VADANZ
Voluntary Assisted Dying Australia and New Zealand

Submission to

Review of the operation of the Voluntary Assisted Dying Act 2017 (Victoria)

February 2024

Introduction

VADANZ (Voluntary Assisted Dying Australia and New Zealand) is an independent membership body representing health professionals working in voluntary assisted dying (VAD).

We welcome the opportunity to submit evidence to Victoria's review of the Voluntary Assisted Dying Act 2017 (hereafter 'the Act'). This signifies almost five years of the compassionate choice of VAD being available to our patients and relief to many more family members.

This submission is informed by the collective experience of our Victorian members working in VAD. It also draws on the experience of VAD nationally to suggest improvements, based on what is working well in other jurisdictions and our keen understanding of the issues faced in delivering high-quality VAD care.

We would be delighted to share more of our expertise and insights with your committee in-person.

We have also encouraged our members to make their own submissions by completing the shorter survey.

The following submission responds to the questions posed by the review, followed by our further comments on the current Victorian legislation and our recommendations following this review.

Thank you again for the opportunity to contribute to the review process.

Yours sincerely,

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VADANZ’s involvement in VAD in Victoria

VADANZ (Voluntary Assisted Dying Australia and New Zealand) is an independent membership body representing health professionals working in voluntary assisted dying (VAD). All our members have direct involvement in VAD.

One in four VADANZ members works in Victoria. It is not surprising the state is strongly represented given its VAD law has been in place the longest.

VADANZ represents a varied yet deeply informed perspective on VAD.

- Multidisciplinary: Our members’ insights range from medicine, nursing, pharmacy and other areas of allied health such as social work and psychology.
- Diverse roles: Our members cover all areas of VAD practice, from care navigation and assessment through to substance prescription, dispensing and administration, and after care bereavement support.
- Diverse settings: Our members also work in a number of different settings; community healthcare, private practice, aged care and palliative care.

Meeting the needs of patients, families, and carers

Overall:

The system is working well, providing compassionate high-quality care. Victoria's Care Navigation and Statewide Pharmacy Services have been models for other states and should continue to be supported to meet the growing demand.

- There have been no reports of patients where self-administration has not resulted in death.
- There have been no cases in Victoria where the substance has not been used correctly or has been misplaced.

The inability to initiate discussions.

Many patients learn of their healthcare options from their usual treating GP or specialist. Section 8 of the Act prohibits the initiation of discussions about VAD by these individuals. This has led to a deficit in the ability to educate patients in Victoria of their rights to access VAD, and by extension, compromised the nature of the practice of fully informed decision-making. Prohibiting the informing of patients by their medical practitioners disproportionately disadvantages less-health literate patients, including those of culturally and linguistically diverse (CALD) backgrounds.

Recommendation:

Medical practitioners and other health professionals should be able to initiate discussions with patients regarding voluntary assisted dying, provided it is done in the context of a broader discussion including all active and palliative treatment options, in line with other jurisdictions (WA, Tas, QLD, NSW).

The inability to use telehealth.

In the most-recent Victorian VAD Review Board report, 36% of applicants were from regional Victoria, whilst most specialists are based in metropolitan areas. In a case series of 344 Victorian VAD applicants, 55% reported inadequate pain control or concern about it as being a reason that they were applying for VAD. The inability to use a now-established and accepted mode of care delivery (telehealth) to provide equitable access to VAD for rural and regional patients who are by definition in the last six-twelve months of their lives and have such a high rate of self-reported pain, is unconscionable, and suggests that the needs of the people seeking VAD have clearly not been met.

It is the position of Voluntary Assisted Dying Australia New Zealand (VADANZ) that people can receive high-quality and effective Voluntary Assisted Dying (VAD) services using **telehealth** and that telecommunications have become an integral and vital mode of delivery of care across countless other specialities and subspecialities in medicine. When approached for comment regarding any concerns with the use of Telehealth in New Zealand, Dr Kristin Good, Registrar of Assisted Dying at the New Zealand Ministry of Health, said: "we couldn't have provided a timely service without it!" (personal communication).

Every Voluntary Assisted Dying Review Board in Australia, including Victoria's, whose ultimate role is ensuring the safe operation of VAD laws, have recommended the use of telehealth in VAD care delivery:

- **Victoria:** "As access to voluntary assisted dying becomes more widespread in Australia, the Board will continue to advocate for a change in the Commonwealth Criminal Code, which currently impedes the use of telehealth in relation to voluntary assisted dying. The law as it exists creates barriers to access to care and, in some cases, imposes unreasonable travel demands on people suffering from life-ending medical conditions. A change to the law will enhance access for all Victorians, regardless of their location or mobility."
- **Western Australia:** "The Voluntary Assisted Dying Board identified key areas for improvement to voluntary assisted dying: Amendments to the Commonwealth Criminal Code Act 1995 relating to the use of a carriage service that has limited the use of Telehealth for voluntary assisted dying in Western Australia."
- **Tasmania:** "The Commission urges amendments to the Criminal Code to expressly exclude participation in voluntary assisted dying in accordance with state legislation from the scope of sections 474.29A and 474.29B of the Criminal Code."
- **South Australia:** "The Voluntary Assisted Dying Review Board supports the need to remove the exclusion of telehealth and other online channels in relation to voluntary assisted dying."
- **Queensland:** "The Review Board makes the following recommendations: Amendments to the Criminal Code Act 1995 (Cth) to enable carriage services (such as telehealth) to be used for the provision of voluntary assisted dying services."

While telehealth is now an essential part of the healthcare landscape, the optimal mode of delivery for VAD services will be in-person. We advocate for at least one VAD eligibility assessment, where possible, be conducted in person. However, when needed to deliver timely, person-led care, telehealth is an alternative for VAD practitioners to consider.

Recommendation:
The use of telecommunications is fundamental to the function of all VAD support services. The current Criminal Code conflict puts all support services clinicians (usual clinical providers, Secretariat, Navigators, Hospital Coordinators, Pharmacy) at risk **and advocacy to the Federal Government for Criminal Code amendment** is strongly recommended. The inability to use telehealth also greatly impacts the care provided by non-VAD clinicians – including grief and psychological support providers – who routinely use telehealth and have clients raising VAD with them.

The need for dedicated grief and bereavement support.

The grief and bereavement experience for friends and family members of those who opt for VAD is not well-documented. Funding for VAD research is scarce. It has been assumed the grief and bereavement support would be integrated into usual care provision, however experience is showing this to not always be the case. Challenges have been encountered when bereavement support is provided by a non-supportive agency, when the agency has no VAD experience or when the family had the perception or experience of a VAD request being not supported.

Recommendation:
We recommend state-based funding of a dedicated VAD bereavement service, which includes training for existing bereavement services and an intent of publishing findings relating to potential positive and negative impacts of VAD on bereavement, so that this can be better understood.

Australian citizenship / permanent residency:

The requirement for patients to be able to prove that they are an Australian citizen or permanent resident has led to cases of miscarriage of justice. We find it confusing that these specific criteria require documentary evidence, whereas other eligibility criteria, such as their diagnosis and prognosis, requires only a statement from the coordinating and consulting medical practitioner that they meet the eligibility criteria. Many patients do not have copies of birth certificates, and often have expired and/or disposed of their passports.

Another issue that has arisen is that the term ‘permanent resident’, although written in lower-case letters in the Act, has been interpreted to mean “Permanent Resident” (ie holding a permanent residency visa). Cases, such as VAD000548, have been found ineligible despite the applicant living in Australia for many years, due to the fact that they never took out this visa. Many more people have sought access to VAD and not pursued assessment due to this barrier, these people are not counted in any VAD statistics.

Recommendation:

That the interpretation of permanent resident as an eligibility criterion in the Act be at the discretion of the assessing medical practitioners, and not require documentary evidence.

Usual resident of Victoria:

When the Act was being debated in the Victorian state parliament, the need to prevent Victoria becoming a centre for VAD in Australia was recognised. This led to the inclusion of being ordinarily a resident of the state of Victoria, and having been ordinarily a resident in Victoria for at least 12 months.

As VAD becomes legislated across Australia there is a decreasing need to protect Victoria against “VAD-tourism”, and a growing need to acknowledge situations such as border towns, or when an individual may have family in Victoria, and move in with them from another state when their health deteriorates in the context of a progressing, incurable illness. In situations such as these, patients should not be excluded from VAD eligibility.

Recommendation:

That the requirement of being ordinarily a resident of Victoria, or a resident of Victoria for greater than 12 months be discarded. If legislative review on this matter is not an option, establish cross-jurisdictional agreements to protect cross border applicants and their clinicians – for example people who may choose to ingest the substance in their usual health service in another state.

Institutional heterogeneity:

A person and family’s experience of access to VAD can vary greatly according to the position of their local health service or influential members of that health service leadership.

We have observed many instances where staff (particularly nursing staff) in institutions that do not support VAD access, have felt a sense of injustice in not being able to support their patients’ wishes to access VAD. The overwhelming support for VAD by Victorian nurses has been known for many years, including but not limited to Kuhse and Singer (1993), who found 78% of respondents to their survey of Victorian nurses “supported a change in law to allow doctors to take active steps to bring about a patient’s death under some circumstances.” Whilst some institutions claim that by not engaging in VAD care provision, they are protecting their staff from the moral injury of being complicit in a patient availing themselves of VAD, it is more likely that they are subjecting a greater number to the moral injury of abandoning their patients' and their wishes. In this sense, the Victorian VAD system has failed healthcare workers (not just nurses) who wish to support their patients' wishes but cannot do so due to the allowance of institutional objection.

Recommendations:

A renewed standardisation of institutional governance, guidelines, and standards for the handling of VAD requests. We suggest that the originally-designed tier system be reintroduced: Pathway A providing all VAD-related care including Practitioner Administration, Pathway B providing for access to VAD services on-site, and allows self-administration of VAD on-site, Pathway C serves as an advice and referral service to the Statewide VAD Care Navigators. We further suggest that hospitals are required to declare their Pathway level to patients to be admitted for palliative care, and aged care facilities are required to declare their Pathway level to prospective residents. We further recommend that all public hospitals be required to provide Pathway A services.

Meeting the needs of people from diverse backgrounds and geographical locations

The government funded statewide Pharmacy, Care Navigators and Secretariat deliver the same service to all applicants regardless of background and geographic locations. Interpreter services are used when required and interpreters who have undergone specific education in voluntary assisted dying are utilised when able. There are resources written in multiple languages.

However, there are idiosyncratic barriers to access for people from diverse backgrounds, those living rural or remotely, those in aged care, with neurological illness, or without family support. Such barriers include:

Lack of awareness of VAD as an end-of-life option:
In significant part due to health professionals being unable to initiate discussion about VAD. The extent of unmet need amongst diverse communities, due to this clause is unknown, but hypothesis can be drawn by comparing uptake in Victoria which is much lower per population compared to states where VAD can be included in an end-of-life conversation such as WA and QL.

General awareness raising about VAD among all communities may help reduce potential inequities.

Post-war European immigrants and New Zealanders:
This population, who have lived in Australia for most of their lives, but not formally applied for citizenship or a permanent residency visa, as the residency requirements of the Act have been specifically interpreted, are able to access all healthcare except VAD.

Interpretation of 'permanent resident' should include *people who permanently reside in Australia* as is the case elsewhere in Australia.

People who are isolated or without someone to advocate for them:
These people can find accessing VAD very difficult. Very specific ID documentation is required to prove citizenship and Victorian residency that more isolated people can have difficulty sourcing, and often someone is needed to help a person navigate through the complex legislated process.

Regional and remote Victorians:
All Victorians but especially people in regional and remote Victoria are impacted by:

- A **lack of VAD trained doctors**, in particular neurologists and other specialists.
- The **inability to use telehealth**, a significant barrier when the person is unable to travel – often the case for neurological illness and towards end of life (as are all applicants).
- The **limitations on provision of information and support by phone or telehealth by support services** (navigators, coordinators, pharmacy, usual care team) due to Criminal Code restrictions.

In addition to the above, cases in rural areas where access to specialists is scarce, General Physicians (with relevant experience and expertise) are often alongside a General Practitioner as the two assessing medical practitioners. This is inconsistent to what is required in metropolitan areas, where the requirement for a craft group Specialist (ie Medical Oncologist or Respiratory Physician) is more stringently enforced.

We suggest that the application of a specialist with relevant expertise and experience in the disease suffered by the patient should firstly be re-interpreted as including General Practitioners with relevant experience and expertise. If this is not possible, the physician-specialist involvement should be standardised across metropolitan and rural areas so that specialists working in General Medicine units be considered to meet this criterion in metropolitan areas also.

People in non-supportive aged care or the catchment of non-supportive public health care institutions:
Aged care or publicly funded palliative care **institutional objection** to voluntary assisted dying, may impact a person's ability to also die *in their own home* (aged care) or force them to choose between VAD OR palliative care.

Pharmacy

- "Regional hubs" of the Victorian Voluntary Assisted Dying Statewide Pharmacy Service should be explored with potential for an integrated hub-and-spoke pharmacist hybrid telehealth and face-to-face service.
- The requirement for unused voluntary assisted dying substances to be returned to the pharmacist at the dispensing pharmacy be amended to enable return to an appropriate regional public hospital and for destruction to be undertaken there.

Timely, safe, compassionate VAD care

Timeliness

There continues to be frequent requests from patients, their carers and coordinating medical practitioners for “as soon as possible” access to the voluntary assisted dying substance. This is currently occurring in approximately one third of cases in Victoria.

These “ASAP” requests can be due to unexpected patient deterioration however in many cases these requests are related to factors associated with the process such as:

- Delayed commencement of the application process due to a lack of awareness of the existence of VAD.
- Delayed decision to access VAD due to the will to live.
- Institutional barriers to accessing voluntary assisted dying – conscientious or non-conscientious objection, lack of process, lack of understanding how to respond to an initial request for VAD or information about VAD.
- Delays in service provision, for example due to the limited number trained and available medical practitioners.
- Time delays inherent in the application process itself, including but not only:
    - The observation of the 9-day waiting period between the First and Final Requests
    - The need for neurological 6-12 month prognosis letter *after* the coordinating assessment, often forcing people to see their neurologist both before and after coordinating assessment.
- Time delays in finding a VAD-trained specialist in the disease that the patient has. As September 2023, AHPRA Registration data shows that there are 8,610 General Practitioners in Victoria, compared to 313 Medical Oncologists, 270 Neurologists, 232 Respiratory and Sleep Medicine specialists, 439 Cardiologists. Given that 76% of VAD applicants list cancer as the life limiting condition for which they are applying for VAD, it is not sustainable, not reasonable to expect there to not be delays when the system continues to expect 50% of these VAD assessments to be conducted by a medical oncology workforce – which is a mere 3.6% of the general practitioner workforce.
- Time required to obtain documents proving Australian citizenship or permanent residency.
  Delays introduced through the requirement for face-to-face assessments.
- Delays in transferring from self-administration (oral) processes to practitioner administration (IV), when patients lose the ability to swallow – often when time is even more critical.
- Routine time frames to permit application processing (e.g. three business days) after a case is expedited due to a less than 9-day prognosis.
- Passive delays inherent in the process by not having access to the Board secretariat, permit processing, or pharmacy services seven days a week.

These delays are often be compounded when doctors are less experienced in VAD pathways and can make administrative errors that require correction.

The management of ‘not-yet-eligible’ patients has also been problematic; patients who meet the other criteria of eligibility, however their prognosis is either unclear, or longer than the required 6-12 months. It has been interpreted that in this situation, if a previously ineligible patient wishes to re-apply when the become eligible on prognostic grounds, a new First Request must be lodged, triggering a new 9-day waiting period. This extra waiting period is entirely superfluous, as the patients have a longstanding wish to engage in this process and have always served a 9-day cooling off period from the date of their original First Request.

Recommendations:

- Reduce the time delays in accessing VAD, including:
    - Reducing the 9-day cooling-off period between First and Final Requests to 48-hours. Patients have already self-imposed a waiting period before contacting the VAD Navigators, and the delays to accessing practitioners, completing documentation, applying for permits, and organising medication delivery already impose their own inherent cooling-off periods.
    - Reducing the routine time frames to permit application processing.
- Resource an on-call process for VAD practitioners for after-hours support, including urgent permit approvals and medication access.
- Allow permits for both oral and intravenous to be granted concurrently and allow doctors and their patients to choose which is both clinically appropriate, and preferable for the patient. This system is already in-place in New Zealand where practitioners take both oral and intravenous medications to every admin in case they are needed.
- Advocate for the re-interpretation of section 10 – Minimum requirements for co-ordinating medical practitioners and consulting medical practitioners, subsection (3). This has been interpreted as requiring a physician specialist in the disease the patient has, rather than for example, a GP specialist with relevant experience and expertise managing patients with their condition. We advocate that experienced General Practitioners, and Physician-specialists working in General Medicine units are 'specialists with relevant expertise and experience' in managing all diseases, particularly in the deteriorating and terminal phases, and should be considered to meet the criterion stipulated in section 10(3).
- Removed requirement for the appointment of a contact person for cases that progress to Practitioner Administration – IV protocols, where the return of the medication is the responsibility of the coordinating medical practitioner.
- Allow new cases for previously ineligible patients to utilise the date of their original First Request for the purposes of their renewed application process.

Safety:

- When a patient has attempted self-administration of the voluntary assisted dying substance there have been no reports when this has not resulted in their death.
- In over 1500 instances of providing the voluntary assisted dying substance to patients there has been no cases where the substance has not been used correctly or has been misplaced.

This does not mean there have not been complications during administration, such as vomiting, and prolonged time to death, particularly in self-administered (oral) administrations.

Recommendation:
That VAD permits grant the ability to prescribe both the oral and intravenous protocols of medications concurrently (see next section for further discussion), and that a Practitioner Administration (IV) kit be available for use if complications such as these occur.

Compassion:

There have been multiple reports, in addition to patient feedback reports, of the compassionate approach provided by the Statewide services. This includes, but not limited to:

- Voluntary Assisted Dying Review Board Annual Reports

- Independent qualitative evaluation of family caregivers' feedback (Med J Aus 2023; 219(5): 211-6)

A key area for improvement is that there have been many cases where practitioner administered voluntary assisted dying would have been a more compassionate option for the patient and family rather than self-administration but was not an option available to them.

In Victoria, practitioner administration is only an option if the patient is unable to "ingest or digest" the oral substance protocol. The anxiety of a patient self-administering with their family having to prepare the mixture for administration is evident on many visits and has also been reported in the feedback the Statewide Pharmacy has received.

Obstacles or inability to access VAD have resulted in what has at times been perceived as a non-compassionate approach and caused more distress to the person and family than if VAD had not been a potential option.

Recommendation:
That the choice between oral and intravenous administration be at the discretion of the coordinating medical practitioner or administering health practitioner, based on preference and clinical appropriateness.

Meeting the needs of organisations and involved healthcare practitioners

We believe that when practising patient-centred care, the needs of the organisation and health practitioners should be considered below the needs of the patient.

The barriers faced by patients, outlined previously, are also faced by the Coordinating Medical Practitioner who is advocating for their patient's right to access healthcare relevant to their needs. Significant frustration and moral injury have occurred to many VAD practitioners who have had to face these barriers on behalf of their patients, and we are aware of several practitioners who have ceased to provide VAD assessments due to the poor experience that they have had along the way.

Remuneration:

Remuneration is another area where the needs of supportive healthcare workers have not been met. Many practitioners conduct their VAD work on a pro bono basis. Others claim what they can through existing Medicare items for consultations, however due to the existence of Medicare's General Explanatory Note GN 13.33€, "euthanasia and any service directly related to the procedure", does not attract Medicare benefits. This has led to the need to privately bill end-of-life patients and their families.

End-of-life care, including palliative care and VAD, should be funded for all Victorians (and indeed all Australians). To establish sustainable delivery of VAD service provision, the removal of GN13.33 from Medicare and the introduction of dedicated Medicare item numbers needs to be advocated for, and/or the establishment of a standardised, state-funded remuneration program (an example being New Zealand's Assisted Dying Service Gazetted Fees List), needs to be introduced.

Recommendation:

- That the Victorian State government introduce a uniform remuneration scheme for private VAD medical practitioners and public health services to appropriately pay their doctors for engagement in VAD work, including out of hours work and home visits.
- Advocate for both the removal of Medical Explanatory Note GN13.33, and the introduction of dedicated Medicare item numbers for VAD care provision.

Training:

VAD training needs to extend more broadly than the current education that is centred around the legalities and processes surrounding the VAD Act. The current education aims to inform doctors who not to break the law it does not education doctors how to do their job *well*. We recommend the funding of further education with regards to prognostication, exploring coercion, assessing capacity, and experienced clinicians sharing their challenging cases, would both raise and standardise the quality of VAD service provision, and improve the confidence and retention of VAD clinicians across the state.

Recommendation:
That the Victorian State government work with VADANZ to produce a series of training webinars on topics in VAD care provision.

Practitioner Administration:
Currently, the only person who can administer a VAD substance to a patient is their coordinating medical practitioner. The only ways to become a Coordinating Medical Practitioner are to receive the patient's First Request or be the patient's Consulting Medical Practitioner and accept a transfer of roles initiated by the Coordinating Medical Practitioner. There have been several cases (e.g. VAD000599) where patients have lost the ability to self-administer, and neither their Coordinating nor Consulting Medical Practitioner has been prepared to offer practitioner administration (intravenous). Patients have been required to recommence the entire application process to introduce a third provider who is willing to provide practitioner administration (IV) to the patient. This takes time when time is of the essence and causes great angst to the applicant and family, and contrary to the claims of the Voluntary Assisted Dying Review Board, does then constitute an 'emergency procedure'. This is a clear failing of the legislation that requires urgent attention. VADANZ has provided these experiences to VAD legislators from other jurisdictions to ensure that this role can be completed by another individual (in some states, known as an Administering Health Practitioner), and in some states, the use of nurse practitioners and senior nurses for this and as an assessing health practitioner has also been explored. Currently, Coordinating Medical Practitioners find it confronting to go on leave, or even away for the weekend, if they know they have a patient that may require their presence for administration during or even near to that time.

Recommendation:
Advocate for the ability to appoint an Administering Health Practitioner.

Telehealth:
During the first few days of the Victorian VAD Act, providers who had completed the training were contacted and advised to not conduct any aspect of VAD eligibility assessment over Telehealth due to concerns about the interaction with the Commonwealth Criminal Code Act amendment (2005) for Suicide Related Materials. Doctors were told that conducting VAD over a carrier service 'may' constitute a breech of the Criminal Code Act. As a craft group, doctors asked for this to be confirmed whether it did constitute a breech many times over the ensuing years. In the interim, they continued to conduct face to face reviews throughout the pandemic, often to nursing homes and hospitals, putting themselves at significant personal risk, and this question was never clarified by the Victorian state government.

It took Dr Nick Carr to personally fund a hypothetical case through the Supreme Court to finally get an answer that yes, the transmission of VAD-related materials is no different (in law) to transmitting suicide-related materials, and there is indeed a risk to providers in engaging in this. In response to this, representatives from all impacted craft groups, including medical practitioners, navigators, and pharmacists, have asked for clarification from both state and federal Attorneys General about whether they could receive reassurance that prosecution of VAD providers under the Criminal Code would not be in the public interest, and still have not received an answer.

Victorian state government has entirely failed to meet the needs of all VAD healthcare providers by not pushing hard enough for at least a straight answer from the Attorney General's office on clinicians' behalf. VADANZ strongly recommends that the Victorian State government works for a clear resolution to this matter to protect healthcare workers engaged in VAD practice so that all practitioners can not only conduct VAD assessments via telehealth, but have confidence that when they act in good faith within the confines of state-sanctioned VAD legislation and call patients to discuss their appointments and the documents that they need, when they email or fax a prescription to the statewide pharmacy, or when they call a patient to advise them that their application has been approved, that they are not at risk of prosecution under Federal law. The entire VAD workforce is impacted - medical practitioners, navigator service, hospital coordinators, statewide pharmacy service, and a person's usual care team.

Recommendation:

That the Victorian state government take responsibility for placing the entirety of healthcare workers involved in the provision of VAD at personal, physical, and legal risk with regards to the Commonwealth Criminal Code Act (Suicide Related Materials) and resolve this with the Attorney General and/or Federal Health Minister as a matter of urgency.

Improvement of systems:

Assessing Medical Practitioners are currently unable to access the VAD portal to progress applications while outside the country, which can introduce profoundly impactful delays during holidays or conferences. The VAD portal has been re-vamped, and the improvements have seen a drastic reduction in the errors seen by the VAD secretariat. Further improvements need to be considered, such as the ability to submit prescriptions to the Statewide Pharmacy through the portal.

Recommendation:

Advocate for the continuing discussion between relevant parties, with provider inclusion, to address further improvements to the VAD portal and to enable access while abroad.

Review Board Interaction and reporting:

There is currently very little interaction between the VAD Review Board and medical practitioners. Welcome efforts were made to engage with attendance at VAD Community of Practice meetings, however that has not continued.

The Victorian VAD Review Board reports began with very little data, which was understood to be due to the need to ensure data remained unidentifiable. With now over 3000 cases registered in the VAD portal, medical practitioners would welcome the opportunity to delve into the reasons that people apply for VAD, differences (for example) between breast cancer and prostate cancer patients' reasons for applying for VAD. As the practitioners working in this field, VAD doctors, pharmacy and navigators would welcome an opportunity to contribute to what should be included in the Review Board reports.

Recommendations:

- Advocate for the inclusion of a Community of Practice or VADANZ member attend VAD Review Board meeting/s where appropriate, to improve transparency and communication between the Board and the practitioners.
- Recommend the harmonisation of Review Board data reporting across jurisdictions in Australia and the inclusion of data on reasons for applying, a breakdown of data between cancer types to inform VAD, Oncology, and Palliative Care practice, and the opportunity to have VADANZ member or Community of Practice member representation on the VAD Review Board meetings or relevant subcommittee that decides on the contents of the Review Board report.

Unintended consequences of implementation

VADANZ agrees that many, if not most of the issues outlined previously have been unintended. For the sake of brevity, the above issues will not be reiterated in this section - please refer to previous challenges described.

Summary of Recommendations

- Medical practitioners and other health professionals be able to initiate discussions with patients regarding voluntary assisted dying, within the context of a broader discussion including all active and palliative treatment options.
- Strongly advocate to the Federal Government to reach a resolution to allow the use of Telehealth in VAD care provision that does not risk being in breech of section 474.29 of the Commonwealth Criminal Code Act.
- Introduction of a dedicated VAD grief and bereavement service, with the incorporation of research funding to better understand the impacts of VAD on grief and bereavement.
- That interpretation of permanent resident as an eligibility criterion in the Act be at the discretion of the assessing medical practitioners, and not require documentary evidence.
- That requiring applicants to be ordinarily a resident of Victoria, or a resident of Victoria for greater than 12 months, be discarded.
- A renewed standardisation of governance, guidelines, and standards for the response and approach to VAD requests in hospitals and aged care facilities.
- That all public hospital networks be required to provide all aspects of VAD care.
- Consider “regional hubs” of the Victorian Voluntary Assisted Dying Statewide Pharmacy Service.
- Alternative pathways for the disposal of unused voluntary assisted dying substances.
- Reduce the 9-day cooling-off period between First and Final Requests to 48-hours.
- Discard the timeline requirement to undergo neurological prognosis assessment *after* coordinating assessment.
- Establish an on-call process for after-hours access to VAD.
- Allow permits for both oral and intravenous to be granted concurrently and allow doctors and their patients to choose which is both clinically appropriate, and preferable for the patient.
- Allow for the administration of IV protocols in the event of complications during oral administration.
- Advocate for the re-interpretation of section 10 – Minimum requirements for co-ordinating medical practitioners and consulting medical practitioners, subsection (3), to allow two non-physician specialists to progress a case through the application process.
- Remove the requirement for the appointment of a contact person for cases that progress to Practitioner Administration (IV).
- Introduce a uniform remuneration scheme for VAD medical practitioners in both private and public settings.
- Advocate for the removal of Medical Explanatory Note GN13.33 to allow for Medicare funding for all aspects of VAD care provision.
- Advocate for the introduction of dedicated Medicare item numbers for VAD care provision.
- Work with VADANZ to produce a series of training webinars on topics in VAD care provision.
- Include a representative from the Victorian VAD Community of Practice or VADANZ member to attend VAD Review Board meeting/s where appropriate.
- Advocate for the ability to appoint an Administering Health Practitioner.
- Advocate for the continuing discussion between relevant parties, with provider inclusion, to address further improvements to the VAD portal.
- The harmonisation of Review Board data reporting across jurisdictions in Australia
- The inclusion of data in Review Board reports pertaining to reasons for applying for VAD, as well as a breakdown of data between cancer types to inform VAD, Oncology, and Palliative Care practice.