediately before the person makes the first request• Decision-making capacity in relation to voluntary assisted dying• Acting voluntarily and without coercion
Consulting practitioner	Consulting assessment	
Coordinating practitioner	Final review	<ul style="list-style-type: none">• Decision-making capacity in relation to voluntary assisted dying• Acting voluntarily and without coercion

Who can apply for a review by QCAT

An application to review a decision may be made by:

- the **person**
- an **agent** of the person (i.e. someone acting on the person's behalf)
- **any other person** who has a sufficient and genuine interest in the rights and interests of the person (for example, another member of the person's healthcare team, a spouse or other close family member, or carer).

It is up to QCAT to determine if the person making the application for review is eligible to do so. Being a family member of the person accessing voluntary assisted dying does not mean the applicant is automatically considered to have a sufficient and genuine interest.

During QCAT review

Once an application has been made to QCAT to review a decision, the voluntary assisted dying request and assessment process is suspended. No further steps may be taken until the matter is resolved, including:

- conducting further assessments
- prescribing or supplying a voluntary assisted dying substance; or
- administering a voluntary assisted dying substance.

Procedural matters

To review an eligibility decision, an application must be promptly made to QCAT. The Act requires an application for review to be made within **five business days** of the 'relevant day'. This means five business days after the day the coordinating practitioner or consulting practitioner gives the person requesting access to voluntary assisted dying a copy of the relevant form or the day the eligible person making the application becomes aware of the reviewable decision—whichever is later.

Both the coordinating practitioner and consulting practitioner (if there is one):

- will be notified of an application for review by QCAT, regardless of which practitioner made the decision under review
- will be asked to provide relevant documents to QCAT within two business days of receiving a notice to produce
- will be notified of the outcome of the review.

QCAT hearings regarding voluntary assisted dying must be held in private. Once QCAT makes a decision, both the coordinating practitioner and consulting practitioner will receive a written copy of QCAT's reasons for the decision.

There is no prescribed period within which QCAT must make its decision.

Reported decisions of QCAT are anonymised and do not include personal information about the person seeking voluntary assisted dying or the participating practitioners.

After QCAT makes its decision, the coordinating practitioner must notify the Review Board of the decision within two business days, via QVAD Review Board IMS.

If the person dies prior to completion of the review, the QCAT application is withdrawn.

Effect of a decision

QCAT may decide to uphold or overturn the original decision made by the coordinating practitioner or consulting practitioner.

If the outcome of QCAT's review is that the person has been ordinarily resident in Australia for at least three years at the time of first request; or has been ordinarily resident in Queensland for at least 12 months at the time of first request; or has decision-making capacity in relation to voluntary assisted dying; or is acting voluntarily and without coercion, the suspension ends, and the process may continue. If the person has satisfied all the other eligibility requirements, they are eligible for voluntary assisted dying.

If the outcome is that the person has not been ordinarily resident in Australia for at least three years at the time of first request; or has not been ordinarily resident in Queensland for at least 12 months at the time of first request; or does not have decision-making capacity in relation to voluntary assisted dying; or is not acting voluntarily and without coercion, the person is ineligible for voluntary assisted dying and the process ends. This does not preclude the person from making another first request if the situation giving rise to the QCAT decision changes.

When the QCAT decision differs to that of the original practitioner

If the QCAT decision differs to the original decision of a coordinating practitioner or consulting practitioner, the original decision is overturned, and the QCAT decision is substituted in its place.

If the original decision by the coordinating practitioner in the first assessment or final review meant that the person was ineligible and the substituted QCAT decision (along with the rest of the eligibility criteria) means that the person is now eligible for voluntary assisted dying, the coordinating practitioner may refuse to continue in the role. In this situation the coordinating practitioner must transfer their role in accordance with the transfer process described in [Chapter 24: Transferring authorised voluntary assisted dying practitioner roles](#).

If the decision was in relation to an assessment by the consulting practitioner, then the process will continue in accordance with the usual process depending on the outcome of the decision.

Chapter 4: Information management

Queensland Voluntary Assisted Dying Information Management System

The [Queensland Voluntary Assisted Dying Review Board Information Management System](#) (QVAD Review Board IMS) supports the delivery of voluntary assisted dying in Queensland.

Functions of QVAD Review Board IMS

QVAD Review Board IMS:

- allows authorised voluntary assisted dying practitioners and pharmacists to view, complete, and submit the forms required to meet their statutory obligations under the Act
- assists authorised voluntary assisted dying practitioners, QVAD-Support and QVAD-Pharmacy to manage a person's case workflow
- assists with management of the practitioner registration, eligibility assessment, and training process
- enables the Review Board and the Office of the Review Board to review completed cases and monitor the operation of the Act
- enables data collection and reporting to support the Review Board's functions.

Access to QVAD Review Board IMS

Access to QVAD Review Board IMS is available to:

- medical practitioners, nurse practitioners, and registered nurses, both internal and external to Queensland Health, who are eligible to participate as coordinating, consulting, or administering practitioners (authorised voluntary assisted dying practitioners)
- authorised suppliers (pharmacist employed by QVAD-Pharmacy)
- the Review Board members
- the Office of the Review Board
- QVAD-Support (read-only access).

The Office of the Review Board undertakes the administrator role and provides support related to QVAD Review Board IMS.

Approved forms

The Act requires coordinating, consulting, and administering practitioners, and in some cases other medical practitioners, to submit approved forms to the Review Board throughout the voluntary assisted dying process. This ensures the voluntary assisted dying process is appropriately documented. [Table 6](#) provides an overview of all approved forms, which practitioner completes each form, and timeframes for submission.

Submission of approved forms via QVAD Review Board IMS is considered giving a form to the Review Board. QVAD Review Board IMS is the link between the services practitioners provide, and the Review Board.

Completing approved forms in QVAD Review Board IMS and submitting them to the Review Board does not replace the need for documentation in the person's medical record(s).

Identification of a minor or technical error in any of the forms does not invalidate the form or a step in the voluntary assisted dying process. For example, an incorrect date or spelling error does not invalidate the process. These errors can be corrected with minimal impact. The practitioner completing the form should contact QVAD-Support in relation to any corrections required.

Summary: Approved forms overview

Table 6: Approved forms overview

Form name	Form completed/submitted by	Timeframe for submission to Review Board via QVAD Review Board IMS ⁶
First Assessment Record Form	Coordinating practitioner	Within two business days after completing the first assessment
Consulting Assessment – Referral Acceptance or Refusal Form	Medical practitioner who receives a referral to act as consulting practitioner (regardless of whether they accept the referral)	Within two business days after the medical practitioner's decision to accept or refuse the referral
Consulting Assessment Record Form	Consulting practitioner	Within two business days after completing the consulting assessment
Second Request Form	Completed by the person and witnesses Submitted by coordinating practitioner	Within two business days after receiving the <i>Second Request Form</i> from the person
Final Request Form	Coordinating practitioner	Within two business days after receiving the final request
Final Review Form	Coordinating practitioner	Within two business days after completing the final review
Coordinating Practitioner Transfer Form	Original coordinating practitioner	Within two business days after acceptance of the role by the consulting practitioner
Contact Person Appointment Form	Completed by the person and contact person Submitted by the coordinating practitioner	Within two business days after receiving the <i>Contact Person Appointment Form</i> from the person
Administration Decision and Prescription Form	Coordinating practitioner	Within two business days after prescribing the substance

6. **Note:** Two business days is calculated commencing from the day after a step is completed. For example, if a step is completed on a Monday, the relevant form must be submitted by 11:59pm on Wednesday.

Form name	Form completed/submitted by	Timeframe for submission to Review Board via QVAD Review Board IMS⁶
<i>Revocation of Administration Decision Form</i>	Coordinating practitioner (for revocation of self-administration decision) or administering practitioner (for revocation of practitioner administration decision)	Within two business days after the person revoking their administration decision
<i>Practitioner Administration Form</i>	Administering practitioner	Within two business days after administering the substance
<i>Administering Practitioner Transfer Form</i>	Original administering practitioner	Within two business days after acceptance of the role by an eligible medical practitioner, nurse practitioner or registered nurse
<i>Authorised Supply Form</i>	Authorised supplier (pharmacist)	Within two business days after supplying the substance to the person or their administering practitioner
<i>Authorised Disposal Form</i>	Authorised disposer (pharmacist)	Within two business days after disposing of the substance
<i>Practitioner Disposal Form</i>	Administering practitioner	Within two business days after disposing of the substance
<i>Notification of Death – Coordinating Practitioner / Administering Practitioner</i>	Coordinating practitioner / administering practitioner	Within two business days after the coordinating or administering practitioner becomes aware of the death
<i>Notification of Death – Other Medical Practitioner</i>	Medical practitioner (other than the coordinating practitioner / administering practitioner) who completes the cause of death certificate	Within two business days after the medical practitioner becomes aware of the death

Clinical documentation

In addition to the forms submitted via QVAD Review Board IMS, the Act sets out requirements for mandatory documentation in the medical record at specific points in the voluntary assisted dying process. Throughout the QVAD Handbook, guidance is provided in each relevant chapter to indicate the specific documentation requirements. However, as part of good clinical practice, it is recommended that all episodes of care be accurately documented in the person's medical record.

Authorised voluntary assisted practitioners may choose to maintain their own medical records, and/or use existing digital or manual clinical record management processes as required by their organisational policies.

When practitioners provide voluntary assisted dying services in a facility, clinical documentation in the facility's medical record system will support continuity of care and communication with other healthcare workers.

External practitioners should provide the facility with a voluntary assisted dying-specific progress note documenting their visit (available on the [Queensland Health website](#)).

Pharmacists employed by QVAD-Pharmacy as the authorised supplier use their existing pharmacy software to manage prescription processing and management of the voluntary assisted dying substance.

Limits on clinical documentation

To protect the right of individuals to their privacy, the Act prohibits recording or disclosing personal information obtained while exercising a function or power under the Act, unless the record is made or the personal information is disclosed in the following circumstances:

- for a purpose under this Act,
- with the consent of the person to whom the information relates,
- in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal, or
- as authorised or required by law.

As outlined above, the Act requires particular steps in the voluntary assisted dying process to be documented in the person's medical record. Where a particular step is required to be recorded in the medical record, this is required 'for a purpose under the Act' and is therefore permitted.

Making a record in a public or private health facility is also permitted by the Act as this is authorised under other laws (the *Hospital and Health Boards Act 2011*, if making such a record is for the person's care and treatment, and the [Information management standard](#) made under the *Private Health Facilities Act 1999*, which requires the keeping of medical records in private health facilities).

Noting that bilateral communication between healthcare workers is considered good clinical practice to ensure continuity of care, the prohibition in the Act may impact how authorised voluntary assisted dying practitioners keep medical records or communicate with other members of the person's healthcare team. Healthcare workers must seek the person's consent whenever there is uncertainty about whether communication or correspondence with a third party (including other healthcare workers) may constitute unauthorised or unlawful disclosure under the Act. This includes where clinical documentation is shared to electronic information management systems, such as The Viewer and My Health Record, which would constitute a disclosure.

Importantly, if a person does not wish for healthcare workers who are not involved in the person's voluntary assisted dying case to be informed of their circumstances with respect to voluntary assisted dying, this must be upheld to comply with a healthcare worker's obligations under the Act.

Refer to [Chapter 2: The regulatory framework for voluntary assisted dying](#) for more information about privacy and confidentiality.

Optional clinical forms

In addition to the approved forms required by the Act, additional forms have been developed to support the delivery of voluntary assisted dying in Queensland. These are summarised in Table 7. Use of these forms is optional. However, their use helps to ensure the requirements of the Act are met by practitioners, and clinical care is delivered efficiently. These clinical forms are available on the [Queensland Health website](#).

Table 7: Optional clinical forms

Form name	Form completed by	Purpose	More information
<i>Voluntary Assisted Dying Referral Form</i>	Any healthcare worker	This form can be used to refer a person to: <ul style="list-style-type: none"> • QVAD-Support • a healthcare worker or service who can assist with providing information about voluntary assisted dying • medical practitioner who may accept a first request for voluntary assisted dying. 	Chapter 10: The first request
<i>Referral for Determination Form</i>	Coordinating or consulting practitioner	The coordinating practitioner or consulting practitioner may be unable to determine whether or not the person: <ul style="list-style-type: none"> • has an eligible disease, illness, or medical condition) • has decision-making capacity in relation to voluntary assisted dying • is acting voluntarily and without coercion. <p>In these circumstances, they must refer the person to a registered health practitioner or a person with appropriate skills and training for a determination in relation to the matter (depending on the referral matter).</p> <p>This form is received by a registered health practitioner or other person with relevant skills and training who may provide a determination on the matter.</p>	Chapter 11: The first assessment
<i>Determination Assessment Report</i>	Registered health practitioner or person who accepts referral for determination	The registered health practitioner or person who completes the assessment provides their determination assessment report.	Chapter 11: The first assessment
<i>Consulting Assessment Referral Form</i>	Coordinating practitioner	Used when a person has been assessed as eligible to access voluntary assisted dying in the first assessment.	Chapter 12: The consulting assessment

Form name	Form completed by	Purpose	More information
<i>Voluntary assisted dying progress note</i>	Any healthcare worker	Used by a healthcare worker to document voluntary assisted dying clinical notes.	

Clinical coding and data collection

Clinical coding

Currently, voluntary assisted dying is not covered under any classifications or standards for clinical coding. Coding should reflect the underlying disease, illness, or medical condition for which the person is accessing voluntary assisted dying.

Data collection and reporting

Queensland Health Hospital and Health Services are required to report voluntary assisted dying activity as outlined in the Patient access to voluntary assisted dying Health Service Directive.

Hospital and Health Services and private entities may choose to develop their own local reporting mechanisms to monitor activity in their facilities.

Chapter 5: Restrictions on communication about voluntary assisted dying

Under both the [Voluntary Assisted Dying Act 2021](#) (the Act) and the [Criminal Code Act 1995](#) (Cth) (Commonwealth Criminal Code), there are restrictions related to communicating about voluntary assisted dying. These include:

- who can initiate a discussion relating to voluntary assisted dying with a person (the Act)
- how certain components of the voluntary assisted dying process can be communicated (Commonwealth Criminal Code).

Queensland legislation

Healthcare workers are prohibited from initiating a discussion with a person about voluntary assisted dying or suggesting voluntary assisted dying to a person. This includes registered health practitioners and other people who provide health services or personal care services.

This prohibition is intended to protect vulnerable people from improper influence and coercion by ensuring that someone in a therapeutic relationship with a person, who is likely to be influential and trusted by the person, is not seen to be recommending voluntary assisted dying.

If a registered health practitioner or other healthcare worker is not compliant with this prohibition, a complaint may be made to the [Office of the Health Ombudsman](#) which may result in serious professional consequences.

A registered health practitioner or other healthcare worker is not prevented from providing information about voluntary assisted dying to a person **at the person's request**.

However, a medical practitioner or nurse practitioner **may** initiate a discussion about voluntary assisted dying if, at the same time, the practitioner also informs the person about the:

- treatment options available to the person and the likely outcomes of that treatment; and
- palliative care treatment and support options available to the person and the likely outcomes of that care.

These requirements are consistent with informed consent. They reflect the importance of people being provided with the necessary information to make informed decisions about their condition, prognosis, preferences, and available treatment options.⁷

Commonwealth legislation

Commonwealth Criminal Code

The Commonwealth Criminal Code contains offences which limit the use of a carriage service to access and transmit suicide-related material. A carriage service is an electronic means of communication, including telehealth, telephone, fax, email, internet, videoconference or similar.

7. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. [www.qlrc.qld.gov.au/_data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf](http://www qlrc.qld.gov.au/_data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf)

The Act provides that for the purposes of the law of Queensland, voluntary assisted dying is not suicide. However, the Act cannot override Commonwealth legislation, and there is risk that aspects of the Queensland voluntary assisted dying process would amount to an offence under the Commonwealth Criminal Code if conducted over a carriage service.

Prohibited discussions and activities

There is risk that an offence will be committed if activities related to voluntary assisted dying are conducted over a carriage service and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

As a general rule, information of this nature must not be discussed or shared by telehealth, telephone, fax, email, internet, videoconference or similar.

Therefore, some discussions and activities cannot occur over a carriage service including:

- a person's **administration decision**
- informing a person about how to **prepare or administer/self-administer** the voluntary assisted dying substance
- **prescription** of the voluntary assisted dying substance.

Any written information related to these activities must be provided to the person in hard copy (by post or face-to-face). Using email, fax or other electronic means is prohibited.

In addition to affecting discussions with the person, if a practitioner provides information to another practitioner while knowing the second practitioner intended to share the material via a carriage service, the first practitioner could be in breach of the Commonwealth Criminal Code.

For example, if a practitioner physically hands another practitioner a fact sheet with information on preparing the voluntary assisted dying substance and is aware the second practitioner intends to scan and email this information to a person, both practitioners could be in breach of the Commonwealth Criminal Code.

Acceptable discussions and activities

Discussions and activities that can be undertaken via a carriage service (outlined in [Box A](#)) to the extent that the information does not advocate, encourage, incite, promote, urge, or teach about how to undertake the act of administration of a voluntary assisted dying substance include:

- responding to questions and informing people about the voluntary assisted dying legislation and associated processes in Queensland (either generally or in relation to a person's circumstance)
- a first request
- a first or consulting assessment
- submitting approved forms for any step in the process to the Review Board via QVAD Review Board IMS
- general communication about voluntary assisted dying with the QVAD-Support, QVAD-Pharmacy, interpreters, or other healthcare workers.

Box A: Example scenarios that are compliant with the Act:

- A medical registrar can initiate a conversation about voluntary assisted dying with a person at the same time as informing them of their other palliative care and treatment options. The medical registrar can again raise voluntary assisted dying during a subsequent consultation without discussing available palliative care and treatment options.
- A care coordinator employed by QVAD-Support can discuss voluntary assisted dying with a person following a referral from a doctor who has refused their first request. The care coordinator is able to discuss voluntary assisted dying because the person has requested the information.
- A social worker in a hospital ward can discuss voluntary assisted dying with a person following a referral from a person's treating oncologist who has agreed to be the person's coordinating practitioner. The social worker is able to discuss voluntary assisted dying because the person has requested the information.
- A registered nurse can discuss voluntary assisted dying with a person who has previously asked them questions about it. The registered nurse is able to discuss voluntary assisted dying because the person has previously requested the information.
- A psychologist attends a family meeting. Voluntary assisted dying is raised by the patient and discussed at the family meeting as a possible end-of-life option. Following the family meeting, the psychologist can raise voluntary assisted dying with the person when they see them individually for a consultation as the patient has previously requested information about voluntary assisted dying.
- A hospital has a voluntary assisted dying coordinator, who is an occupational therapist. The coordinator receives a referral from a ward. A patient on the ward has asked their nurse if they can speak to someone about voluntary assisted dying. The voluntary assisted dying coordinator can discuss voluntary assisted dying with the person who has previously asked about it, because the person has requested the information.
- A pharmacist employed by QVAD-Pharmacy is an authorised supplier. They are required to supply a voluntary assisted dying substance to a person who made a self-administration decision, and who has requested supply from QVAD-Pharmacy. When the pharmacist delivers the substance to the person who has requested supply, they can discuss voluntary assisted dying with the person as the person has been through the request and assessment process for voluntary assisted dying.

Commonwealth Criminal Code guidance



Throughout the QVAD Handbook, warning boxes have been incorporated into each chapter where there is a risk that an offence will be committed under the Commonwealth Criminal Code if activities related to that voluntary assisted dying step are conducted over a 'carriage service'.

Chapter 6: Authorised voluntary assisted dying practitioners

This chapter describes the roles and responsibilities of the coordinating, consulting, and administering practitioners, collectively referred to as ‘authorised voluntary assisted dying practitioners’.

This information will assist medical practitioners, nurse practitioners, and registered nurses to decide if participating in the voluntary assisted dying process is right for them.

It also provides information about additional eligibility requirements of coordinating, consulting, and administering practitioners in relation to their independence of a person requesting access to voluntary assisted dying.

Detailed information about the practitioner authorisation process, as well as recognition and acceptance of practitioner authorisation, is available in the [Queensland Voluntary Assisted Dying: Practitioner Authorisation Guideline](#).

Becoming an authorised voluntary assisted dying practitioner

Practitioner eligibility is defined in [Part 5](#) of the Act. Additional eligibility requirements are approved by the Director-General of Queensland Health under ss.161-163 of the Act (refer [Appendix H](#)).

A medical practitioner, nurse practitioner or registered nurse can become an authorised voluntary assisted dying practitioner by:

- submitting an application to Queensland Health via the [QVAD Review Board IMS](#), along with evidence to demonstrate that they meet the eligibility requirements
- having their application verified by Queensland Health as meeting the eligibility requirements
- successfully completing mandatory online training
- acknowledging receipt and understanding of the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols*
- completing a declaration agreeing to act in accordance with policies and procedures for voluntary assisted dying in Queensland, including any specific organisational requirements
- receiving authorisation approved by the Chief Medical Officer of Queensland Health.

A high-level overview of the process is depicted in Figure 2.

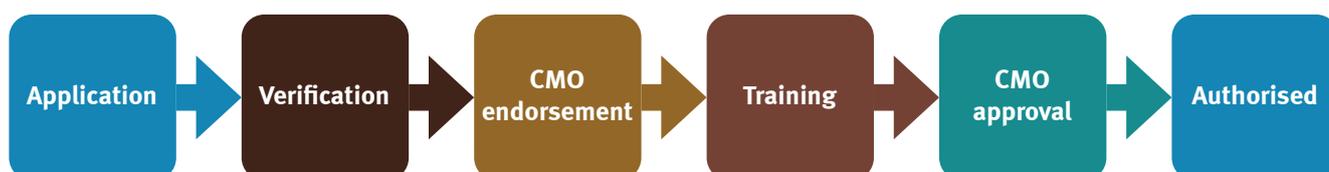


Figure 2: Practitioner authorisation process flow

Overview of roles

An authorised voluntary assisted dying practitioner can provide services in accordance with the Act, as described in Table 8.

Table 8: Authorised voluntary assisted dying practitioner roles

Role	Functions	Who can act in this role	More information
Coordinating practitioner	<ul style="list-style-type: none"> • Coordinates the voluntary assisted dying process • Primary voluntary assisted dying clinician contact for the person • Conducts eligibility assessment (first assessment) • Prescribes the voluntary assisted dying substance • As a default, acts as administering practitioner (if practitioner administration) 	Eligible medical practitioner who has successfully completed mandatory training and has been approved as an authorised voluntary assisted dying practitioner	Appendix B provides a detailed list of the tasks and actions required of the coordinating practitioner.
Consulting practitioner	<ul style="list-style-type: none"> • Conducts eligibility assessment (consulting assessment) 	Eligible medical practitioner who has successfully completed mandatory training and has been approved as an authorised voluntary assisted dying practitioner	Appendix C provides a detailed list of the tasks and actions required of the consulting practitioner.
Administering practitioner	<ul style="list-style-type: none"> • Only involved in practitioner administration (not self-administration) • Administers the voluntary assisted dying substance • Disposes of any unused or remaining voluntary assisted dying substance As a default, this will be the coordinating practitioner. 	The role can be transferred to another eligible medical practitioner, nurse practitioner, or registered nurse who has successfully completed mandatory training and has been approved as an authorised voluntary assisted dying practitioner (refer to Chapter 24: Transferring authorised voluntary assisted dying practitioner roles)	Appendix D provides a detailed list of the tasks and actions required of the administering practitioner.

Additional person-specific eligibility requirements

In addition to eligibility requirements to become an authorised voluntary assisted dying practitioner, the Act requires all coordinating, consulting, and administering practitioners to be independent of a person accessing voluntary assisted dying.

To be eligible to provide voluntary assisted dying services to a person, a coordinating, consulting, or administering practitioner must **not**:

- be a family member of the person requesting access to voluntary assisted dying—including their spouse, parent, grandparent, sibling, child, or grandchild
- be a person who, under Aboriginal or Torres Strait Island custom, is regarded as a person mentioned above in relation to the person accessing voluntary assisted dying
- know or believe they are a beneficiary under the person’s will
- know or believe they may otherwise benefit financially or in any other material way from the person’s death (other than receiving reasonable fees for the provision of services related to the coordinating, consulting, or administering practitioner role).

Chapter 7: Healthcare worker conscientious objection

A healthcare worker can choose whether or not to participate in voluntary assisted dying. Deciding whether to participate in voluntary assisted dying, and if so, the extent of participation, can be ethically and emotionally complex. The position of a healthcare worker's employer or workplace may also impact a decision to participate in voluntary assisted dying.

Refer to:

- [Chapter 8: The role of Hospital and Health Services and private entities in voluntary assisted dying](#) and the *Queensland Voluntary Assisted Dying: Private entity guidance*, available on the [Queensland Health website](#), for more information about the obligations of entities
- [Chapter 26: Support for healthcare workers](#) for more information about resources for responding to clinician wellbeing and education.

Ensuring the rights of people accessing voluntary assisted dying

All people have the right to be supported to make informed decisions about their end-of-life care and treatment, and to receive compassionate and respectful care.

Healthcare workers are expected to:

- demonstrate a willingness to listen carefully, empathise with, and support people to make an informed decision about their end-of-life care and treatment
- respect their patient's autonomy, beliefs, values, and the choices they make about end-of-life care, including voluntary assisted dying, even if it conflicts with their own values or religious beliefs
- provide routine and other care unrelated to a request for voluntary assisted dying.

Registered health practitioner conscientious objection

Registered health practitioners can choose not to participate in voluntary assisted dying because they have a conscientious objection. [Section 84](#) of the Act specifically protects this right.

A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following:

- provide information to another person about voluntary assisted dying
- participate in the request and assessment process
- participate in an administration decision
- prescribe, supply, or administer a voluntary assisted dying substance
- be present at the time of the administration or self-administration of a voluntary assisted dying substance.

Participation in voluntary assisted dying is not an all-or-nothing proposition. As described in [Box B](#), a registered health practitioner may be willing to participate in some components, but not others.

Box B: Examples of practitioner conscientious objection

- A **healthcare worker** may be comfortable providing a person with general information, but can choose to take no further part.
- A medical practitioner can choose to be the coordinating practitioner for a person, but not administer the substance.
- A **medical practitioner** may be willing to participate in eligibility assessments as a consulting practitioner, but not prescribe the voluntary assisted dying substance (a function of the coordinating practitioner).
- A **nurse practitioner** may be willing to provide information about the process to a person, but not administer the voluntary assisted dying substance as administering practitioner.
- A **psychologist** may be willing to accept a referral for determination of decision-making capacity for voluntary assisted dying for a person with whom they have a longstanding therapeutic relationship, but not for other people.
- A **social worker** may choose to not be directly involved in the voluntary assisted dying process but may provide bereavement counselling for the spouse of a person who has died as a result of voluntary assisted dying.

How registered health practitioners must respond if they have a conscientious objection

If a person raises voluntary assisted dying with a registered health practitioner who conscientiously objects to participation, certain obligations apply. Voicing a conscientious objection to voluntary assisted dying should be done sensitively, with consideration for the person's context and experience. This should be done as early as possible to limit interruption to care.

Good clinical practice requires that a conscientious objection does not impede a person's access to lawful clinically appropriate treatments and does not negatively impact a person's dignity and right to choose.

Registered health practitioners should be familiar with any conscientious objection policies of their employer or workplace. Even if the entity has chosen not to participate, all entities have certain obligations relating to voluntary assisted dying. Healthcare workers should discuss any conscientious objection to voluntary assisted dying with their employers or workplace so that this can be accommodated.

Registered health practitioner obligations

All registered health practitioners who refuse to participate in any part of the process due to a conscientious objection must:

- inform the person that other healthcare workers, health service providers or services may be able to assist the person (see [Box C](#) for example statements)
- provide information about where the person can get further information or support, such as a colleague or the details of QVAD-Support
- continue to support a person and be involved in their care in other ways, including as part of a treating team for underlying conditions—a person's access to care and treatment must not change or be compromised due to their decision to ask questions about or access voluntary assisted dying.

A person raising voluntary assisted dying presents an opportunity to explore their goals of care, symptom management, palliative care options, support for their family, and their priorities as they approach the end-of-life.

Non-compliance by registered health practitioners with these requirements may be subject to referral to the relevant professional board and disciplinary proceedings.

Box C: Examples of phrases to voice a conscientious objection by a registered health practitioner

- *'You mentioned that you were thinking about voluntary assisted dying. Would you like to talk to someone about this? Although I am not going to be involved with voluntary assisted dying, I can refer you on to a doctor who is.'*
- *'You've asked me for information about voluntary assisted dying. I've decided not to take part in this process, but I will provide you the details of the statewide support service and they will be able to assist you. I am willing to discuss how else I can support you and what else I can do to help.'*
- *'A first request needs to be made to a medical practitioner. As a registered nurse, I cannot receive a first request, and I have chosen not to participate in the voluntary assisted dying process. However, I will provide you with the details of the statewide support service and they will be able to connect you with a doctor who may be willing to assist you. I will also continue to be involved in your care outside of the voluntary assisted dying process.'*

Additional medical practitioner obligations

In addition to the requirements of all registered health practitioners above, a medical practitioner who conscientiously objects to participation has other obligations.

A medical practitioner who conscientiously objects to participation and receives a **first request**:

- must immediately:
 - » inform the person that they refuse the request
 - » the reason for the refusal
- must record in the medical record as soon as practicable:
 - » that the person has made a first request
 - » the date the first request was made
 - » the medical practitioner's decision to refuse the request
 - » the reason for refusal
 - » the steps taken to comply with their obligations to:
 - inform the person help is available
 - provide information about where the person can get help.

A medical practitioner who receives a **consulting assessment referral**:

- must immediately:
 - » inform the coordinating practitioner that they refuse the referral
 - » the reason for the refusal
- must record in the medical record as soon as practicable:
 - » that the referral was received
 - » their decision to refuse the referral
 - » the reason for refusal.

Speech pathologist conscientious objection obligations

Speech pathologists are not registered health practitioners. However, [section 85](#) of the Act specifically protects the right of speech pathologists to conscientiously object to participating in voluntary assisted dying, and places obligations on the speech pathologist.

A speech pathologist who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following:

- provide information to another person about voluntary assisted dying
- participate in the request and assessment process
- participate in an administration decision
- be present at the time of the administration or self-administration of a voluntary assisted dying substance.

The Act requires speech pathologists who conscientiously object to voluntary assisted dying, and who have been asked by their employer or another person to provide speech pathology services in relation to voluntary assisted dying, to take certain steps. The speech pathologist must:

- inform the employer or other person that they conscientiously object to voluntary assisted dying
- inform the employer or other person of another person who they believe is likely to be able to assist in providing speech pathology services
- not intentionally impede access to voluntary assisted dying.

If a speech pathologist is employed at a health service that is likely to provide voluntary assisted dying, they must also inform the health service of their objection and discuss ways they can continue to provide speech pathology services without placing a burden on their colleagues or compromising a person's access to voluntary assisted dying.

A breach of the conscientious objection requirements by a speech pathologist could be addressed by:

- an employer
- a body such as Speech Pathology Australia's Ethics Board
- a complaint to the Office of the Health Ombudsman.

Other healthcare workers who are not registered health practitioners—conscientious objection

Healthcare workers who are not registered health practitioners can conscientiously object to participating in voluntary assisted dying. However, only registered health practitioners and speech pathologists have specific rights and obligations under the Act.

Unregistered health practitioners are people who work in healthcare who are not required to be registered under the Health Practitioner Regulation National Law (including deregistered health practitioners). This may include (but is not limited to) social workers, dietitians, administration officers, or wardspersons.

If a healthcare worker is not a registered health practitioner and has a conscientious objection to voluntary assisted dying, they should act in a way that is consistent with good clinical practice. It is recommended they:

- inform their employer, colleagues, and any other relevant persons of their objection
- consider any workplace guidelines, professional codes of conduct, and workplace agreements related to conscientious objection
- ensure that a person's access to voluntary assisted dying is not impeded by their objection
- tell the person that other registered health practitioners, health service providers, or services may be able to help them with their request
- refer any requests for information to a colleague who they believe will be able to assist the person
- give the details of QVAD-Support, which may be able to provide the person with contact details of a health provider who can help them with their request.

Chapter 8: The role of Hospital and Health Services and private entities in voluntary assisted dying

Many people accessing voluntary assisted dying in Queensland will be receiving care in a health or aged care facility. This may be a public facility operated by a Queensland Health Hospital and Health Service or a private facility operated by a private or not-for-profit organisation.

Further information about the role and obligations of private entities is included in the *Queensland Voluntary Assisted Dying Private Entity Guidance* (available on the [Queensland Health website](#)).

Permanent residents

“(A) person should be able to access a lawful end-of-life option in the privacy of their own home... Being required to go somewhere else, and away from one’s home, seems a harsh thing to require in those circumstances. It is also inconsistent with the inclination of many people to be able to die in their home, if that is possible.”⁸

Under the Act, a person is a permanent resident at a facility if the facility is the person’s settled and usual place of abode where the person regularly or customarily lives, for example a resident of a supported independent living facility. Also, a person is a permanent resident at a facility that is a residential aged care facility if the person has security of tenure at the facility under the *Aged Care Act 1997* (Cth) or on some other basis.

If a person seeking to access voluntary assisted dying is a permanent resident at a facility, voluntary assisted dying services—including administration of the substance—should be provided at the facility, the person’s home. The entity should provide reasonable access to the person at the facility by the relevant practitioner.

Private entity obligations

The Act outlines the requirements for entities. For the purposes of the Act, an entity is the organisation that operates a:

- hospital
- residential aged care facility
- hospice
- facility at which accommodation, nursing or personal care is provided to persons who need nursing or personal care.

The provisions about entities in the Act apply when a person is receiving a health service, residential aged care, or a personal care service from an entity at a facility. They do not apply when a person is receiving these services outside of a facility, for example, when a person is receiving aged care or palliative care at a private residence.

The Act seeks to support access to voluntary assisted dying by balancing the interests of a person seeking voluntary assisted dying with the interests of an entity that does not want to provide these services. Private entities may choose not to participate in the provision of voluntary assisted dying services, however, there are obligations under the Act in relation to providing a person access to information and practitioners.

8. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. www.qld.gov.au/data/assets/pdf_file/0020/681131/qldrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf

Obligations of private entities differ depending on the stage of the voluntary assisted dying process, as well as whether or not the person accessing the scheme is a permanent resident at a facility.

Table 9 outlines the minimum obligations for entities under the Act. Entities may choose a higher level of involvement in voluntary assisted dying for operational reasons or to support a person's choice. For example, for a non-permanent resident an entity may allow access to a practitioner for an assessment instead of transferring a person.

Table 9: Minimum obligations for entities

Voluntary assisted dying step	Entity obligations	
	Non-permanent resident	Permanent resident
Request for information	<ul style="list-style-type: none"> • Not hinder access at the facility to information about voluntary assisted dying • Allow reasonable access by a registered health practitioner or a QVAD-Support employee 	
Requests (first request, second request, final request)	<ul style="list-style-type: none"> • Allow reasonable access by a medical practitioner who can receive the request (for a first request)/coordinating practitioner (for a second or final request), plus two eligible witnesses for the second request • If the practitioner is unable to attend, take reasonable steps to facilitate transfer of the person to a place the request can be made 	
Assessments (first assessment, consulting assessment, referral for determination)	<ul style="list-style-type: none"> • Take reasonable steps to facilitate transfer of the person to and from a place where the assessment may be carried out • If the person is unable to be transferred, allow reasonable access by the coordinating practitioner (first assessment), consulting practitioner (consulting assessment), or registered health practitioner (referral for determination) 	<ul style="list-style-type: none"> • Allow reasonable access by the coordinating practitioner (first assessment), consulting practitioner (consulting assessment), or registered health practitioner (referral for determination) • If the practitioner is unable to attend, take reasonable steps to facilitate transfer of the person to and from a place where the assessment may be carried out
Administration decision	<ul style="list-style-type: none"> • Take reasonable steps to facilitate transfer of the person to and from a place where the decision can be made • If the person is unable to be transferred, allow reasonable access by the coordinating practitioner 	<ul style="list-style-type: none"> • Allow reasonable access by the coordinating practitioner • If the practitioner is unable to attend, take reasonable steps to facilitate transfer of the person to and from a place the decision can be made

Voluntary assisted dying step	Entity obligations	
	Non-permanent resident	Permanent resident
Self-administration of the VAD substance	<ul style="list-style-type: none"> • Take reasonable steps to facilitate transfer of the person to a place the person can self-administer a voluntary assisted dying substance • If the person is unable to be transferred, not hinder access by the person to the voluntary assisted dying substance 	<ul style="list-style-type: none"> • Not hinder access by the person to the voluntary assisted dying substance
Practitioner administration of the VAD substance	<ul style="list-style-type: none"> • Take reasonable steps to facilitate transfer of the person to a place the person can be administered the voluntary assisted dying substance • If the person is unable to be transferred, allow reasonable access by the administering practitioner and an eligible witness 	<ul style="list-style-type: none"> • Allow reasonable access by the administering practitioner and an eligible witness

Good clinical practice in voluntary assisted dying: Considerations for private entities

Determining whether transfer is reasonable

In some circumstances, a private entity may take reasonable steps to facilitate the transfer of a person to and from a place where a step in the process can be carried out. Transferring someone away from a facility to access voluntary assisted dying may impact the person physically, emotionally, and financially. It may also impact their ability to access voluntary assisted dying. For example, a person may be so unwell that the transfer process would be traumatic or painful, or the medications required for transfer, including analgesia, could affect the person's decision-making capacity and make them ineligible for voluntary assisted dying.

A transfer is not permitted if it would not be reasonable in the circumstances. The entity must provide reasonable access to voluntary assisted dying in the facility.

The Act outlines considerations for a deciding practitioner to determine if it is reasonable to transfer a non-permanent resident to access voluntary assisted dying services. [Table 10](#) outlines what the deciding practitioner must consider.

The deciding practitioner is normally the person's coordinating practitioner. However, it may be a different practitioner if chosen and agreed to by the person accessing voluntary assisted dying and the entity.

Table 10: Deciding practitioner considerations

The deciding practitioner must consider...	
First assessment, consulting assessment, administration decision	<ul style="list-style-type: none"> • whether the transfer would be likely to cause serious harm to the person <ul style="list-style-type: none"> » examples of serious harm: <ul style="list-style-type: none"> – significant pain – significant deterioration to the person’s condition • whether the transfer would be likely to adversely affect the person’s access to voluntary assisted dying <ul style="list-style-type: none"> » examples of adverse effects: <ul style="list-style-type: none"> – the transfer would likely result in a loss of decision-making capacity of the person – the pain relief or medication required for the transfer would likely result in a loss of decision-making capacity of the person • whether the place to which the person is proposed to be transferred is available to receive the person • whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying • whether the person would incur financial loss or costs because of the transfer.
Administration of the voluntary assisted dying substance	<ul style="list-style-type: none"> • whether the transfer would be likely to cause serious harm to the person <ul style="list-style-type: none"> » examples of serious harm: <ul style="list-style-type: none"> – significant pain – significant deterioration to the person’s condition • whether the transfer would be likely to adversely affect the person’s access to voluntary assisted dying <ul style="list-style-type: none"> » examples of adverse effects: <ul style="list-style-type: none"> – the transfer would likely result in a loss of decision-making capacity of the person – the pain relief or medication required for the transfer would likely result in a loss of decision-making capacity of the person • whether the place to which the person is proposed to be transferred is available to receive the person.

All decisions to transfer a patient must be based on an appropriate clinical risk assessment by the deciding practitioner. It is good clinical practice for the deciding practitioner to consult with the person’s treating team and other relevant practitioners involved in the person’s care (for example, general practitioner, palliative care, physiotherapy) to discuss how the transfer may affect the person.

The deciding practitioner will consider the individual circumstances and needs of the person, which may include, but are not limited to:

- the person's physical condition:
 - » age
 - » frailty
 - » function and mobility
 - » severity and complexity of their condition
 - » severity, complexity, and number of comorbidities
 - » pain and discomfort
 - » effects of medication
 - » delirium risk
- the person's physical, psychological, and emotional suffering and whether this will be worsened by the transfer process
- whether the place to which the person is proposed to be transferred will be able to meet the person's health, cultural, and linguistic needs
- timeliness of transfer—logistical delays hindering transfer may unnecessarily prolong a person's suffering or prevent access to voluntary assisted dying if it contributes to loss of decision-making capacity
- suitability of the place to which the person is proposed to be transferred.

Referral pathways for people requesting access to voluntary assisted dying

If a person requests access to voluntary assisted dying in a facility that does not provide voluntary assisted dying services, either because it is a non-participating entity or there are no authorised voluntary assisted dying practitioners working in the facility, QVAD-Support can assist in finding a suitable authorised practitioner.

If a person needs to be transferred to another facility, QVAD-Support may be able to assist with connecting the referring and accepting facilities. Alternatively, a health service may wish to put their own arrangement in place with another service which provides voluntary assisted dying.

More information about QVAD-Support is in [Chapter 25: Queensland Voluntary Assisted Dying Support and Pharmacy Service](#).

Transfer arrangements

Usual organisational policies and procedures relating to patient transfer and clinical handover should be followed. It should be made clear to the accepting facility that the purpose of the transfer is for provision of voluntary assisted dying services. QVAD-Support may be able to assist with connecting referring and accepting facilities to arrange a transfer.

Before the transfer takes place, the accepting location must confirm they are available to receive the person and have a suitable space available. They should also provide a reasonable estimate of the timeliness of transfer, considering factors such as bed availability and clinic wait times. For transfers to a hospital, the receiving medical practitioner and Bed Management/Patient Flow Unit should be notified.

The accepting location is to advise of the entry point for the person where relevant: direct ward admission, transit lounge, or to an appropriate outpatient consultation space. It is not appropriate for the person to go via the emergency department for a planned transfer for voluntary assisted dying unless deterioration in transit necessitates emergency care.

Transfers should be scheduled at times, which take into account clinical risk and emergency demand.

An appropriate clinical risk assessment must be undertaken prior to transfer of the person. As outlined in the previous section, the person's deciding practitioner (usually the coordinating practitioner) determines whether transfer is reasonable. Appropriate escorts are to be arranged by the referring facility as clinically indicated.

The referring facility is required to receive the person back following the voluntary assisted dying consultation, with the exception of transfers for administration of the voluntary assisted dying substance.

Recognition and acceptance of practitioner authorisation

In some circumstances external practitioners who are not employed by or do not normally provide contracted services to a facility may need to enter a facility for the purpose of providing voluntary assisted dying services. This includes:

- authorised voluntary assisted dying practitioners: medical practitioners, nurse practitioners, and registered nurses who are acting as the coordinating, consulting, or administering practitioner
- pharmacists employed by the QVAD-Pharmacy
- care coordinators from QVAD-Support
- other support persons, such as interpreters.

The minimum requirements for an authorised voluntary assisted dying practitioner to be recognised and accepted by an entity to provide services within a relevant facility include:

- providing a copy of their letter of authorisation to the entity, which demonstrates they have been approved to provide voluntary assisted dying services by the Chief Medical Officer, Queensland Health
- adhering to the entity's local approval process and policies related to credentialling (where applicable), clinical documentation and handover
- adhering to the entity's notification of visit process.

A practitioner should contact the entity prior to entry to confirm processes and requirements. QVAD-Support can also provide assistance.

Under the Act, entities must not hinder a person's access to information about voluntary assisted dying and must allow reasonable access by an authorised practitioner who is seeking access to undertake an authorised function for a person.

Queensland Health Hospital and Health Services

Hospital and Health Services are not required to undertake local credentialing of:

- Hospital and Health Service employees who provide voluntary assisted dying services
- external practitioners (including general practitioners, private practitioners, and employees of another Hospital and Health Service) who need to visit a facility for the purpose of providing voluntary assisted dying services.

Hospital and Health Services should undertake due diligence by asking authorised voluntary assisted dying practitioners to show evidence of their approval, or by contacting QVAD-Support to confirm a practitioner is authorised.

Subject to local risk assessment, a Hospital and Health Service may choose to implement a local credentialing process for authorised practitioners. This may be applicable to authorised practitioners employed by the Hospital and Health Service or those needing to access a Hospital and Health Service public health facility. If a Hospital and Health Service decides to implement a local credentialing process, then the process must meet the requirements of the Act.

Private entities

Private entities are not required to undertake local credentialing of practitioners who need to visit a facility for the purpose of providing voluntary assisted dying services. Entities should maintain a procedure outlining local processes for entry of external practitioners.

Authorised voluntary assisted dying practitioners who act as coordinating, consulting, or administering practitioners have been authorised by the Chief Medical Officer, Queensland Health (valid for up to three years). This process is outlined in the *Queensland Voluntary Assisted Dying Practitioner Authorisation Guideline*. Private entities may undertake due diligence by asking authorised voluntary assisted dying practitioners to show evidence of their approval, or by contacting QVAD-Support to confirm a practitioner is authorised.

Private entities are not required to undertake their own local credentialing process in addition to practitioner authorisation by Queensland Health, but may choose to.

Documentation

There are requirements for mandatory documentation in the medical record at specific points in the voluntary assisted dying process. Authorised voluntary assisted practitioners may choose to maintain their own medical records.

Other care relating to voluntary assisted dying—in addition to what is required by the Act—may also be documented in the medical record as part of good clinical practice. This may help to support continuity of care and communication with other health practitioners. Making such a record for the person's care and treatment is permitted under section 145 of the *Hospital and Health Boards Act 2011*.

External practitioners should provide the facility with a progress note documenting their visit. A progress note template is available on the [Queensland Health website](#).

Clinical handover and interdisciplinary coordinated care

There are a number of people involved in the care of a person who is accessing voluntary assisted dying. This may include the treating team, authorised voluntary assisted dying practitioners, QVAD-Support, QVAD-Pharmacy, and healthcare workers at the accepting facility if the person is transferred. Effective communication and good clinical handover are important to ensure continuity of care and avoid disruptions to the person's care.

A person's treating team may be asked to share information, which is used by a coordinating or consulting practitioner to determine eligibility for voluntary assisted dying. For example, a coordinating practitioner may need information from the treating medical practitioner to inform assessment of diagnosis and prognosis. Entities should not develop policies and procedures which preclude sharing of medical information for purposes relating to voluntary assisted dying.

Mechanisms have been built into the voluntary assisted dying process to facilitate coordinated care. As outlined in the previous section, external practitioners are required to contact a facility before visiting to provide voluntary assisted dying services. Facilities are asked to consider and document their requirements so that the right people in the facility are aware of the upcoming visit and appropriate arrangements can be made. Considerations for clinical handover requirements are outlined in Box D.

Box D: Clinical handover–facility requirements for external practitioners

Consider the following:

- **method:** face-to-face, telephone, email, clinical correspondence, medical records
- **place where the clinical handover takes place:** for example, person's bedside, consultation room, office. Consider how privacy and confidentiality for the person and practitioners can be maintained
- **who is involved in the clinical handover:** facility contact person/coordinator for voluntary assisted dying, treating clinician/team.

Questions to consider as part of clinical handover may include:

- At what point in the voluntary assisted dying process is the person?
- Is the person in possession of the voluntary assisted dying substance?
- Who is the contact person?
- Where does the person want death to occur?
- What psychological, emotional, social, cultural, spiritual, and practical factors need to be considered as part of the person's care?
- Which carers, family members, or friends know about the person's voluntary assisted dying request?
- Has the person specified a date for planned administration?
- What are the person's plans in the lead-up to administration?
- What is the person's decision-making capacity in relation to voluntary assisted dying?
- Is there any risk of the person's physical condition or cognition deteriorating?
- Who does the person want present during administration?
- Does the person have any specific requirements following administration of the voluntary assisted dying substance and for after-death care?
- What bereavement support may be required?

Additionally, external practitioners should document each visit with a progress note which a facility may choose to include in the person's medical record. This documentation will support clinical handover and coordinated care. A progress note template is available on the [Queensland Health website](#).

Privacy and confidentiality

Deciding whether to access voluntary assisted dying is a sensitive, personal end-of-life choice for an eligible person who is suffering and dying. As in all healthcare contexts, it is important to protect the person's privacy and right to confidentiality throughout the voluntary assisted dying process.

Consider the environment and how privacy can be provided for the person and the healthcare workers involved in voluntary assisted dying. This may include:

- providing a single room for the person
 - » if this is not feasible due to other space constraints and clinical needs of other patients, consider alternatives such as:
 - providing access to private spaces or a safe space for conversations about voluntary assisted dying, for example, requests, assessments, family meetings, bereavement care
 - transferring other patients/residents to a lounge area during conversations about voluntary assisted dying
- placing patient information about voluntary assisted dying in a discreet place where it can be easily accessed by the person, for example, in the bedside drawer
- supporting family members, carers, and friends with access to an appropriate space, for example, family room around the time of death
- ensuring only essential members of the care team enter the person's room, with consent, when the substance is being administered and the person is dying.

Careful consideration of these factors will also help to minimise any potential impact on other residents and patients in a facility.

For more information about privacy and confidentiality, refer to [Chapter 2: The regulatory framework for voluntary assisted dying](#).

Chapter 9: Voluntary assisted dying as an end-of-life choice

Overview

Voluntary assisted dying is a choice available to an eligible person who is approaching the end of their life. This is in addition to other choices that people may make about their end-of-life care, including palliative care.

Voluntary assisted dying is distinct from palliative care.

A fundamental part of the legislative framework is that voluntary assisted dying should complement, not detract from, a person's right to access high-quality palliative care and other services to reduce their suffering.⁹ A person's decision to seek information about, or access to, voluntary assisted dying has no impact on the person's access to palliative care.

The Act explicitly requires that information is given to a person about the palliative and end-of-life care and treatment options available to them, and the likely outcomes of that care and treatment. It is therefore critical that healthcare workers with these obligations under the Act have knowledge of palliative and end-of-life care. This chapter:

- provides guidance to assist medical practitioners and nurse practitioners to meet their legislative obligations
- situates voluntary assisted dying in the context of palliative and end-of-life care and advance care planning.

Defining palliative and end-of-life care

Palliative care and end-of-life care are an important part of improving quality of life and promoting wellness for people living with a life-limiting illness, their families, and carers.¹⁰ Compassionate palliative care and end-of-life care is respectful of a person's cultural, emotional, spiritual, and physical needs and preferences. This care is appropriate for anyone living with a life-limiting illness, including cancer, other chronic conditions, dementia, and non-malignant degenerative diseases.

Palliative care and end-of-life care may be required at any age. Considering people's cultural needs and ensuring culturally safe practices for everyone receiving care is also important. Considering people's cultural needs and ensuring culturally safe practices for everyone receiving care is also important. For First Nations peoples, the time before and after death, which may be referred to as Sad News and/or Sorry Business, are subject to customary practices and beliefs, which should be respected and accommodated during the provision of palliative and end-of-life care.

People with a life-limiting illness should be at the heart of their care, surrounded by their family, carers, community and supported by services, which may include one or more of a range of formal and informal supports.¹¹ This includes supporting relationships between individuals, family, kin and community while providing care, and recognising the importance of connection to land, culture, spirituality and ancestry, and how these affect an individual.¹²

9. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. [www.qlrc.qld.gov.au/_data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf](http://www qlrc.qld.gov.au/_data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf)

10. Palliative Care Australia. 2018. *National Palliative Care Standards 5th Edition*. <https://palliativecare.org.au/standards>

11. Australian Government Department of Health. 2018. *National Palliative Care Strategy*. www.health.gov.au/resources/publications/the-national-palliative-care-strategy-2018

12. Australian Government. 2017. *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*. www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_o.pdf

Palliative care

Palliative care is an approach that improves the quality of life of people and their families who are living with a life-limiting illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.¹³

Access to high-quality palliative care is a right that all Queenslanders should expect. Healthcare workers and services across Queensland provide high-quality, holistic, and compassionate palliative care that many people seeking access to voluntary assisted dying will already receive.

End-of-life care

End-of-life care includes physical, spiritual, and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the patient's body after their death. People are 'approaching the end-of-life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean that they are expected to die within 12 months
- existing conditions, if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events.

Voluntary assisted dying and palliative care

For some Queenslanders suffering from a life-limiting condition, even the best quality palliative care is unable to effectively manage their pain, symptoms or suffering. For some people with a life-limiting illness, simply having the knowledge that they can access voluntary assisted dying may alleviate their suffering. The Act allows for individuals to maintain independence, choice, and control in relation to their death.

A person's decision to seek information about, or access to, voluntary assisted dying has no impact on the person's access to palliative care. Palliative care will continue to be available to a person seeking access to voluntary assisted dying, right up until the time of their death. A person will not have to choose one or the other.

Palliative care services can be provided by a range of health professionals and may be delivered in a person's home, including a residential aged care facility, or in a hospice or hospital setting.

As people's end-of-life care needs become more complex, they may need support from more specialised palliative care services, which can change over time. Although not everyone will need specialist palliative care, it is important that palliative care is delivered in an integrated way when required, in a range of settings and by a wide range of health professionals.

If a person seeking information about or access to voluntary assisted dying is not receiving specialist palliative care and support, a referral is recommended.

13. Australian Government Department of Health. 2018. National Palliative Care Strategy. www.health.gov.au/resources/publications/the-national-palliative-care-strategy-2018

To find a palliative care service:

- [National Palliative Care Service Directory](#): provides information about specialist medical, nursing or allied health palliative care service providers, organisations and community support agencies
- [Queensland Palliative Care Clinical Network webpage](#): provides information on Queensland Health's palliative care service details.

Legislative requirements

Consistent with professional standards and codes of ethics regarding informed consent and respect for patient choice, people who are considering voluntary assisted dying should be provided with all the necessary information to make informed decisions about their condition, prognosis, preferences, and all alternative treatment options.¹⁴ Therefore, the Act explicitly requires that information is given to a person about the palliative and end-of-life care treatment options available to them, and the likely outcomes of that care and treatment.

To comply with the legislation, this information must be given by:

- medical practitioners and nurse practitioners, at the same time as initiating a conversation about voluntary assisted dying
- coordinating practitioners, if they assess a person as eligible for voluntary assisted dying at the first assessment
- consulting practitioners, if they assess a person as eligible for voluntary assisted dying at the consulting assessment.

The role of all healthcare workers¹⁵

End-of-life care frequently involves a multidisciplinary team approach, where medical, nursing, and allied health professionals are all a critical part of a person's care. Good communication within the team, with the person, and (where appropriate and with the person's consent) their family, is essential to quality care. Conversations with the person are also a key safeguard in ensuring that voluntary assisted dying is only provided to eligible people.

Essential to providing high-quality end-of-life care is the capacity of healthcare workers to talk with patients about their prognosis and options for treatment and care, even when the actual timeframe for end-of-life is uncertain. Conversations about dying and preparing for death should not wait until the last weeks of life.

In the context of voluntary assisted dying, early conversations become even more pressing where future loss of decision-making capacity is anticipated, and healthcare workers need to be proactive in having timely conversations.

14. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. [www.qlrc.qld.gov.au/ data/assets/ pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf](http://www qlrc.qld.gov.au/ data/assets/ pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf)

15. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Key resources

Useful resources related to palliative and end-of-life care include:

- [Queensland Health](#) palliative care information
- [Palliative Care Queensland](#)
- [CareSearch Palliative Care Knowledge Network](#)
- [End of Life Law in Australia](#)
- [End of Life Directions for Aged Care](#)
- [Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers.](#)

Advance care planning

Advance care planning is an important part of end-of-life care. It provides people an opportunity to think about, discuss and document their future health, care and treatment preferences, for a time when they become seriously ill and unable to communicate for themselves.¹⁶ Advance care planning enables understanding and respect for a person's wishes, and the outcomes they would consider acceptable or unacceptable.

Advance care planning can include conversations between a person, their family and/or substitute decision-maker(s), and healthcare workers. Ideally, advance care planning will result in a person's preferences being documented to help ensure these preferences are respected. A person may complete whichever advance care planning document(s) they consider meet their needs.

Advance care planning documents cannot be used to make requests for voluntary assisted dying.

Key terms relevant to advance care planning in Queensland

Advance health directive (AHD) form: This is a legally binding document that can be used in certain circumstances to provide directions about future healthcare and to appoint an attorney for health matters. A medical practitioner or nurse practitioner is required to complete the certificate stating the person has capacity to make the document. To be complete, an advance health directive must also be witnessed by an eligible witness.

Enduring power of attorney (EPOA) short and long form: These documents allow a person to legally appoint attorney(s) and set out terms for how the power operates. These documents must be witnessed by an eligible witness.

Statement of Choices (SoC) form: This is a values-based document that records a person's wishes and preferences for their healthcare into the future. It is not legally binding and does not provide consent to healthcare in advance. A medical practitioner or nurse practitioner signs and dates the form, but it does not require witnessing.

16. Advance Care Planning Australia. 2021. Health professionals: roles and responsibilities. www.advancereplanning.org.au/understand-advance-care-planning/health-professionals-roles-and-responsibilities

A **substitute decision-maker** is a person with legal authority to make decisions (except about matters addressed in an advance health directive, if one exists) on behalf of another person, in accordance with that person's values and wishes. A substitute decision-maker might be either:

- a guardian appointed by a tribunal
- an enduring power of attorney appointed by the person
- a statutory health attorney.

Advance care planning and voluntary assisted dying¹⁷

Conversations about voluntary assisted dying may arise in the context of broader discussions about advance care planning and end-of-life care. However, voluntary assisted dying cannot be accessed through an advance health directive, enduring power of attorney, statement of choices, or substitute decision-maker, as these come into effect when a person loses decision-making capacity.

To access voluntary assisted dying, a person must make the decision themselves, and the coordinating practitioner must be satisfied the person has decision-making capacity at certain points throughout the process. This means the request will **not** be valid if:

- a person requests voluntary assisted dying in an advance health directive
- a substitute decision-maker requests voluntary assisted dying on behalf of another person.

Although a person cannot validly request voluntary assisted dying in an advance health directive, or via a substitute decision-maker, conversations about advance care planning can present an opportunity to discuss the person's concerns and wishes for their care at the end-of-life.

For more information about advance care planning, refer to:

- Queensland Health's [Statewide Office of Advance Care Planning](#)
- Queensland University of Technology's end-of-life law for clinicians—[advance health directives](#) and [substitute decision-making](#) in Queensland.

Involving family and carers in end-of-life care

People accessing voluntary assisted dying may wish to have family, friends, or carers involved through the process. Family, friends, and carers may ask for information about voluntary assisted dying or attend appointments with a person. This is appropriate, and may help the person feel comfortable and supported, but should be done at the discretion and direction of the person. As part of good clinical practice, you should document conversations with the person's family, friends, or carers in the person's medical notes.

Only the person themselves can request voluntary assisted dying. Friends, family, or carers **cannot** make a request for voluntary assisted dying on behalf of a person.

A person may prefer not to involve anyone else in the voluntary assisted dying process, and that is appropriate too. However, every person who makes an administration decision must appoint a contact person. The contact person is someone chosen by the individual. Although the contact person can be any person aged over 18 who agrees to accept the role, it will often be a family member, friend, or carer of the person (refer to [Chapter 18: Appointing the contact person](#)).

17. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

A person's family, friends, or carers may be supportive of the person's choice to access voluntary assisted dying. Sometimes, the person's family, friends, or carers may not be supportive of their choice to access voluntary assisted dying, and this can be difficult for the person. In these instances, additional support for the person may be required.

Key resources

Useful resources for family, friends, or carers supporting a person who is accessing voluntary assisted dying include:

- [Australian Centre for Grief and Bereavement](#)
- [Palliative Care Australia](#)
- [Carer Help](#).

Voluntary assisted dying for diverse populations

One of the key principles underpinning the Act is that a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected. Factors including a person's religion, belief, and culture can influence their attitudes to, and experiences of, end-of-life care and voluntary assisted dying.

Considerations may arise for a variety of diverse populations, including (but not limited to):

- First Nations peoples
- people from a culturally and linguistically diverse background
- people with disability.

Specific guidance is available on the [Queensland Health website](#).

This guidance is created in partnership with targeted committees, working groups and forums. This includes healthcare workers, peak bodies, networks, consumers, and content experts from across Queensland.

Key resources

Useful resources related to culturally competent end-of-life care include:

- Queensland Health: [*Sad news, sorry business: guidelines for caring for Aboriginal and Torres Strait Island people through death and dying*](#)
- Queensland Health: [Framework for Integration of Spiritual Care in Queensland Health Facilities](#)
- Indigenous Program of Experience in the Palliative Approach: [Cultural Considerations: Providing end-of-life care for Aboriginal peoples and Torres Strait Islander peoples](#)
- CareSearch Palliative Care Knowledge Network: [Culturally and linguistically diverse](#)
- End of Life Directions for Aged Care: [Aboriginal and Torres Strait Islander Peoples](#)
- End of Life Directions for Aged Care: [Spirituality and Faith](#).

Section II: The voluntary assisted dying process

Phase 1: Request and assessment

Chapter 10: The first request

Overview

A first request is a person’s clear, unambiguous request for assistance to die through access to voluntary assisted dying. It must be made to a medical practitioner, who can accept or refuse the first request. All medical practitioners have certain responsibilities under the Act when they receive a first request for access to voluntary assisted dying. If a medical practitioner accepts a person’s first request for voluntary assisted dying, they become the person’s coordinating practitioner.

A first request is the first formal step in the voluntary assisted dying process and is the first of three requests—the first request, the second request, and the final request. The final request cannot occur until nine days have ended since the first request, i.e. on the tenth day (refer to Figure 3). This nine-day period affirms the person’s decision is enduring and well-considered before making a final request, allowing time for the person to reflect on their choices without prolonging suffering.

If the medical practitioner refuses the person’s first request, the person can make another request to a different medical practitioner, and the nine-day period restarts. The nine-day period can be shortened if both the coordinating and consulting practitioners believe the person is likely to die or lose decision-making capacity in relation to voluntary assisted dying during that time (refer to [Timing of the final request in Chapter 14: The final request](#)).

First request – final request timeframe

Example: If the person made the first request on the 17 April, the earliest they could make the final request is on the 26 April (i.e., nine days later).

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
17 April	18 April	19 April	20 April	21 April	22 April	23 April	24 April	25 April	26 April
First request made								Last day consulting assessment can occur if final request occurs on Day 10	Final request can be made

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Figure 3: First request – final request timeframe

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to the first request?

A first request for voluntary assisted dying may be made over the telephone or by videoconference, provided this is appropriate in the circumstances.

If a person wishes to discuss in detail how the substance will be administered at the time of the first request, this discussion must be held face-to-face.

In accordance with good clinical practice, healthcare workers should consider whether the use of telehealth (e.g. video conference, or telephone) is appropriate in the circumstances.

Before a person makes a first request

Initiating a discussion about voluntary assisted dying before a first request

A medical practitioner or nurse practitioner may initiate a discussion about voluntary assisted dying if, at the same time, the practitioner also informs the person about the:

- treatment options available to the person and the likely outcomes of that treatment; and
- palliative care treatment and support options available to the person and the likely outcomes of that care.

This discussion does not constitute a first request unless the person clearly and unambiguously requests voluntary assisted dying, and that request is made to a medical practitioner.

For more information, refer to:

- [Chapter 5: Restrictions on communication about voluntary assisted dying](#)
- [Chapter 9: Voluntary assisted dying as an end-of-life choice.](#)

Responding to questions about voluntary assisted dying

Conversations about death and dying can be complex. If a person raises voluntary assisted dying, it is important to respond appropriately and in a person-centred manner.

All healthcare workers can provide information about voluntary assisted dying to a person who requests it if they feel comfortable and informed to do so. Recommended sources include:

- [Queensland Health website](#)
- healthcare worker education (refer to [Chapter 26: Support for healthcare workers](#))
- QVAD-Support.

Responding to questions from an ineligible person before it becomes a first request

There may be circumstances where a person whose preference is to access voluntary assisted dying will clearly not meet all eligibility criteria. For example:

- they do not have a life-limiting disease, illness, or medical condition
- they are under the age of 18
- they do not have decision-making capacity
- they do not meet the residency criteria and have not received a residency exemption from Queensland Health.

Managing expectations during voluntary assisted dying conversations is central to appropriately supporting a person. An informal enquiry should be explored with respect and consideration. Talking through the voluntary assisted dying eligibility criteria with the person may help them decide whether making a first request is right for them. Furthermore, a person raising the topic of voluntary assisted dying provides an opportunity for meaningful discussion about their care needs and symptom management.

It is important to consider the impact these discussions may have on the person. Someone who is clearly ineligible may become distressed if they are informed they will be unable to access voluntary assisted dying.

In these instances, exploring the topic with sensitivity, scheduling extra time for the conversation, and providing additional support, information and counselling to the person should be considered.

Even if a person is unlikely to meet all eligibility criteria for accessing voluntary assisted dying, they have the right to make a first request. If a person makes a valid first request, the medical practitioner who received the request must complete the steps outlined in [Responding to a first request](#).

Recognising a first request

A first request is a person's clear, unambiguous request for assistance to die through access to voluntary assisted dying. It is the first formal step in the voluntary assisted dying process and is the first of three requests—the first request, the second request, and the final request.

A first request is different from a person asking for information about voluntary assisted dying. As part of good medical practice, a first request should be part of discussions about end-of-life care options, goals of care, and the voluntary assisted dying process.

A first request must be:

- clear and unambiguous
- made by the person
- made to a medical practitioner.

A first request can be made through any of the following means:

- verbally
- by gestures
- by other means of communication available to the person.

A person must make the first request themselves (directly, through an accredited interpreter, or with the support of a relevant healthcare worker such as a speech pathologist or occupational therapist).

The first request cannot be made by another person on the person's behalf.

The person does not have to use the term 'voluntary assisted dying', but the request must be clear and unambiguous. Box E provides examples of how people may phrase a first request. The first request should prompt a careful discussion with the person about their circumstances and preferences.

Box E: Examples of a first request

- *'Can you help me die?'*
- *'I want to access voluntary assisted dying.'*
- *'I don't want to go on like this. I am in too much pain. Can I get medicine to die?'*
- *'I would like to die on my own terms. How can I access voluntary assisted dying?'*
- *'I want euthanasia.'*

The first request will ordinarily be made during a medical consultation. This consultation may occur:

- in person or via telehealth
- in a clinical setting (such as a hospital or clinic)
- in a non-clinical setting (such as during a home visit).

If a first request is made via telehealth, the medical practitioner must ensure that any discussion of the voluntary assisted dying process does not breach the Commonwealth Criminal Code.

The first request should be made at a time and place when the medical practitioner and the person can have a sensitive conversation about the person's care and treatment options. If a person raises voluntary assisted dying with the medical practitioner in an informal setting, the practitioner should suggest arranging a more appropriate time for the discussion.

To determine if the person is making a first request, the medical practitioner should:

- carefully explore what the person is asking with respect and in a non-judgemental way, so they can be very clear about exactly what it is the person wants from them
- empathise with the person's experience of distress or suffering and ask clarifying questions to understand its source
- clarify their circumstances, including their understanding of their diagnosis and prognosis, palliative care and other treatment options, any unmet needs, and the motivation for their request
- explore whether the desire for hastened death is persistent, intermittent, or new
- ascertain the person's values and preferences for end-of-life care, with specific attention to their culture and beliefs.

[Box F](#) outlines how a medical practitioner may do this.

Box F: Determining whether a person is making a first request

A person may tell their medical practitioner that they want assistance to die. To determine whether the person is making a first request, the medical practitioner should confirm what they have heard.

Example:

‘Thank you for sharing this with me. It is important I understand exactly what you are saying. Can you please confirm that you are making a request for voluntary assisted dying? If you are, this conversation is the first step in the process.’

After providing information about the voluntary assisted dying, process, and discussing treatment options, a medical practitioner may choose to ask the person about whether they want to make a first request.

Example:

‘The first step in the voluntary assisted dying process is to make a first request. Would you like to make a first request today and start the process? If you do, I can accept your request and be your coordinating practitioner during the process.’

What is not considered a first request

Scenarios that are **not** considered first requests include:

- a person seeking more information or expressing curiosity about voluntary assisted dying
- a person making a request for voluntary assisted dying to anyone who is not a medical practitioner
- a medical practitioner or nurse practitioner initiating a discussion about voluntary assisted dying at the same time as informing the person about the treatment options available to them
- a request for voluntary assisted dying made by someone else on the person’s behalf.

If a person makes a clear, unambiguous request for assistance to die through access to voluntary assisted dying to any healthcare worker other than a medical practitioner, the person should be informed they must make their request to a medical practitioner.

Responding to a first request

All medical practitioners have obligations under the Act when they receive a first request for voluntary assisted dying. These are depicted in [Figure 4](#).

How to respond to a first request

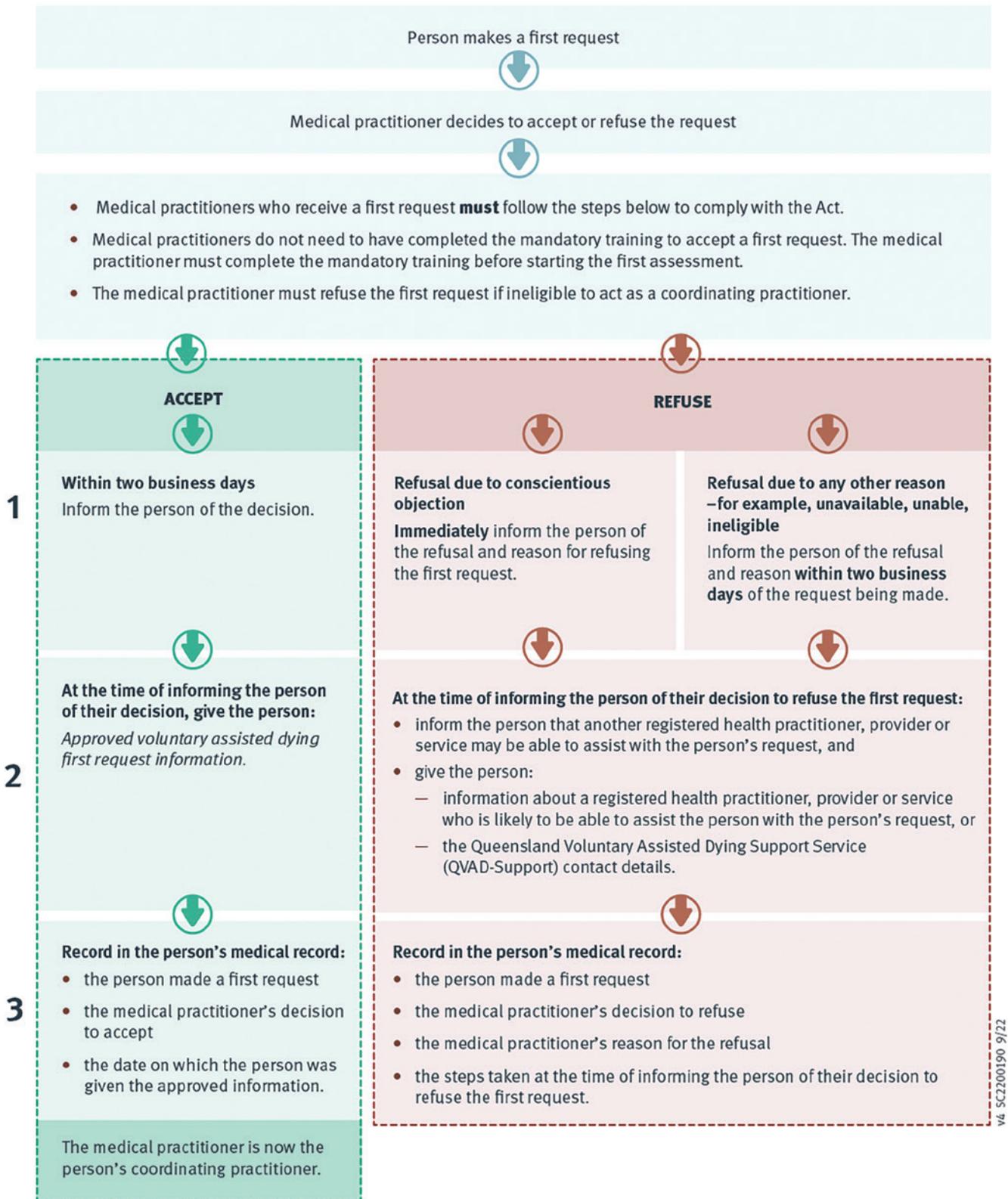


Figure 4: Responding to a first request.

If a person makes a first request, the medical practitioner must:

1. **accept or refuse** the request
2. **inform** the person of their decision to accept or refuse the first request
 - a) for a refusal, inform the person of the reason for the decision
3. **provide information** to the person:
 - a) if accepting: Acceptance of the first request: Queensland Health approved information
 - b) if refusing: details of QVAD-Support, another registered health practitioner or service (such as a voluntary assisted dying coordinator at a hospital) who the medical practitioner believes is likely to be able to help the person with their request
4. **document** in the person's medical record that:
 - a) the person made a first request
 - b) the medical practitioner's decision to accept or refuse the first request
 - c) steps taken to comply with their legal obligations.

This must be followed by any medical practitioner who receives a first request, regardless of:

- the person's potential eligibility for voluntary assisted dying
- whether or not the medical practitioner is eligible to accept the request
- whether the medical practitioner intends to participate in voluntary assisted dying.

Failing to complete any of these steps is a breach of the Act.

Accepting or refusing the first request

There is no obligation for a medical practitioner to accept a first request—it is a personal choice. Regardless of whether a first request is accepted or refused, the medical practitioner is required to complete certain steps.

When deciding whether to accept or refuse a first request, a medical practitioner should consider their:

- willingness to be involved
- ability to perform the necessary duties
- eligibility to become an authorised voluntary assisted dying practitioner.

Some medical practitioners may have clear views on whether they want to be involved with voluntary assisted dying. Others may only be prompted to consider involvement when someone under their care makes a first request or asks for information about voluntary assisted dying.

The decision may also depend on the health service or facility where the practitioner is employed or provides services for. For example, a private hospital may have a policy of non-participation in voluntary assisted dying.

Additionally, the medical practitioner must understand the responsibilities and tasks of the role detailed in [Appendix B](#) and be aware of the clinical requirements, time commitment, and administrative duties associated with the role of coordinating practitioner.

Accepting the first request

If the medical practitioner accepts the first request, they become the person's coordinating practitioner and are required to complete certain steps. These are summarised in Table 11.

Coordinating practitioner eligibility

A medical practitioner can accept a first request if they are eligible to act as the coordinating practitioner (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#)).

In addition to being an authorised voluntary assisted dying practitioner, the medical practitioner:

- must not be a family member of the person requesting access to voluntary assisted dying—including their spouse, parent, grandparent, sibling, child, or grandchild
- be a person who, under Aboriginal or Torres Strait Island custom, is regarded as a person mentioned above in relation to the person accessing dying
- must not know or believe that they:
 - » are a beneficiary under a will of the person requesting access to voluntary assisted dying
 - » may otherwise benefit financially, or in any other material way, from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services as the coordinating practitioner for the person.

Summary: Requirements for a medical practitioner who accepts a first request¹⁸

Table 11: Requirements for a medical practitioner who accepts a first request

Requirement	Details	Timeframe
Inform the person they accept the first request	Inform the person that they accept the first request and will become their coordinating practitioner.	Within two business days, not including the day the first request was made. ¹⁹
Provide information	<p>Give the person the <i>Acceptance of the first request: Queensland Health approved information</i> for a person making a first request for voluntary assisted dying.</p> <p>This resource summarises the voluntary assisted dying process in Queensland and includes relevant resources and supports. It can be downloaded and printed from the Queensland Health website.</p>	

18. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

19. If a person makes a first request on a Friday, they must respond to their request by the end of the day (11:59pm) on Tuesday.

Requirement	Details	Timeframe
Document in the person's medical record	Record in the person's medical record: <ul style="list-style-type: none"> • that the person has made a first request • the date the first request was made • the medical practitioner's decision to accept the request • the day on which the person is given the approved first request information. 	As soon as practicable.
Complete the mandatory training	The medical practitioner does not need to have completed the voluntary assisted dying mandatory training to accept the first request, but they must complete it before beginning the first assessment.	Must complete prior to beginning the first assessment.

Clinical considerations

Each person who seeks information about voluntary assisted dying or makes a first request does so for reasons important and unique to them, and will bring to this their own medical, psychosocial, and cultural background and circumstances. Some people may require counselling and support with the request and assessment process over multiple consultations. Others may approach their initial appointment with a depth of understanding and knowledge about the voluntary assisted dying process, along with insight and confidence in their own decisions.

Medical practitioners who accept a first request should acknowledge these differences and set expectations early with the person about the voluntary assisted dying process. This may include setting expectations related to the number of appointments required, where consultations may occur, costs involved, and the time it will take to move through the voluntary assisted dying process.

This may include informing the person that while there is generally a minimum nine-day period between when the first request and final request can be made, voluntary assisted dying is not emergency care. The process often takes longer than nine days, and in practice it can take several weeks or even months. As outlined in Box G, it is possible to complete a number of the clinical components of the voluntary assisted dying process within a small number of consultations; however, consideration should be given to what is most appropriate for the person.

Box G: Consultation timing

Some steps in the process may be completed at the same consultation if this is consistent with the person's wishes and appropriate in the circumstances. For example:

- the first request and first assessment could occur within the same consultation
- the final review, administration decision, and appointment of a contact person could occur within the same consultation, if it was conducted face-to-face.

However, these scenarios may be unachievable or inappropriate in certain circumstances and should not be considered a baseline or recommendation.

Refusing a first request

A medical practitioner must refuse the first request if they are not eligible to act as a coordinating practitioner (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#)).

A medical practitioner may refuse the first request if they:

- are unwilling to perform the duties of coordinating practitioner
 - » for example, they do not want to be the coordinating practitioner for the person
- are unable to perform the duties of coordinating practitioner
 - » for example, they cannot commit the time required
- hold a conscientious objection to voluntary assisted dying
- are employed by a health service that does not provide access to the request and assessment process at the facility
 - » for example, because the entity has a policy of non-participation (refer to [Chapter 8: The role of Hospital and Health Services and private entities in voluntary assisted dying](#)).

All medical practitioners must take certain steps within specified timeframes after refusing a first request, regardless of their reason for refusal, as summarised in [Table 12](#).

Summary: Requirements for a medical practitioner who refuses a first request

Table 12: Requirements for a medical practitioner who refuses a first request

Requirement	Details	Timeframe
Inform the person they refuse the first request and the reason why	Tell the person that they cannot accept the first request, and provide the reason for their decision to refuse (for example, due to conscientious objection or another reason)	Refusal due to conscientious objection: Immediately Refusal due to all other circumstances: Within two business days, not including the day the first request was made ²⁰
Inform the person help is available	Tell the person that other registered health practitioners, health service providers, or services may be able to help them with their request.	
Provide information about where the person can get help	Give the person either: <ul style="list-style-type: none"> • information about a registered health practitioner, health service provider, or service (such as a voluntary assisted dying coordinator at a hospital) who the medical practitioner believes is likely to be able to help the person with their request; or • details of the QVAD-Support, which can provide the person with contact details of a practitioner who may be able to help them with their request. 	
Document in the person's medical record	Record in the person's medical record: <ul style="list-style-type: none"> • that the person has made a first request • the date the first request was made • the medical practitioner's decision to refuse the request • the reason for refusal • the steps taken to comply with their obligations to: <ul style="list-style-type: none"> » inform the person help is available » provide information about where the person can get help. 	As soon as practicable

20. If a person makes a first request on a Friday, they must respond to their request by the end of the day (11:59pm) on Tuesday.

Private entity requirements: Managing a first request

Private entities, such as private hospitals, hospices, and residential aged care facilities, must not hinder a person's access to information about voluntary assisted dying, and must provide reasonable access to authorised voluntary assisted dying practitioners.

If a person residing in or admitted to a facility that does not provide voluntary assisted dying services makes a first request, the entity must:

- allow reasonable access to the facility by an eligible medical practitioner who is willing to accept a first request and whose presence for that purpose is requested by the person or the person's agent
- if the requested practitioner is not available to attend to receive a first request at the facility, then the relevant entity must take reasonable steps to facilitate the transfer of the person to a place at which the request may be made, and their return thereafter to the facility.

QVAD-Support can assist with these arrangements, including identifying an available authorised voluntary assisted dying practitioner for the person.

Entities may have policies and procedures for individual healthcare workers employed by or providing services within the facility in relation to their involvement with voluntary assisted dying. Healthcare workers should follow their service's processes and procedures, whilst also complying with the legislation and supporting the person's choice and autonomy.

For more information about entity participation:

- Refer to [Chapter 8: The role of Hospital and Health Services and private entities in voluntary assisted dying](#)
- Review resources on the [Queensland Health website](#):
 - » *Queensland Voluntary Assisted: Private Entity Guidance*
 - » *Queensland Voluntary Assisted Dying: Practitioner Authorisation Guideline*.

Documentation

Person's medical record

Consistent with good clinical practice, the details of the consultation should be documented in the person's medical record.

The medical practitioner is required to follow the steps outlined in [Accepting or refusing the first request](#).

As part of that documentation, a medical practitioner who **accepts** a first request must record (at minimum):

- that a first request has been made
- the date the first request was made
- their decision to accept the first request
- the date on which the person is given the *Acceptance of the first request: Queensland Health approved information*.

A medical practitioner who **refuses** a first request must record (at minimum):

- that a first request has been made
- the date the first request was made
- their decision to refuse the first request
- their reason for refusal
- the steps taken to comply with their obligations to:
 - » inform the person help is available
 - » provide information about where the person can get help.

A record of the date on which the first request was made is important information. The date of the person's first request marks the start of the designated waiting period before the person can make a final request. A person cannot make their [final request](#) for voluntary assisted dying until a minimum of nine days²¹ have passed since they made their first request.

This nine-day period starts on the day the person makes the first request. If the medical practitioner refuses the person's first request, the person can make another request to a different medical practitioner, and the nine-day timeframe restarts.

If the first request is made in the medical practitioner's workplace (for example, they are an employee, visiting medical practitioner, or general practitioner in private practice) they should document this in the person's existing medical record.

The first request may be made somewhere other than the medical practitioner's workplace (for example, a medical practitioner who is authorised to enter a facility and accepts a person or resident's first request to act as the coordinating practitioner).

External practitioners should provide the facility with a progress note documenting their visit. This will help to support continuity of care and communication with other healthcare workers. The progress note template is available on the [Queensland Health website](#). Facilities may choose to include this in the person's medical record.

21. While voluntary assisted dying is not emergency care, some cases might be more urgent than others, and the Act allows for the nine-day period to be shortened in exceptional circumstances (refer to [Chapter 11: The first assessment](#)).

Chapter 11: The first assessment

Overview

A medical practitioner who accepts a first request becomes the coordinating practitioner. In this role, they will coordinate the voluntary assisted dying process for the person. Before commencing the first assessment, the medical practitioner must become an authorised voluntary assisted dying practitioner (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#)).

The first step for the coordinating practitioner is to assess and determine whether the person satisfies each of the eligibility criteria for voluntary assisted dying. This assessment is called the **first assessment**. The process is summarised in [Table 13](#).

This chapter provides:

- the process for undertaking the first assessment
- detailed information about the eligibility criteria
- guidance for assessing a person against the eligibility criteria.

Eligibility criteria for access to voluntary assisted dying

Assessment of whether a person satisfies eligibility criteria occurs at numerous stages of the voluntary assisted dying process:

- in the first assessment and consulting assessment, two appropriately qualified medical practitioners must independently assess whether the person meets all the eligibility criteria
- at the final review stage, the coordinating practitioner must certify that they are satisfied the person has decision-making capacity and is acting voluntarily, without coercion
- if a person has chosen practitioner administration, the administering practitioner (who must be an appropriately qualified medical practitioner, nurse practitioner or registered nurse) must certify they believe the person has decision-making capacity and is acting voluntarily at the time a voluntary assisted dying substance is administered.

Because the assessment of eligibility occurs at various stages, it is important for practitioners involved to have a thorough understanding of the criteria.

Note: The consulting practitioner must conduct an independent assessment of the person's eligibility to access voluntary assisted dying. Therefore, the [eligibility assessment](#) information contained in this chapter is also relevant for the completion of the **consulting assessment by the consulting practitioner**.

Commonwealth Criminal Code



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to first assessment?

An eligibility assessment for voluntary assisted dying can be conducted over telephone or videoconference, provided this is appropriate in the circumstances.

Email, telephone, and videoconference can be used to liaise with other healthcare workers, including a consulting practitioner, about a person's access to voluntary assisted dying.

If a person meets all the eligibility criteria, the coordinating practitioner must provide the person with specific information, including the method by which the voluntary assisted dying substance is likely to be administered. Provided these discussions are factual and neutral in nature, this information can be provided via a carriage service.

If a person wishes to discuss how the substance will be administered in detail at the time of the first or consulting assessment, this discussion should occur face-to-face.

In accordance with good practice, healthcare workers should consider whether the use of telehealth (e.g. video conference or telephone) is appropriate in the circumstances.

Summary: First assessment process²²

Table 13: First assessment process

Key element	Process details
Overview	The coordinating practitioner completes the first assessment of the person's eligibility to access voluntary assisted dying. They must assess whether: <ul style="list-style-type: none">• the person meets the eligibility criteria for access to voluntary assisted dying• the person understands the specific information given to them.
Before the assessment	Before commencing the first assessment, the medical practitioner must have: <ul style="list-style-type: none">• completed the mandatory training• been approved by the Chief Medical Officer as an authorised voluntary assisted dying practitioner• confirmed they are authorised to act as the coordinating practitioner for the person• accepted the person's first request.

22. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Key element	Process details
Timeframe	<p>There is no timeframe in which the first assessment must be completed. It may take place over more than one consultation if necessary. However, it is important to consider the progression of the person’s illness and the first assessment as soon as possible after the person has made the first request.</p> <p>In practice, the first assessment may occur immediately after a first request and during the same consultation.</p>
Requirement to independently form own opinion	<p>The coordinating practitioner must form their own opinion about a person’s eligibility for voluntary assisted dying. However, the coordinating practitioner may take into account information about the person that has been prepared by another registered health practitioner, such as information in medical records.</p>
Referral for determination	<p>If the coordinating practitioner is unable to determine:</p> <ul style="list-style-type: none"> • whether the person has a disease, illness or medical condition that is advanced, progressive, and is expected to cause death within 12 months, that is causing intolerable suffering; or • whether the person has decision-making capacity in relation to voluntary assisted dying <p>they must refer the person to another registered health practitioner with appropriate skills and training to determine the matter.</p> <p>If the coordinating practitioner is unable to determine:</p> <ul style="list-style-type: none"> • whether the person is acting voluntarily and without coercion <p>they must refer the person to another person with appropriate skills and training to determine the matter.</p>
Person understands person specific information	<p>If a person meets all the eligibility criteria, the coordinating practitioner must provide the person with specific information (refer to Eligibility assessment: Understands specific information related to voluntary assisted dying and Appendix F: Information to be provided to the person if assessed as meeting eligibility criteria).</p> <p>Both the coordinating practitioner and the consulting practitioner must be independently satisfied that the person understands the specific information for the person to be eligible for voluntary assisted dying.</p>
Outcomes	<p>Eligible: The coordinating practitioner must assess the person as eligible for voluntary assisted dying if they are satisfied that:</p> <ul style="list-style-type: none"> • the person meets all the eligibility criteria; and • the person understands the specific information given to them. <p>Ineligible: The coordinating practitioner must assess the person as ineligible for voluntary assisted dying if they are not satisfied that:</p> <ul style="list-style-type: none"> • the person meets all the eligibility criteria; or • the person understands each matter in the specific information given to them. <p>Even if the person meets all the eligibility criteria, they must still be assessed as ineligible if they do not understand all the specific information given to them.</p>

Key element	Process details
Notifications and documentation	<p>After completing the first assessment, the coordinating practitioner must:</p> <ul style="list-style-type: none"> inform the person of the outcome of the first assessment as soon as practicable after completing the assessment complete the <i>First Assessment Record Form</i> and submit it and any supporting documents to the Review Board via QVAD Review Board IMS within two business days after completing the assessment provide a copy of the <i>First Assessment Record Form</i> and any supporting documents to the person as soon as practicable after completing the form.
Next steps	<p>If the person is assessed as eligible for voluntary assisted dying, the coordinating practitioner must refer the person to another medical practitioner for a consulting assessment.</p> <p>If the person is ineligible for voluntary assisted dying, the request and assessment process ends. The documentation outlined above must be completed.</p>

Completing a first assessment

During the first assessment, the coordinating practitioner must assess the person to determine whether or not they meet all eligibility criteria, as summarised in Table 14.

Summary: Eligibility criteria for accessing voluntary assisted dying

Table 14: Eligibility criteria for accessing voluntary assisted dying

Criterion	Details	Referral for determination
<u>Disease, illness, or medical condition</u>	<p>The person has been diagnosed with a disease, illness, or medical condition that:</p> <ul style="list-style-type: none"> is advanced, progressive and will cause death; and is expected to cause death within 12 months; and is causing suffering that the person considers to be intolerable. 	<p>Any registered health practitioner with appropriate skills and training can determine:</p> <ul style="list-style-type: none"> whether a person has an eligible diagnosis or prognosis <ul style="list-style-type: none"> » for example, a medical practitioner with a relevant scope of practice (such as the person's treating specialist) that the disease, illness or medical condition is causing the person's suffering <ul style="list-style-type: none"> » for example, a psychiatrist or psychologist.

Criterion	Details	Referral for determination
<u>Decision-making capacity</u>	The person has decision-making capacity in relation to voluntary assisted dying.	Any registered health practitioner with appropriate skills and training can determine whether a person has decision-making capacity in relation to voluntary assisted dying after receiving a referral. For example, a psychiatrist or psychologist.
<u>Acting voluntarily and without coercion</u>	The person is acting voluntarily and without coercion.	Any person with appropriate skills and training can determine whether a person is acting voluntarily and without coercion after receiving a referral. For example, a social worker or psychologist.
<u>Age</u>	The person is at least 18 years of age.	Not applicable
<u>Australian citizen or resident</u>	The person: <ul style="list-style-type: none"> • is an Australian citizen; or • is a permanent resident of Australia; or • has been ordinarily resident in Australia for at least three years immediately before they make the first request; or • has been granted an Australian residency exemption by Queensland Health. 	Not applicable
<u>Queensland resident</u>	The person: <ul style="list-style-type: none"> • has been ordinarily resident in Queensland for at least 12 months immediately before they make the first request; or • has been granted a Queensland residency exemption by Queensland Health. 	Not applicable

Eligibility assessment: Disease, illness, or medical condition

The coordinating practitioner and consulting practitioner must assess whether the person has been diagnosed with a disease, illness, or medical condition that:

- is advanced, progressive and will cause death; and
- is expected to cause death within 12 months; and
- is causing suffering that the person considers to be intolerable.

This involves the practitioner assessing the person's diagnosis and prognosis in relation to their eligibility for voluntary assisted dying. They must also explore the person's perception of the suffering they are experiencing because of their disease, illness or medical condition, and the options available to alleviate their suffering.

Note: A person who refuses medical treatment (including symptom management) may still be eligible to access voluntary assisted dying if they meet all eligibility criteria.

Assessing diagnosis in relation to voluntary assisted dying

The coordinating practitioner and consulting practitioner must independently determine if the person has at least one disease, illness or medical condition that is advanced, progressive and will cause death.

Advanced refers to a point in the trajectory of the person's medical condition.

Progressive indicates that the person is experiencing an active deterioration that will continue to decline. A person whose condition is stable will not satisfy this criterion.

Will cause death means the person's condition must be one which will foreseeably cause death.

Assessment of whether the person has an eligible diagnosis should take into consideration:

- the current consultation
- the person's circumstances including their condition, comorbidities, and treatment choices
- the entirety of the context of the person's history and investigations, including relevant reports and information about the person that have been prepared by, or at the instigation of, another registered health practitioner.

Assessing prognosis in relation to voluntary assisted dying

The eligibility criteria requires that the person's disease, illness, or medical condition is expected to cause death within a period of 12 months.

The coordinating practitioner and consulting practitioner are expected to use their clinical judgement to make this determination.

Determination of whether the person has an eligible prognosis should take into consideration:

- the current consultation
- an individual's circumstances including their condition, comorbidities, and treatment choices
- the entirety of the context of the person's history and investigations, including relevant reports and information about the person that have been prepared by, or at the instigation of, another registered health practitioner.

During the final 12 months of life, a person with a life-limiting disease, illness or medical condition may experience rapid and severe changes and fluctuations in their condition. However, predicting when the person is entering the final months of their life can be difficult.

Most prognostication tools have been developed to assist in identifying a person's needs as they approach the end-of-life and to plan care and support, not for determining a predictable timescale for death. It is important that in making any such determination, the coordinating practitioner and consulting practitioner act within their scope of expertise and experience and seek a further opinion where appropriate. [Appendix G](#) contains a list of resources which may be helpful in assessing whether the person's disease, illness or medical condition can be expected to cause death within 12 months. These are for guidance only; they have not been developed specifically for voluntary assisted dying and are not intended to replace individual clinical judgement.

A person may choose to withdraw from active treatment for their disease, illness, or medical condition and this may lead to the person dying within 12 months—for example, ceasing chemotherapy for managing cancer. Under these circumstances, the person should be assessed as satisfying the prognosis criteria and may become eligible to access voluntary assisted dying where previously, they were not.

Assessing suffering in relation to voluntary assisted dying

To be eligible for voluntary assisted dying, a person must be diagnosed with a disease, illness, or medical condition that is causing suffering that the person considers to be intolerable.

Suffering is defined to include:

- physical or mental suffering
- suffering caused by the treatment provided for the disease, illness, or medical condition.

The Act requires that the person's suffering must be caused by their disease, illness, or medical condition. Suffering can be caused by:

- the medical condition itself (alone, or in combination with the person's other medical conditions)
- the treatment provided for the disease, illness, or medical condition
- complications of the person's medical treatment.

A person's request for voluntary assisted dying can result from (but is not limited to):

- multiple interconnected factors related to their disease, illness, or medical condition, including both physical and psychological suffering
- a wish to control the circumstances of their death
- a desire to relieve distress over a loss of autonomy.

Suffering is a subjective experience, and the coordinating practitioner and consulting practitioner must document the person's own assessment of whether they are experiencing suffering that cannot be relieved in a manner the person considers tolerable.

If the person is suffering because of the disease, illness, or medical condition, then this eligibility requirement is met. Suffering arising from an unrelated or pre-existing condition, the person's living situation, or generalised fears about the future, does not satisfy the requirements under the Act.²³

23. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. [www.qlrc.qld.gov.au/_data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf](http://www qlrc.qld.gov.au/_data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf).

In exploring the person's suffering, it is good clinical practice to explain all available care and treatment options to the person that could relieve their suffering, including palliative care. The coordinating practitioner and consulting practitioner may recommend a referral to a palliative care team or specialist about options for symptom management and end-of-life care planning.

Furthermore, the presence of mental illness in people who are at the end-of-life and experiencing suffering is not uncommon. As part of the assessment related to the person's experience of suffering, the coordinating practitioner and/or consulting practitioner may form the opinion that the person is experiencing mental illness. In these circumstances, they should carefully explore with the person how this is affecting them. If uncertainty remains about whether the person's mental suffering is caused by their disease, illness, or medical condition, the coordinating practitioner and consulting practitioner must make a referral for determination to a registered health practitioner with relevant training and skills to determine the matter. This may include a psychiatrist or psychologist.

At all times the person should have a choice about what options are most suitable for them.

Referral for a determination of diagnosis, prognosis, or suffering

The coordinating practitioner or consulting practitioner may be unable to determine the person's:

- diagnosis or prognosis (to the extent that it would be acceptable to the majority of their peers)
- whether the person's suffering is caused by the eligible disease, illness, or medical condition.

In these circumstances, they must refer the person to a registered health practitioner with appropriate skills and training for a determination in relation to the matter.

More information is available in [Referrals for determination](#).

Eligibility assessment: Decision-making capacity

A person must have decision-making capacity in relation to voluntary assisted dying to be assessed as eligible. All people requesting voluntary assisted dying are presumed to have decision-making capacity, including in relation to voluntary assisted dying, unless there is evidence otherwise.

Capacity is a legal term referring to the ability to exercise the decision-making process.

Capacity is specific to the type of decision to be made and when the decision must be made. It can change or fluctuate and may be influenced by many factors, including:

- the complexity of the decision
- the support available to the person
- the time the decision is made.

An adult with capacity has the right to make legally recognised decisions about their life, including (but not limited to):

- healthcare choices
- support services they may need
- where they live
- how they manage their finances.

Assessing decision-making capacity in relation to voluntary assisted dying

The coordinating practitioner and consulting practitioner must assess the person's capacity to make decisions about voluntary assisted dying according to the legal test set out in the Act. This is different from other decision-making capacity tests as it relates specifically to a voluntary assisted dying decision.

A person has decision-making capacity in relation to voluntary assisted dying if the coordinating practitioner and consulting practitioner are both satisfied that the person is capable of:

- understanding the nature and effect of decisions about access to voluntary assisted dying
- freely and voluntarily making decisions about access to voluntary assisted dying
- communicating decisions about access to voluntary assisted dying in some way.

Understand the nature and effect of decisions about access to voluntary assisted dying

The [Queensland Government Queensland Capacity Assessment Guidelines](#) clarify that 'understanding the nature and effect of the decision' means the person is able to:²⁴

- understand the information relevant to the decision
- retain the information (at least for a short time)
- understand the main choices
- understand the consequences of each choice and how these consequences will affect the person and their situation
- weigh up the consequences of the choices, and
- make a decision.

In other words, to have decision-making capacity for voluntary assisted dying, a person must understand the matters involved at each step in the voluntary assisted dying process, the effect of taking that step, and any information provided at that step. The person must also understand other treatment or care options, and the risks and benefits of those options. The person must then be able to weigh up any information and advice before making the decision to take that step.

Freely and voluntarily make decisions about access to voluntary assisted dying

It must be clear the person is making the decision freely and voluntarily and is not being pressured or coerced into making the decision.

Communicate decisions about access to voluntary assisted dying in some way

The person must be able to communicate their decision about voluntary assisted dying. The person may communicate their decision using speech, gestures, or other means available to the person, such as using symbol boards or sign language.

24. Department of Justice and Attorney-General. 2020. Queensland Capacity Assessment Guidelines. www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/23e5bde1-40d7-4115-a15d-c15165422020/qld-capacity-assessment-guidelines-version-2-to-upload-28-04-21.pdf?ETag=8be7451b7432cea4533983685981f72b

When decision-making capacity is assessed

A practitioner must be satisfied the person has decision-making capacity in relation to voluntary assisted dying at multiple points in the process. These include:

- first assessment by the coordinating practitioner
- consulting assessment by the consulting practitioner
- final review by the coordinating practitioner, before an administration decision is made
- administration (by the administering practitioner, if the person has made a practitioner administration decision).

Decision-making capacity may also be assessed at other times throughout the process.

For example:

- when the person is making their second and final requests, to inform the final review
- by the coordinating practitioner, if they or another healthcare worker involved in the person's care are concerned the person has lost decision-making capacity in relation to voluntary assisted dying
- immediately prior to supply of a substance by an authorised supplier (if the person has made a self-administration decision).

Factors to consider when assessing decision-making capacity

Factors that must be considered include:

- a person may have decision-making capacity to make some decisions but not others
- capacity can change or fluctuate, and a person may temporarily lose capacity and later regain it
 - » this is particularly relevant if the person is taking certain medications (for example, opioids, benzodiazepines, or other sedatives), is in considerable pain, or is experiencing other circumstances which may impact their capacity temporarily (for example, an intercurrent illness).

All people requesting voluntary assisted dying are presumed to have decision-making capacity, including in relation to voluntary assisted dying, unless there is evidence otherwise. It should not be presumed a person does not have decision-making capacity:

- because of a personal characteristic such as age, appearance, or language skills
- because the person has a disability or illness
- because the person makes a decision other people may not agree with.

A person has the right to be supported in decision-making. A person is considered to have decision-making capacity in relation to voluntary assisted dying if the person can understand the nature and effect of decisions, with adequate and appropriate support. Examples of support include (but are not limited to):

- giving information to a person in a way that is tailored to their needs
- communicating, or assisting a person to communicate, the person's decision, for example, with the assistance of an interpreter or speech pathologist
- giving a person additional time when discussing the matter with the person
- using technology that alleviates the effects of a person's disability.

Conducting the decision-making capacity assessment

There are no validated tools specific to assessing decision-making capacity in relation to voluntary assisted dying. However, the coordinating practitioner and consulting practitioner may use other resources to guide their assessment, including (but not limited to):

- reviewing [Appendix H: Assessing decision-making capacity](#)
- referring to [Queensland Health's Guide to Informed Decision-making in Health Care](#)
- using Queensland's Department of Justice and Attorney General [Queensland Capacity Assessment Guidelines 2020](#) practical guide to assessing decision-making capacity.

These resources are for guidance only; they have not been developed specifically for voluntary assisted dying and are not intended to replace individual clinical judgement.

Referral for a determination of decision-making capacity

If the coordinating practitioner or consulting practitioner is unable to determine whether or not the person has decision-making capacity in relation to voluntary assisted dying, they must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter. Depending on the person's medical condition and comorbidities, appropriate registered health practitioners may include a psychiatrist, geriatrician, neuropsychologist, or psychologist.

The coordinating practitioner or consulting practitioner may adopt the determination of the registered health practitioner in relation to the matter relevant to the referral was made.

Consistent with good clinical practice, the coordinating practitioner or consulting practitioner should explain the reason for the referral to the person whose eligibility is being assessed. More information is available in [Referrals for determination](#).

Reviewable decision

Decision-making capacity may also be assessed by QCAT, if an application is made for review of a decision by the coordinating practitioner or consulting practitioner about the person's decision-making capacity. For more information about QCAT, refer to [Chapter 3: Oversight](#).

Eligibility assessment: Voluntariness and coercion

The requirement that a person's decision must be voluntary and not coerced reflects a fundamental principle that participation in voluntary assisted dying must be completely voluntary in all respects.

Coercion is defined in the Act as intimidation or a threat or promise, including by an improper use of a position of trust or influence.

Assessing voluntariness and coercion in relation to voluntary assisted dying

A practitioner must be satisfied the person's decision is made voluntarily and without coercion at several points in the voluntary assisted dying process, including:

- by the coordinating practitioner and a consulting practitioner during each of their assessments
- by the coordinating practitioner at the final review before an administration decision is made
- by the administering practitioner at the time of administration of the voluntary assisted dying substance, if this is occurring by practitioner administration.

Factors to consider when assessing voluntariness and coercion

The coordinating practitioner and consulting practitioner must be satisfied the person is acting voluntarily and without coercion. Exploring and understanding the reasons why the person is requesting access to voluntary assisted dying will provide insight into the person's concerns and why they think accessing voluntary assisted dying will address these concerns. The coordinating practitioner and consulting practitioner can ask the person how they reached their decision, including what or who may have influenced them.

If a person is requesting access to voluntary assisted dying because they are worried about being a burden on their carers or family, their situation should be explored. This may include investigating additional options for supportive care or respite care. The coordinating practitioner and consulting practitioner should also seek to understand why the person has raised this concern and what they mean by it. Some people may say they feel like they are a burden because members of their family are struggling, while others may use this to start a conversation about their experience of being cared for. Such comments should also raise a 'red flag' to the coordinating practitioner or consulting practitioner to explore whether there may be any element of explicit or implicit coercion underlying the person's request for voluntary assisted dying.

It is also relevant for the coordinating practitioner and consulting practitioner to recognise if the person is being coerced or pressured not to access voluntary assisted dying. This will indicate the person is likely to need additional support and planning. Box H describes indicators of possible coercion. The coordinating practitioner and consulting practitioner must be careful to maintain appropriate patient confidentiality while also considering strategies to assist in managing a potentially complex family situation as the person progresses through the voluntary assisted dying process.

The assessment should in the first instance include talking with the person on their own and, if appropriate and with the person's consent, discussing with the family how they feel about the person's decision (along with observation and assessment of family dynamics). Discussion with members of the treating team about observations and conversations they may have had with the person or their carers, family or friends may also provide useful insights into the motivation behind the person's decision.

Box H: Indicators of possible coercion²⁵

- Excessive deferment by the person to carers, family or friends for answers, reassurance, or explanation
- Carers, family, or friends talking over the person and answering on their behalf
- Inconsistencies in the person's answers to questions about their suffering, illness, experience, or voluntary assisted dying in general
- Family conflict, especially if one family member has isolated the person from other family members or their usual support networks
- The history or presence of threats or perceived threats and abuse
- Threats to withdraw care and support
- Sudden decisions to make significant changes to their arrangements (like large gifts of money or property) that are out of character and would disadvantage the person
- Other risk factors or signs of potential abuse or neglect.

25. Queensland Government. 2020. Queensland Capacity Assessment Guidelines. www.publications.qld.gov.au/dataset/capacity-assessment-guidelines/resource/23e5bde1-40d7-4115-a15d-c15165422020

It may be necessary to talk with the person away from others to determine if there is potential coercion. However, it is important not to apply this test too broadly. Many people will seek advice from others before they come to a decision. This doesn't mean the decision wasn't made freely and voluntarily; the focus is on whether the person can make a decision free of intimidation, pressure, or influence. Box I provides guidance on assessing voluntariness and coercion.

Box I: Assessing voluntariness and coercion

Ask the person (alone) about the origin of the request for voluntary assisted dying:

- *'Have you been thinking about voluntary assisted dying for long?'*
- *'Who first suggested voluntary assisted dying to you? When did this happen? What were the circumstances?'*
- *'Do any of your friends, family or carers know you are considering voluntary assisted dying? Do they support it?'*
- *'How do the views of your friends, family, or carers affect your request?'*
- *'Is your GP aware of your request for voluntary assisted dying? Does your GP support it?'*
- *Ask the person (alone) about any pressures or concerns:*
- *'Do you feel safe?'*
- *'Do you feel afraid of or uncomfortable with any of your friends, family, or carers?'*
- *'Do you have any significant financial concerns?'*
- *'Whose views are you most likely to take into consideration when deciding whether or not to access voluntary assisted dying?'*
- *'Has anyone suggested to you that they want you to choose voluntary assisted dying?'*
- *'Do you feel any pressure from others to request voluntary assisted dying?'*
- *'Do you have any concerns about your family after you die?'*
- *'Is there anything I need to know which you do not want your friends, family, or carers to know?'*

Ask the person (alone) about available support:

- *'If you were worried about dying or about the progression of your illness, who could you talk to?'*
- *'Do you feel comfortable speaking to your friends, family, or carers about your choice for voluntary assisted dying?'*
- *'If your friends, family, or carers did not agree with your request, would you still request voluntary assisted dying?'*
- *'If you changed your mind and decided not to proceed with voluntary assisted dying, how do you expect your friends, family or carers would respond?'*
- *'What support do you have if you choose not to proceed with voluntary assisted dying?'*

Ask friends, family, or carers (without the person but with their consent):

- *'What do you think of the voluntary assisted dying request?'*
- *'If the person changed their mind, how would you respond?'*
- *'What support does the person have if they choose not to proceed with voluntary assisted dying?'*

If there is a concern the person may be experiencing domestic and family violence, financial abuse, elder abuse, or other forms of abuse, it is imperative that a safe, appropriate, and timely response is provided separate to the voluntary assisted dying process. This includes ensuring immediate safety; risk assessment; safety planning and management; and referral to an expert within the clinical context or a specialist service.

If the coordinating practitioner or consulting practitioner is not satisfied the person's decision is voluntary and without coercion, they must assess the person as ineligible.

Referral for a determination of voluntariness and coercion

If the coordinating practitioner or consulting practitioner is unable to determine whether or not the person is acting voluntarily and without coercion in relation to voluntary assisted dying, they must refer the person to a **person (a referee)** who has appropriate skills and training to determine the matter. For example, this may be a social workers or lawyer. The coordinating practitioner or consulting practitioner may adopt the determination of the referee.

Consistent with good clinical practice, the coordinating practitioner or consulting practitioner should explain the reason for the referral to the person whose eligibility is being assessed.

This is different to the requirement for referral for determination of prognosis, diagnosis, suffering or decision-making capacity where only **registered health practitioners** with appropriate skills and training can determine the matter.

More information is available in [Referrals for determination](#).

Reviewable decision

Voluntariness and coercion may also be assessed by QCAT, if an application is made for review of a decision by the coordinating practitioner or consulting practitioner. For more information about QCAT, refer to [Chapter 3: Oversight](#).

Eligibility assessment: Age

Voluntary assisted dying is only available for people aged **18 years or over at the time of the first request**. It is not an option available to anyone under the age of 18, and therefore Gillick competency (also known as the mature minor principle) does not apply.

The coordinating practitioner and consulting practitioner must be satisfied the person has reached 18 years of age. If there is doubt, the coordinating practitioner and consulting practitioner should seek relevant documentation to make an evidence-informed decision.

The coordinating practitioner and consulting practitioner should record in the person's medical record what evidence they used to confirm the person's age, for example:

- medical records
- birth certificate or passport
- Queensland driver's licence
- photo identification card.

Eligibility assessment: Australia citizenship and residency

The coordinating practitioner and consulting practitioner must be satisfied the person meets the citizenship and residency eligibility requirements. They should explicitly confirm this with the person and, if relevant, sight supporting documentation.

To access voluntary assisted dying (unless granted an exemption) a person must meet one of these requirements:

- be an Australian citizen
- be a permanent resident of Australia
- have been ordinarily resident in Australia for at least three years immediately before the person makes the first request.

Confirming Australian citizenship

The coordinating practitioner and consulting practitioner can confirm Australian citizenship status based on the following documents:

- Australian birth certificate²⁶
- Australian passport
- Australian citizenship certificate.

Confirming permanent residency

The coordinating practitioner or consulting practitioner can confirm if the person is a permanent resident of Australia if they are one of the following:

- a person who holds a permanent visa in Australia; or
- a New Zealand citizen who holds a special category visa (subclass 444).

In most cases, proof of a permanent residency status in Australia can be located in the person's:

- passport
- ImmiCard
- electronic visa record (accessible via the [Commonwealth Government's Visa Entitlement Verification Online \[VEVO\] website](#)).

A special category visa (subclass 444) is granted to New Zealand citizens on arrival into Australia. It is usually in a person's electronic VEVO record.

Assessing if the person has been ordinarily resident in Australia for three years

If a person has not become an Australian citizen or permanent resident or does not have access to documents to prove their status, they can satisfy this criterion if they can demonstrate they have been ordinarily resident in Australia for at least three years prior to making a request for voluntary assisted dying.

It is recommended the coordinating practitioner or consulting practitioner obtains evidence from the person to inform their decision.

26. For people born in Australia on or after 20 August 1986 there are additional requirements in the absence of documentation such as an Australian passport or Australian Citizenship Certificate. Further information is available on the [Australian Government website](#).

A person may provide one or more of these documents to demonstrate they were ordinarily resident in Australia for three years:

- Australian vehicle registration records or driver's licence
- person's medical record
- Australian bank statements
- tax or employment records
- utility bills
- Australian contract of sale, lease, or rental document.

The documents (alone or in combination) must establish that the person was ordinarily resident in Australia for the three-year time period preceding the first request.

There are no fixed criteria for determining whether a person has been ordinarily resident in Australia. It does not mean the person must have lived continuously in Australia for three years. A person can have periods outside of Australia and still be a resident of Australia—for example, travelling internationally for holidays or business trips.

Exemption: Australian residency

A person who is not an Australian citizen or permanent resident and has not been ordinarily resident in Australia for the three years immediately before making their first request may still be eligible for voluntary assisted dying if they are granted an Australian residency exemption by Queensland Health.

To enable access to voluntary assisted dying for people who have a substantial connection with Queensland, a person can apply for a residency exemption. Under [section 12](#) of the Act, the Director-General of Queensland Health, or delegate, has discretionary power to exempt the person from the residency requirement.

Queensland Health must grant an Australian residency exemption if satisfied:

- the person has a substantial connection to Queensland ([Box J](#) provides examples of this); and
- there are compassionate grounds for granting the exemption.

Refer to the *Residency Exemption Process Guideline* on the [Queensland Health website](#) for more information about how to apply for an exemption.

Eligibility assessment: Queensland residency

In addition to being an Australian citizen or resident, to be eligible for voluntary assisted dying a person must meet Queensland residency requirements.

The coordinating practitioner or consulting practitioner must be satisfied the person has been ordinarily resident in Queensland for the previous 12 months at the time of making the first request (or be granted an exemption). This means Queensland has been their home or usual place of residence for at least one year.

There are no fixed criteria for determining whether a person has been ordinarily resident in Queensland. It does not mean the person must have lived continuously in Queensland for the entire 12 months. A person can have periods outside of Queensland and still be a resident of Queensland—for example, travelling outside of Queensland on holiday, or for a fly-in/fly-out job.

If the coordinating practitioner or consulting practitioner have had an ongoing clinical relationship with the person for over a year, they may have personal knowledge that they have been ordinarily resident in Queensland for that time. In other instances, it is recommended the practitioner obtain evidence from the person to inform their decision:

- Queensland vehicle registration records or driver's licence
- registration on the Queensland electoral roll
- the person's medical record
- Australian bank statements
- tax or employment records
- utility bills
- a contract of sale, lease, or rental document

Exemption: Queensland residency

A person who has not been ordinarily resident in Queensland for the 12 months immediately before making their first request may still be eligible for voluntary assisted dying if they are granted a Queensland residency exemption by Queensland Health.

To enable access to voluntary assisted dying for people who have a substantial connection with Queensland, a person can apply for a residency exemption. Under [section 12](#) of the Act, the Director-General of Queensland Health, or delegate, has discretionary power to exempt the person from the residency requirement.

Queensland Health must grant the person a Queensland residency exemption if satisfied:

- the person has a substantial connection to Queensland (Box J provides examples of this); and
- there are compassionate grounds for granting the exemption.

Refer to the Residency Exemption Process Guideline on the [Queensland Health website](#) for more information about how to apply for an exemption.

Box J: Examples of a substantial connection to Queensland

- A person who is not a citizen or permanent resident of Australia but has been living in Queensland for several years.
- A person who resides outside Queensland but who is a former resident of Queensland and whose family resides in Queensland.
- A person who is a long-term resident of a place close to the Queensland border and who works in Queensland and receives medical treatment in Queensland.

Note: All steps in the process must occur in Queensland. For the protections from liability under the Act to apply, all steps in the voluntary assisted dying process must occur with both the practitioner and the person accessing voluntary assisted dying located in Queensland at the time the steps are undertaken (refer to [Chapter 2: The regulatory framework for voluntary assisted dying](#)).

Eligibility assessment: Understands specific information related to voluntary assisted dying

The coordinating practitioner and consulting practitioner must give the person **specific information** if they independently assess the person as eligible for voluntary assisted dying on the basis of their:

- disease, illness or medical condition
- decision-making capacity
- voluntariness and coercion
- age
- Australian citizenship and residency
- Queensland residency.

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to the eligibility assessment?

If a person meets all the eligibility criteria, the coordinating practitioner and consulting practitioner must provide the person with specific information, including the method by which the voluntary assisted dying substance is likely to be self-administered or practitioner administered. Provided these discussions are factual and neutral in nature, this information can be provided over the telephone or by videoconference.

If a person wishes to discuss how the substance will be administered in detail at the time of the first or consulting assessment, this discussion should occur face-to-face.

Specific information

Under the Act, specific information must be provided to the person by the coordinating practitioner and consulting practitioner. This entails informing the person about each of the following matters:

- the person's diagnosis and prognosis
- the available treatment options and the likely outcomes of that treatment
- palliative care treatment and support options and likely outcomes of this care
- the potential risks of self-administering or being administered a voluntary assisted dying substance
- the method by which the voluntary assisted dying substance is likely to be administered (i.e. self-administered or administered by a practitioner)

- that the expected outcome of taking the voluntary assisted dying substance is death
- the request and assessment process, including the requirement for a second request to be signed in the presence of two witnesses
- the requirement to appoint a contact person if the person makes an administration decision
- the right to decide at any time not to continue with the voluntary assisted dying process or use the voluntary assisted dying substance
- whether the person informs other medical practitioners involved in their care of their request for voluntary assisted dying.

Both the coordinating practitioner and the consulting practitioner must be independently satisfied the person **understands the specific information** for the person to be eligible for voluntary assisted dying.

If either practitioner is not satisfied the person understands this information, they must assess the person as not meeting the requirements for voluntary assisted dying.

The information does not need to be provided to the person in writing. It may be part of the discussions between the coordinating practitioner or consulting practitioner and the person during the assessment process.

A checklist of the specific information that must be provided to the person is available (refer to [Appendix F](#)) and in the *First Assessment Record Form* and *Consulting Assessment Record Form*. The coordinating practitioner and consulting practitioner may refer to this checklist as a prompt to ensure all the specific information is provided to the person.

Under the Commonwealth Criminal Code some of this information cannot be discussed or provided over a carriage service (for example, telephone, videoconference, email) and will need to be discussed in person.

Referrals for determination

If the coordinating practitioner or consulting practitioner is unable to determine whether or not a person meets certain eligibility criteria for access to voluntary assisted dying, they are able to make a referral for determination of the matter.

Under the Act:

- a **registered health practitioner** with appropriate skills and training can accept a referral to assist in determining whether or not the person has:
 - » an **eligible condition** (i.e. that the disease, illness, or medical condition is advanced, progressive and will cause death; is expected to cause death within 12 months; and is causing suffering that the person considers intolerable)
 - » **decision-making capacity** in relation to voluntary assisted dying
- a **person (otherwise known as a referee)** with appropriate skills and training can accept a referral to assist in determining whether or not a person is acting **voluntarily and without coercion**.

If the coordinating practitioner or consulting practitioner makes a referral for determination, they may adopt the determination of the registered health practitioner or referee.

This referral process is a safeguard to ensure that anyone who is assessed as eligible for access to voluntary assisted dying is in fact eligible.²⁷ A requirement to refer a person elsewhere when a medical practitioner cannot determine a matter is also consistent with good clinical practice. It is important the coordinating practitioner and consulting practitioner can recognise and act within their scope of clinical practice, experience, and expertise.

Eligibility to accept a referral of determination

A registered health practitioner or referee who accepts the referral:

- must have appropriate skills and training to determine the matter
- must not be a family member of the person requesting access to voluntary assisted dying—including their spouse, parent, grandparent, sibling, child, or grandchild
- must not be a person who, under Aboriginal or Torres Strait Island custom, is regarded as a person mentioned above in relation to the person accessing voluntary assisted dying
- must not know or believe they are a beneficiary under the will of the person or may otherwise benefit financially or in any other material way, from the death of the person (other than by receiving reasonable fees for the provision of services in connection with the referral)
- does not need to be an authorised voluntary assisted dying practitioner
- does not need to have undertaken any training related to voluntary assisted dying but may choose to complete the healthcare worker online education (refer to [Chapter 26: Support for healthcare workers](#)).

How to refer for determination of diagnosis, prognosis, or suffering

Consistent with good clinical practice, the coordinating practitioner or consulting practitioner should explain the reason for the referral to the person being assessed.

Referrals for determination follow the usual pathway for medical referrals to other health professionals—for example, it can be a verbal or written referral. However, to ensure requirements of the Act are met, it is recommended the referral for determination is documented in the *Referral for Determination Form*, available on the [Queensland Health website](#). Use of this form is optional.

It is recommended the referring coordinating practitioner or consulting practitioner include as much detail as possible in their referral. This should include details (if known) of:

- the eligible diagnosis and its prognosis
- other relevant medical history including comorbidities and medication history
- treatment options accepted or refused by the person and expected outcomes
- relevant family, psychological, social, cultural, and spiritual factors
- communication and support needs of the person.

The coordinating practitioner or consulting practitioner may know a suitable registered health practitioner or referee from their professional networks who can accept the referral. Alternatively, coordinating practitioners and consulting practitioners can contact QVAD-Support for advice about identifying registered health practitioners or referees who may be willing to accept a referral for determination.

27. Queensland Law Reform Commission. 2021. *A legal framework for voluntary assisted dying: Report No 79*. www.qirc.qld.gov.au/_data/assets/pdf_file/0020/681131/qirc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf

It is recommended the coordinating practitioner or consulting practitioner includes a request in their referral that the registered health practitioner or referee provides declarations in the report back to confirm they accept or refuse the referral, and that if they accept the referral, they are not a family member, a beneficiary, or may benefit from the person accessing voluntary assisted dying.

Receiving a referral for determination for diagnosis, prognosis, or suffering

A registered health practitioner or referee who receives a referral for determination must either accept or refuse the referral.

If the registered health practitioner or referee **accepts** the referral, they should inform the referring practitioner of their acceptance and eligibility to do so as soon as practicable. If the registered health practitioner **refuses** the referral, they should advise the coordinating practitioner or consulting practitioner as soon as practicable so that a new referral can be made in a timely manner.

The registered health practitioner or referee who has accepted the referral for determination must complete an assessment of the person's circumstances as soon as practicable. An interpreter may be required to assist the person with communication during any consultations related to the determination assessment. The registered health practitioner or referee must ensure the interpreter meets the requirements outlined in the Act.

The registered health practitioner or referee who has accepted the referral can choose how to provide the outcome of the referral for determination to the coordinating practitioner or consulting practitioner. To ensure the requirements of the Act are met, it is recommended the determination and declaration is provided in a report, letter or template as provided in the *Determination Assessment Report*, available on the [Queensland Health website](#). However, use of this form is optional. The coordinating practitioner or consulting practitioner should make the registered health practitioner or referee aware of this report template.

Consistent with good clinical practice, information about the referral for determination should be documented in the person's medical record.

Receiving the outcome for the referral for determination of diagnosis, prognosis, or suffering

Once the coordinating practitioner or consulting practitioner has received the report, they can choose to:

- adopt the determination of the registered health practitioner or referee
- rely on their own determination
- seek a further determination from another registered health practitioner or referee (there is no limit on the number of times this can occur).

The coordinating practitioner or consulting practitioner should use their clinical judgement and expertise when making this decision. If the coordinating practitioner or consulting practitioner decides not to adopt the determination of the registered health practitioner or referee, they should document the reasons for their decision.

As a requirement of the Act, the coordinating practitioner or consulting practitioner must include any material related to this determination with the *First Assessment Record Form* or *Consulting Assessment Record Form* when submitting the forms to the Review Board via QVAD Review Board IMS.

Outcome of the first assessment

The coordinating practitioner must inform the person of the outcome of the first assessment as soon as practicable after its completion. The coordinating practitioner must also complete specific [documentation](#) following the first assessment to comply with the Act.

The person must be assessed as meeting the requirements of the first assessment if the coordinating practitioner is satisfied the person:

- meets all the eligibility criteria; and
- understands the information required to be provided to them.

If the coordinating practitioner is not satisfied as to either of these matters, they must assess the [person as ineligible](#).

The person is assessed as eligible by the coordinating practitioner

If the person has been assessed as eligible for voluntary assisted dying, the coordinating practitioner must refer the person to another eligible medical practitioner for a consulting assessment.

A *Consulting Assessment Referral Form* is on the [Queensland Health website](#). Use of this form is optional. The coordinating practitioner may know a participating medical practitioner from their professional networks. Alternatively, the coordinating practitioner can contact QVAD-Support who can provide the details of medical practitioners who may be willing to accept a referral.

For more information about this process, refer to [Chapter 12: The consulting assessment](#).

Note: If a coordinating practitioner has an informal or preliminary discussion with a medical practitioner but does not make a formal referral, the discussion does not trigger the consulting assessment process.

The person is assessed as ineligible by the coordinating practitioner

If the coordinating practitioner decides the person does not meet the eligibility requirements or the person has not understood the information required to be given, the request and assessment process ends.

The person can make a new first request to a different medical practitioner (or to the same practitioner at a different time), commencing a new request and assessment process.

It may be difficult or distressing for a person seeking to access voluntary assisted dying to be informed that they are not eligible. The coordinating practitioner should listen compassionately to the person and provide extra support where appropriate. This may include:

- clearly explaining to the person why they are ineligible
- answering questions the person or their support network may have
- discussing with the person how their treating healthcare team may alleviate any physical symptoms, psychosocial and spiritual distress they may be experiencing
- updating the person's goals of care and advance care plans

- providing referrals to relevant healthcare workers for psychosocial support (such as support from a social worker, psychologist, or Aboriginal and Torres Strait Islander Health Worker/ Practitioner or Liaison Officer)
- referring for additional support from a specialist palliative care team (if one is not already involved in the person’s care)
- if relevant, explaining that the person’s eligibility may change if their circumstances change, and the person may start the process again by making a new first request to the same medical practitioner or a different one—for example, if the person’s prognosis changes, they may become eligible for voluntary assisted dying
- providing the person with information about other crisis support services (such as [Lifeline](#), [Beyond Blue](#), or [13YARN](#)).

Box K summarises a five-step approach for having discussions with ineligible people developed by an experienced voluntary assisted dying practitioner in Victoria.

If the person consents, it may be helpful to discuss the person’s ineligibility for voluntary assisted dying with their treating healthcare team and family. However, the person’s confidentiality and privacy must always be respected. If they do not wish for others to be informed of their request to access voluntary assisted dying, this must be upheld.

Box K: Practice tips for supporting an ineligible person²⁸

The following five-step approach for having discussions with ineligible people is used by an experienced voluntary assisted dying practitioner in Victoria.

1. Acknowledge feelings

- Genuinely acknowledge the person’s disappointment or anger at the outcome of the assessment

2. Explain reasons

- Carefully explain the reasons why the person has not met the requirements for voluntary assisted dying
- Answer any questions the person has about why they have not met the requirements

3. Explore future possibilities

- Discuss with the person whether they could become eligible in the future, and if so, explain what this might look like

4. Discuss options to address suffering

- Acknowledge the person’s subjective sense of ongoing suffering
- Assure the person of your determination to help reduce their suffering
- Discuss palliative care and other treatment options and how this might assist the person
- Discuss all other possible supports that may be available to the person and how these could assist in addressing the person’s suffering

28. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

5. Assess suicidality

- Make an assessment of suicidality. This may include directly asking the person about any thoughts, plans, or methods for suicide
- Where appropriate and with the person's consent, involve family or close friends
- If suicidality is a concern, consider:
 - whether a psychiatric crisis assessment and treatment team needs to be involved urgently and arrange if necessary
 - how the person could be further connected to other support services
 - any other steps that may be required to ensure the person's safety.

Reviewable decisions

Certain decisions made in the first assessment can be requested to be reviewed by QCAT under the Act.

If relevant, the coordinating practitioner may inform the person:

- which decisions are considered reviewable decisions in the first assessment
- that they have the right to request a review of the outcomes by QCAT.

Reviewable decisions are those regarding:

- decision-making capacity in relation to voluntary assisted dying
- voluntariness
- residency.

More information on the role of QCAT is available in [Chapter 3: Oversight](#).

Documentation

First Assessment Record Form

The coordinating practitioner must complete the *First Assessment Record Form* and provide a copy to the Review Board within two business days of completing the first assessment.

This form can be accessed and submitted via QVAD Review Board IMS (including upload of other relevant documents). Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

The *First Assessment Record Form* includes the details of any referrals for determination and the outcome of those referrals, as well as copies of any reports received. The coordinating practitioner must also give a copy of the *First Assessment Record Form* to the person.

Person's medical record

There are no requirements in the Act to document information about the first assessment in the person's medical record, however it would be good clinical practice to do so.

Chapter 12: The consulting assessment

Overview

After the coordinating practitioner has assessed a person as eligible to access voluntary assisted dying, they will refer the person to another medical practitioner for a second assessment. This is called the consulting assessment.

The medical practitioner who accepts a referral for a consulting assessment becomes the consulting practitioner. The consulting practitioner must independently assess the person's eligibility for voluntary assisted dying.

Before commencing the consulting assessment, the medical practitioner must become an authorised voluntary assisted dying practitioner (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#)).

To prevent any undue or unnecessary delays in provision of services to a person, it would be good clinical practice for a coordinating practitioner (or QVAD-Support on their behalf) to informally check that a potential consulting practitioner is willing and able to undertake that role prior to a formal referral. This could include:

- confirming availability in case of leave
- geographic considerations if travel may be necessary
- specific experience related to a person's underlying condition
- any other factors.

The consulting assessment follows a similar process to the first assessment conducted by the coordinating practitioner. Refer to the guidance related to the eligibility assessment process in [Chapter 11: The first assessment](#).

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Criminal Code apply to this chapter?

An eligibility assessment for voluntary assisted dying can be conducted over telephone or videoconference, provided this is appropriate in the circumstances.

Email, telephone, and videoconference can be used to liaise with other healthcare workers, including a consulting practitioner, about a person's access to voluntary assisted dying.

If a person meets all the eligibility criteria, the consulting practitioner must provide the person with specific information, including the method by which the voluntary assisted dying substance is likely to be self-administered or administered. Provided these discussions are factual and neutral in nature, this information can be provided over the telephone or by videoconference.

If a person wishes to discuss in detail how the substance will be administered at the time of the consulting assessment, this discussion should occur face-to-face.

In accordance with good clinical practice, healthcare workers should consider whether the use of telehealth, video conference, or telephone is appropriate in the circumstances.

Making and receiving a referral for a consulting assessment

Under the Act, a medical practitioner must complete certain steps when they accept or refuse a referral for a consulting assessment.

The referral from the coordinating practitioner to the medical practitioner follows a usual referral pathway—for example, it can be a verbal or written referral.

To ensure requirements of the Act are met, it is recommended the referral for a consulting assessment is documented in the *Consulting Assessment Referral Form*, available on the [Queensland Health website](#). However, use of this form is optional.

Documentation

Consulting Assessment – Referral Acceptance or Refusal Form

Under the Act, a medical practitioner who receives a consulting assessment referral from a coordinating practitioner is required to complete the *Consulting Assessment – Referral Acceptance or Refusal Form* and give a copy to the Review Board within two business days of their decision to accept or refuse the referral. This form must be completed regardless of whether the practitioner accepts or refuses the referral.

Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The medical practitioner will receive a confirmation of receipt once submitted. A medical practitioner does not need to be registered on QVAD Review Board IMS to be able to complete and submit the form.

Person's medical record

The decision to refer should be documented in the person's medical record as part of good clinical practice by the coordinating practitioner.

As a requirement of the Act, and consistent with good clinical practice, details of the consulting assessment referral received by a medical practitioner must be documented in the person's medical record. As part of that documentation, a medical practitioner who receives a consulting assessment referral from a coordinating practitioner is required to record (at minimum) the following information in the person's medical record:

- the referral
- their decision to accept or refuse the referral
- if refused, their reason for refusal.

Accepting the consulting assessment referral

A medical practitioner can only accept the referral for a consulting assessment from the coordinating practitioner if they are eligible to do so.

The consulting practitioner is not required to be an authorised voluntary assisted dying practitioner to **accept** the consulting assessment referral. However, the medical practitioner must become an authorised voluntary assisted dying practitioner **before** conducting the consulting assessment, and be eligible to be the consulting practitioner for the person (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#)). The process for accepting a consulting assessment referral is summarised in Table 15.

Summary: Requirements for a medical practitioner who accepts a consulting assessment referral²⁹

Table 15: Requirements for medical practitioner who accepts a consulting assessment referral

Requirement	Details	Timeframe
Inform the person and coordinating practitioner	Inform the person and the coordinating practitioner that they accept the consulting assessment referral and will become the consulting practitioner	Within two business days, not including the day the referral was made ³⁰
Document in the person's medical record	Record in the person's medical record: <ul style="list-style-type: none">• that the consulting assessment referral was received• the medical practitioner's decision to accept the referral.	As soon as practicable
Complete the <i>Consulting Assessment – Referral Acceptance or Refusal Form</i> in QVAD Review Board IMS	Complete the <i>Consulting Assessment – Referral Acceptance or Refusal Form</i> and submit to the Review Board via QVAD Review Board IMS	Within two business days, not including the day the referral was made ³¹

Refusing the consulting assessment referral

The medical practitioner must refuse the referral if they are not eligible to act as the consulting practitioner for the person (refer to [Table 16](#) and [Chapter 6: Authorised voluntary assisted dying practitioners](#)). There are several other reasons why a medical practitioner may refuse the referral for the consulting assessment. The medical practitioner may:

- be ineligible to accept the referral for the consulting assessment (for example, they do not meet the eligibility requirements to become an authorised voluntary assisted dying practitioner; they are a family member of the person; or beneficiary of the person's will)
- be unwilling to perform the duties of consulting practitioner (for example, they do not want to be the consulting practitioner for the person)

29. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

30. If a person makes a first request on a Friday, they must respond to their request by the end of the day (11:59pm) on Tuesday.

31. Ibid.

- be unable to perform the duties of consulting practitioner (for example, they cannot commit the time required)
- hold a conscientious objection to voluntary assisted dying.

If a medical practitioner refuses the consulting assessment referral based on a conscientious objection, they must inform the person and the coordinating practitioner **immediately**. In all other circumstances the medical practitioner must inform the person and the coordinating practitioner within two business days of the referral being made of their decision to refuse the referral.

It is considered a professional obligation that a medical practitioner not unduly delay a person’s access to voluntary assisted dying. The medical practitioner should make their decision and inform the person and the coordinating practitioner as soon as practicable.

Summary: Requirements for a medical practitioner who refuses a consulting assessment referral³²

Table 16: Requirements for a medical practitioner who refuses a consulting assessment referral

Requirement	Details	Timeframe
Inform the person and consulting practitioner	Inform the person and coordinating practitioner that they cannot accept the consulting assessment referral, and provide the reason for their decision to refuse (for example, due to conscientious objection or another reason)	Conscientious objection: Immediately All other circumstances: Within two business days, not including the day the referral was made ³³
Document in the person’s medical record	Record in the person’s medical record: <ul style="list-style-type: none"> • that the consulting assessment referral was received • the medical practitioner’s decision to refuse the referral • the reason for refusal. 	As soon as practicable
Complete the <i>Consulting Assessment – Referral Acceptance or Refusal Form</i> via QVAD Review Board IMS	Complete the <i>Consulting Assessment – Referral Acceptance or Refusal Form</i> and submit to the Review Board via QVAD Review Board IMS	Within two business days, not including the day the referral was made ³⁴

Conducting the consulting assessment

Following acceptance of the referral, the consulting practitioner’s primary role in the process is completing a consulting assessment to determine a person’s eligibility to access voluntary assisted dying. The consulting assessment process is summarised in [Table 17](#).

This follows a similar process to the first assessment conducted by the coordinating practitioner. Refer to the eligibility assessment guidance provided in [Chapter 11: The first assessment](#).

32. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

33. If a person makes a first request on a Friday, they must respond to their request by the end of the day (11:59pm) on Tuesday.

34. Ibid.

Summary: The consulting assessment³⁵

Table 17: The consulting assessment

Key element	Process details
Overview	<p>The consulting practitioner completes the consulting assessment. They must assess whether:</p> <ul style="list-style-type: none"> the person meets the eligibility criteria for access to voluntary assisted dying the person understands the specific information given to them.
Before the assessment	<p>Before commencing the consulting assessment, the medical practitioner must have:</p> <ul style="list-style-type: none"> completed the mandatory training been approved by the Chief Medical Officer as an authorised voluntary assisted dying practitioner confirmed they are authorised to act as the consulting practitioner for the person accepted the consulting assessment referral.
Timeframe	<p>There is no timeframe in which the consulting assessment must be completed. However, it is important to consider the progression of the person's illness and conduct the consulting assessment as soon as practicable.</p>
Requirement to independently form own opinion	<p>The consulting practitioner must form their own decision about a person's eligibility, independently of the coordinating practitioner. The requirement of independence is a key safeguard in ensuring voluntary assisted dying is only accessed by eligible persons.</p> <p>The fact the coordinating practitioner considers the person to be eligible (which has resulted in the referral) should not influence the consulting practitioner's decision.</p> <p>However, the consulting practitioner may take into account information about the person prepared by another registered health practitioner, such as information in health records or reports. This includes the coordinating practitioner's assessment stored in QVAD Review Board IMS.</p>
Referral for determination	<p>If the consulting practitioner is unable to determine:</p> <ul style="list-style-type: none"> whether the person has a disease, illness, or medical condition that is advanced, progressive, and is expected to cause death within 12 months, that is causing intolerable suffering; or whether the person has decision-making capacity in relation to voluntary assisted dying <p>they must refer the person to another registered health practitioner with appropriate skills and training to determine the matter.</p> <p>If the consulting practitioner is unable to determine:</p> <ul style="list-style-type: none"> whether the person is acting voluntarily and without coercion <p>they must refer the person to another person with appropriate skills and training to determine the matter.</p>

35. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Key element	Process details
Person understands person specific information	<p>If a person meets all the eligibility criteria, the consulting practitioner must provide the person with specific information.</p> <p>Both the coordinating practitioner and the consulting practitioner must be independently satisfied that the person understands the specific information for the person to be eligible for voluntary assisted dying.</p>
Outcomes	<p>Eligible: The consulting practitioner must assess the person as eligible for voluntary assisted dying if they are satisfied that:</p> <ul style="list-style-type: none"> • the person meets all the eligibility criteria; and • the person understands the specific information given to them <p>Ineligible: The consulting practitioner must assess the person as ineligible for voluntary assisted dying if they are not satisfied that:</p> <ul style="list-style-type: none"> • the person meets all the eligibility criteria; or • the person understands each matter in the specific information given to them <p>Even if the person meets all the eligibility criteria, they must still be assessed as ineligible if they do not understand all the specific information given to them.</p>
Notifications and documentation	<p>After completing the consulting assessment, the consulting practitioner must:</p> <ul style="list-style-type: none"> • inform the person and the coordinating practitioner of the outcome of the consulting assessment as soon as practicable after completing the assessment • complete the <i>Consulting Assessment Record Form</i> and submit it and any supporting documents to the Review Board via QVAD Review Board IMS within two business days after completing the assessment • provide a copy of the <i>Consulting Assessment Record Form</i> and any supporting documents to the person and the coordinating practitioner as soon as practicable after completing the form.
Next steps	<p>If the person is assessed as meeting the requirements for voluntary assisted dying, the person may make their second request.</p> <p>If the person is assessed as not meeting all the requirements for voluntary assisted dying, the coordinating practitioner for the person may refer them to another medical practitioner for a further consulting assessment. However, if a person is assessed as not meeting all the requirements by more than one consulting practitioner, this may signal that the person is ineligible for voluntary assisted dying and should prompt further consideration of the person's circumstances and whether the requirements for voluntary assisted dying are met for this person.</p>

Assessing the person against the eligibility criteria

Note: As the consulting practitioner must conduct an independent assessment of the person's eligibility to access voluntary assisted dying, the eligibility assessment information in [Chapter 11: The first assessment](#) is also relevant for the completion of the consulting assessment by the consulting practitioner.

The consulting practitioner completes the consulting assessment of the person's eligibility to access voluntary assisted dying. They must assess whether:

- the person meets the eligibility criteria for access to voluntary assisted dying; and
- the person understands the specific information (refer to [Appendix F: Information to be provided to the person if assessed as meeting eligibility criteria](#)) given to them.

This specific information has already been provided by the coordinating practitioner, but must also be separately provided by the consulting practitioner. The information does not need to be provided to the person in writing. It should instead form part of the discussion between the consulting practitioner and the person during the assessment process.

The consulting practitioner must determine whether the person meets the eligibility criteria independently of the coordinating practitioner. The consulting practitioner may consider reports and relevant information from other registered health practitioners as part of the assessment process, including the coordinating practitioner's assessment stored in QVAD Review Board IMS. However, the consulting practitioner must form their own professional opinion in making the determination, and act independently of the coordinating practitioner in doing so.

Referral for determination

As with the first assessment, if the consulting practitioner is unable to determine whether or not the person meets any of the eligibility criteria, they must refer the person to a:

- registered health practitioner who has appropriate skills and training to determine:
 - » diagnosis
 - » prognosis
 - » whether the person's suffering meets the disease-related requirements
 - » decision-making capacity in relation to voluntary assisted dying
- person (a referee) who has appropriate skills and training to determine the matter, in relation to:
 - » voluntariness and coercion.

The consulting practitioner may adopt the determination of the registered health practitioner or referee in relation to the matter relevant to the referral was made. The consulting practitioner should use their clinical judgement and expertise in making this decision. If the consulting practitioner decides not to adopt the determination of the registered health practitioner, they should document the reasons for their decision.

Referral for determination made during the consulting assessment follows the usual pathway for medical referrals to other health professionals—for example, it can be a verbal or written referral or determination. To ensure requirements of the Act are met, it is recommended the following (optional) forms are used:

- *Referral for Determination Form*
- *Determination Assessment Report.*

These forms are available on the [Queensland Health website](#).

As part of good clinical practice, information about the referral should be documented in the person's medical record.

The consulting practitioner may know a suitable registered health practitioner from their professional networks. Alternatively, consulting practitioners can contact QVAD-Support who can provide the details of registered health practitioners who may be willing to accept a referral.

Outcome of the consulting assessment

The consulting practitioner must inform the person and the coordinating practitioner of the outcome of the consulting assessment as soon as practicable after its completion. The person must be assessed as eligible for access to voluntary assisted dying if the consulting practitioner is satisfied that they:

- meet all the eligibility criteria; and
- understand the specific information required to be provided to them.

If the consulting practitioner is not satisfied as to either of these matters, they must assess the person as ineligible for access to voluntary assisted dying.

Person assessed as ineligible

The discussion with a person assessed as ineligible following a consulting assessment may be challenging, especially given that the person was assessed as eligible by the coordinating practitioner at the first assessment. The consulting practitioner will need to be clear and sensitive in how they inform the person of the assessment outcome. More guidance is available [Chapter 11: The first assessment](#).

Coordinating practitioner may refer for a further consulting assessment

If the consulting practitioner assesses the person as ineligible, the coordinating practitioner may refer the person to another medical practitioner for a further consulting assessment. There is no limit on the number of times this can happen.

However, if a person is assessed as not meeting all the requirements by more than one consulting practitioner, this may signal that the person is ineligible for voluntary assisted dying and should prompt further consideration of the person's circumstances.

Reviewable decisions

As is the case following the first assessment, certain decisions made in the consulting assessment can be requested to be reviewed by QCAT under the Act.

If relevant, the consulting practitioner may inform the person:

- which decisions are considered reviewable decisions in the consulting assessment
- that they have the right to request a review of the outcomes by QCAT.

Reviewable decisions are those regarding:

- decision-making capacity in relation to voluntary assisted dying
- voluntariness
- residency.

More information on the role of QCAT is available in [Chapter 3: Oversight](#).

Documentation

Consulting Assessment Record Form

The consulting practitioner must complete the *Consulting Assessment Record Form* and provide a copy to the Review Board within two business days of completing the consulting assessment. The *Consulting Assessment Record Form* includes the details of any referrals for determination and the outcome of those referrals, as well as copies of any reports received.

This form can be accessed and submitted via QVAD Review Board IMS (including upload of any other relevant documentation). Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The consulting practitioner will receive a confirmation of receipt once submitted.

The consulting practitioner must also give a copy of the consulting assessment record form to the person making the request for voluntary assisted dying, and the coordinating practitioner.

Person's medical record

There are no requirements in the Act to document information about the consulting assessment in the person's medical record, however it would be good clinical practice to do so.

Chapter 13: The second request

Overview

If a person has been assessed as eligible by both the coordinating practitioner and consulting practitioner, they may make a second request in writing for access to voluntary assisted dying. The second request process is summarised in Table 18.

Summary: The second request³⁶

Table 18: The second request

Key element	Process details
Overview	<p>The second request for voluntary assisted dying must be set out in writing in the <i>Second Request Form</i>.</p> <p>The coordinating practitioner can download and print the <i>Second Request Form</i> from QVAD Review Board IMS to give to the person for completion.</p> <p>The second request must:</p> <ul style="list-style-type: none">• specify the person makes the request voluntarily and without coercion• specify the person understands the nature and effect of the request• be signed by the person (or by someone else at the person’s direction)• be witnessed by two eligible witnesses who sign the document in the presence of the person. <p>The second request does not have to be completed or signed by the person and their witnesses in the presence of the coordinating practitioner.</p>
Timeframe	<p>The second request can be made at any time after the consulting assessment is completed, and the person has been assessed as eligible.</p>
Notifications and documentation	<p>After the <i>Second Request Form</i> is completed, the person should give it to the coordinating practitioner. After receiving the <i>Second Request Form</i> from the person, the coordinating practitioner must:</p> <ul style="list-style-type: none">• record in the person’s medical record:<ul style="list-style-type: none">» the date the second request was made» the date the <i>Second Request Form</i> was received by the coordinating practitioner• within two business days after receiving a second request, scan and upload the <i>Second Request Form</i> to QVAD Review Board IMS.
Next steps	<p>If the person wishes to continue with the request process, the next step is to make a final request.</p>

36. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

The second request must be in writing

The second request for voluntary assisted dying must be in writing and set out in the *Second Request Form*. The coordinating practitioner can download and print the form from the QVAD Review Board IMS and give the form to the person to complete.

The Act requires that the person (or where appropriate, a proxy) must sign the second request in the presence of two eligible witnesses. There are also specific steps to complete if an interpreter assists the person with communication.

Signatory requirements

If the person is able to sign the second request, they must sign it in the presence of two eligible witnesses.

If the person is unable to sign the second request (for example, because of weakness, pain, or disability), another person (a proxy) may sign the second request on their behalf and at their direction.

The proxy signing on behalf of the person seeking access to voluntary assisted dying must:

- be at least 18 years of age
- not also be a witness to the signing of the request
- not be the coordinating practitioner or consulting practitioner
- sign the request in the presence of the person making the request and two eligible witnesses.

Witness requirements

The person (or proxy) must sign the *Second Request Form* in the presence of two witnesses. This is to ensure the person is making their own decision to access voluntary assisted dying voluntarily and without coercion.

The person's decision-making capacity in relation to voluntary assisted dying will have already been independently assessed by two medical practitioners during the first and consulting assessments.

Each witness must:

- be at least 18 years of age
- not know or believe they are a beneficiary under a will, or otherwise going to receive a financial or material benefit from the person's death
- not be an owner, or responsible for the management of, a health facility at which the person is being treated or resides
- not be the coordinating practitioner or consulting practitioner.

Each witness must sign the second request form in the person's presence and certify that the person making the request:

- appeared to freely and voluntarily sign the request; and
- signed the request in the presence of the witness, or directed the proxy to sign the request in the presence of the person making the request and the witness.

Each witness must also state in the request that they are not knowingly ineligible to witness the signing of the second request.

One or both witnesses may be family members of the person, provided they are not otherwise ineligible (for example, because they know or believe they are a beneficiary of the person's will).

Interpreter requirement

A person can make their second request with the assistance of an interpreter who meets certain certification requirements as provided for in the Act. The interpreter must certify on the *Second Request Form* that they provided a true and correct translation of any material translated.

Documentation

Second Request Form

Once the second request is completed, the person must give the *Second Request Form* to the coordinating practitioner. The coordinating practitioner must submit this form via QVAD Review Board IMS.

The coordinating practitioner must give a copy of the *Second Request Form* to the Review Board within two business days. Scanning the form, uploading, and submitting via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

Person's medical record

The coordinating practitioner must record (at minimum) the following details in the person's medical record:

- the date the second request was made
- the date the *Second Request Form* was received by the coordinating practitioner.

If the second request is made in the medical practitioner's workplace (for example, they are an employee, visiting medical officer or general practitioner in private practice) they should document this in the person's existing medical record. This should be done in compliance with organisational clinical record management policies and procedures.

The second request may be made somewhere other than the medical practitioner's usual workplace—for example, a coordinating practitioner who is authorised to enter a facility and receive the person's *Second Request Form*.

External practitioners should provide the facility with a progress note documenting their visit (available on the [Queensland Health website](#)). Facilities may choose to include this in the person's medical record.

Consumer resources

Available on the [Queensland Health website](#):

- **Completing the Second Request:** Information sheet providing guidance for the person making the second request
- **Choosing your witnesses to the second request:** Information sheet providing an overview of what people accessing voluntary assisted dying should consider when choosing their witnesses to the second request
- **Being a witness to the second request:** Information sheet providing an overview of what is involved in acting as a witness to the second request for people who are asked to take on this role.
- **Checklist for being a witness to the second request:** A high-level checklist for people acting as the witness to the second request.

Chapter 14: The final request

Overview

After the second request is completed, signed, witnessed, and given to the coordinating practitioner, the person may make a third and final request for access to voluntary assisted dying. The final request process is summarised in [Table 19](#).

The Act places some restrictions around when a final request may be made (refer to [Timing of the final request](#)).

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to this chapter?

A final request for voluntary assisted dying may be made over the telephone or by videoconference, provided this is appropriate in the circumstances.

Email, telephone, and videoconference can be used to liaise with other healthcare workers, including a consulting practitioner, about a person's access to voluntary assisted dying.

If a person wishes to discuss in detail how the substance will be administered at the time of the final request, this discussion should occur face-to-face.

In accordance with good practice, healthcare workers should consider whether the use of video and telephone is appropriate in the circumstances.

Summary: The final request³⁷

Table 19: The final request

Key element	Process details
Overview	<p>The third and final request for voluntary assisted dying must be:</p> <ul style="list-style-type: none">• made to the coordinating practitioner either verbally, by gestures, or other means of communication available to the person• clear and unambiguous• made by the person and not by another person on their behalf. <p>The final request can be made either in person or via telehealth.</p> <p>If a final request is made via telehealth, the coordinating practitioner must ensure any discussion of the voluntary assisted dying process does not breach the Commonwealth Criminal Code.</p>
Timeframe	<p>In all cases, the final request cannot be made until at least the day after the consulting assessment was completed.</p> <p>Additionally, in most circumstances, the final request cannot be made until at the end of nine days from and including the day on which the person made a first request (refer to Timing of the final request).</p>
Notifications and documentation	<p>After a person makes a final request, the coordinating practitioner must:</p> <ul style="list-style-type: none">• record the date the final request was made in the person’s medical record• if the final request was made before the end of the nine-day period, record in the person’s medical record the reason it was made before the end of that period• within two business days after receiving a final request, complete and submit the <i>Final Request Form</i> (which includes providing information about whether there was an exception to the nine-day period) to the Review Board via QVAD Review Board IMS.
Next steps	<p>The next step in the process is the final review by the coordinating practitioner.</p> <p>A coordinating practitioner who receives a final request from a person must take certain steps (refer to Chapter 15: The final review).</p>

Timing of the final request

Under the Act, there is a designated waiting period between the person’s first and final requests. This period is defined as the period of nine days from and including the day on which the person made the first request. The final request may not be made before the end of the period—that is, it must be made on the tenth day.

The intent of the nine-day period ending before a final request can be made is to ensure a person’s decision is well considered, and is balanced with the need to avoid prolonging suffering.

37. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

If the medical practitioner refuses the person’s first request, the person can make another request to a different medical practitioner, and the nine-day period restarts. An example of how this applies is depicted in Figure 5.

First request – final request timeframe

Example: If the person made the first request on the 17 April, the earliest they could make the final request is on the 26 April (i.e., nine days later).

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
17 April	18 April	19 April	20 April	21 April	22 April	23 April	24 April	25 April	26 April
First request made								Last day consulting assessment can occur if final request occurs on Day 10	Final request can be made

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Figure 5: First request – final request timeframe

Nine-day period exception

While voluntary assisted dying is not emergency care—and in practice the process can take several weeks or months—some cases might be more urgent than others. The Act allows for the final request to be made **before** the end of the nine-day designated period in specific circumstances. This nine-day period can be shortened if both the coordinating practitioner and consulting practitioner believe the person is likely to die or lose decision-making capacity in relation to voluntary assisted dying before the nine-day period elapses.

If the nine-day period is shortened in these circumstances:

- all steps of the voluntary assisted dying process as set out in the Act must still be followed
- the final request must occur no earlier than the day after the consulting assessment, i.e. not on the same day
- the coordinating practitioner is required to:
 - » declare the following when completing the *Final Request Form*:
 - that the person is likely to die or lose decision-making capacity in relation to voluntary assisted dying before the end of the nine-day period
 - detail about why the coordinating practitioner has formed this opinion
 - that the consulting practitioner has formed the same opinion
 - record in the person’s medical record the reason the final request was made before the end of the nine-day period.

Documentation

Final Request Form

The coordinating practitioner must complete the *Final Request Form* and give a copy to the Review Board within two business days of receiving the final request. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

Person's medical record

The coordinating practitioner must record (at minimum) the following information in the person's medical record:

- the date the final request was made
- if the final request was made before the end of the nine-day period, the reason for it being made before the end of that period.

If the final request is made in the medical practitioner's workplace (for example, they are an employee, visiting medical officer or general practitioner in private practice) they should document this in the person's existing medical record in compliance with organisational clinical record management policies and procedures.

The final request may be made somewhere other than the medical practitioner's workplace (for example, a coordinating practitioner who is authorised to enter a facility and receive a person's final request). External practitioners should provide the facility with a progress note documenting their visit (available on the [Queensland Health website](#)). Facilities may choose to include this in the person's medical record.

Chapter 15: The final review

Overview

After receiving a final request, the coordinating practitioner must complete a final review. The final review is the last step in the request and assessment process, and is summarised in Table 20. The coordinating practitioner is not required to consult with the person at the final review.

The final review is an additional safeguard to ensure that:

- the person’s request is enduring
- the person retains decision-making capacity
- the person is acting voluntarily and without coercion
- the request and assessment process has been completed in accordance with the Act.

Summary: The final review³⁸

Table 20: The final review

Key element	Process details
Overview	<p>To complete the final review, the coordinating practitioner must:</p> <ul style="list-style-type: none">• review the <i>First Assessment Record Form</i>, the <i>Consulting Assessment Record Form</i>, and the <i>Second Request Form</i>• complete the <i>Final Request Form</i>• take into consideration any decision made by QCAT related to the request and assessment process (if relevant)• complete and submit the <i>Final Review Form</i> via QVAD Review Board IMS. <p>The coordinating practitioner must certify on the <i>Final Review Form</i>:</p> <ul style="list-style-type: none">• the request and assessment process has been completed in accordance with the Act• they are satisfied the person has decision-making capacity in relation to voluntary assisted dying and is acting voluntarily and without coercion.
Timeframe	<p>The final review can take place at any time after the final request has been made.</p> <p>However, this should generally be done as soon as practicable, taking into account any clinical considerations, such as the progression of the person’s illness.</p>
Notifications and documentation	<p>As part of the final review, the coordinating practitioner must complete the <i>Final Review Form</i> and submit it to the Review Board via QVAD Review Board IMS within two business days.</p> <p>The coordinating practitioner must provide a copy of the <i>Final Review Form</i> to the person as soon as practicable after completion.</p>
Next steps	<p>If the person wishes to continue with the voluntary assisted dying process, the next step is to make an administration decision.</p>

38. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Consultation with the person

If the coordinating practitioner has recently met with the person at the final request stage and can confidently certify these matters, the coordinating practitioner is not required under the Act to undertake an additional consultation.

If there has been a delay between the final request and final review, an additional consultation with the person may be required to ensure the coordinating practitioner is satisfied that the person:

- retains decision-making capacity in relation to voluntary assisted dying (for guidance, refer to [Eligibility assessment: Decision-making capacity in Chapter 11: The first assessment](#))
- is acting voluntarily and without coercion (for guidance, refer to [Factors to consider when assessing voluntariness and coercion in Chapter 11: The first assessment](#)).

If it is appropriate for the person's circumstances and if the consultation occurs in person, the administration decision (refer to [Chapter 17: Administration decision](#)) may occur in the same consultation as the final review.

Documentation

Final Review Form

Within two business days of completing the *Final Review Form*, the coordinating practitioner must give a copy to the Review Board. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

The coordinating practitioner must also provide a copy of the *Final Review Form* to the person as soon as practicable after completion.

Person's medical record

There are no requirements in the Act to document information about the final review in the person's medical record, however it would be good clinical practice to do so.

Phase 2: Administration of the voluntary assisted dying substance

Chapter 16: Planning for death

Planning for administration of the voluntary assisted dying substance and the person's death is an important part of providing person-centred care. The coordinating practitioner should explore with the person what their expectations or assumptions about the voluntary assisted dying process may be and consider how best to support them in their plans for death.

These discussions should be handled sensitively and compassionately and may include:

- when and where³⁹ administration of the voluntary assisted dying substance might occur:
 - » in their own home
 - » in another home environment
 - » on country
 - » in hospital
 - » in a palliative care unit or hospice
 - » in a residential aged care facility
- cultural, spiritual, religious, or other aspects of death that are important to the person
- discussing ongoing symptom management, goals of care and other palliative care needs
- carrying out advance care planning⁴⁰ including review (as relevant) of the person's:
 - » Advance Health Directive form
 - » Enduring Power of Attorney form
 - » Statement of Choices form
- ensuring the person has a current Acute Resuscitation Plan (ARP); confirming it is uploaded to The Viewer; and giving them with a copy to keep with other important documents to ensure anyone attending to the person following administration (including emergency services) does not attempt resuscitation
- identifying who the person would like to be present during administration of the voluntary assisted dying substance
- discussing available supports to help navigate family conflict (if any arises in relation to voluntary assisted dying)
- preparing those who will be present during voluntary assisted dying administration, so everyone understands what will happen
- providing instruction about comfort care to family, carers and friends
- preparing family, carers and friends for what happens immediately after death has occurred
- planning for which medical practitioner will complete the person's cause of death certificate if the coordinating practitioner is not available to do so (refer to [Chapter 22: Death certification, notification, and bereavement care](#))

39. For the protections from liability under the Act to apply, all steps in the voluntary assisted dying process **must occur in Queensland**. This includes **administration of a voluntary assisted dying substance**.

40. **Please note:** a request for voluntary assisted dying cannot be made in an advance care planning document. Refer to [Chapter 9: Voluntary assisted dying as an end-of-life choice](#) for information about how voluntary assisted dying and advance care planning intersect.

- recommending the person makes a will, or ensures their existing will is up-to-date and easy to find
- funeral planning, including who will be the point of contact for organising the funeral
- considering who will care for children, other dependents, and pets
- saying goodbye to those the person loves and cares about.

If the person consents, these discussions can also include a support person. Involvement with planning for death may help family, carers, and friends' manage the experiences of adjustment, grief, and bereavement. However, while the inclusion of carers, family, or friends in these discussions should be encouraged, it must always remain the person's choice as to who is involved.

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to planning for death?

If a person wishes to discuss in detail how the substance will be administered or what they, their family, friends and carers can expect during and after administration when having discussions about planning for death, this discussion should occur face-to-face.

Organ, tissue, and body donation

Some people accessing voluntary assisted dying may wish to learn more about organ, tissue, and body donation.

Organ and tissue donation

Organ and tissue donation have strict eligibility criteria. Some medical conditions, including malignancies and neurodegenerative diseases, prevent people donating their organs or tissue. Very few people accessing the voluntary assisted dying process would be eligible for organ and tissue donation for transplant purposes.

The coordinating practitioner can call [DonateLife](https://www.donatelife.org.au) on 1800 777 203 for more information.

Body donation

Several Queensland universities have programs for people to donate their body for the purposes of teaching, study, research, and investigation of human anatomy. Interested people should contact universities directly to understand more about their programs. Each case will be considered on an individual basis.

Universities that run body donation programs in Queensland are:

- [Griffith University](#)
- [James Cook University Australia](#)
- [Queensland University of Technology](#)
- [The University of Queensland](#)

Chapter 17: Administration decision

Overview

After the person makes a final request, and has completed the request and assessment process as confirmed by the coordinating practitioner during the final review, the next step is to make an administration decision.

This chapter should be read in conjunction with the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols* provided to authorised voluntary assisted dying practitioners in hard copy and on USB as part of the Queensland voluntary assisted dying mandatory training. Only practitioners who have completed mandatory training have access to this information.

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to the administration decision?

To avoid breaching the Commonwealth Criminal Code, the administration decision and all discussions about prescribing, preparing, or administering a voluntary assisted dying substance must occur in person. This includes any associated language interpretation services, if required.

The administration phase

The administration phase is depicted in [Figure 6](#).

Administration phase



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Figure 6: Administration phase

Making the administration decision

After the request and assessment phase is completed, and if the person has been confirmed as eligible at the final review, an administration decision may be made in consultation with, and on the advice of, the coordinating practitioner. Discussions about the administration decision may occur in a single consultation, or can be ongoing. If it is face-to-face and the designated period of nine days have ended after the first request, the administration decision may be made at the same consultation as the final request and final review, or at a later time.

There are two types of administration decision:

- **self-administration decision:** the person decides to self-administer the voluntary assisted dying substance
- **practitioner administration decision:** the person decides an administering practitioner will administer the voluntary assisted dying substance.

Self-administration is the default method of administration under the Act. A practitioner administration decision may only be made if the coordinating practitioner advises self-administration would be inappropriate after considering the following factors:

- the person's ability to self-administer the voluntary assisted dying substance
- the person's concerns about self-administration
- the method of administration suitable for the person.

An administration decision must be, clear, unambiguous, and made in the presence of, and in collaboration with, the coordinating practitioner. The administration decision may be communicated verbally, or by other means of communication available to the person, such as hand gestures.

A discussion between the coordinating practitioner and a person when making an administration decision must **not** occur using telehealth and **must** be in person. This is because it will likely involve detailed discussion about the following topics which are not permitted over a carriage service under the Commonwealth Criminal Code:

- administration options
- the method of administration
- the person's ability and concerns about administration.

Self-administration

Self-administration of the voluntary assisted dying substance requires the person to prepare and ingest the substance by mouth (orally), or via enteral access devices including nasogastric tube (NGT), nasojejunal tube (NJT), percutaneous endoscopic gastrostomy (PEG) and similar devices.

At the person's request, another person (such as a family member, friend, or healthcare worker) can prepare the voluntary assisted dying substance for self-administration. Preparation includes doing anything necessary to ensure the substance is in a form suitable for administration, including to decant, dilute, dissolve, reconstitute, colour, or flavour the substance. This must be strictly in accordance with the instructions provided by the pharmacist. However, they **cannot** administer the substance to the person. Only the person accessing voluntary assisted dying can self-administer the substance. Unauthorised administration of the substance can result in criminal prosecution and imprisonment.

If the person is unable to swallow or digest the oral substance or syringe the substance into the enteral access device, or is concerned about their ability to undertake these actions, self-administration may not be a suitable option.

Practitioner administration

Practitioner administration of the voluntary assisted dying substance requires the administering practitioner to administer the substance to the person. Practitioner administration of the voluntary assisted dying substance may be via intravenous administration or enteral access devices.

A practitioner administration decision may only be made if the coordinating practitioner for the person advises self-administration is inappropriate after considering the following:

- the person is unable to self-administer the substance
- the person has concerns about self-administering the substance
- the self-administration method is unsuitable for the person.

The coordinating practitioner becomes the default administering practitioner. If the coordinating practitioner is unable or unwilling to be the administering practitioner, the role is transferred to another eligible medical practitioner, nurse practitioner, or registered nurse who must accept or refuse the role (refer to [Chapter 24: Transferring authorised voluntary assisted dying practitioner roles](#)).

Revocation of an administration decision

A person may revoke their administration decision and make a new administration decision at any time, for any reason. This does not invalidate the request and assessment process.

The person may inform the relevant practitioner of their decision in writing, verbally, using gestures, or in another way (for example, through a communication aid). The process is summarised in Table 21.

Summary: Administration decision revocation⁴¹

Table 21: Administration decision revocation

Requirement	Details	Timeframe
Inform the practitioner	<p>To revoke a self-administration decision the person must tell the coordinating practitioner that they have decided not to self-administer.</p> <p>To revoke a practitioner administration decision the person must tell the administering practitioner that they have decided not to proceed with practitioner administration.</p> <p>The person can inform the relevant practitioner in writing, verbally, or by gestures or other means of communication available to the person.</p>	At any time after making an administration decision

41. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Requirement	Details	Timeframe
Document in the person's medical record	The coordinating or administering practitioner who was informed must record the revocation in the person's medical record.	As soon as practicable
Complete the <i>Revocation of Administration Decision Form</i> in QVAD Review Board IMS	The coordinating or administering practitioner who was informed must complete the <i>Revocation of Administration Decision Form</i> via QVAD Review Board IMS.	Within two business days
Notify coordinating practitioner	For revocation of a practitioner administration decision, if the administering practitioner is not the coordinating practitioner, they must also notify the coordinating practitioner of the revocation.	As soon as practicable

Making an administration decision after a revocation

After revoking an administration decision, the person can make another administration decision to their coordinating practitioner; see Box L for examples. The administration decision can be for same method, or different method, as their earlier administration decision.

Box L: Examples of a revocation and subsequent decision

- A person chose self-administration but loses the ability to physically self-administer the voluntary assisted dying substance. They revoke their decision and choose practitioner administration.
- A person revokes a self-administration decision because of swallowing difficulties and chooses practitioner administration. Their swallowing difficulties improve, or they have an enteral access device inserted, so they decide to revoke their practitioner administration decision and again choose self-administration.

Documentation

Administration Decision and Prescription Form

An approved form does not need to be submitted at the time the person makes their administration decision. The coordinating practitioner must record the administration decision in the person's medical record.

After a contact person has been appointed (refer to [Chapter 18: Appointing the contact person](#)) and the coordinating practitioner has prescribed the voluntary assisted dying substance (refer to [Chapter 19: Prescription](#)), they must complete the *Administration Decision and Prescription Form*. A copy of the form must be given to the Review Board within two business days of prescribing the substance. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

Revocation of Administration Decision Form

If the person revokes their administration decision, the coordinating practitioner must complete the *Revocation of Administration Decision Form* and give a copy to the Review Board within two business days of the revocation. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

Person's medical record

The coordinating practitioner must record (at minimum) the following information in the person's medical record:

- the person's administration decision
- if the administration decision is revoked:
 - » that the revocation occurred
 - » a new administration decision, if one is made.

If the administration decision is made in the medical practitioner's workplace (for example, they are an employee, visiting medical officer or general practitioner in private practice) they should document this in the person's existing medical record in compliance with organisational clinical record management policies and procedures.

The administration decision may be made somewhere other than the medical practitioner's workplace (for example, a coordinating practitioner who is authorised to enter a facility and receive a person's final request). External practitioners should provide the facility with a progress note documenting their visit (available on the [Queensland Health website](#)). Facilities may choose to include this in the person's medical record.

Chapter 18: Appointing the contact person

Overview

A person who makes an administration decision must appoint a contact person before they can be prescribed a voluntary assisted dying substance. The process is summarised in Table 22.

The contact person has duties under the Act, particularly if the person has made a self-administration decision. The coordinating practitioner cannot prescribe the voluntary assisted dying substance until the contact person is appointed.

Summary: Appointing the contact person⁴²

Table 22: Appointing the contact person

Key element	Process details
Overview	<p>The person can appoint anyone to be their contact person provided they:</p> <ul style="list-style-type: none">• are at least 18 years old• consent to the appointment. <p>The coordinating practitioner can download and print the <i>Contact Person Appointment Form</i> from QVAD Review Board IMS to give to the person for completion.</p> <p>The coordinating practitioner does not need to be present for the contact person appointment or for the completion of the <i>Contact Person Appointment Form</i>.</p> <p>If appropriate and possible, it would be useful for a contact person to accompany the person to an appointment with their coordinating practitioner to ask any questions or seek clarification.</p> <p>It is strongly recommended the coordinating practitioner provides the person the <i>Choosing a contact person</i> information sheet available on the Queensland Health website.</p> <p>If the person makes a self-administration decision, their contact person will receive information from the Review Board via email. This will include information on how to complete their role as contact person.</p>
Timeframe	<p>The contact person must be appointed:</p> <ul style="list-style-type: none">• after the person makes an administration decision; and• before the coordinating practitioner prescribes the voluntary assisted dying substance.

42. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Key element	Process details
Notifications and documentation	<p>The <i>Contact Person Appointment Form</i> must be completed by the person and the contact person.</p> <ul style="list-style-type: none"> • This form is signed by: <ul style="list-style-type: none"> » the person accessing voluntary assisted dying (or another person who completes the form on their behalf); and » the contact person. • After the <i>Contact Person Appointment Form</i> is completed, it should be given to the coordinating practitioner by the person or the contact person. The coordinating practitioner must submit the form to the Review Board via QVAD Review Board IMS within two business days of receiving it.
Next steps	The next step in the process is the prescription of the voluntary assisted dying substance by the coordinating practitioner.

Eligibility to act as a contact person

Anyone aged 18 years of age or over is eligible to be the contact person for a person accessing voluntary assisted dying.

The person undertaking the role of contact person must consent to the appointment and may choose to withdraw from the role at any time.

The contact person can be a:

- carer
- family member, partner, or spouse
- friend
- healthcare worker involved in the person's care—for, example, their coordinating or consulting practitioner, or another health professional.

It is important the person chooses a contact person they trust can fulfill the responsibilities of the role.

Roles and responsibilities of the contact person

Under the Act, the contact person's responsibilities differ depending on whether a person has made a self-administration or practitioner administration decision. These responsibilities are summarised in [Table 23](#).

If the person has chosen self-administration, the contact person has a role in relation to managing the voluntary assisted dying substance.

Authorised voluntary assisted dying practitioners and other healthcare workers involved in the person's care should be aware of the contact person's role and provide support, where appropriate. QVAD-Support can also provide support to someone in the contact person role.

Summary: Contact person's role for each type of administration decision⁴³

Table 23: Contact person's role for each type of administration decision

Contact person role	Self-administration decision	Practitioner administration decision
Must give any unused or remaining voluntary assisted dying substance to an authorised disposer	Yes	No
Must notify the coordinating practitioner if the person dies	Yes (if the person dies by self-administration or another cause)	Yes (if the person dies prior to practitioner administration)
Must be present at the time of substance administration	No	No
May be contacted by the Review Board to request information	Yes	Yes

Contact person role: Self-administration decision

For self-administration, the contact person's most important duty is returning any unused or remaining voluntary assisted dying substance.

This applies in these circumstances:

- The person revokes their self-administration decision:** If a pharmacist employed by QVAD-Pharmacy has already supplied the voluntary assisted dying substance (to the person, contact person, or agent) and the person revokes their self-administration decision, the contact person must give the substance to an authorised disposer as soon as practicable and within 14 days of the person revoking the self-administration decision.
- The person has died:** Where unused or remaining voluntary assisted dying substance remains following the death of the person (through self-administration of the voluntary assisted dying substance, or because of another reason), the contact person must give the unused or remaining substance to an authorised disposer as soon as practicable and within 14 days of the person's death.

Failure to return the voluntary assisted dying substance in either circumstance has a maximum penalty of [100 penalty units](#). This requirement does not apply if the person has self-administered all the voluntary assisted dying substance.

The contact person is also responsible for informing the coordinating practitioner if the person dies. This must be done if the person has died because of self-administration of the voluntary assisted dying substance, or if they have died because of another cause.

43. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

To carry out their responsibilities, the contact person is authorised under the Act to:

- receive the voluntary assisted dying substance from the authorised supplier (a pharmacist employed by QVAD-Pharmacy)
- supply the voluntary assisted dying substance to the person
- give the voluntary assisted dying substance or any unused or remaining portion of the substance to an authorised disposer:
 - » if the person dies (by self-administration or another cause) after the voluntary assisted dying substance has been supplied
 - » if the person revokes their self-administration decision (i.e. decides not to access voluntary assisted dying or makes a practitioner administration decision) after the voluntary assisted dying substance has been supplied

The contact person is not required to be present or witness the person's self-administration of the substance.

The Review Board may reach out to the contact person to request information about any matter.

Contact person role: Practitioner administration decision

For a practitioner administration decision, the contact person's role is to inform the coordinating practitioner for the person if the person dies because of a cause other than the administration of the voluntary assisted dying substance. The contact person must do this within two business days of becoming aware of the death.

The Review Board may reach out to the contact person to request information about any matter.

Information to be provided to the contact person

All contact persons should be provided the below information sheets available on the [Queensland Health website](#), regardless of the administration decision:

- *Being the contact person*
- *Contact person checklist*

Self-administration decision

When a contact person is appointed after a self-administration decision, the Review Board will provide the contact person with information about:

- the contact person's duty to give any unused or remaining voluntary assisted dying substance to an authorised disposer
- support services available for the contact person to assist them in fulfilling this duty.

The Review Board will provide this information within two business days of receiving the contact person appointment form via QVAD Review Board IMS. This is a requirement of the Act.

Practitioner administration decision

The Review Board will not provide the contact person with any information when a contact person is appointed after a practitioner administration decision.

Documentation

Contact Person Appointment Form

The person accessing voluntary assisted dying and their contact person must complete the *Contact Person Appointment Form*.

This form can be downloaded and printed from QVAD Review Board IMS by the coordinating practitioner and given to the person to complete. Alternatively, the person can download and print the form directly from the [Queensland Health website](#).

The form includes:

- details of the person accessing voluntary assisted dying
- details of the contact person
- details of the coordinating practitioner
- details of an interpreter or another person used for assistance (if applicable)
- a statement that the contact person consents to their appointment
- a statement that the contact person understands their role.

The person or their contact person must give this form to the coordinating practitioner once completed. The coordinating practitioner must submit the form via QVAD Review Board IMS within two business days of receiving the form. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The coordinating practitioner will receive a confirmation of receipt once submitted.

Assistance from an interpreter or another person

If required, a person can be assisted by an accredited interpreter or another person to complete the form.

If the person requires an interpreter, the interpreter must provide the following details on the *Contact Person Appointment Form*:

- the interpreter's name, accreditation, and contact details
- a certification that they provided a true and correct translation.

The person can have someone else complete the form for them as a proxy if:

- the person is unable to complete the form (for example, due to frailty, issues with manual dexterity, or inability to write)
- the proxy is at least 18 years of age; and
- the proxy signs the form in the person's presence.

Changing the contact person

The contact person can be changed in two circumstances:

1. **Person revokes the appointment:** the person may revoke the contact person appointment by telling the contact person they no longer want them to act in this role, at which time the appointment immediately ceases
2. **Contact person refuses to continue:** the contact person may refuse to continue in the role by telling the person of the refusal, at which time the appointment immediately ceases.

In either case, if the person wishes to proceed with voluntary assisted dying, they must appoint a new contact person by completing a new *Contact Person Appointment Form* and giving it to the coordinating practitioner.

Within two business days of receiving the revocation, the coordinating practitioner must submit the new *Contact Person Appointment Form* via QVAD Review Board IMS.

Chapter 19: Prescription

Overview

After the person has appointed a contact person, the coordinating practitioner can prescribe the voluntary assisted dying substance.

The prescription process is summarised in Table 24. This chapter should be read in conjunction with the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols* provided to practitioners as part of the Queensland voluntary assisted dying mandatory training. Only practitioners who have completed the mandatory training have access to this information. It is not publicly accessible.

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Commonwealth Criminal Code apply to prescription?

To avoid breaching the Commonwealth Criminal Code, all discussions about prescribing, preparing, or administering a voluntary assisted dying substance must occur in person. This includes any associated language interpretation services, if required.

Summary: The prescription process⁴⁴

Table 24: The prescription process

The prescription process	
Prerequisites to prescribing the voluntary assisted dying substance	
1. Administration decision	The person must have made an administration decision (self-administration or practitioner administration).
2. Contact person appointment	The coordinating practitioner must have received the completed <i>Contact Person Appointment Form</i> .
3. Provide written information about administration	The coordinating practitioner must have given the person written information about the substance and administration of the substance. This information can be provided during the same consultation that the administration decision is made, if appropriate.

44. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

The prescription process

Prescribing process

1. Contact QVAD-Pharmacy	The coordinating practitioner should first liaise with QVAD-Pharmacy to discuss any considerations specific to the person.
2. Write prescription	The coordinating practitioner must write the prescription in the required template and provide it directly to QVAD-Pharmacy, either by hand or post/courier. It must not be transmitted electronically.
3. Report to Review Board	Within two business days after writing the prescription, the coordinating practitioner must complete and submit the <i>Administration Decision and Prescription Form</i> to the Review Board via QVAD Review Board IMS.
4. Inform relevant person that prescription has been issued	<p>For self-administration: The coordinating practitioner advises the person to contact QVAD-Pharmacy to arrange for delivery or collection of the voluntary assisted dying substance.</p> <p>For practitioner administration: If the administering practitioner role has been transferred, the coordinating practitioner should inform the administering practitioner they have issued the prescription. When a date and time has been planned for administration to occur, the administering practitioner must contact QVAD-Pharmacy to organise delivery or collection of the voluntary assisted dying substance.</p>

Before prescribing

There are three prerequisites that must be completed before the prescription is issued:

1. the person must have made an administration decision (i.e. self-administration or practitioner administration)—refer to [Chapter 17: Administration decision](#)
2. the coordinating practitioner must have received the completed *Contact Person Appointment Form*—refer to [Chapter 18: Appointing the contact person](#)
 - » note: the coordinating practitioner is permitted to prescribe the voluntary assisted dying substance prior to uploading the *Contact Person Appointment Form* in QVAD Review Board IMS, as long as the form is submitted within two business days of the coordinating practitioner receiving it
3. the coordinating practitioner must have given to the person written information about the voluntary assisted dying substance and administration of the substance.

Written information to be provided to the person

At this stage, the coordinating practitioner will have had several conversations with the person covering key issues and concerns about their individual circumstances and the voluntary assisted dying process.

However, before prescribing the voluntary assisted dying substance, the coordinating practitioner must provide certain information **in writing** to the person in accordance with the Act.

This information can be provided during the same consultation that the administration decision is made, if appropriate.

Information for a person accessing self-administration

Before prescribing the substance for **self-administration**, the coordinating practitioner must provide the following information to the person, in writing:

- the Schedule 4 substance or Schedule 8 substance, or combination of those substances, constituting the voluntary assisted dying substance
- that the person is not under any obligation to self-administer the substance
- that the substance must be stored in accordance with requirements prescribed by the regulation
- how to prepare and self-administer the substance
- the expected effects of self-administration of the substance
- the period within which the person is likely to die after self-administration of the substance
- the potential risks of self-administration of the substance
- that, if the person decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal
- that, if the person dies, their contact person must give any unused or remaining substance to an authorised disposer for disposal
- the name of the authorised supplier who will be supplying the voluntary assisted dying substance
- the name of one or more registered health practitioners or class of registered health practitioners who are authorised disposers.

Some of this information is not publicly accessible. It is provided to authorised voluntary assisted dying practitioners in the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols*.

Information for a person accessing practitioner administration

Before prescribing the substance for **practitioner administration**, the coordinating practitioner must provide the following information to the person, in writing:

- the Schedule 4 or Schedule 8 substance, or combination of substances, constituting the substance
- that the person is not under any obligation to have the substance administered to the person
- the method by which the substance will be administered
- the expected effects of administration of the substance
- the period within which the person is likely to die after administration of the substance
- the potential risks of administration of the substance
- that, if the practitioner administration decision is made after the revocation of a self-administration decision, the person's contact person must give any substance received by the person, the contact person or an agent of the person to an authorised disposer for disposal
- if the practitioner administration decision is made after the revocation of a self-administration decision—the name of one or more registered health practitioners or class of registered health practitioners who are authorised disposers.

Some of this information is not publicly accessible. It is provided to authorised voluntary assisted dying practitioners in the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols*.

Preparing the prescription

The coordinating practitioner must prescribe the voluntary assisted dying substance on a specific template and in accordance with the instructions and protocols in the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols*.

Some information in the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols*, such as what to prescribe and how to complete the prescription, is only accessible to authorised voluntary assisted dying practitioners. It is not publicly accessible.

The prescription must be given directly to the QVAD-Pharmacy either:

- in person
- via registered post
- via courier.

Care must be taken to complete the prescription clearly and accurately in accordance with the protocols so that it is able to be validated by QVAD-Pharmacy without causing delay.

Documentation

Administration Decision and Prescription Form

The coordinating practitioner must complete the *Administration Decision and Prescription Form* and submit to the Review Board via QVAD Review Board IMS within two business days after prescribing the voluntary assisted dying substance for the person.

If the person has made a self-administration decision, the coordinating practitioner must also submit a copy of the *Contact Person Appointment Form* to the Review Board via QVAD Review Board IMS within two business days of receiving the form. The coordinating practitioner will receive confirmation of receipt once submitted.

Chapter 20: Supply

Overview

Only authorised suppliers can supply the voluntary assisted dying substance upon receipt of the prescription. In Queensland authorised suppliers are pharmacists employed by QVAD-Pharmacy. The supply of the voluntary assisted dying substance does not occur until QVAD-Pharmacy is informed that the substance is being requested.

The person must request the supply of the voluntary assisted dying substance, including adjunct medications, from QVAD-Pharmacy for self-administration or from the administering practitioner for practitioner administration. This ensures the process remains in their control and is voluntary.

The authorised supplier (i.e. a pharmacist employed by QVAD-Pharmacy) must not supply the voluntary assisted dying substance until they have confirmed:

- the authenticity of the prescription
- the identity of the prescriber (the coordinating practitioner)
- the identity of the person to whom the substance is to be supplied.

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Criminal Code apply to supply?

To avoid breaching the Commonwealth Criminal Code, the authorised supplier must provide instructions and information about preparing and administering the substance in person.

Supply of the substance for self-administration

If the voluntary assisted dying substance is supplied for self-administration, pharmacists employed by the QVAD-Pharmacy will supply the substance to the person.

The pharmacist will counsel the person on the safe use of the substance and must provide them with written information at the same time. This information includes:

- that the person is not under any obligation to self-administer the voluntary assisted dying substance
- what the substance is
- how to store the substance in a safe and secure way in compliance with the regulation
- how to prepare and self-administer the substance
- the expected effects of self-administering the substance

- the period within which the person is likely to die after self-administration of the substance
- the potential risks of self-administration of the substance
- that, if the person decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal
- that, if the person dies, their contact person must give any unused or remaining substance to an authorised disposer for disposal.

The person will also be provided with a self-administration substance kit. This kit contains contact details for the person's coordinating practitioner and QVAD-Support, as well as guidance to advise anyone attending the person following self-administration (including emergency services) to notify the coordinating practitioner of the death.

Supply of the substance for practitioner administration

QVAD-Pharmacy must supply the voluntary assisted dying substance to the administering practitioner where the person has made a practitioner administration decision.

The administering practitioner will make a plan with the person for when practitioner administration of the voluntary assisted dying substance will occur. When a date and time has been confirmed, the administering practitioner must contact QVAD-Pharmacy to arrange supply of the substance. As some forms of the voluntary assisted dying substance used in practitioner administration have a limited shelf life, it is important to liaise closely with QVAD-Pharmacy to ensure the substance can be supplied in a timely manner without risk of expiry before the anticipated practitioner administration.

Once supplied, the administering practitioner will be responsible for the safe storage of the substance in accordance with the guidance provided in the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols* until the person requests for it be administered.

Key resource

More information is available in Queensland Health's *Managing, storing, and disposing of voluntary assisted dying substances: Guidance for health services* available on the [Queensland Health website](#).

Chapter 21: Administration

Overview

This chapter provides guidance on:

- considerations for self-administration
- considerations for practitioner administration
- required documentation.

Commonwealth Criminal Code guidance



There is risk an offence will be committed under the Commonwealth Criminal Code if activities related to voluntary assisted dying are conducted over a 'carriage service' and are considered to:

- **urge or advise** a person to access voluntary assisted dying; or
- **encourage** the administration or self-administration of a voluntary assisted dying substance; or
- **provide instructions** on administering the voluntary assisted dying substance.

How does the Criminal Code apply to administration?

Information about self-administration of the voluntary assisted dying substance should not be provided over a carriage service and should occur in-person or via hard copy documents to avoid breaching the Commonwealth Criminal Code.

Self-administration of the voluntary assisted dying substance

If the person has made a self-administration decision, they are authorised to self-administer the substance. No one else is authorised to administer the substance for them.

Self-administration of the voluntary assisted dying substance requires the person to prepare and ingest the substance by mouth (orally), or via enteral access devices including nasogastric tubes (NGT), nasojejunal tubes (NJT), percutaneous endoscopic gastrostomy (PEG) tubes and similar devices.

Detailed information on the self-administration of the voluntary assisted dying substance, including instructions, will be provided to the person during consultations with the coordinating practitioner and by QVAD-Pharmacy at the time the substance is supplied.

Considerations for self-administration

Once the substance has been supplied, the person may self-administer it at a time and place of their choosing, provided they remain within Queensland.

Choosing an environment to self-administer that is safe and supportive is an important part of end-of-life planning. A person may choose to self-administer in one of a number of locations, including in:

- a public or private hospital
- a hospice
- a residential aged care facility
- their home or a home environment
- on country.

If the person seeks to self-administer somewhere other than a private home, they should be encouraged to have a plan in place to ensure the location is appropriate and can safely meet their needs. The location must be within Queensland for the protections under the Act to apply to anyone present at the time of administration.

Planning who should be present

The person should consider who they want to be present when they self-administer the voluntary assisted dying substance.

At least one person attending the death must know what to do after the person has self-administered the substance. Anyone who chooses to self-administer the voluntary assisted dying substance should be encouraged not to self-administer alone. However, if a person plans to self-administer alone, appropriate planning should occur to ensure the requirements of the Act can be met:

- the contact person giving any unused or remaining voluntary assisted dying substance to an authorised disposer
- the contact person notifying the coordinating practitioner that the person has died
- the coordinating practitioner notifying the Review Board of the person's death.

Being present for the person's death can be a positive experience for carers, family, or friends, but it may also be confronting. As part of the planning process, people who may be present during self-administration should be informed and prepared for what to expect so they can make an informed decision about whether attending the death is right for them.

At the person's request, another person (such as a family member, friend, or healthcare worker) can prepare the voluntary assisted dying substance for self-administration. Preparation includes doing anything necessary to ensure the substance is in a form suitable for administration, including to decant, dilute, dissolve, reconstitute, colour, or flavour the substance. This must be strictly in accordance with the instructions provided by the pharmacist. However, they cannot administer the substance to the person. Only the person accessing voluntary assisted dying can self-administer the substance. Unauthorised administration of the substance can result in criminal prosecution and imprisonment.

A healthcare worker, including the coordinating practitioner, is not required to be present at the time the person self-administers the substance, or to assess the person's decision-making capacity again prior to self-administration.

However, the person may wish to have the coordinating practitioner or other members of their treating healthcare team in attendance. Accommodating these requests is entirely up to these individuals and the Act provides protections for those attending a self-administration (refer to [Chapter 2: The regulatory framework for voluntary assisted dying](#)). Alternatively, the person may wish for independence and privacy in their final moments.

Practitioner administration of the voluntary assisted dying substance

If the person makes a practitioner administration decision, the administering practitioner is authorised to prepare and administer the substance to the person in the presence of an eligible witness, if they are satisfied of certain matters at the time of administration.

The administering practitioner must:

- be eligible to act as an administering practitioner (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#))
- not be a family member of the person requesting access to voluntary assisted dying—including their spouse, parent, grandparent, sibling, child, or grandchild
- be a person who, under Aboriginal or Torres Strait Island custom, is regarded as a person mentioned above in relation to the person accessing voluntary assisted dying
- not know or believe that they:
 - » are a beneficiary under a will of the person requesting access to voluntary assisted dying
 - » may otherwise benefit financially, or in any other material way, from the death of the person requesting access to voluntary assisted dying, other than by receiving reasonable fees for the provision of services for the person.

Practitioner administration of the voluntary assisted dying substance may be via intravenous administration or enteral access devices. Detailed information about practitioner administration of the voluntary assisted dying substance is available in the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols* provided to practitioners as part of the Queensland voluntary assisted dying mandatory training. This information is not publicly accessible.

The administering practitioner must arrange supply of the voluntary assisted dying substance with QVAD-Pharmacy. Detailed information and instructions about the practitioner administration process are provided to the administering practitioner when the voluntary assisted dying substance is supplied (refer to [Chapter 20: Supply](#)).

The administering practitioner must certify in writing that:

- the person made a practitioner administration decision
- the person did not revoke the decision.

The administering practitioner must also certify that, at the time of administering the substance, they were satisfied the person:

- retained decision-making capacity in relation to voluntary assisted dying (for guidance, refer to [Eligibility assessment: Decision-making capacity in Chapter 11: The first assessment](#))
- acted voluntarily and without coercion (for guidance, refer to [Factors to consider when assessing voluntariness and coercion in Chapter 11: The first assessment](#)).

Consent should be confirmed in the presence of the witness. There may also be organisational policies or procedures related to informed consent that should be followed if practitioner administration of a voluntary assisted dying substance occurs in a facility.

Witnessing practitioner administration

When planning for practitioner administration, the administering practitioner should reiterate that an eligible witness must be present, and confirm the person's preferences for the administration of the substance. This includes:

- ensuring the person is comfortable with the witness
- ensuring the witness is prepared to take on the role, including certifying specific details on the *Practitioner Administration Form*
- agreeing on a time, date, and place that the administering practitioner and at least one eligible witness can be present
- answering any questions the person may have about the process
- any other clinical considerations, such as deactivating implantable cardioverter defibrillators.

A person is eligible to be a witness to practitioner administration if they are at least 18 years of age. There is no requirement for the witness to be independent of the person—for example, it can be a person who is a beneficiary under their will.

The person may have selected several family members, carers or friends to be with them at their death. If willing, one of these people may act as the witness to the practitioner administration of the voluntary assisted dying substance.

In accordance with good clinical practice, the administering practitioner should remain with the person until the person dies.

Involvement of other healthcare workers

As with any other medical treatment and care, other healthcare workers may assist the administering practitioner—for example, with cannulation. However, only the administering practitioner is authorised under the Act to administer the voluntary assisted dying substance. Other healthcare workers should consider whether:

- the person wants them to be present at the administration of the voluntary assisted dying substance
- they are willing to be present
- they are comfortable assisting the administering practitioner with tasks not directly related to the administration of the voluntary assisted dying substance.

Members of the healthcare team who are present may have an important role in providing support to family, carers, and friends as part of the person's care.

The Act provides protection for persons who are present at the time of practitioner administration (refer to [Chapter 2: The regulatory framework for voluntary assisted dying](#)).

If administration cannot proceed

The administering practitioner must not proceed with the administration of the voluntary assisted dying substance at the planned time if they are not satisfied that:

- the person has decision-making capacity in relation to voluntary assisted dying
- the person is acting voluntarily and without coercion
- the person has made (and not revoked) a practitioner administration decision
- the person consents to the administration of the substance
- an eligible witness is present.

Authorised voluntary assisted dying practitioners should refer to the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols* for more information.

This may be very distressing for a person who had expected to have the substance administered, as well as their family, carers, and friends. How the administering practitioner responds should be managed on a case-by-case basis, and in consultation with the coordinating practitioner if the role has been transferred. The administering practitioner should acknowledge emotional reactions, listen compassionately to the person and provide extra support where appropriate.

This may include:

- explaining to the person why administration cannot proceed
- answering any questions the person or their support network may have
- rescheduling administration of the voluntary assisted dying substance for a different time, if the circumstances preventing the administration are expected to change
- discussing with the person how their healthcare team may alleviate any physical symptoms, psychosocial, and spiritual distress they may be experiencing
- referring for additional support, such as from a general practitioner, specialist palliative care team, social worker or psychologist.

If the person consents, it may be helpful to discuss their situation with their treating healthcare team and family. However, the person's confidentiality and privacy must always be respected. If they do not wish for others to be informed of their circumstances, this must be respected.

Adverse events

Being present for a voluntary assisted death will be an unfamiliar and highly emotive experience for most people. Attendees may experience distress or panic in response to something they witness at the death of someone they are close to.

Planning for death may decrease the likelihood of unexpected events occurring during the administration process, including for those who will be in attendance. Everyone intending to be present at a voluntary assisted death should be aware beforehand of what is likely to happen:

- once the voluntary assisted dying substance has been administered
- after the person has died.

If the person has accessed voluntary assisted dying in a supported location (for example, a hospital, hospice, or residential aged care facility), or in the presence of a healthcare worker (for example, administering practitioner, nurse, medical practitioner), a healthcare worker who is present can respond to an unexpected medical event within their usual scope of practice.

If an unexpected medical event occurs, healthcare workers (including paramedics and other first responders) are under no obligation to attempt life-sustaining measures (unless the person requests this). The person should receive appropriate treatment and care to ensure they are comfortable. However, this treatment and care cannot intentionally hasten death.

Where the person intends to self-administer the voluntary assisted dying substance with no healthcare worker present, instructions in comfort care should be provided to family, carers and friends planning to be present.

More information about adverse and unexpected medical events is outlined in the *Queensland Voluntary Assisted Dying Safety and Quality Guidance*, available on the [Queensland Health website](#).

Documentation

Practitioner Administration Form

The administering practitioner is required to complete and submit the *Practitioner Administration Form* via QVAD Review Board IMS within two business days after administering the voluntary assisted dying substance. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The administering practitioner will receive a confirmation of receipt once submitted.

This form includes details of the practitioner administration, such as the time that lapsed between administration of the voluntary assisted dying substance and death, and details about any complications relating to the administration of the substance.

In the *Practitioner Administration Form*, the administering practitioner must certify in writing that:

- the person made a practitioner administration decision and did not revoke that decision
- the administering practitioner was satisfied at the time of administration that the person:
 - » had decision-making capacity in relation to voluntary assisted dying; and
 - » was acting voluntarily and without coercion.

The witness must also sign the *Practitioner Administration Form* and certify that:

- the person appeared to be acting voluntarily and without coercion; and
- the administering practitioner administered the voluntary assisted dying substance to the person in the presence of the witness.

The form should be printed in advance and brought along to the administration so that it can be sighted and signed by the witness.

Person's medical record

There are no requirements in the Act to document information about self-administration or practitioner administration in the person's medical record, however it would be good clinical practice to do so.

Phase 3: After the person dies

Chapter 22: Death certification, notification, and bereavement care

Overview

This chapter covers the required steps under the Act after a person dies:

- completing a cause of death certificate
- notifying the Review Board.

It also provides information about supporting bereaved carers, family and friends.

Cause of death certificate

The cause of death certificate is an important legal document that notifies the Registry of Births, Deaths and Marriages of a person's death. In Queensland, a cause of death certificate needs to be issued within two business days of a person's death, or when the person's body is found, whichever is the later.

A cause of death certificate must be completed by a medical practitioner after the death of a person who has accessed voluntary assisted dying.

Completing the cause of death certificate is in addition to completion of the:

- *Practitioner Administration Form* for practitioner administration
- *Notification Of Death Form (Coordinating/Administering Practitioner)* for:
 - » self-administration
 - » death where the voluntary assisted dying substance has not been used.

The person's cause of death

When completing the cause of death certificate, a medical practitioner who knows or reasonably believes that a person self-administered or was administered a voluntary assisted dying substance under the Act:

- **must state the cause of death was the disease, illness, or medical condition** that was the basis for the person being eligible for voluntary assisted dying
- **must not refer to voluntary assisted dying** (either as a main cause of death or antecedent).

These provisions are designed to protect a person's privacy and to reflect that the underlying disease, illness, or medical condition would have led to the person's death. This [Australian Bureau of Statistics Quick Reference Guide](#) provides further guidance for medical practitioners about how to record the specific cause of death.

Medical practitioner to complete the cause of death certificate

Any medical practitioner can complete the cause of death certificate, provided they can satisfy the requirements in [section 30](#) of the *Births, Deaths and Marriages Registration Act 2003*. This would most likely be the person's coordinating practitioner or administering practitioner (if they are a medical practitioner). It may also be another medical practitioner known to the person including:

- their general practitioner
- a palliative care specialist
- a treating specialist, for example, oncologist or neurologist
- another medical practitioner.

A medical practitioner must complete a cause of death certificate if they are able to form an opinion about the probable cause of death and have:

- attended the person prior to death; or
- seen the person's body after death; or
- considered information about a person's medical history and circumstances of their death.

The medical practitioner does not need to have examined the body or otherwise seen the person, provided they are able to form an opinion about the probable cause of death.

Where the person has made a **self-administration decision**, their family, carers or friends should be supported to consider ahead of time who they will call to confirm the death and complete the cause of death certificate. Ideally, the coordinating practitioner and the person will discuss these matters and make a plan for who will complete the cause of death certificate before administration of the substance.

The self-administration substance kit will contain contact details for the person's coordinating practitioner and QVAD-Support, as well as guidance to advise anyone attending the person following self-administration (including emergency services) to notify the coordinating practitioner of the death.

Practitioners or persons who can certify life extinct

A life extinct form is only completed when a cause of death certificate is not likely to be issued expediently. When a cause of death certificate exists, a life extinct form is not required.

A person who has accessed voluntary assisted dying may have an administering practitioner who is a nurse practitioner or registered nurse. A nurse practitioner or registered nurse cannot complete a cause of death certificate. If a cause of death certificate completed by a medical practitioner cannot be issued expediently, the nurse practitioner or registered nurse should complete a life extinct form to allow the deceased person's body to be removed and transported.

An ambulance officer may complete the life extinct form for the deceased person, if:

- a medical practitioner is not available to complete the cause of death certificate
- a nurse practitioner or registered nurse acting as the administering practitioner is not available to complete a life extinct form.

A cause of death certificate completed by a medical practitioner is still required in all circumstances.

Voluntary assisted dying is not a reportable death

Under the *Coroners Act 2003* (Qld), a death brought about by voluntary assisted dying in accordance with the Act is not reportable death. For example, a death brought about by voluntary assisted dying in a hospital, in care, or in custody would not be reportable to the coroner.

If a death occurs that was not in accordance with the Act—for example, there were any unusual or suspicious circumstances surrounding a death—this death would be reportable under the *Coroners Act 2003*. A death suspected of meeting this criterion can be reported to the coroner directly by a person, or retrospectively after consideration by the Review Board.

Refer to the [State Coroner's Guidelines 2013 Chapter 3: Reporting deaths](#) for more information.

Notifying the Review Board of the person's death

If the person dies, the coordinating practitioner, administering practitioner or another medical practitioner must notify the Review Board via a form in QVAD Review Board IMS that the death has occurred within two business days of becoming aware of the death, regardless of whether the voluntary assisted dying substance was administered. Submission via QVAD Review Board IMS is considered notifying the Review Board.

The form used to notify the Review Board differs depending on whether the person made a self-administration or practitioner administration decision. Responsibilities of the [coordinating practitioner](#), [administering practitioner](#) and [other medical practitioners](#) are outlined in Table 25.

Summary: The Review Board notification⁴⁵

Table 25: The Review Board notification

Administration decision	Scenario	Coordinating practitioner	Administering practitioner (coordinating practitioner, unless the role is transferred)	Other medical practitioner (if they complete the cause of death certificate)
Person made self-administration decision	Person dies after self-administration	Yes <i>Notification of Death Form (Coordinating/ Administering Practitioner)</i>	N/A	Yes <i>Notification of Death Form (Other Medical Practitioner)</i>
	Person dies without self-administering	Yes <i>Notification of Death Form (Coordinating/ Administering Practitioner)</i>	N/A	No

45. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Administration decision	Scenario	Coordinating practitioner	Administering practitioner (coordinating practitioner, unless the role is transferred)	Other medical practitioner (if they complete the cause of death certificate)
Person made practitioner administration decision	Person dies after practitioner administration	Yes <i>Notification of Death Form (Coordinating/ Administering Practitioner) unless the administering practitioner has submitted the Practitioner Administration Form</i>	Yes <i>Practitioner Administration Form</i>	Yes <i>Notification of Death Form (Other Medical Practitioner)</i>
	Person dies prior to practitioner administration	Yes <i>Notification of Death Form (Coordinating/ Administering Practitioner)</i>	Yes <i>Notification of Death Form (Coordinating/ Administering Practitioner)</i>	No

Role of the contact person

If a person who has made a **self-administration** or **practitioner administration** decision dies, either because of self-administering the voluntary assisted dying substance or because of another cause, the contact person must inform the coordinating practitioner of the person's death. This is in addition to requirements for disposing of the substance (refer to [Chapter 23: Disposal of the voluntary assisted dying substance](#)).

Role of the coordinating practitioner

Person died by self-administration or by another cause

If the coordinating practitioner is made aware by the contact person or by another means that the person has died by either self-administering the voluntary assisted dying substance or by another cause, the coordinating practitioner must complete the *Notification of Death Form (Coordinating/ Administering Practitioner)*.

A copy of this form must be submitted via QVAD Review Board IMS within two business days of the coordinating practitioner becoming aware of the death. The coordinating practitioner will receive a confirmation of receipt.

Person dies by practitioner administration

If the person dies by practitioner administration and the coordinating practitioner is also in the role of administering practitioner, they are **not required** to complete the *Notification of Death Form (Coordinating/Administering Practitioner)* as they will have already completed the *Practitioner Administration Form* and submitted a copy of this to the Review Board within two business days of the person's death (refer to [Chapter 21: Administration](#)).

Role of the administering practitioner

Person died prior to the administration of the substance

If the administering practitioner is made aware that the person has died prior to the administration of the voluntary assisted dying substance, they must complete the *Notification of Death Form (Coordinating/Administering Practitioner)* and submit this via QVAD Review Board IMS within two business days of becoming aware of the death. The administering practitioner will receive a confirmation of receipt.

The administering practitioner role may have been transferred from the coordinating practitioner. In this circumstance, it is recommended that the administering practitioner inform the coordinating practitioner of the death as a matter of good practice.

Person dies by practitioner administration

If the person dies by practitioner administration the administering practitioner is not required to complete the *Notification of Death Form (Coordinating/Administering Practitioner)* as they will have already completed the *Practitioner Administration Form* and submitted a copy of this to the Review Board within 2 business days of the person's death (refer to [Chapter 21: Administration](#)).

Role of another medical practitioner

If a medical practitioner (who is not the coordinating practitioner or administering practitioner) completes the cause of death certificate for a person they know or reasonably believe has died because of the self-administration or practitioner administration of a voluntary assisted dying substance in accordance with the Act, the medical practitioner must complete the *Notification of Death Form (Other Medical Practitioner)* and submit this via QVAD Review Board IMS within two business days of becoming aware of the death.

A medical practitioner does not need to be registered on QVAD Review Board IMS to be able to complete and submit this form. The medical practitioner will receive a confirmation of receipt.

Support for family, carers, and friends

A person who has chosen to access voluntary assisted dying is aware of their approaching death. It is likely that at least some of their family, carers or friends are also aware the person may die soon. Those close to the person will likely experience a level of anticipatory grief as they prepare for the impending loss.

Accepting another person's choice to access voluntary assisted dying will be easy for some people and very difficult for others. They may experience conflicting feelings of sadness, relief, or distress. For some people, voluntary assisted dying may include stigma that can complicate the grieving process.

Even those who are supportive will face an inevitable outcome—the loss of a loved one and the grief that follows.

Once the death has occurred, those present should be supported according to their individual needs. This may include:

- providing privacy if desired
- allowing family, carers and friends to spend time with the person
- involvement in helping with personal care of the person
- support to carry out specific cultural, spiritual, or religious practices or rituals
- assistance with practical matters such as contacting a funeral director.

Bereavement care

Bereavement care should be provided to a person's carers, family, and friends if required, whether directly or via their health service's existing bereavement support services. Where palliative care services have been involved in the care of the person, they may be able to offer bereavement support or referral to other services.

Key resources

Queensland Health bereavement resources:

- [When someone dies: A practical guide for family and friends](#)
- [During sad news and sorry business: Information for family](#): a resource for First Nations peoples
- [What to do when someone dies: Information for family and friends – Easy English](#): a resource for people with low English literacy, using simplified language and visual cues, compatible with screen readers
- [صاخش أأا دأ ةافو دنع نول عفأ ا ذام](#): an Arabic language resource.
- [有人去世时该怎么办](#): a Simplified Chinese language resource.
- [Nên làm gì khi có người qua đời](#): a Vietnamese language resource
- [Checklist: Tasks and contact list](#): a checklist that outlines tasks to carry out and people/ organisations to contact.

For more information on printing these resources, please review the [printing guide](#).

Other resources to support the person's family, friends, cares and others:

- [Palliative Care Australia](#)
- [The Australian Centre for Grief and Bereavement](#)
- [CareSearch Palliative Care Knowledge Network](#)
- [Lifeline](#) can provide 24/7 crisis support
- [13YARN](#) can provide 24/7 crisis support for Aboriginal and Torres Strait Islander peoples.

Chapter 23: Disposal of the voluntary assisted dying substance

Overview

There may be times when a voluntary assisted dying substance is no longer required and must be disposed of. This may occur, for example, if a person dies without administering the substance or if a person has revoked their decision to undertake voluntary assisted dying.

There are specific requirements when disposing of any unused or remaining voluntary assisted dying substance. Responsibility for undertaking these requirements depends on whether the person made a self-administration or practitioner administration decision.

Self-administration decision

If a person who has made a self-administration decision revokes their decision or dies, either because of self-administering the voluntary assisted dying substance or from another cause, responsibility for disposal of unused or remaining substance lies with the contact person and an authorised disposer.

Contact person responsibilities

Under a self-administration decision, the contact person must give any unused or remaining voluntary assisted dying substance to an authorised disposer for disposal. This is necessary when:

- the person revokes their self-administration decision after the voluntary assisted dying substance has been supplied; or
- the person dies either:
 - » before self-administering the voluntary assisted dying substance; or
 - » without ingesting all the voluntary assisted dying substance.

If the contact person knows there is voluntary assisted dying substance unused or remaining, they must give it to an authorised disposer as soon as practicable, or in any event within 14 days of the revocation or the person's death.

Failure to return the voluntary assisted dying substance in either circumstance has a maximum penalty of [100 penalty units](#). This requirement does not apply if the person has self-administered all the voluntary assisted dying substance.

Authorised disposer responsibilities

Authorised disposers are pharmacists authorised by Queensland Health to legally dispose of the voluntary assisted dying substance. In Queensland, authorised disposers are pharmacists who hold general registration and are employed at:

- QVAD-Pharmacy
- a public or private hospital
- a community pharmacy.

There are authorised disposers at hospitals and community pharmacies throughout Queensland who can receive the voluntary assisted dying substance and dispose of it safely. The coordinating practitioner, QVAD-Pharmacy or QVAD-Support can assist the contact person to find an authorised disposer, if required.

Pharmacists are not obligated to accept substances for disposal if they conscientiously object to voluntary assisted dying or do not have the resources to carry out the disposal. The contact person should phone ahead to check that the pharmacist will accept the substance for disposal and, if necessary, arrange a suitable time to hand over the voluntary assisted dying substance.

An authorised disposer is authorised under the Act to:

- possess the voluntary assisted dying substance or unused or remaining substance for the purpose of disposing of it
- dispose of the substance.

The authorised disposer must dispose of the voluntary assisted dying substance or unused or remaining substance as soon as practicable after receiving it.

Documentation

Authorised Disposal Form

An authorised disposer who disposes of the voluntary assisted dying substance must complete the *Authorised Disposal Form* and provide a copy to the Review Board within two business days. This form can be accessed and submitted via QVAD Review Board IMS. Authorised disposers do not need to register for QVAD Review Board IMS to be able to complete and submit the form. The authorised disposer will receive a confirmation of receipt once submitted.

Authorised disposers can contact QVAD-Pharmacy for advice and support to ensure compliance with the Act.

Note: If a person who has made a self-administration decision dies, either because of self-administering the voluntary assisted dying substance or because of another cause, the contact person must also inform the coordinating practitioner of the person's death. This is in addition to requirements for disposing the voluntary assisted dying substance.

Person's medical record

There are no requirements in the Act to document information about substance disposal in the person's medical record, however it would be good clinical practice to do so.

Practitioner administration decision

Under a practitioner administration decision, disposal of any unused voluntary assisted dying substance is the responsibility of the administering practitioner, as summarised in [Table 26](#). The administering practitioner must personally dispose of the substance and cannot give the substance to an authorised disposer. A pharmacist from QVAD-Pharmacy will provide resources and information to facilitate the safe disposal of any unused substance at the time of supplying the substance.

Summary: Practitioner disposal responsibilities⁴⁶

Table 26: Practitioner disposal responsibilities

Circumstance	Duty to dispose	When to dispose
Revocation	The administering practitioner must dispose of the voluntary assisted dying substance: <ul style="list-style-type: none">• if the person revokes their practitioner administration decision; and• the administering practitioner is in possession of the voluntary assisted dying substance when the decision is revoked.	As soon as practicable after the revocation
Death	The administering practitioner must dispose of the voluntary assisted dying substance: <ul style="list-style-type: none">• if the person dies (whether or not after being administered the voluntary assisted dying substance); and• the administering practitioner is in possession of any unused or remaining voluntary assisted dying substance at the time of the person's death.	As soon as practicable after the person's death

Administering practitioner responsibilities

The administering practitioner should follow the substance disposal guidance provided to them by the pharmacist at the time of supply of the substance. QVAD-Pharmacy can be contacted for additional guidance about disposal if required.

Documentation

Practitioner Disposal Form

The administering practitioner must complete and submit the *Practitioner Disposal Form* via QVAD Review Board IMS within two business days of disposing the voluntary assisted dying substance. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The administering practitioner will receive a confirmation of receipt once submitted.

Person's medical record

There are no requirements in the Act to document information about substance disposal in the person's medical record, however it would be good clinical practice to do so.

More information

Find the following resources on the [Queensland Health website](#):

- *Disposing of voluntary assisted dying substances: Guidance for administering practitioners*
- *Disposing of voluntary assisted dying substances: Guidance for pharmacists.*

46. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Section III: Other considerations

Chapter 24: Transferring authorised voluntary assisted dying practitioner roles

Overview

There may be circumstances in which an authorised voluntary assisted dying practitioner role will need to be transferred from one practitioner to another. The coordinating practitioner role and the administering practitioner role can be transferred if certain conditions are met.

As with other aspects of good clinical practice, healthcare workers should strive to ensure continuity of care when facilitating transfers of care or referrals.

Requesting a transfer

The person accessing voluntary assisted dying can request transfer of the coordinating practitioner role, or the transfer can be initiated by the coordinating practitioner. The coordinating practitioner needs to contact the consulting practitioner and ask them to take on the role.

The request for role transfer follows the usual pathway for referrals to other healthcare workers, for example, it can be a verbal or written referral.

As per good clinical practice, if the coordinating practitioner is instigating the transfer, they should explain the reason for the transfer to the person who is accessing voluntary assisted dying and document this in their medical record.

Transferring the coordinating practitioner role

The coordinating practitioner's role can be transferred for any reason including:

- the coordinating practitioner is no longer available
- the person has found someone else they would like to take on this role.

Only the person's consulting practitioner can accept transfer of the role of coordinating practitioner. The role transfer can occur to the consulting practitioner if the consulting practitioner:

- has already assessed the person as meeting the requirements of the consulting assessment; and
- formally accepts the transfer.

The consulting practitioner must inform the original coordinating practitioner of their decision to accept or refuse the transfer within two business days.

Summary: Process for transferring coordinating practitioner role to the consulting practitioner⁴⁷

The process for transferring the coordinating practitioner role to the consulting practitioner is depicted in Figure 7.

Transfer process: Coordinating practitioner

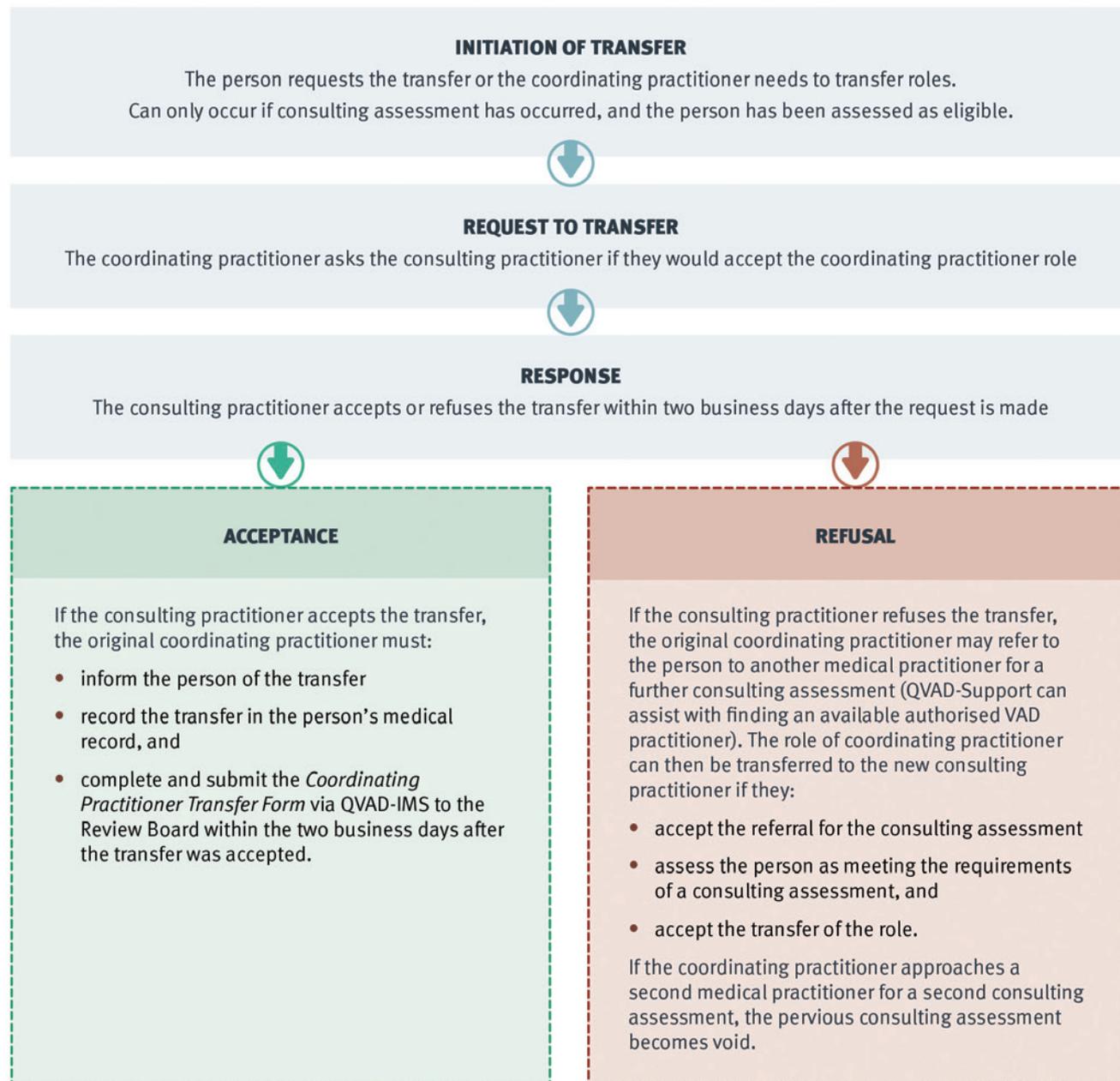


Figure 7: Transfer process

47. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Consulting practitioner accepts the role transfer

If the consulting practitioner accepts the transfer, the original coordinating practitioner must:

- inform the person of the transfer
- record the transfer in the person's medical record
- complete the *Coordinating Practitioner Transfer Form* and submit via QVAD Review Board IMS within two business days after the acceptance. Submission via QVAD Review Board IMS is considered giving a copy to the Review Board. The original coordinating practitioner will receive a confirmation of receipt once submitted.

Consulting practitioner refuses the role transfer

If the consulting practitioner **refuses the transfer**, the original coordinating practitioner will need to find a new consulting practitioner. This is because only the person's consulting practitioner can accept transfer of the role of coordinating practitioner.

Referral to another medical practitioner to be the consulting practitioner

If the original consulting practitioner **refuses the transfer**, the coordinating practitioner may refer the person to a **different medical practitioner** for another consulting assessment.

Before the new consulting assessment is undertaken, the medical practitioner receiving the referral must:

- be eligible to act as a consulting practitioner for the person (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#))
- accept the consulting assessment referral.

After accepting and completing the new consulting referral, the **original consulting assessment becomes void**.

The medical practitioner becomes the coordinating practitioner after the following has occurred:

- the medical practitioner has accepted the referral for a further consulting assessment
- the new consulting practitioner has undertaken the consulting assessment
- the outcome of the new consulting assessment is that the person is eligible to access voluntary assisted dying
- the new consulting practitioner chooses to accept the transfer of the coordinating practitioner role.

If the original coordinating practitioner is also the administering practitioner for the person (i.e. the person has made a practitioner administration decision) and the role of administering practitioner also needs to be transferred. This must be done separately via the transferring the administering practitioner role process.

Transferring the administering practitioner role

This section only applies if a practitioner administration decision has been made.

As a default, the coordinating practitioner acts as the person's administering practitioner if they make a practitioner administration decision. However, sometimes the coordinating practitioner may need to transfer this role, for example:

- if they are unable to administer the voluntary assisted dying substance (for example, due to illness)
- due to a scheduling conflict
- geographic distance from the person seeking voluntary assisted dying
- if the coordinating practitioner is not comfortable with participating in the administration of the voluntary assisted dying substance.

The role of administering practitioner can be transferred once the person has made an administration decision and the coordinating practitioner has prescribed the voluntary assisted dying substance.

The role cannot be transferred at the person's instigation. The role is only transferred if the administering practitioner is unable or unwilling to administer the voluntary assisted dying substance.

If a coordinating practitioner does not intend to administer a voluntary assisted dying substance, they should raise this with the person at the start of the voluntary assisted dying process. The coordinating practitioner should ensure the person understands that if they make a practitioner administration decision, the administering practitioner role will need to be transferred to another authorised voluntary assisted dying practitioner.

The role of administering practitioner can be transferred to another medical practitioner, nurse practitioner, or registered nurse who is eligible to act in the role.

Before becoming the administering practitioner, the new administering practitioner must:

- be eligible to act as an administering practitioner (refer to [Chapter 6: Authorised voluntary assisted dying practitioners](#))
- accept the transfer of the role.

If the new practitioner accepts, the original administering practitioner must:

- inform the person of the transfer and the new administering practitioner's contact details
- record the transfer in the person's medical record
- complete and submit the *Administering Practitioner Transfer Form* via QVAD Review Board IMS within two business days after the transfer was accepted. The original practitioner will receive a confirmation of receipt once submitted.

It is good practice for a comprehensive clinical handover to occur from the coordinating practitioner to the administering practitioner. This handover should include a summary of the person's relevant medical history, as well as any specific or significant considerations about their voluntary assisted substance and adjunct medication prescription (including contraindications).

In considering how clinical handover is delivered, practitioners should adhere to any local policies and procedures that are in place, and consider any risks associated with the local context.

A checklist of information to consider communicating at handover is provided to authorised voluntary assisted dying practitioners on USB.

The new administering practitioner can also transfer the role if they subsequently become unable or unwilling to administer the voluntary assisted dying substance to the person. They should use the same transfer process as set out above.

QVAD-Support can assist with identifying authorised voluntary assisted dying practitioners who may be available to act as the administering practitioner.

Note: Even if the administering practitioner role is transferred, the coordinating practitioner remains the coordinating practitioner.

In practice, this means if the coordinating practitioner wants to transfer both the role of administering practitioner and coordinating practitioner, both transfer processes may need to be completed.

Possession of the voluntary assisted dying substance

If the administering practitioner possesses the voluntary assisted dying substance when the role is transferred, they must give this to the new administering practitioner. If the administering practitioner does not have the voluntary assisted dying substance at the time of transfer, the new administering practitioner will need to collect it from QVAD-Pharmacy.

Chapter 25: Queensland Voluntary Assisted Dying Support and Pharmacy Service

Queensland Voluntary Assisted Dying Support Service (QVAD-Support)

Overview

QVAD-Support provides support to anyone involved with voluntary assisted dying in Queensland.

QVAD-Support does not directly provide voluntary assisted dying services, but can connect people with appropriate practitioners, services, and referral pathways, and provide follow up care and support.

Services

QVAD-Support:

- is a statewide service staffed by multidisciplinary care coordinators and administration professionals
- provides a statewide model of care, including:
 - » assistance connecting people with coordinating, consulting, and administering practitioners
 - » support for people, carers, and families as they navigate the voluntary assisted dying process
 - » connections with local services and providers to facilitate coordination of care across public and private hospitals, primary care, aged care facilities, hospices, and community-based services
- information for people wishing to access the scheme, carers and family members, healthcare workers, and service providers.
- manages the regional access support scheme (QVAD-Access)
- delivers healthcare worker education to support capacity building and awareness about voluntary assisted dying, as required
- links practitioners with the QVAD Community of Practice (refer to [Chapter 26: Support for healthcare workers](#)).

More information about QVAD-Support is available on the [Queensland Health website](#).

Queensland Voluntary Assisted Dying Pharmacy Service (QVAD-Pharmacy)

Overview

QVAD-Pharmacy facilitates safe and high-quality access to substances approved for the purpose of voluntary assisted dying in Queensland.

QVAD-Pharmacy key functions include:

- being the authorised supplier of voluntary assisted dying substances in Queensland
- providing a central hub for information about prescribing, storage, administration, and disposal of voluntary assisted dying substances
- providing support to eligible persons accessing voluntary assisted dying, families, and carers, and administering and coordinating practitioners.

More information about QVAD-Pharmacy is available on the [Queensland Health website](#).

QVAD-Access

QVAD-Access enables equitable access to voluntary assisted dying for people living in regional, rural, and remote areas of Queensland. It supports the travel costs of a voluntary assisted dying practitioner (and/or interpreter if required) or a person accessing voluntary assisted dying if there is no suitable local practitioner and telehealth is not appropriate.

QVAD-Access is coordinated by QVAD-Support, who assess requests to access the scheme and arrange travel and accommodation. Practitioners or people accessing voluntary assisted dying who wish to apply for QVAD-Access should contact QVAD-Support for more information.

QVAD-Access does not cover employees travelling as part of their role with a Queensland Health Hospital and Health Service, including voluntary assisted dying practitioners, QVAD-Support care coordinators, and pharmacists employed by QVAD-Pharmacy. These travel expenses are covered under Queensland Health and Hospital and Health Service staff travel policies and procedures.

Chapter 26: Support for healthcare workers

Overview

Voluntary assisted dying is a multidisciplinary model of service delivery. The Act identifies specific roles and responsibilities for medical practitioners, nurse practitioners, registered nurses, and pharmacists. As members of a multidisciplinary team, many other healthcare workers are likely to provide support and assistance to a person accessing voluntary assisted dying.

It is widely recognised that healthcare workers provide the best care when they are experiencing their own optimal wellbeing. Caring for people at the end-of-life can be extremely rewarding, but it can also be emotionally challenging. Healthcare workers must manage the needs and expectations of people accessing voluntary assisted dying, carers and families, and their colleagues. Professional demands, workload pressures, and accumulated grief can cause stress and personal distress, which can escalate to burnout and compassion fatigue. This can manifest in a variety of ways.

Education and training

Mandatory training for authorised practitioners

Medical practitioners, nurse practitioners, and registered nurses have specific roles under the Act and are required to complete mandatory training to participate in voluntary assisted dying. This training is not accessible to other healthcare workers.

The mandatory training content is approved by the Director-General of Queensland Health under [section 165](#) of the Act. It has been developed by the Australian Centre for Health Law Research at the Queensland University of Technology in collaboration with Queensland Health, with valuable input from medical, nursing, allied health and consumer stakeholders.

Building on existing clinical skills, the mandatory training:

- introduces practitioners to the legal framework for voluntary assisted dying in Queensland
- provides the core knowledge required to participate in voluntary assisted dying
- consists of:
 - » nine modules of content
 - » an assessment component
 - » acknowledging receipt and understanding of the *Queensland Voluntary Assisted Dying Prescription and Administration Protocols*.

Voluntary assisted dying education for all healthcare workers

An [online education resource](#) has been developed to build the knowledge of healthcare workers who are either ineligible or unwilling to undertake the mandatory training. It is accessible to healthcare workers internal and external to Queensland Health via iLearn, an online learning management system.

It is suited to any healthcare worker, including:

- registered health practitioners (for example, medical practitioners, registered nurses, psychologists, paramedics, Aboriginal and Torres Strait Islander health practitioners, pharmacists)
- providers of healthcare services who are not registered health practitioners (for example, speech pathologists, social workers, Aboriginal and Torres Strait Islander healthcare workers)
- providers of personal care services who are not registered health practitioners (for example, aged care workers, disability care workers).

The education provides a general overview of voluntary assisted dying legislation in Queensland, and has three parts:

1. **Voluntary assisted dying in context:** what voluntary assisted dying is; where it is currently legal in Australia; and how it relates to other end-of-life choices.
2. **Overview of the voluntary assisted dying process in Queensland:** who is eligible; how the request and assessment process operates; methods by which voluntary assisted dying may be provided; and legislative safeguards.
3. **Healthcare worker participation in voluntary assisted dying:** roles of healthcare workers in the voluntary assisted dying process; discussing voluntary assisted dying with patients; key services; conscientious objection; and institutional participation.

Optional resources for further learning

Some professional organisations, such as specialist medical colleges, may have developed specific guidance around voluntary assisted dying. Healthcare workers should check with relevant professional organisations and familiarise themselves with any guidance.

Healthcare workers should also familiarise themselves with any models of care, policies, and procedures relating to voluntary assisted dying in their own health service or at facilities where they may provide professional services. Healthcare workers are encouraged to check with the relevant organisation to see if local education and training is available.

QVAD Community of Practice

Connecting with others who are providing voluntary assisted dying services and supporting families can help manage the challenging aspects of voluntary assisted dying. QVAD-Support facilitates the QVAD Community of Practice. It is an inclusive forum, which offers practical and emotional support for authorised voluntary assisted dying practitioners to continually improve their practice through interactive case-based discussions, mentoring, structured education, and psychosocial support.

Meetings

Authorised voluntary assisted dying practitioners will be invited to attend one-hour monthly meetings using a Queensland Health Microsoft Teams guest account.

Additionally, Primary Health Networks will host quarterly or half-yearly events on a rotating basis. The events will be open to eligible practitioners with an interest in voluntary assisted dying, as well as authorised practitioners.

Support for members

Following authorisation, practitioners will receive a pack containing QVAD Community of Practice information, as well as access to other support and resources.

Self-care

Self-care is an essential part of participating in the voluntary assisted dying process. Even in jurisdictions where it has been legalised for several years, voluntary assisted dying is a relatively uncommon practice and due to its nature, healthcare workers are potentially at increased risk of professional isolation.

There may also be additional workplace stressors in navigating various viewpoints around voluntary assisted dying. Different organisations may provide varying levels of support. Practitioners in rural and remote areas may be further isolated. All practitioners who provide voluntary assisted dying services must also navigate their own reactions to, and experiences of, supporting a planned death.

As a healthcare worker, if you choose to participate in voluntary assisted dying, it is essential that you prioritise self-care. Being aware of available supports, developing a plan for self-care, and engaging in protective behaviours can reduce the likelihood and severity of any potential negative impacts.

Existing resources to support self-care for participating practitioners

Resources for medical practitioners⁴⁸

Table 27: Resources for medical practitioners

Organisation	Resources
Australian College of Rural and Remote Medicine (ACRRM) Practitioner Health and Wellbeing resources	The ACRRM website provides a number of external resources for physical and mental health and other concerns. ACRRM's Employee Assistance Program can provide 24/7 support by calling 1800 818 728.
Doctors' Health in Queensland	The Doctors' Health in Queensland, Queensland Doctors' Health Programme provides confidential advice and support for medical practitioners in Queensland. Call (07) 3833 4352 to access support and advice 24/7. They also provide information and further resources on health and common problems medical practitioners face. Further information can be found online from Doctors' Health in Queensland .
DRS4DRS	Doctors' Health Services maintains a website, DRS4DRS, which contains useful general resources related to the health and wellbeing of doctors. Access these resources .

48. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Organisation	Resources
Employee Assistance Programs	<p>Doctors employed by Queensland Health can access the Employee Assistance Service for free, confidential counselling. You can access this service 24/7.</p> <p>Visit the Queensland Health Employee Support and Counselling website to obtain the phone number for the Employee Assistance Program in the district where you live.</p> <p>If you are not employed by Queensland Health, contact your employer to find out what employee assistance program they offer.</p>
Royal Australian College of General Practitioners (RACGP) Support Program	<p>The GP Support Program is a free service available to all RACGP members. It provides professional advice and support with managing a range of issues including conflict, grief and loss, anxiety and depression, and substance use.</p> <p>Call 1300 361 008 during business hours to make an appointment.</p> <p>See additional support resources for GPs, including the factsheet <i>Self-care and mental health resources for general practitioners</i>.</p>
Royal Australasian College of Physicians (RACP) Resources	<p>The RACP website provides a compilation of external resources for physical and mental health and other concerns.</p> <p>The RACP also offer a professional and confidential counselling service. Access the contact details for these services.</p> <p>The RACP has a position statement on self-care: Health of Doctors Position Statement (2017).</p>
Royal Australian and New Zealand College of Psychiatrists (RANZCP) Wellbeing Support	<p>The RANZCP website provides a number of external resources for physical health, mental health and other concerns.</p> <p>Confidential advice is also available to all members of RANZCP through its Member Welfare Support Line.</p>

Resources for nurse practitioners and registered nurses⁴⁹

Table 28: Resources for nurse practitioners and registered nurses

Organisation	Resources
Australian College of Nurse Practitioners Peer Support	<p>The Australian College of Nurse Practitioners will provide all nurse practitioners involved in voluntary assisted dying with mentors and/or peer support.</p> <p>Contact admin@acnp.org.au for more information.</p>
Australian Primary Care Nurses Association (APNA) Nurse Support	<p>APNA runs a Nurse Support Line which provides professional support, guidance, and referrals for APNA members.</p> <p>Operates Monday to Friday, 9am to 5pm.</p> <p>Call: 1300 303 184 (or 03 9322 9598).</p> <p>Email: nursesupport@apna.asn.au</p> <p><i>APNA suggests its members contact Nurse and Midwife Support (see Nursing and Midwifery Board of Australia Nurse and Midwife Support below) if they need ongoing counselling.</i></p>
CareSearch Palliative Care Knowledge Network	<p>CareSearch Palliative Care Knowledge Network is a website which provides information about self-care strategies and protective practices for those who work in palliative care or end-of-life care. It includes a self-care training module and self-care plan template.</p>
Cancer Nurses Society of Australia Nurse Practitioner Specialist Practice Network	<p>The Cancer Nurse Practitioners Specialist Practice Network provides networking opportunities and support from peers working at a senior clinical level to nurse practitioners who are members.</p>
Employee Assistance Programs	<p>Nurses and nurse practitioners employed by Queensland Health can access the Employee Assistance Service for free, confidential counselling. You can access this service 24/7.</p> <p>Visit the Queensland Health Employee Support and Counselling website to obtain the phone number for the Employee Assistance Program in the district where you live.</p> <p>If you are not employed by Queensland Health, contact your employer to find out what employee assistance program they offer.</p>
Nursing and Midwifery Board of Australia Nurse and Midwife Support	<p>The national Nurse and Midwife Support organisation, supported by the Nursing and Midwifery Board of Australia, provides a number of resources for health and wellbeing.</p> <p>They also provide resources for dealing with compassion fatigue.</p>

49. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

General resources for mental health and wellbeing⁵⁰

Table 29: General resources for mental health and wellbeing

Organisation	Resources
Australian Centre for Grief and Bereavement	<p>Provides support, advice and recommendations for practitioners, to enhance their capacity to provide support to people experiencing bereavement, which may be useful for people accessing voluntary assisted dying and for their families (fees apply).</p> <p>Call 1800 642 066 or visit the Australian Centre for Grief and Bereavement website.</p>
BeyondBlue	<p>Information and support to help individuals experiencing anxiety and depression.</p> <p>Call 1300 224 636 or visit the BeyondBlue website.</p>
CRANA plus Bush Support Line	<p>A free telephone counselling and support service for health workers (and their families) in rural and remote areas.</p> <p>Call 1800 805 391 or visit the CRANA plus website.</p>
Lifeline	<p>24/7 crisis support and suicide prevention.</p> <p>Call 13 11 14 or visit the Lifeline website.</p>
Palliative Care Australia Self-Care Matters	<p>A resource to support health professionals providing palliative care, including the <i>Self-Care Matters planning tool</i> and mindfulness and meditation exercises.</p>
ReachOut.com Developing a Self-Care Plan	<p>Resources for developing a self-care plan, including a template.</p>
TEN – The Essential Network for Health Professionals (Black Dog Institute)	<p>A range of resources for health professionals, including mental health self-assessment, confidential online courses, resources for managing burnout, and professional peer support and mentoring.</p>

50. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Appendices

Appendix A: Operational structure

Operational structure: Voluntary assisted dying in Queensland

VOLUNTARY ASSISTED DYING REVIEW BOARD	VOLUNTARY ASSISTED DYING UNIT	QVAD-SUPPORT (SUPPORT SERVICE)	QVAD-PHARMACY (PHARMACY SERVICE)	AUTHORISED VOLUNTARY ASSISTED DYING PRACTITIONERS
<p>Independent Board established under the Act</p> <hr/> <p>Responsible for monitoring compliance with the Act</p> <hr/> <p>Annual reporting</p> <hr/> <p>Liaison with other agencies and bodies re: non-compliance by a practitioner</p> <hr/> <p>Office of the Voluntary assisted Dying Review Board</p>	<p>Policy and program focus</p> <hr/> <p>Residency and interpreter exemptions</p> <hr/> <p>Coordinate practitioner eligibility process for Chief Medical Officer approval</p> <hr/>	<p>Multidisciplinary Care Coordinators</p> <hr/> <p>Assistance connecting people with coordinating, consulting, administering practitioners</p> <hr/> <p>Support patients, families and clinicians as they navigate the voluntary assisted dying process</p> <hr/> <p>Coordinate care—including across public and private hospitals, residential aged care, hospices and primary care</p>	<p>Authorised supplier of voluntary assisted dying substance</p> <hr/> <p>Central hub for information about prescribing, storage, administration and disposal of voluntary assisted dying substances</p> <hr/> <p>Provide support to patients, families, administering and coordinating practitioners</p>	<p>Eligibility verified, mandatory training completed, approved by Chief Medical Officer</p> <hr/> <p>Act as coordinating, consulting, administering practitioners</p> <hr/> <p>Provide voluntary assisted dying services in settings including Hospital and Health Service facilities, private hospitals, residential aged care, hospices, primary care, community</p>
Department of Health		Hospital and Health Service (Metro South Health)		Health services

v3 SC2200190 6/10/22

Appendix B: Summary of coordinating practitioner key tasks and actions⁵¹

Voluntary assisted dying process step	Tasks and actions
Become an authorised voluntary assisted dying practitioner	<ul style="list-style-type: none"> • Submit an application to Queensland Health. • Application verified by the Practitioner Eligibility Panel as meeting the eligibility requirements. • Successfully complete mandatory online training. • Acknowledge receipt and understanding of the <i>Queensland Voluntary Assisted Dying Prescription and Administration Protocols</i>. • Complete a declaration agreeing to act in accordance with policies and procedures for voluntary assisted dying in Queensland, including any specific organisational requirements. • Receive authorisation to provide voluntary assisted dying services in Queensland from the Chief Medical Officer of Queensland Health.
Accept a first request	<ul style="list-style-type: none"> • Receive a clear and unambiguous first request for access to voluntary assisted dying in person or via audiovisual communication (i.e. telehealth where people can see and hear each other in real time). • Within two business days: <ul style="list-style-type: none"> » inform the person that they accept the first request and will become their coordinating practitioner » give the person the <i>Acceptance of the first request: Queensland Health approved information</i>, available on the Queensland Health website. • Record in the person’s medical record: <ul style="list-style-type: none"> » that the person has made a first request » the date the first request was made » the medical practitioner’s decision to accept the request » the day on which the person is given the approved first request information.
First assessment	<ul style="list-style-type: none"> • Conduct the first assessment to determine whether the person is eligible for voluntary assisted dying. • When conducting the first assessment, consider any relevant information about the person that has been prepared by, or is provided at the instigation of, another registered health practitioner, healthcare workers or other relevant source. • Refer for determination: <ul style="list-style-type: none"> » to a registered health practitioner who has appropriate skills and training to determine the matter if unable to determine if the person: <ul style="list-style-type: none"> – has a disease, illness or medical condition that meets the eligibility requirements – has decision-making capacity in relation to voluntary assisted dying

51. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Voluntary assisted dying process step	Tasks and actions
<p>First assessment (continued)</p>	<ul style="list-style-type: none"> » to a person who has appropriate skills and training to determine the matter if unable to determine if the person: <ul style="list-style-type: none"> – is acting voluntarily and without coercion. – If the person is assessed as meeting the eligibility criteria for voluntary assisted dying, provide required information to the person. • If the coordinating practitioner is: <ul style="list-style-type: none"> » satisfied the person meets all the eligibility criteria and understands the information provided, the person is assessed as meeting the requirements of a first assessment and is therefore eligible to access voluntary assisted dying » not satisfied the person meets all the eligibility criteria and understands the information provided, the person is assessed as ineligible to access to voluntary assisted dying—the request and assessment process ends. • Inform the person of the outcome of the first assessment as soon as practicable. • If the person is assessed as ineligible for voluntary assisted dying, provide support as required. • Complete the <i>First Assessment Record Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days. • Give a copy of the <i>First Assessment Record Form</i> and any accompanying documents to the person as soon as practicable.
<p>Referral for consulting assessment</p>	<ul style="list-style-type: none"> • Refer the person to a medical practitioner for the consulting assessment. This can be in any format—including verbally, via email, or by using the optional consulting assessment referral proforma. • Await notification from the medical practitioner as to whether they accept the referral or not (must be within two business days). • If the medical practitioner accepts and becomes the consulting practitioner for the person, the coordinating practitioner is informed of the outcome of the consulting assessment. • If the medical practitioner refuses, make another referral for a consulting assessment. • If the outcome of the consulting assessment is that the person is ineligible, the coordinating practitioner may make a further referral for a consulting assessment to another medical practitioner—there is no limit on the number of times this can happen.

Voluntary assisted dying process step	Tasks and actions
Person's second request	<ul style="list-style-type: none"> • Give the <i>Second Request Form</i> to the person. • Receive the completed Second Request Form from the person, ensuring it has been signed by two eligible witnesses. • Record in the person's medical record: <ul style="list-style-type: none"> » the date the second request was made » the date the second request form was received by the coordinating practitioner. • Submit copy of the <i>Second Request Form</i> to the Review Board via QVAD Review Board IMS within two business days.
Person's final request	<ul style="list-style-type: none"> • Accept the person's clear and unambiguous final request for access to voluntary assisted dying in person or via audiovisual communication (i.e. telehealth where people can see and hear each other in real time). • Confirm the final request has been made after the designated period of nine days or the person meets criteria for the final request to be made prior to end of designated period. • Record the date when the final request was made (and the reason if made before the end of the designated period) in the person's medical record. • Complete <i>Final Request Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days.
Final review	<ul style="list-style-type: none"> • Complete the final review. • Review the following forms: <ul style="list-style-type: none"> » <i>First Assessment Record Form</i> » <i>Consulting Assessment Record Form</i> » <i>Second Request Form</i>. • Consider any decision made by QCAT in relation to decision-making capacity, voluntariness and coercion, and residency. • Confirm that the request and assessment process has been completed in accordance with the Act. • Confirm remain satisfied that the person has decision-making capacity for voluntary assisted dying and that they are acting voluntarily and without coercion. • Complete the <i>Final Review Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days. • Give a copy of the <i>Final Review Form</i> to the person as soon as practicable.
Administration decision	<ul style="list-style-type: none"> • Consult with and advise the person to assist them in making a clear and unambiguous administration decision. • The administration decision must be made in person. • Record the administration decision in the person's medical record.

Voluntary assisted dying process step	Tasks and actions
Revocation of an administration decision by the person	<ul style="list-style-type: none"> • If the person revokes their administration decision, accept the revocation. • Record the revocation in the person’s medical record. • Complete the <i>Revocation of Administration Decision Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days. • If the person chooses to make another administration decision, consult with and advise the person about this.
Appoint a contact person	<ul style="list-style-type: none"> • Give the <i>Contact Person Appointment Form</i> to the person. • Receive the completed <i>Contact Person Appointment Form</i> from the person and submit to the Review Board via QVAD Review Board IMS within two business days.
Prescribing	<ul style="list-style-type: none"> • Prior to prescribing the voluntary assisted dying substance, provide information in writing to the person as required by section 65 of the Act. The content of this information must be discussed face-to-face; it cannot be discussed or shared by phone, fax, email, videoconference or internet. • Complete the prescription for the person in accordance with the relevant prescribing protocol (as per the <i>Queensland Voluntary Assisted Dying Prescription and Administration Protocols</i>). • Give the prescription directly to QVAD-Pharmacy either in person or via post/courier. • Complete <i>Administration Decision and Prescription Form</i> within two business days after completing the prescription and submit to the Review Board via QVAD Review Board IMS.
Transferring the coordinating practitioner role	<ul style="list-style-type: none"> • The coordinating practitioner’s role can only be transferred to the consulting practitioner. • The person accessing voluntary assisted dying can request a transfer of the coordinating practitioner role, or the transfer can be initiated by the coordinating practitioner. This could be for any reason. • The role transfer can occur if the consulting practitioner: <ul style="list-style-type: none"> » has already assessed the person as meeting the requirements of the consulting assessment » formally accepts the transfer. • If the consulting practitioner accepts the transfer, the original coordinating practitioner must: <ul style="list-style-type: none"> » inform the person of the transfer » record the transfer in the person’s medical record » complete the <i>Coordinating Practitioner Transfer Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days. • If the consulting practitioner refuses the transfer, the original coordinating practitioner may refer the person to a different eligible medical practitioner for another consulting assessment.

Voluntary assisted dying process step	Tasks and actions
Administration/ transferring the administering practitioner role	<ul style="list-style-type: none"> • If a practitioner administration decision has been made, the coordinating practitioner becomes the administering practitioner. • If the coordinating practitioner is unable or unwilling to administer the substance, the role can be transferred to another eligible medical practitioner, nurse practitioner or registered nurse. • If the coordinating practitioner is willing to undertake the role they become the administering practitioner (refer to Appendix D). • If transferring the role to another eligible medical practitioner, nurse practitioner or registered nurse: <ul style="list-style-type: none"> » identify an eligible practitioner who is willing to be transferred the role of administering practitioner. QVAD-Support can assist with this » if relevant, supply the voluntary assisted dying substance to the new administering practitioner » provide a handover consistent with good clinical practice to the new administering practitioner » complete the <i>Administering Practitioner Transfer Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days.
After the person dies	<ul style="list-style-type: none"> • If the administering practitioner is a medical practitioner—issue the cause of death certificate after the person’s death. It must state that the cause of death of the person was the underlying disease, illness or medical condition, and must not include any reference to voluntary assisted dying. • Complete the <i>Notification of Death – (Coordinating/Administering Practitioner) Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days of becoming aware of the person’s death (unless a practitioner administration form has been submitted). • Provide support and information to family and carers as required. • Make appropriate referrals for ongoing support as required, including to QVAD-Support, GP or grief and bereavement services. • Provide specific information to the Review Board on request, if required.

Appendix C: Summary of consulting practitioner key tasks and actions⁵²

Voluntary assisted dying process step	Tasks and actions
Receives referral for consulting assessment	<ul style="list-style-type: none"> Decide whether to accept or refuse the referral for consulting assessment and inform the person and coordinating practitioner within two business days (or immediately in the case of conscientious objection).
Record referral and acceptance or refusal	<ul style="list-style-type: none"> Record the referral and decision to accept or refuse the referral (including reason if refused) in the person's medical record. Complete the <i>Consulting Assessment – Referral Acceptance or Refusal Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days of the decision to accept or refuse the referral.
After accepting the referral and becoming the consulting practitioner	
Become an authorised voluntary assisted dying practitioner (if not already)	<ul style="list-style-type: none"> Submit an application to Queensland Health. Application verified by the Practitioner Eligibility Panel as meeting the eligibility requirements. Successfully complete mandatory online training. Acknowledge receipt and understanding of the <i>Queensland Voluntary Assisted Dying Prescription and Administration Protocols</i>. Complete a declaration agreeing to act in accordance with policies and procedures for voluntary assisted dying in Queensland, including any specific organisational requirements. Receive authorisation to provide voluntary assisted dying services in Queensland from the Chief Medical Officer of Queensland Health.
Consulting assessment	<ul style="list-style-type: none"> Conduct the consulting assessment. Refer for determination: <ul style="list-style-type: none"> » to a registered health practitioner who has appropriate skills and training to determine the matter if unable to determine if the person: <ul style="list-style-type: none"> – has a disease, illness or medical condition that meets the eligibility requirements – has decision-making capacity in relation to voluntary assisted dying » to a person who has appropriate skills and training to determine the matter if unable to determine if the person: <ul style="list-style-type: none"> – is acting voluntarily and without coercion. If the person is assessed as meeting the eligibility criteria for voluntary assisted dying, provide required information to the person. If satisfied that the person meets all the eligibility criteria and understands the information provided, assess the person as eligible for access to voluntary assisted dying.

52. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Voluntary assisted dying process step	Tasks and actions
Consulting assessment <i>(continued)</i>	<ul style="list-style-type: none"> • Inform the person and the coordinating practitioner of the outcome of the consulting assessment. • Complete the <i>Consulting Assessment Record Form</i> and submit it and any supporting documentation to the Review Board via QVAD Review Board IMS within two business days of completing the consulting assessment. • Give a copy of the <i>Consulting Assessment Record Form</i> and any supporting documentation to the person and the coordinating practitioner.

Appendix D: Summary of administering practitioner key tasks and actions⁵³

Voluntary assisted dying process step	Tasks and actions
Become an authorised voluntary assisted dying practitioner	<ul style="list-style-type: none"> • Submit an application to Queensland Health. • Application verified by the Practitioner Eligibility Panel as meeting the eligibility requirements. • Successfully complete mandatory online training. • Acknowledge receipt and understanding of the <i>Queensland Voluntary Assisted Dying Prescription and Administration Protocols</i>. • Complete a declaration agreeing to act in accordance with policies and procedures for voluntary assisted dying in Queensland, including any specific organisational requirements. • Receive authorisation to provide voluntary assisted dying services in Queensland from the Chief Medical Officer of Queensland Health.
If role is transferred from coordinating practitioner	<ul style="list-style-type: none"> • If relevant, be supplied the voluntary assisted dying substance from the original administering practitioner. • Receive a handover consistent with good clinical practice from the original administering practitioner.
Administration	<ul style="list-style-type: none"> • If a practitioner administration decision has been made, be advised by the person as to when they intend to have the substance administered. • Contact QVAD-Pharmacy to arrange supply of the voluntary assisted dying substance, unless substance already received as part of transfer of role. • Administer the voluntary assisted dying substance at the time agreed and with an eligible witness present in accordance with the <i>Queensland Voluntary Assisted Dying Prescription and Administration Protocols</i>, if the person has made a practitioner administration decision and not revoked it, and are satisfied that at the time of administration the person has decision-making capacity in relation to voluntary assisted dying and they are acting voluntarily and without coercion. • Complete the <i>Practitioner Administration Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days after administering the voluntary assisted dying substance. • If relevant, dispose of any unused or remaining voluntary assisted dying substance and complete the <i>Practitioner Disposal Form</i>. This form must be submitted to the Review Board via QVAD Review Board IMS within two business days of disposal.

53. Adapted from the voluntary assisted dying mandatory training produced by the Australian Centre for Health Law Research, QUT.

Voluntary assisted dying process step	Tasks and actions
<p>After the person dies</p>	<ul style="list-style-type: none"> • If the administering practitioner is a medical practitioner—issue the cause of death certificate after the person’s death. It must state that the cause of death of the person was the underlying disease, illness or medical condition, and must not include any reference to voluntary assisted dying. • If the person dies prior to administration of the substance, complete the <i>Notification of Death (Coordinating/Administering Practitioner) Form</i> and submit to the Review Board via QVAD Review Board IMS within two business days of becoming aware of the person’s death (this is not required if a <i>Practitioner Administration Form</i> has been submitted following administration of the substance). • Inform the coordinating practitioner of the person’s death, if the administering practitioner role has been transferred. • Provide support and information to the family as required.

Appendix E: Practitioner eligibility requirements

These eligibility requirements are subject to change by approval of the Director-General of Queensland Health.

Practitioner eligibility to participate as an authorised voluntary assisted dying practitioner is defined in [Part 5](#) of the *Voluntary Assisted Dying Act 2021*. Additional eligibility requirements have been approved by the Director-General of Queensland Health under ss.161-163 of the Act and are described below.

Medical practitioner requirements

To be eligible to participate in voluntary assisted dying in Queensland as a coordinating, consulting or administering practitioner, a medical practitioner must:

- hold specialist registration and have practised for at least 1 year as the holder of specialist registration; *OR*
- hold general registration and have practised for at least 5 years as the holder of general registration; *OR*
- hold specialist registration and have practised for at least 5 years as the holder of general registration.

Overseas-trained specialist eligibility

An overseas trained specialist without general or specialist registration must hold:

- limited registration with a sub-type of:
 - » area of need – Specialist Pathway; *OR*
 - » post-graduate training or supervised practice – Specialist Pathway – Specialist Recognition; *OR*
 - » provisional registration as an international medical graduate eligible for the competent authority pathway as an overseas-trained specialist.

They must also have:

- completed at least 12 months working in a supervised position in Australia and met the approved supervised practice plan arrangements; *AND*
- at least 5 years of experience practicing as a specialist overseas or in Australia; *AND*
- undergone formal assessment by the relevant Australian college.

All medical practitioners

Additionally, all medical practitioners must:

- have completed the approved training (also referred to as the voluntary assisted dying mandatory training)

- have clinically practised twice the minimum hours per registration period⁵⁴ described in the [Registration Standard: Recency of Practice](#) published by the Medical Board of Australia. This must include a relevant scope of clinical practice, including experience in caring for people towards the end of life, patient assessment, and clinical decision-making; applicants who do not meet these criteria but can demonstrate comparable experience may be considered at the discretion of the Chief Medical Officer
- declare, for the consideration of the Chief Medical Officer:
 - » any notations, conditions, undertakings, or reprimands on their Australian Health Practitioner Regulation Authority registration record which make the practitioner unsuitable to undertake roles under the *Voluntary Assisted Dying Act 2021* as determined by the Director-General (or delegate).
 - » any current or previous substantiated claims, complaints or adverse findings made against them by a registration authority and/or ethical standards/regulatory complaints authority, or any other professional, disciplinary, or similar bodies including those outside Australia which make the practitioner unsuitable to undertake roles under the *Voluntary Assisted Dying Act 2021* as determined by the Director-General (or delegate)
 - » any physical or other medical conditions, including substance abuse, which may limit the medical practitioner's ability to undertake the role of coordinating practitioner, consulting practitioner, or administering practitioner in accordance with the *Voluntary Assisted Dying Act 2021*
 - » any disclosable criminal convictions i.e. convictions as an adult that form part of the medical practitioner's criminal history and which have not been rehabilitated under the *Criminal Law (Rehabilitation of Offenders) Act 1986*
 - » they have professional indemnity insurance, which may be through an employer.

Nursing requirements

Nurse practitioners

To be eligible to participate in voluntary assisted dying in Queensland as an administering practitioner, a nurse practitioner must:

- have practiced as a nurse practitioner for at least 1 year
- hold registration endorsement as a Nurse Practitioner in the Division/Registration Type - Registered Nurse (Division 1).

Registered nurses

To be eligible to participate in voluntary assisted dying in Queensland as an administering practitioner, a registered nurse must:

- have practiced as registered nurse for at least 5 years
- hold registration in the Division/Registration Type - Registered Nurse (Division 1).

54. Medical practitioners must have clinically practiced for a minimum of 8 weeks full-time equivalent in 12 months (304 hours), or 24 weeks full-time equivalent over 36 months (912 hours). Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours.

All nurse practitioners and registered nurses

Additionally, all nurse practitioners and registered nurses must:

- have completed the approved training (also referred to as the voluntary assisted dying mandatory training)
- have clinically practised twice the minimum hours per registration period⁵⁵ described in the [Registration Standard: Recency of Practice](#) published by the Nursing and Midwifery Board of Australia. This must include a relevant scope of clinical practice, including experience in caring for people towards the end of life, patient assessment and clinical decision-making; applicants who do not meet these criteria but can demonstrate comparable experience may be considered at the discretion of the Chief Medical Officer
- declare, for consideration by the Chief Medical Officer:
 - » any notations, conditions, undertakings, or reprimands on their Australian Health Practitioner Regulation Authority (Ahpra) registration record which make the nurse practitioner or registered nurse unsuitable to undertake roles under the *Voluntary Assisted Dying Act 2021* as determined by the Director-General (or delegate)
 - » any current or previous substantiated claims, complaints or adverse findings made against them by a registration authority and/or ethical standards/regulatory complaints authority, or any other professional, disciplinary, or similar bodies including those outside Australia which make the practitioner unsuitable to undertake roles under the *Voluntary Assisted Dying Act 2021* as determined by the Director-General (or delegate)
 - » any physical or other medical conditions, including substance abuse, which may limit the nurse practitioner or registered nurse's ability to undertake the role of administering practitioner in accordance with the *Voluntary Assisted Dying Act 2021*
 - » any disclosable criminal convictions i.e. convictions as an adult that form part of the nurse practitioner or registered nurse's criminal history and which have not been rehabilitated under the *Criminal Law (Rehabilitation of Offenders) Act 1986*
 - » they have professional indemnity insurance, which may be through an employer.

Additional person-specific eligibility requirements

In addition to eligibility requirements to become an authorised voluntary assisted dying practitioner, the Act requires all coordinating, consulting, and administering practitioners to be independent of a person accessing voluntary assisted dying.

To be eligible to provide voluntary assisted dying services to a person, a coordinating, consulting, or administering practitioner must not:

- be a family member of the person requesting access to voluntary assisted dying—including their spouse, parent, grandparent, sibling, child, or grandchild
- be a person who, under Aboriginal or Torres Strait Island custom, is regarded as a person mentioned above in relation to the person requesting access to voluntary assisted dying
- know or believe they are a beneficiary under a will of the person requesting access to voluntary assisted dying
- know or believe they may otherwise benefit financially or in any other material way from the death of the person requesting access to voluntary assisted dying (other than receiving reasonable fees for the provision of services related to the coordinating, consulting, or administering practitioner role).

55. For nurses the current standard states: 450 hours within the past 5 years, for both clinical and non-clinical practice roles for nurses and midwives.

Appendix F: Information to be provided to the person if assessed as meeting eligibility criteria

If the person meets the eligibility criteria for voluntary assisted dying, the coordinating practitioner and consulting practitioner must:

- provide the person with the information below (as required under [section 22](#) of the Act; and
- confirm in the *First Assessment Record Form* and *Consulting Assessment Record Form* whether they are satisfied that the person understands the information.

This checklist is provided as a **tool** to aid practitioners in meeting these requirements.

Information that must be provided to the person by the coordinating practitioner and consulting practitioner	
<input type="checkbox"/>	The person's diagnosis and prognosis.
<input type="checkbox"/>	The treatment options available to the person and the likely outcomes of that treatment.
<input type="checkbox"/>	The palliative care and treatment options available to the person and the likely outcomes of that care and treatment.
<input type="checkbox"/>	The potential risks of self-administering or being administered the voluntary assisted dying substance likely to be prescribed under the <i>Voluntary Assisted Dying Act 2021</i> for the purpose of causing the person's death.
<input type="checkbox"/>	That the expected outcome of self-administering or being administered the substance is death.
<input type="checkbox"/>	The method by which the substance is likely to be self-administered or administered.
<input type="checkbox"/>	The request and assessment process, including the requirement for a written request (the second request) signed in the presence of two witnesses.
<input type="checkbox"/>	That if the person makes an administration decision, they must appoint a contact person.
<input type="checkbox"/>	That the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying.
<input type="checkbox"/>	That, if the person is receiving ongoing health services from a medical practitioner other than the coordinating practitioner, the person may consider informing the other medical practitioner of their request to access voluntary assisted dying.

Appendix G: Resources to assist with prognostication

Tool/resource/paper	Contains	Additional information
<p>Australia-modified Karnofsky Performance Status Scale</p> <p>Abernethy AP, et al. 2005. “<i>The Australia-modified Karnofsky Performance Status (AKPS) Scale: a revised scale for contemporary palliative care clinical practice.</i>” <i>BMJ Palliative Care</i> 4:7.</p>	<p>Measures the patient’s overall performance status or ability to perform their activities of daily living.</p>	<p>Not a prognostic tool—mainly used by palliative care clinicians as a flag for the likelihood of need for services, timing of interventions, and as outcome measurement for clinical programs and research.</p>
<p>Charlson Comorbidity Index</p> <p>Charlson ME, et al. 1987. “<i>A new method of classifying prognostic comorbidity in longitudinal studies: Development and validation</i>”. <i>Journal of Chronic Diseases</i> 40(5): 373-83.</p>	<p>Validated tool which quantifies a person’s burden of disease and mortality risk.</p>	<p>Internationally validated, disease specific, and easy to use using information from clinical notes.</p>
<p>CareSearch review collection – Prognosis</p> <p>CareSearch. 2022. “<i>CareSearch review collection – Prognosis</i>”. Last modified August 2022.</p>	<p>Collection of systematic reviews relating to prognostication.</p>	
<p>Early Identification & Prognostic Indicator Guide</p> <p>Mississauga Halton Regional Hospice Palliative Care. 2017. “<i>Early Identification & Prognostic Indicator Guide</i>”. Last modified March 2017.</p>	<p>Guidance for clinicians to support earlier identification of patients nearing the end of life who could benefit from a hospice palliative care approach.</p>	<p>Adapted from the UK’s GSF Prognostic Indicator Guidance.</p>
<p>Supportive and Palliative Care Indicators Tool (SPICt)</p> <p>The University of Edinburgh. “<i>SPICtTM: Supportive and Palliative Care Indicators Tool.</i>” Last modified Nov 2021.</p>	<p>Helps identify people at risk of deteriorating health and dying. Identifies general indicators of poor and deteriorating health; clinical indicators for cancer, heart/vascular disease, kidney disease, dementia/frailty, respiratory disease, liver disease and neurological disease; but doesn’t narrow this down to a prognosis.</p>	<p>May be useful as a generic guide, but is not definitive.</p>

Tool/resource/paper	Contains	Additional information
<p>The Gold Standards Framework Prognostic Indicator Guidance</p> <p>Thomas K, et al. 2011. <i>“The GSF Prognostic Indicator Guidance 4th edition”</i>. Last modified October 2011.</p>	<p>Guidance to help health practitioners with earlier identification of adult patients who are nearing the end of their life and may need additional support.</p>	<p>Relatively succinct tool with information and specifics about individual medical conditions.</p> <p>Uses the surprise question.</p>
<p>The surprise question</p> <p>van Lummel, EV, et al. 2022. <i>“The utility of the surprise question: A useful tool for identifying patients nearing the last phase of life? A systematic review and meta-analysis”</i>. Palliative Medicine 36(7), pp. 1023–1046.</p>	<p>Asks <i>“Would I be surprised if this patient died in the next 12 months?”</i> to identify patients at high risk of death who might benefit from palliative care services.</p>	<p>High specificity and sensitivity.</p>

Appendix H: Assessing decision-making capacity

The resource referred to in Appendix H is for guidance only. It is not intended to replace individual clinical judgement.

Assessing decision-making capacity in relation to voluntary assisted dying, possible approaches and red flags.⁵⁶

Person's task	Medical practitioner, nurse practitioner or registered nurse's assessment approach	Red flags—require further investigation
Criterion: (a) Understand the nature and effect of decisions about access to voluntary assisted dying		
<p>Understand their current health situation, their options, and the decisions they are making.</p> <p>Grasp the fundamental nature of voluntary assisted dying—and that it would lead to their death.</p> <p>Weigh up the information and the consequences of the decision about access to voluntary assisted dying.</p>	<p>Ask the person to describe in their own words:</p> <ul style="list-style-type: none"> • the problem with their health now • their end-of-life options including further active treatment, palliative care, and voluntary assisted dying • the possible benefits and risks (or discomforts) of the options • what they expect will happen if they choose voluntary assisted dying • what they expect will happen if they do not choose voluntary assisted dying • how they decided to accept or decline the other options • what makes [voluntary assisted dying or the chosen option] better than [alternative options] <p>Ask the person to describe their thoughts and feelings:</p> <ul style="list-style-type: none"> • about their health now • about their treatment options • about accessing voluntary assisted dying 	<ul style="list-style-type: none"> • Person fails to remember or understand their medical condition or prognosis or does not accept it (for example, those who lack insight because of delusions or denial). • Person cannot recount the possible options, and their consequences (including no treatment), and their benefits and risks. • Person cannot remember their prior choices or express them in a consistent way. • Person engages in a decision-making process that does not lead logically to the outcome communicated. • Person makes an unusually quick decision. • Person's decision does not appear to be based on the person's expressed beliefs or values, or that rejects alternative options without explanation. • Person frequently reverses their decision.

⁵⁶. Table adapted from original article by Appelbaum PS 2007, 'Assessment of patients' competence to consent to treatment', *New England Journal of Medicine*, no. 357, pp. 1834–1840 and Willmott L, White B 2018, *Voluntary Assisted Dying Act 2017 Assessment Training Module 4*, for the Department of Health and Human Services, Melbourne.

Person's task	Medical practitioner, nurse practitioner or registered nurse's assessment approach	Red flags—require further investigation
Criterion: (b) Freely and voluntarily make a decision about voluntary assisted dying		
To make their own decision independent of the views of others.	<p>Ensure the person's request is voluntary and free of coercion.</p> <p>If coercion is suspected, ask the person to speak to you privately and probe:</p> <ul style="list-style-type: none"> • why they are seeking voluntary assisted dying • whether friends, family or carers know they are seeking voluntary assisted dying, and their views • whether they feel safe • whether they are under pressure from others or have any related concerns • what support they would have if they chose not to proceed with voluntary assisted dying. 	<ul style="list-style-type: none"> • Person whose conversations seem more constrained when in the company of others. • Friends, family, or carers encouraging the person to seek voluntary assisted dying. • Person who feels unsafe or uncomfortable with family or carers. • Person who has inadequate support at home for their condition. • Any evidence of domestic violence (for example, signs of physical or verbal abuse).
Criterion: (c) Communicate a voluntary assisted dying decision in some way		
Clearly state their decision using words, gestures, or other forms of communication available to the person (including communication aids).	<ul style="list-style-type: none"> • Listen to the person's request and seek clarification if necessary. • If the person has not decided which treatment option to follow, ask what is making it hard for the person to decide. 	<ul style="list-style-type: none"> • Person who appears to respond inconsistently to questions. • Person whose family member or carer constantly speaks or communicates for them.

