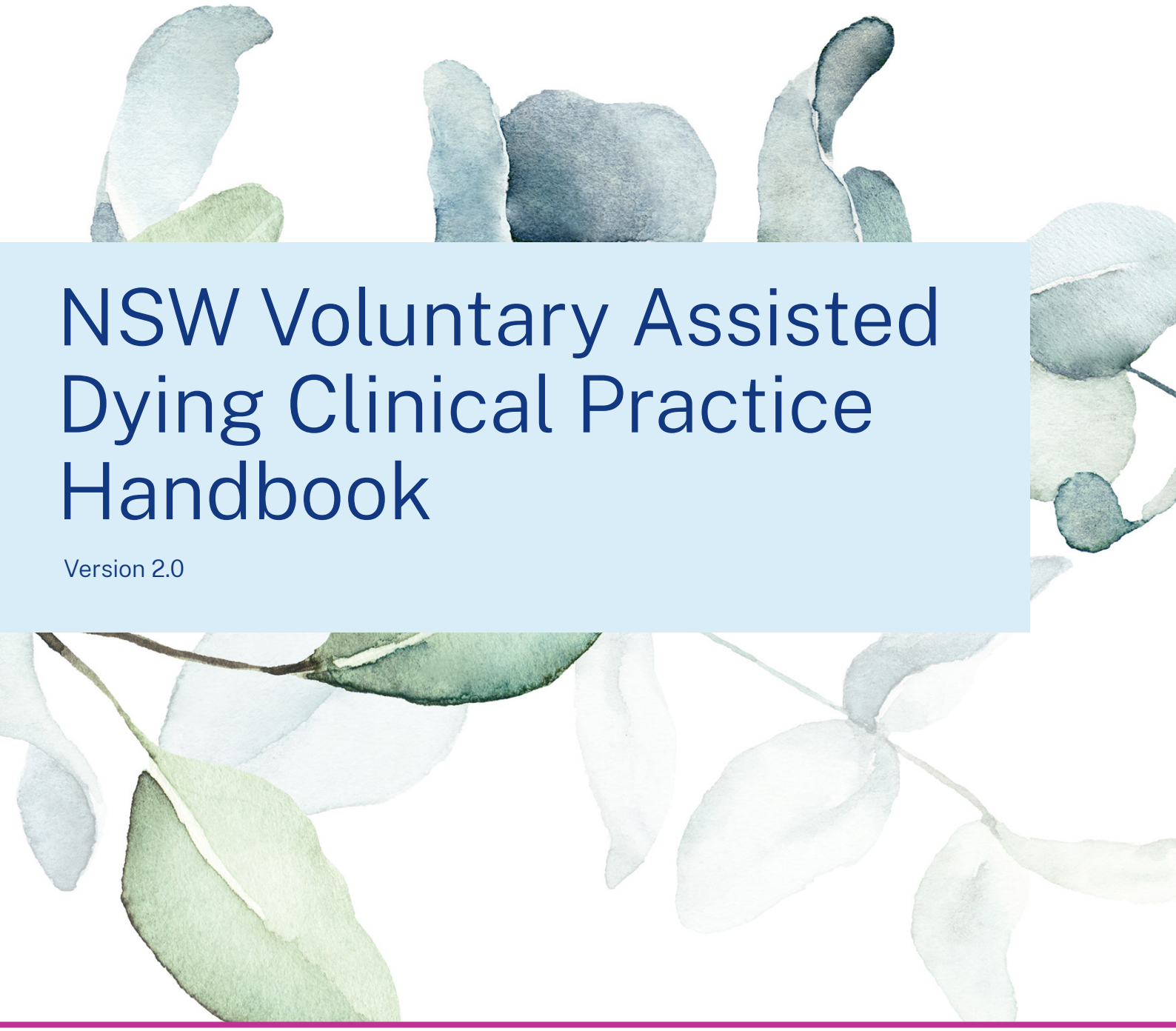
NSW Health

NSW Voluntary Assisted Dying Clinical Practice Handbook

Version 2.0



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SHPN (OCHO) 230964
ISBN 978-1-76023-693-9

Version control

Version	Release date	Details
2.0	28 November 2023	Approved by NSW Health Secretary
1.0	9 October 2023	Approved by NSW Health Secretary

Contents

1 Acknowledgements

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The NSW Voluntary Assisted Dying Clinical Practice Handbook was drafted in consultation with the NSW Voluntary Assisted Dying Clinical Advisory Group.

Some of the content has been extracted or adapted, with permission, from:

- The Western Australian Voluntary Assisted Dying Guidelines, from the End of Life Care Program, WA Department of Health
- The Queensland Voluntary Assisted Dying Handbook version 2.0, from Queensland Health
- The *Voluntary Assisted Dying for Medical Practitioners* mandatory training package developed by Flinders University for SA Health

With permission, some of the content in this document is also adapted from resources created by the Australian Centre for Health Law Research, Queensland University of Technology.

2 Background

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2.1 About this document

The NSW Voluntary Assisted Dying Clinical Practice Handbook (the Handbook) outlines the voluntary assisted dying process in NSW and the roles and responsibilities of key stakeholders supporting a person through voluntary assisted dying.

The Handbook is intended for use primarily by medical practitioners and nurse practitioners who meet the professional qualifications and eligibility requirements to act as coordinating, consulting or administering practitioners and who have completed the approved voluntary assisted dying training. These practitioners are collectively referred to as authorised voluntary assisted dying practitioners (authorised practitioners).

The Handbook aims to support authorised practitioners to understand the voluntary assisted dying process in NSW, their roles and responsibilities and how to comply with the Voluntary Assisted Dying Act 2022 (the Act).

The Handbook may also be a useful reference tool for:

- local health districts and public or private health or care facilities.
- other health professionals involved in the voluntary assisted dying process or providing care for a patient accessing, or considering accessing, voluntary assisted dying.

For authorised practitioners, sections of this document should be read in conjunction with the NSW Voluntary Assisted Dying Prescription and Administration Handbook (the Prescription and Administration Handbook). The Prescription and Administration Handbook is only available for authorised practitioners, and will be supplied upon successful completion of the online assessment component of mandatory training.

Information and guidance in the Handbook is general in nature and is not a substitute for the Act. Practitioners should exercise individual clinical judgment and best practice care when providing voluntary assisted dying services in NSW. Authorised practitioners and other healthcare workers involved in voluntary assisted dying are encouraged to read the Act and need to familiarise themselves with any local processes or procedures of the district or facility where they practice.

The Handbook outlines the:

- steps involved in voluntary assisted dying,
- roles and responsibilities of key stakeholders, and
- functions of the NSW Voluntary Assisted Dying Support Services, including the NSW Voluntary Assisted Dying Care Navigator Service (VAD-CNS) and the NSW Voluntary Assisted Dying Pharmacy Service (VAD-PS).

This handbook has been approved by the NSW Health Secretary under section 181 of the Act and are the guidelines for the purpose of that section.

2.2 Key definitions

The table below provides definitions for a selection of key terms relevant for this Handbook and the broader process of voluntary assisted dying. This is not an exhaustive list. Further definitions can be found in the Act or related legislation.

Term	Definition
Administering practitioner (relevant for practitioner administration only)	The authorised voluntary assisted dying practitioner responsible for administering the voluntary assisted dying substance to a patient who has chosen practitioner administration and has followed all the required steps in the process, including obtaining a substance authority from the Voluntary Assisted Dying Board. The coordinating practitioner is by default the patient's administering practitioner, but the role can be transferred after the prescription step.
Administration decision	This refers to a patient's choice to either self-administer the voluntary assisted dying substance (self-administration decision), or have it administered to them by an administering practitioner (practitioner administration decision).
Agent of the patient	A person who acts on behalf of the patient.
Authorised disposer	A registered health practitioner who is authorised by the Secretary to dispose of the voluntary assisted dying substance.
Authorised voluntary assisted dying practitioner (authorised practitioner)	Although not used in the Act, for the purposes of this Handbook this term refers to medical and nurse practitioners who meet the professional experience eligibility requirements in the Act and who have completed the approved voluntary assisted dying training. *Note: Some authorised practitioners will only be eligible to undertake the role of administering practitioner* (*7.1 Practitioner eligibility and roles under the Act*).
Authorised supplier	A registered health practitioner who is authorised by the Secretary to supply the voluntary assisted dying substance.
Carriage service	Electronic method of communication, including telephone, internet, email, fax or videoconference.
Care navigator	An employee of the NSW Voluntary Assisted Dying Care Navigator Service who can provide support, assistance and information relating to voluntary assisted dying.
Consulting assessment	The second of two eligibility assessments of a patient to determine their eligibility to access voluntary assisted dying, conducted by the patient's consulting practitioner, following the coordinating practitioner assessing the patient as eligible.
Consulting practitioner	The authorised voluntary assisted dying practitioner responsible for undertaking the consulting assessment for the patient. *Note: The consulting practitioner must be a medical practitioner* (*7.1 Practitioner eligibility and roles under the Act*).

Term	Definition
Contact person	A person appointed (via the ***Contact Person Appointment Form***) by a patient who has made a self-administration decision, to undertake specific activities described in the Act, such as returning unused or remaining voluntary assisted dying substance to an authorised disposer and notifying the patient's coordinating practitioner of the patient's death.
Coordinating practitioner	The authorised voluntary assisted dying practitioner who accepts a patient's first request for voluntary assisted dying and is responsible for assessing and supporting the patient throughout the voluntary assisted dying process. *Note: The coordinating practitioner must be a medical practitioner (7.1 Practitioner eligibility and roles under the Act).*
Designated period	The designated period is the period after a patient's first request, during which time a patient cannot make their final request (unless certain conditions apply). The designated period starts on the day of the first request and ends five days after that day.
Disability	Disability, in relation to a person, includes a long-term physical, psychiatric, intellectual or sensory impairment that, in interaction with various barriers, may hinder the person's full and effective participation in the community on an equal basis with others (Disability Inclusion Act 2014 s.7).
Enduring request	The request is lasting over time. To ensure that the request is enduring, the Act requires that the request for voluntary assisted dying be made at three different points of time (First Request, Written Declaration and Final Request).
Final request	A clear and unambiguous request for access to voluntary assisted dying, made by the patient to their coordinating practitioner. This can occur any time after the patient makes a ***Written Declaration***, and is the last of three formal requests for access to voluntary assisted dying that are required during the request and assessment process.
Final review	The review conducted by the coordinating practitioner after receiving the patient's final request. This is the final step in the request and assessment process and is required for the coordinating practitioner to confirm the process has been completed in accordance with the Act.
First assessment	The first of two eligibility assessments of a patient to determine their eligibility to access voluntary assisted dying, conducted by the patient's coordinating practitioner.
First request	A clear and unambiguous request for access to voluntary assisted dying, made to a medical practitioner during a medical consultation, by the patient themselves. This is the first of three formal requests for access to voluntary assisted dying that are required during the request and assessment process.
Healthcare worker	A registered health practitioner or a person who provides health services or professional care services.
Medical Certificate of Cause of Death (MCCD)	The form in which a medical practitioner responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, notifies the Registrar of the Registry of Births, Deaths & Marriages of a death and the cause of that death.

Term	Definition
Medical practitioner	A registered medical practitioner.
Mental health impairment	A person has a mental health impairment if – (a) the person has a temporary or ongoing disturbance of thought, mood, volition, perception or memory, and (b) the disturbance would be regarded as significant for clinical diagnostic purposes, and (c) the disturbance impairs the emotional wellbeing, judgment or behaviour of the person (Mental Health and Cognitive Impairment Forensic Provisions Act 2020 s.3).
Nurse practitioner	A person registered under the Health Practitioner Regulation National Law to practise in the nursing profession whose registration is endorsed as being qualified to practise as a nurse practitioner.
NSW Voluntary Assisted Dying Care Navigator Service (VAD-CNS)	The Voluntary Assisted Dying Care Navigator Service provides support, assistance and information in relation to voluntary assisted dying to entities involved with voluntary assisted dying in NSW. This includes patients, the family, friends and carers of patients, health practitioners and residential facility managers and employees.
NSW Voluntary Assisted Dying Pharmacy Service (VAD-PS)	The Voluntary Assisted Dying Pharmacy Service is responsible for coordinating the safe procurement, supply and disposal of voluntary assisted dying substances across NSW.
NSW Voluntary Assisted Dying Portal (the Portal)	The Portal is a secure online platform used for the management of requests and submission of required documentation for voluntary assisted dying in NSW.
NSW Voluntary Assisted Dying Support Service	This refers to the three inter-linked operational services hosted by Northern Sydney Local Health District to support voluntary assisted dying activity across NSW. It includes the: • NSW Voluntary Assisted Dying Access Service (providing medical outreach support) • NSW Voluntary Assisted Dying Care Navigator Service • NSW Voluntary Assisted Dying Pharmacy Service
Palliative care and treatment	Care and treatment that – (a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting, and (b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering to improve their comfort and quality of life.
Practitioner administration	Administration of a voluntary assisted dying substance by an administering practitioner.
Pressure or duress	Includes abuse, coercion, intimidation, threats and undue influence.

Term	Definition
Professional care services	As per the Act, professional care services means any of the following provided to another person under a contract of employment or a contract for services – (a) assistance or support, including the following – (i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals, (ii) assistance for persons with mobility problems, (iii) assistance for persons who are mobile but require some form of assistance or supervision, (iv) assistance or supervision in administering medicine, (v) the provision of substantial emotional support, (b) providing support or services to persons with a disability.
Request and assessment process	This consists of the following steps in the voluntary assisted dying process: • The first request, • The first assessment, • The consulting assessment, • The written declaration, • The final request, and • The final review.
Self-administration	Administration of a voluntary assisted dying substance by the patient themselves.
Supreme Court	The Supreme Court is the highest court in NSW. It may, upon application, review certain decisions made during the voluntary assisted dying process.
Telehealth	The delivery of health care at a distance using technological communication tools such as web-based videoconferencing. *Note: That for the purposes of this Handbook, telehealth refers to methods of telehealth that are audiovisual, where the practitioner can see and hear the patient simultaneously.*
Voluntary assisted dying	The administration of a voluntary assisted dying substance and steps reasonably related to the administration.
Voluntary Assisted Dying Act 2022 **(the Act)**	The legislation (NSW) that legalises and governs voluntary assisted dying in NSW.
Voluntary Assisted Dying Board (the Board)	An independent advisory and decision-making body established by the Act to perform functions related to voluntary assisted dying, such as monitoring the operation of the Act and making decisions to approve or refuse applications for voluntary assisted dying substance authorisations.
Voluntary assisted dying process	The process from the first request step until the notification of death.
Voluntary assisted dying substance	A Schedule 4 or Schedule 8 poison approved by the Health Secretary for use under the Act for the purpose of causing a patient's death.

Term	Definition
Witness to substance administration (only relevant for practitioner administration)	The person in whose presence the voluntary assisted dying substance is administered, and who certifies in the ***Practitioner Administration Form*** that the patient's request for access to voluntary assisted dying appeared to be free, voluntary and enduring. This person must meet eligibility criteria. More information can be found in Administering the voluntary assisted dying substance *Appendix 2*.
Witness to written declaration	A person in whose presence a patient completes their ***Written Declaration*** and who certifies in the ***Written Declaration*** that in their presence, the patient appeared to freely and voluntarily sign the declaration. This person must meet the eligibility criteria. More information can be found in *Appendix 2*.
Written declaration	The formal written request for access to voluntary assisted dying, made by the patient on the approved ***Written Declaration*** form, in the presence of two eligible witnesses. The written declaration can only be completed after the consulting assessment in which the patient has been found to be eligible for voluntary assisted dying. This is the second of three formal requests for access to voluntary assisted dying that are required during the request and assessment process.

3 Voluntary assisted dying in NSW

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3.1 Background to the *Voluntary Assisted Dying Act 2022*

The Voluntary Assisted Dying Bill 2021 (the Bill) was introduced to NSW Parliament on 14 October 2021. The Bill was passed on 19 May 2022 before being assented on 27 May 2022.

Under the *Voluntary Assisted Dying Act 2022* (the Act), eligible people have the choice to access voluntary assisted dying in NSW from 28 November 2023.

3.2 Principles of voluntary assisted dying in NSW

The Act sets out principles of voluntary assisted dying in NSW.

A person exercising a power or performing a function under the Act must have regard to the following principles:

- every human life has equal value,
- a person's autonomy, including autonomy in relation to end of life choices, should be respected,
- a person has the right to be supported in making informed decisions about the person's medical treatment and should be given, in a way the person understands, information about medical treatment options, including comfort and palliative care and treatment,
- a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life,
- a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained,
- a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding the person's care, treatment and end of life should be encouraged and promoted,
- a person should be supported in conversations with the person's health practitioners, family, carers and community about care and treatment preferences,
- a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,
- a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and high quality care and treatment, including palliative care and treatment, as a person who lives in a metropolitan region,
- there is a need to protect persons who may be subject to pressure or duress,
- all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

3.3 Eligibility criteria for access to voluntary assisted dying

The Act outlines strict eligibility criteria for access to voluntary assisted dying. A person must meet all criteria to be considered eligible.

To be eligible for access to voluntary assisted dying, the person must:

- Be an adult (18 years and older), who is an Australian citizen or a permanent resident of Australia or who has been resident in Australia for at least three continuous years,
- Have been ordinarily resident in NSW for at least 12 months (noting the Voluntary Assisted Dying Board may consider a residency exemption on compassionate grounds for a person with a substantial connection to NSW),
- Have at least one disease, illness or medical condition that:
    a. Is advanced and progressive,
    b. Will, on the balance of probabilities, cause their death within six months (or within 12 months for neurodegenerative diseases like motor neurone disease), and
    c. Is causing the person suffering that cannot be relieved in a way the person considers tolerable,
- Have decision-making capacity in relation to voluntary assisted dying,
- Be acting voluntarily and without pressure or duress, and
- Have an enduring request for access to voluntary assisted dying.

The Act specifies that a person is not eligible merely because they have disability, dementia or a mental health impairment.

3.4 Protections and offences under the Act

The Act provides a detailed framework with many safeguards to ensure that accessing voluntary assisted dying is safe and appropriate. It outlines specific protections and offences relating to voluntary assisted dying, that practitioners should be aware of.

The Board has a role in referring matters on voluntary assisted dying to people or bodies including the Police Commissioner, Australian Health Practitioner Regulation Agency or the Health Care Complaints Commissioner.

When providing voluntary assisted dying services, practitioners must consider all other applicable legislation as well as codes of conduct, scopes of practice and other professional boundaries and obligations that exist outside the Act.

3.4.1 Protections

The Act outlines specific protections from liability for individuals undertaking activities under or relating to the Act.

These include:

- A person does not incur criminal liability if they:
  - In good faith, assist another person to request access to, or access, voluntary assisted dying in accordance with the Act, or
  - Are present when another person self-administers, or is administered, a voluntary assisted dying substance in accordance with the Act.
- If a person in good faith and with reasonable care does a thing in accordance with the Act, or believing on reasonable grounds they have done the thing in accordance with the Act:
  - The person will not incur civil liability or criminal liability under the Act for doing the thing, and
  - The thing the person has done will not be regarded as a contravention of professional ethics, standards, or principles of conduct applicable to the person's employment, or
  - The thing the person has done will not be regarded as unsatisfactory professional conduct or professional misconduct under the Health Practitioner Regulation National Law.

A reference above to doing a thing includes a reference to omitting to do a thing.

- Despite any other law, a medical practitioner may refer a patient to another person under the Act and make a request for a copy of the patient's medical records or other information about the patient to another person under the Act. A person to whom a referral was made may despite any other law examine the patient to whom the referral relates and give the medical practitioner who referred the patient copies of the patient's medical records.
- A protected person is not liable if they, in good faith, do not administer lifesaving treatment to another person where:
  - the other person has not requested the lifesaving treatment, and
  - the protected person reasonably believes the other person is dying after administration of a prescribed substance in accordance with the Act.

The failure to administer lifesaving treatment in this circumstance does not constitute:

- professional negligence or another contravention of a duty of care that would incur professional liability, or
- a contravention of professional ethics or standards or a departure from accepted standards of professional conduct, or
- unsatisfactory professional conduct or professional misconduct for the purposes of the Health Practitioner Regulation National Law, or
- a contravention of principles of conduct applicable to the protected person's employment.

In this situation, protected person means –

(a) a registered health practitioner, or

(b) an ambulance officer, or

(c) a person, other than a person referred to in paragraph (a) or (b), who has a duty to administer lifesaving treatment to another person.

3.4.2 Offences

Part 7 of the Act outlines specific offences under the Act. These include offences relating to:

- The requirement for an authorised supplier to cancel any document presented as a voluntary assisted dying substance prescription that does not comply with this Act, and notify the Health Secretary in writing.
- Contact persons giving unused or remaining prescribed substance to an authorised disposer no later than 14 days after the day of the patient's death or the day of revocation of a self-administration decision.
- Recording, use or disclosure of information obtained by a person because of a function under the Act, except where permitted by the Act.
- Publication of personal information concerning a proceeding before the Supreme Court.

Offences relating to or that may apply to voluntary assisted dying, are also contained in legislation other than the *Voluntary Assisted Dying Act 2022*, and practitioners will need to be mindful of these. These include offences under the Crimes Act 1900, such as:

- it is a crime to administer a voluntary assisted dying substance to another person unless authorised to do so,
- a person commits a crime if they, by dishonesty, pressure or duress, induce another person to:
  - request access to voluntary assisted dying,
  - access voluntary assisted dying, or
  - self-administer a voluntary assisted dying substance.
- it is an offence to make a statement or give information the person knows is false or misleading, or omit anything without which the statement is misleading, for any purpose or requirement under the *Voluntary Assisted Dying Act 2022*.

Authorised practitioners should be aware that other offences apply in relation to the voluntary assisted dying process, for example, failure to submit forms to the Voluntary Assisted Dying Board as required. More information can be found in the Act.

3.5 The Voluntary Assisted Dying Board

The Voluntary Assisted Dying Board (the Board) is an independent advisory and decision-making body established by the Act. The Board has a range of functions, including:

- making decisions to approve or refuse applications for voluntary assisted dying substance authorities
- making decisions to approve or refuse applications for residency exemptions
- providing annual reports on the operation of the Act to the Minister for Health
- collecting statistical information about voluntary assisted dying in NSW
- conducting analysis and research in relation information given to the Board under the Act
- making referrals for investigations of suspected breaches of the Act.

The Board is made up of five members jointly appointed by the Minister for Health and Attorney General. The members include two senior legal practitioners, two medical practitioners, and one member with knowledge, skills or experience relevant to the Board's functions.

Under the Act, forms completed by practitioners and patients throughout the process must be submitted to the Board. Submission is via the NSW Voluntary Assisted Dying Portal (the Portal). An overview of the forms that are submitted are at *Appendix 3*. For more information on the Portal, see section below.

The Board is supported by a secretariat team (the Board Secretariat) situated within the Ministry of Health.

3.6 The NSW Voluntary Assisted Dying Portal

The NSW Voluntary Assisted Dying Portal (the Portal) is a secure online platform used for the management of requests and submission of required documentation for voluntary assisted dying in NSW.

The Portal is for health practitioners, where they can:

- Register to be an authorised practitioner and access the mandatory training to become an authorised voluntary assisted dying practitioner.
- Complete and submit required forms to the Board. This includes applying for authorisation from the Board to prescribe a voluntary assisted dying substance for a patient.

Self-guided Portal training will be provided via the Portal's Resource Hub once the practitioner is granted access to the Portal. Patients do not have access to the Portal.

By submitting forms via the Portal, a health practitioner is submitting the forms to the Board. Under the Act, the Board must notify of the receipt of forms submitted, which is done in two ways via the Portal; an email confirmation is sent to the practitioner, and a pdf receipt is displayed and downloadable from the submission page.

Any questions can be referred to the VAD-CNS.

3.7 Completing the voluntary assisted dying process in NSW

Although voluntary assisted dying is available in Australian states other than NSW, legislation differs in each jurisdiction. The *Voluntary Assisted Dying Act 2022* interacts with other laws in NSW to afford certain protections to NSW residents and practitioners in relation to voluntary assisted dying. However, these protections are only available if the entire process is undertaken within NSW. For patients going through the NSW voluntary assisted dying process, every step of the process must occur in NSW for the protections from liability under the *Voluntary Assisted Dying Act 2022* and other legislation to apply. This means that both the patient and the authorised practitioner must be physically in NSW for each step. The same rules apply for patients in border regions outside NSW who obtain a residency exemption to go through the process in NSW.

One of the principles of the Act is that a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and high-quality care and treatment, including palliative care and treatment, as a person who lives in a metropolitan region. The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) may be available for patients to attend appointments required as part of the voluntary assisted dying process. Further information for practitioners and patients on how to access this is available on the NSW Health voluntary assisted dying website.

4 Communicating about voluntary assisted dying

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4.1 Implications of the *Commonwealth Criminal Code Act 1995*

Sections 474.29A and 474.29B of the *Commonwealth Criminal Code Act 1995* (Commonwealth Criminal Code) contain offences related to using a carriage service to disseminate or access suicide related material. A carriage service is an electronic means of communication (including telehealth, telephone, fax, email, internet webpage or a videoconference). Suicide related material is material that directly or indirectly:

- counsels or incites committing or attempting to commit suicide, or
- promotes, or provides instruction on, a particular method of committing suicide.

While the *Voluntary Assisted Dying Act 2022* provides that voluntary assisted dying is not suicide for the purposes of NSW law, it is not clear whether voluntary assisted dying would be considered suicide for the purposes of the Commonwealth Criminal Code. Because of this, there are risks of breaching the Commonwealth Criminal Code if certain discussions about voluntary assisted dying occur via carriage service, in particular, discussions about:

- potential risks of administering the voluntary assisted dying substance, and
- making a plan for the administration of the voluntary assisted dying substance.

This means that some steps in the voluntary assisted dying process should occur in person, including the first assessment, the consulting assessment, the administration decision and other steps of the process where the practitioner or patient wishes to provide or discuss the information mentioned in the paragraph above.

Where an interpreter is required during any discussions that may be at risk of breaching the Commonwealth Criminal Code, the interpreter should also attend in person.

Practitioners should advise patients going through the voluntary assisted dying process that it may be unlawful to hold certain discussions via telehealth.

Subject to the Commonwealth Criminal Code restrictions mentioned above, good clinical practice should always guide decision-making where voluntary assisted dying is concerned, including when deciding if it is appropriate to use telehealth. Practitioners also need to be aware that where telehealth **is used** in the voluntary assisted dying process, it must be conducted via a means that includes visual technology as well as audio, in order to comply with the Voluntary Assisted Dying Act. That is, via video conference so that the practitioner can see the patient as well as hear them.

Throughout this Handbook, warning boxes have been incorporated into each chapter providing guidance on how practitioners may mitigate the risk of potential breaches of the Commonwealth Criminal Code.

4.2 Healthcare worker obligations

A patient may choose to discuss voluntary assisted dying with any healthcare worker. In NSW, all healthcare workers are allowed to answer questions and provide information to a patient who initiates a discussion about voluntary assisted dying. However, healthcare workers should only provide information which is commensurate with their level of expertise and understanding of the process. If a healthcare worker does not feel confident or comfortable answering a patient's questions, they can refer the patient to the VAD-CNS, or another appropriate person, for example, a facility or district coordinator if applicable.

A healthcare worker cannot initiate a discussion about voluntary assisted dying with a person who may be eligible unless they comply with legal obligations to discuss certain things with the patient in the same conversation. These differ for medical practitioners and other healthcare workers.

A medical practitioner **can only initiate a discussion** about voluntary assisted dying or suggest it as an option to a person **if in the same discussion**, they also advise of:

- Standard treatment options and their likely outcomes for the disease, illness or medical condition with which the person has been diagnosed, and
- Palliative care and treatment options and their likely outcomes.

Additional obligations of medical practitioners can be found in the section below.

Any other healthcare worker **can only initiate a discussion** about voluntary assisted dying or suggest it as an option to a person **if in the same discussion**, they also advise that:

- Palliative care and treatment options are available, and
- The person should discuss the palliative care and treatment options with their medical practitioner.

During conversations about voluntary assisted dying, healthcare workers should be cognisant of their clinical role and the scope of their clinical practice to ensure professional conduct in line with the *Health Practitioner Regulation National Law*. A factsheet outlining the *obligations of healthcare workers* is also available, for healthcare workers who are not authorised practitioners.

4.2.1 Responding to enquiries from ineligible patients before they make a first request

Some patients who request information about voluntary assisted dying may be clearly and unequivocally ineligible for voluntary assisted dying, for example, if they are under 18 years of age, or if they do not have a life-limiting disease, illness or medical condition. In these circumstances, the discussion should be given the same respect and consideration as all end of life discussions. However, the healthcare workers should ensure they respond in a way that manages the patient's expectations, and clearly, but sensitively, explains why voluntary assisted dying is not an option for the patient.

Allowing a patient who is clearly ineligible for voluntary assisted dying to progress to a first request may be more difficult for the patient than having a clear, compassionate discussion prior to the enquiry progressing to a first request. A discussion about voluntary assisted dying with a patient in this situation may also indicate that the patient requires other support or counselling. Further support should be considered for every patient in this circumstance.

4.3 Use of interpreters in the voluntary assisted dying process

Interpreters can be used by a patient during any stage of the voluntary assisted dying process. Discussions about voluntary assisted dying should occur with the patient, interpreter and practitioner present.

Interpreters used during the formal steps of voluntary assisted dying process must be:

- credentialled by the National Accreditation Authority for Translators and Interpreters Ltd (NAATI), or
- accredited by the NSW Health Care Interpreter Service (HCIS) to interpret for voluntary assisted dying.

In addition to the above, an interpreter for voluntary assisted dying must not:

- Be a family member of the patient
- Know or believe that they are a beneficiary under the will of the patient
- Know or believe they may benefit from the death of the patient, financially or otherwise, except for reasonable fees for the provision of their services
- Be an owner or manager at a health facility providing services to a patient
- Be someone who is providing health services or professional care services to the patient

4.3.1 Preparing for an appointment with an interpreter

It is the practitioner's responsibility to arrange an interpreter when required.

Where steps of the voluntary assisted dying process need to occur in person to minimise the risk of breaching the Commonwealth Criminal Code, any interpreter should attend the consultation in person (see section *4.1 Implications of the Commonwealth Criminal Code Act 1995*).

The practitioner should prepare for the appointment by considering:

- If the interpreter will attend in person, the seating and space arrangements to allow for the interpreter's presence
- If the interpreter will attend via telehealth, appropriate technology to support a telephone or videoconference appointment (including speaker phone if needed)
- How much time is allowed for the appointment, given the additional time needed to interpret.

When booking an interpreter, practitioners must:

- Include in the booking request that the interpreter is needed for interpreting related to voluntary assisted dying. This is so that the interpreter is aware of the nature of the interpreting required.
- State the level of urgency in the booking request.
- Confirm if the appointment will be in person or via telehealth.

4.3.2 During the appointment

It is also the clinician's responsibility to manage the appointment and to ensure that the patient has understood what has been communicated.

When completing mandatory forms on the Portal,

practitioners must record the interpreter's:

- name,
- contact details, and
- NAATI practitioner number or NSW Health Stafflink number (for interpreters from HCIS without NAATI credentials).

4.3.3 How to contact an interpreting service

NSW Health practitioners

A practitioner employed by NSW Health should contact their local HCIS to arrange an interpreter. For contact details and the area of coverage please visit *NSW Health Care Interpreter Services*.

Non-NSW Health practitioners

Non-NSW Health practitioners must ensure a **NAATI credentialled interpreter is used**.

Spoken language interpreters can be engaged through *Translating and Interpreting Service National* (TIS National). Interpreters for Auslan and sign language interpreting for Deaf, deafblind and hard of hearing patients can be engaged through *Deaf Connect* and *National Auslan Booking System* (NABS).

4.3.4 Forms that need to be completed by patients

Patients who wish to continue the voluntary assisted dying process after being found to be eligible during a consulting assessment will need to complete a ***Written Declaration*** before the final request stage of the voluntary assisted dying process. Patients who choose self-administration will also need to complete a ***Contact Person Appointment Form***.

Both the ***Written Declaration*** and the ***Contact Person Appointment Form*** have been translated into a number of languages to be used as guides, and these translation guides and the official ***Written Declaration*** and the ***Contact Person Appointment Form*** will be provided to the patient by the patient's practitioner. The practitioner can access the translation guides on the Portal.

If the ***Written Declaration*** or the ***Contact Person Appointment Form*** is not available in the patient's required language, an interpreter will be asked to sight translate it for the patient. If the interpreter agrees to provide sight translation of the ***Written Declaration***, they will need to certify on the document that they have provided a true and correct translation. If the interpreter does not agree to provide sight translation, a translator should be arranged by the practitioner via their local HCIS or TIS National.

4.4 Communication in health care

Health care communication is rapidly being recognised as a skill that can be taught and improved upon. While it is recognised that all healthcare workers should engage in communication training, discussions at end of life are often more challenging. Some guiding principles are outlined below. However, this list is in no way exhaustive, but rather provides some ideas for reflection.

As outlined by Paget et al. (2011), the basic principles of patient-clinician communication skills include:

- Mutual respect
- Shared understanding of patient goals
- A supportive environment
- Appropriate decision partners
- Provision of the right information
- Transparency and full disclosure
- Continuous learning

Communication skills can be broken down into three different types of communication (Kurtz, 2002):

1. Content: What you say
2. Process: How you say it
3. Perception: What you are thinking and feeling

All difficult and "breaking bad news" conversations require skilled communication and knowledge, and those on the topic of voluntary assisted dying are no different. These conversations may occur over many consultations, or just one.

Key principles when considering or being involved in difficult conversations may include:

- Ensuring that you have a safe environment and have allowed time and privacy to engage in that conversation.
- Planning what you as the clinician need to cover in the conversation (agenda setting), and also ensuring that the patient's agenda is identified early so that they are ready to receive the new information.
- Establishing the patient's preference for how much information should be given and how they would like it to be delivered.
- Checking if any support people should be present for the conversation.
- Recognising that virtual communication may require different techniques to convey empathy, body language and to sit comfortably with silence.
- Finding out the person's understanding of their healthcare situation. This will give the clinician insight into health literacy and understanding. It will also assist with setting expectations.
- Ensuring that the conversation is an interaction not just a transmission of information (Paget, 2011).
- Exploring what is important to the person and ensuring that it is addressed.
- Actively listening with compassion, empathy and curiosity, which may assist in building rapport and a sense of safety for both the patient and clinician.

Some tips that may be useful to include (Silverman, 2005):

- "Chunk and Check" is a communication technique involving breaking down the information into small manageable segments that can be used. In between each segment, practitioners should check for understanding and give the opportunity for the patient to ask questions.
- The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health (for further information about the teach-back method, see *Home – TeachBackTraining*).
- When delivering bad news, pause, and allow the patient to digest that information.
- The clinician does not have to do all the talking, allow moments of silence and reflection.
- Tone, body language, pace of delivery, and use of appropriate and non-medical jargon and language will all impact the effectiveness of communication.
- At the end of the conversation, ensure that a plan is developed. A summary is important to help the patient understand what will happen next.
- The patient and or carers should know how to contact the clinician for more information or clarification.
- Ensure the patient has any referrals to support services that may be of benefit.

Further resources that may assist to further improve communication skills include:

- *PREPARED communication framework*
- *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*
- End of life Essentials: *End-of-Life Essentials (endoflifeessentials.com.au)*
- Vital Talk: *Home – VitalTalk*
- Deakin University Centre for Organisational Change in Person Centred Healthcare: Courses and Events – *Centre for Organisational Change in Person-Centred Healthcare (deakin.edu.au)*
- Australian National University: Institute for Communication in Health Care: *Institute for Communication in Health Care | School of Literature, Languages and Linguistics (anu.edu.au)*

4.5 Documenting in the medical record

The Act outlines certain information that must be recorded in a patient's medical record at certain stages of the voluntary assisted dying process. These are recorded in *Table 1*. Although the Act specifically details this, it does not remove the requirement for clinical encounters to be well-documented, and practitioners must still comply with usual processes for medical record-keeping, and other documentation requirements, such as those under:

- The *Health Records and Information Privacy Act 2002* No 71 2016
- *Health Practitioner Regulation (New South Wales) Regulation*
- *Poisons and Therapeutic Goods Act 1966*
- Professional Code of Conduct,
- The NSW Health Policy Directive *Health Care Records – Documentation and Management* (for the public health system),
- local policies and procedures.

Table 1. Mandatory documentation in the medical record throughout the voluntary assisted dying process

Step of the process	Minimum documentation in the medical record required under the Act
First request	Any medical practitioner who receives a first request must record in the patient's medical record: • The first request • The practitioner's decision to accept or refuse the first request, • If the request is refused, the reason for refusal, and • Whether the practitioner has given the patient the first request patient information *Note: The **first request patient information** is not required to be provided to the patient if the practitioner has a conscientious objection to voluntary assisted dying.*
Referral for consulting assessment	Any medical practitioner who receives a referral for a consulting assessment must record in the patient's medical record: • The referral, • The practitioner's decision to accept or refuse the referral, and • If the referral is refused, the reason for refusal.
Written declaration	A coordinating practitioner who receives a ***Written Declaration*** from a patient must record in the patient's medical record: • the date the written declaration was made, and • the date the written declaration was received by the coordinating practitioner.
Final request	A coordinating practitioner who receives a final request from a patient must record in the patient's medical record: • the date the final request was made, and • if the final request was made before the end of the designated period – the reason for the final request being made before the end of the period.
Administration decision	Making an administration decision: • If a patient makes an administration decision, the coordinating practitioner must record the administration decision in the patient's medical record. Revoking an administration decision: • If a patient revokes an administration decision, the coordinating or administering practitioner who is informed of the decision must record the revocation in the patient's medical record.
Transfer of the administering practitioner role	If the role of administering practitioner is transferred, the original administering practitioner must record the role transfer in the patient's medical record.
Transfer of the coordinating practitioner role	If the role of coordinating practitioner is transferred, the original coordinating practitioner must record the role transfer in the patient's medical record.

5 Voluntary assisted dying in the context of end of life care

5

5.1 Overview

This chapter provides information about voluntary assisted dying in the context of end of life care, and guidance regarding the roles and legal obligations of health practitioners.

Voluntary assisted dying is a legal choice from 28 November 2023 for eligible people approaching the end of their life in NSW. It offers patients an additional choice regarding their care, alongside the options they already have, namely the treatments they wish to receive; preferences included in their advance care planning; involvement of palliative care; the place in which they would prefer to be cared for and to die; and the people whom they would like to involve in some or all of their care. Choosing voluntary assisted dying does not replace other care and treatment choices a person might make.

5.2 Legislative requirements

The Act articulates principles that reflect best practice in ethical conduct. A person deciding about voluntary assisted dying must be given, in a way that they can understand, information about their condition, their medical treatment options, their likely prognosis and outcomes with different treatment options, and the ways in which palliative care can alleviate suffering.

5.3 Palliative and end of life care

Palliative care belongs within the care continuum and is provided up to and including the final year of life. Although it is not possible to predict with complete accuracy, the end of life phase is typically considered to cover the period in which death is likely within 12 months. Palliative care extends into this final phase of life and needs to remain responsive, coordinated, and flexible according to patients' needs.

End of life care is care delivered to people who have a life-limiting illness, as well as their families and carers. It includes all the care that a person requires when death is imminent (e.g., following a catastrophic event such as an accident or stroke) or when a patient has an advanced incurable illness such as cancer or motor neurone disease. It also refers to care for patients who have existing conditions likely to cause death, which may include but is not limited to, end-stage cardiac or respiratory failure, or people who are generally frail, with multiple co-morbidities.

Patients may decide to forego life-sustaining treatment when such treatment offers little or no benefit, or they may decide to forego artificial hydration. Neither of these decisions constitutes voluntary assisted dying, and nor does administering judiciously titrated medication that is proportional to symptoms. Voluntary assisted dying is not set in motion until an eligible person makes a clear and unambiguous formal first request for medical help to end their life.

The provision of voluntary assisted dying is not part of palliative care, but nor are they exclusive of each other. Healthcare workers are free to decide whether to participate in, or refrain from participating in, voluntary assisted dying. Healthcare workers must continue to provide high quality and compassionate care regardless of a patient's choice in relation to voluntary assisted dying, always acting in accordance with their own professional or personal ethical values and scope of practice.

5.4 The distinction between palliative care and voluntary assisted dying

Palliative care is patient and family-centred care designed to enhance each patient's quality of life by minimising illness-related suffering. Palliative care is explicitly recognised as a human right, the goal of which is to help people with a life-limiting illness to live life as fully and comfortably as possible.

Voluntary assisted dying is not within the scope of palliative care. If a voluntary assisted dying pathway is chosen, palliative care can continue.

Palliative care responds to individuals' needs, recognising that the patient's physical, social, psychological, cultural and/or spiritual needs are often more relevant to overall care than prognosis alone. Palliative care is not designed to hasten or postpone death; it both affirms life and recognises dying as a natural process. Palliative care and disease-modifying therapies are not mutually exclusive and can be delivered at the same time.

Evidence supports the early integration of palliative care in the course of any life-limiting illness to improve symptom control, functional status, and quality of life. Palliative care is delivered on the basis of patients', families' and carers' needs. An individual's choice to explore voluntary assisted dying should never be a choice based on a lack of access to palliative care, or other approaches to supportive care.

Palliative care is applicable in all healthcare settings, whether a place of residence or an institution, and at all levels (primary to tertiary). It is best delivered by a multidisciplinary team. In complex cases, it may be appropriate to refer a patient to a specialist palliative care service with healthcare professionals who have received additional training.

The scope of palliative care treatment and services includes:

- facilitating effective communication for making decisions, identifying and documenting goals of care,
- comprehensive assessment and treatment of pain and other symptoms,
- psychological and emotional support for the patient,
- support for spiritually and culturally safe care,
- support for family/carer stress and distress,
- sourcing equipment to ensure safe care at home, and
- bereavement care, including immediate and follow-up care after a patient dies, grief support and bereavement counselling.

5.5 Voluntary assisted dying and advance care planning

Advance care planning involves a patient thinking about their values, beliefs, wishes and preferences, and about the health care they would like to have or refuse if they could not make or communicate their own decisions. This often involves discussion with family, carers and healthcare providers.

An advance care directive is a document recording a person's preferences for future health care. A valid advance care directive is legally binding and must be followed. Making an advance care directive is part of advance care planning.

Health professionals and substitute decision makers will use advance care directives or plans to inform decisions when a person is unable to make or communicate their own decisions. This ensures that a patient's preferences are respected. An advance care directive or plan should be reviewed regularly and updated if needed.

Advance care directives only come into effect once an individual has lost their decision-making capacity. To access voluntary assisted dying, you must retain decision-making capacity and the ability to communicate requests and decisions throughout the entire process. Because an advance care directive only comes into effect when you no longer have capacity, you cannot access voluntary assisted dying by requesting it in an advance care directive.

If a patient expresses interest in voluntary assisted dying during advance care planning conversations, the health professional facilitating the conversation should provide information about:

- the voluntary assisted dying eligibility criteria under the Act,
- the process of making an official first request, and
- the Care Navigator Service, and any local pathways or contacts who can provide information or help to identify an authorised practitioner.

If the health professional facilitating the advance care planning conversation is a medical practitioner, they can then consider whether the patient's request meets criteria for a formal first request for voluntary assisted dying. If so, the advance care planning conversation might need to be delayed to a later date, and the first request be accepted or refused as per the Act (*8.1 First request overview*).

Advance care planning should be undertaken even when a patient wishes to access voluntary assisted dying. This ensures that end of life preferences can be respected in case the person loses capacity and cannot complete the voluntary assisted dying process.

5.6 Voluntary assisted dying for diverse populations

End of life occurs within a social context, and Australia has a diverse population. Supporting equity of access is especially important in the context of pre-existing health and social care needs that originate in the social determinants of health.

Our diverse population is represented by:

- People from culturally and linguistically diverse (CALD) backgrounds,
- Aboriginal and Torres Strait Islander peoples,
- People with disability, dementia or mental health impairment,
- People experiencing homelessness including unstable housing and financial hardship, and
- People who identify as lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ+).

Safety, choice, collaboration, trust, and empowerment are essential components of trauma-informed care. The therapeutic relationship should be one of inclusivity and respect. The Principles in the Act state that all persons have the right to respect their culture, religion, beliefs, values, and personal characteristics. They outline the importance of supporting all people in their conversations with health practitioners, family, carers and community about care and treatment preferences. This can be achieved in the following ways:

Providing culturally appropriate engagement and culturally safe care: Cultural and religious beliefs influence decision making at all stages of life, including end of life. Although, in the eyes of the health practitioner, an individual patient is the primary client, many cultural groups engage in collective decision-making, and consultation with family and other cultural networks is an important part of the decision-making process. 'Person-centred care' needs to be placed alongside 'relationship-centred care,' an approach which aligns with the Principle in the Act of "respecting culture, religion, beliefs, values and personal characteristics." Whilst ensuring this relationship-centred care approach is respected it is important to remember that only the individual person can request voluntary assisted dying, not anyone else within the relationship.

Recognising diversity within diverse communities: There can be significant diversity within all communities, such as CALD and Aboriginal communities; these are not homogenous groups, and each person should be understood as a unique individual. Health professionals are not expected to understand the breadth and diversity of all cultural beliefs in relation to illness, but there are various resources which offer support in this regard.

A fact sheet for people from culturally and linguistically diverse communities is available in multiple languages. A fact sheet for Aboriginal communities is also available. These fact sheets can be found on the NSW Health website *https://www.health.nsw.gov.au/voluntary-assisted-dying/Pages/considering.aspx*.

The LGBTIQ+ community: Many people in the LGBTIQ+ community have experienced prejudice, discrimination, and stigma; as a result, they express understandable concern about whether they will receive empathic, respectful care. It is important to remember that many in the LGBTIQ+ community have 'families of choice' as well as 'families of origin' and have the right to engage either or both in key decisions regarding their care.

People with a disability, dementia, or mental health impairment: Under the Act, people with these disabilities or impairments will be eligible to request access to voluntary assisted dying if they have decision-making capacity and meet all the eligibility criteria. However, a person is not eligible merely because the person has a disability, dementia or a mental health impairment. They may need extra assistance to exercise their decision-making capacity (Assisted Decision Making). This includes the use of assistive technologies or devices.

People experiencing homelessness: There is a high prevalence of mental illness and substance use among homeless people, as well as family estrangement and isolation. People experiencing homelessness may therefore lack the resources to meet their most basic day-to-day needs.

Most people experiencing homelessness want to stress that the 'face of care' means more to them than the 'place of care' (Webb et al, 2020). As a particularly vulnerable group, they need the reassurance of a non-judgmental, respectful approach that honours their autonomy and treats them with genuine kindness at the end of life. Should a homeless person request voluntary assisted dying, it may be possible to identify resources (such as homeless or other services with which the person has established links) to provide support through the voluntary assisted dying process.

5.7 Key resources for the delivery of high-quality palliative and end of life care

Table 2. Key resources for the delivery of high-quality palliative and end of life care

Title of Resource	Weblink	Overview
Clinical Principles for End of Life and Palliative Care	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_016	NSW Health Guideline for those services providing care and support to people with life-limiting or severe advancing illness, their families, and carers.
NSW Health Consent to Medical and Healthcare Treatment Manual	https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx	Operational guidance and procedures to support compliance with the NSW law on obtaining consent to medical treatment from patients or their substitute consent providers.
NSW Health End of Life & Palliative Care Framework 2019-2024	https://www.health.nsw.gov.au/palliativecare/Pages/eol-pc-framework.aspx	"The Framework" provides a guide to not only improve access to the best possible end of life and palliative care, but to encourage people to talk more openly about death and dying as a normal part of life.
End of Life and Palliative Care Blueprint for Improvement	https://aci.health.nsw.gov.au/palliative-care/blueprint	A flexible guide for health services to meet the needs of people approaching and reaching the end of life, their families, and carers.
Making an advance care directive	https://www.health.nsw.gov.au/patients/acp/Pages/acd-form-info-book.aspx	Information to help complete an advance care directive.
End of Life Care Learning Navigator Tool	Course code 489456659 on My Health Learning (NSW Health staff only)	The Navigator Tool is intended to assist with simplifying and clarifying learning clusters for professional development and practice capability enhancement. The Navigator is multidisciplinary in nature, with an intended audience of nursing, allied health and medical staff involved in the provision of end of life care across all care settings.
Gwandalan Palliative Care for Aboriginal & Torres Strait Islanders	https://gwandalanpalliativecare.com.au/	Online learning modules and resources to support cultural care at end of life for Aboriginal & Torres Strait Islander populations.

Title of Resource	Weblink	Overview
Journey to Dreaming toolkit resource	https://www.ahmrc.org.au/health-topic/palliative-care/	This resource provides information to help Aboriginal and Torres Strait Islander families and their healthcare workers provide family-centred palliative and end of life care for a loved one. There is an accompanying 'My Journey to Dreaming Diary' (available through the same link). The diary is a place to keep personal and medical information and includes mindful activities to prompt reflection, wellness, and gratitude.
End of Life Care and Decision-Making	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_004	NSW Health Guideline providing advice for NSW Health staff about a process for negotiating end of life decisions.
Caresearch: Diverse populations	https://www.caresearch.com.au/tabid/6534/Default.aspx	Learning about diverse populations.
End of Life Directions for Aged Care	https://www.eldac.com.au/tabid/5031/Default.aspx	Aged care resource regarding diversity in Australian populations.
End of Life Law for Clinicians	https://palliativecareeducation.com.au/?tenant=ELLC	For clinicians to learn about end of life law and its effects on palliative and end of life care for patients.
End of Life Essentials	https://www.endoflifeessentials.com.au/	Learning resources for healthcare workers to improve the quality and safety of end of life care in hospitals.
RACGP Palliative and End of Life Care	https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care	Support for GPs in the provision of palliative and end of life care.
Improving Care at the End of Life: Our Roles and Responsibilities (2016)	www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-end-of-life-position-statement.pdf	Support for physicians in the provision of palliative and end of life care.

6 Overview of the voluntary assisted dying process

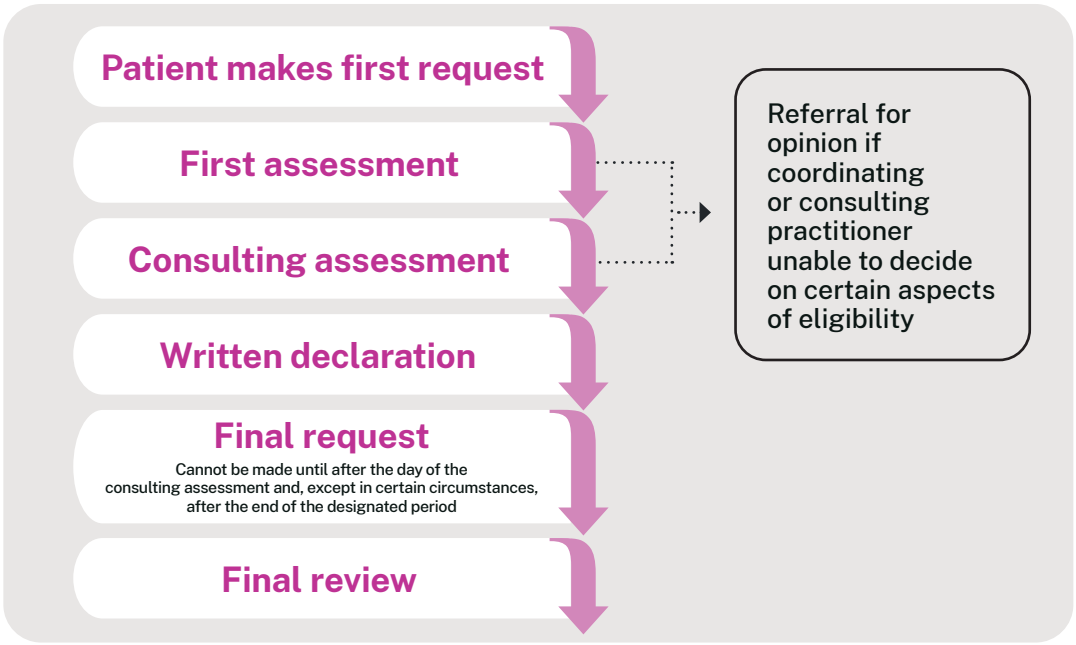
6

Voluntary assisted dying in NSW is patient-centred and patient-directed. As such, the duration and pace of the process will vary from person to person. However, the Act outlines certain minimum timeframes that must be adhered to between the first request and final request and the consulting assessment and final request (see *12 Final request* for details).

The high-level steps involved in the voluntary assisted dying process are shown in *Figure 1*. More detail on each step is provided later in the Handbook. Depending on a number of factors, additional steps may be required to satisfy the legal obligations set out in the Act.

Figure 1. Summary of the key steps of the voluntary assisted dying process

A patient can pause or stop the voluntary assisted dying process at any time



Administration decision

Self-administration process

- Appointment of a contact person
- Application to Board for a substance authorisation
- Substance authority granted by Board
  Note: If Board refuses application, process cannot progress
- Prescription written and sent to Voluntary Assisted Dying Pharmacy Service
- Substance supplied to patient
- Patient self-administers substance
- Contact person notifies coordinating practitioner of death
- Notification of death
- Disposal of unused or remaining substance

Practitioner administration process

- Application to Board for a substance authorisation
- Substance authority granted by Board
  Note: If Board refuses application, process cannot progress
- Prescription written and sent to Voluntary Assisted Dying Pharmacy Service
- Substance supplied to administering practitioner
- Practitioner administers substance to patient in presence of eligible witness
- Notification of death
- Disposal of unused or remaining substance

This is a summary of the key steps of the voluntary assisted dying process under the Voluntary Assisted Dying Act 2022. This summary is indicative only and does not cover all the scenarios that might arise during a patient's individual voluntary assisted dying process.

6.1 A person has no obligation to continue after a first request or after completing the request and assessment process

A patient can, at any stage, decide to pause or stop the voluntary assisted dying process. An application can also be suspended temporarily.

6.1.1 Pausing the voluntary assisted dying process

The pace of the process is patient-directed, so patients may choose to pause and take some time between steps. Pausing between steps does not require any notification to the Board. In this case, the patient's application in the Portal will remain open and ready for them to take the next step if and when they choose. Practitioners should make it clear at the end of each step of the process that the patient can progress to the next stage if and when they choose, and let them know how to do so. They should also confirm that patients wish to continue before conducting each step of the voluntary assisted dying process.

6.1.2 Stopping the voluntary assisted dying process

If the patient chooses to definitively **stop** the request and assessment process, or the patient becomes irreversibly ineligible, the coordinating practitioner should notify the Board by contacting the Board Secretariat who can withdraw the application in the Portal. Withdrawing an application means that the person would need to re-start the process from the first request again, if they decided they wanted to re-apply for voluntary assisted dying at a later date. Therefore, if a patient is unsure about stopping the process, their application should not be withdrawn and it can remain open as long as required.

6.1.3 Suspending an application

A patient's application in the Portal can also be suspended if required (for example, due to a Supreme Court application, or if a patient temporarily loses capacity). Authorised practitioners should discuss this with the Board Secretariat, who can then suspend the application in the Portal. When required, the Board Secretariat can resume the application or withdraw.

7 Practitioner participation in voluntary assisted dying

7

Medical practitioners and nurse practitioners must meet specific criteria and complete mandatory training to provide voluntary assisted dying services as an authorised practitioner in NSW. Eligible medical practitioners can participate in voluntary assisted dying as a coordinating practitioner, consulting practitioner, or administering practitioner. Eligible nurse practitioners can participate as an administering practitioner.

Registration to access the approved training to become an authorised practitioner is completed via the Portal. Practitioners **must** register and complete mandatory training **before** providing voluntary assisted dying services, or undertaking any activities under these roles. More information on becoming an authorised practitioner is available in the practitioner authorisation and participation guidance, found in Appendix 1 of the NSW Health Policy Directive *Voluntary Assisted Dying*.

Authorised practitioners should also be aware that if required to provide voluntary assisted dying services in a public facility, they must first have the appropriate appointment or employment relationship with NSW Health and have the required clinical privileges or scope of practice.

7.1. Practitioner eligibility and roles under the Act

7.1.1 Coordinating practitioner

The coordinating practitioner for a patient coordinates the end-to-end voluntary assisted dying process, ensuring the patient is supported, the correct steps are completed and all requirements of the legislation are met. The coordinating practitioner is the authorised practitioner who accepts the patient's first request.

As the coordinating practitioner for each patient is the main contact point throughout the process for the patient, the Board, the VAD-CNS and other practitioners relevant for each patient's care, this role involves significant time and clinical commitment.

To be eligible to act as a patient's coordinating practitioner, all of the following criteria must be met. The medical practitioner must:

- Hold either:
  - Specialist registration, or
  - General registration and has practised in the medical profession for at least 10 years
- Have completed approved mandatory training
- Not be a family member of the patient
- Not know or believe the practitioner is a beneficiary under a will of the patient or may otherwise benefit financially or in any other material way from the death of the patient other than by receiving reasonable fees for services as the patient's coordinating practitioner

Table 3 provides a summary of the key roles of a coordinating practitioner.

Table 3. Overview of coordinating practitioner role

Step in the voluntary assisted dying process	Coordinating practitioner role
Before accepting a first request	• Registers to become an authorised voluntary assisted dying practitioner by completing the ***Practitioner Registration Form***, available on the *NSW Voluntary Assisted Dying Portal website*, and completing mandatory training. Receives an outcome letter from NSW Ministry of Health indicating they are now an authorised practitioner.
First request	• Receives and accepts the patient's first request *(Note: By accepting the first request, the practitioner becomes the patient's coordinating practitioner).* • Provides the patient with the *first request patient information* within two business days of the first request. • Completes the ***First Request Form*** and submits it to the Board via the Portal within five business days after deciding to accept the patient's first request. • Documents the first request in the patient's medical record, including the decision to accept the request, and whether the *first request patient information* (referenced above) has been provided to the patient as required by the Act.
First assessment	• Assesses the patient and decides whether they meet each eligibility criteria for access to voluntary assisted dying. • Refers the patient for opinion if they are unable to decide if the patient meets certain eligibility criteria. • If patient is assessed as meeting the eligibility criteria, provides required information to the patient. • If the patient meets eligibility criteria and has understood the required information provided, assesses the patient as eligible to access voluntary assisted dying and informs the patient as soon as practicable. • If the patient does not meet all eligibility criteria or does not understand the required information provided, assesses the patient as ineligible to access voluntary assisted dying and informs the patient as soon as practicable. • Completes the ***First Assessment Report Form*** and submits it to the Board via the Portal within five business days after completing the assessment. • Gives a copy of the ***First Assessment Report Form*** to the patient as soon as practicable.
Consulting assessment	• In accordance with patient's timeframe/preference, refers to another authorised practitioner for a consulting assessment. • If the consulting assessment referral is not accepted, refers to another practitioner for consulting assessment. • Is notified of the outcome of the consulting assessment. • May refer to another practitioner for an additional consulting assessment if the consulting assessment finds the patient ineligible *(Note: The decision to refer for an additional assessment to be made in consultation with the patient).*

Step in the voluntary assisted dying process	Coordinating practitioner role
Written declaration	• If the patient is also assessed as eligible by the consulting practitioner, gives the patient a copy of the ***Written Declaration***, downloaded from the Portal. • Receives the completed ***Written Declaration*** from the patient and submits a copy to the Board via the Portal within five business days after receipt. • Records the date of the written declaration and date it was provided to the coordinating practitioner in the patient's medical record.
Final request	• Receives and accepts the patient's final request either in person or via telehealth. • Ensures the final request is made after the end of the designated period (unless there are grounds for exemption) and at least one day after the consulting assessment. • Records details of the final request in the patient's medical record, including date of final request, and if the final request was made before the designated period, the reason for this. • Completes the ***Final Request Form*** and submits it to the Board via the Portal within five days after receiving the final request.
Final review	• Reviews all ***Consulting Assessment Report Forms*** and the ***Written Declaration*** having regard to any Supreme Court decisions relating to the patient's request and assessment process. • Completes the ***Final Review Form*** and submits it to the Board via the Portal within five days after completing the form.

Step in the voluntary assisted dying process	Coordinating practitioner role
Administration decision	• Consults with the patient and provides advice to support the patient to make an administration decision, during a face-to-face consultation. • Records the administration decision in the patient's medical record. • Completes the ***Administration Decision Form*** and submits it to the Board via the Portal within five business days after the decision being made. If the patient makes a self-administration decision: • Gives the patient the ***Contact Person Appointment Form*** for completion, downloaded from the Portal. • Receives the completed ***Contact Person Appointment Form*** from the patient or the contact person and submits it to the Board via the Portal within five business days after receiving the completed form. *Note: The coordinating practitioner must not prescribe a voluntary assisted dying substance before the completed* ***Contact Person Appointment Form*** *is given to the coordinating practitioner.* If the patient makes a practitioner administration decision: • Determines who will complete the role of administering practitioner in consultation with the patient *(Note: the coordinating practitioner is by default the administering practitioner unless this role is transferred after the prescription is written).* • If the role of administering practitioner will be transferred to another eligible medical or nurse practitioner, discusses plans for involving that practitioner in the patient's care. If the patient revokes an administration decision: • Records the revocation of administration decision in the patient's medical record. • Completes the ***Revocation Form*** and submits it to the Board via the Portal within five business days after the decision to revoke. • Consult with the patient to make a further administration decision, during a face-to-face consultation, if the patient wishes to do so.
Obtaining a substance authorisation	• Completes the ***Voluntary Assisted Dying Substance Authorisation Application Form*** and submits to the Board via the Portal (ensuring all forms from previous steps in the process are complete and submitted prior to commencing this step). • Receives the Voluntary Assisted Dying Substance Authority or notice of refusal from the Board once the application has been assessed. • Tells the patient the outcome of the application.

Step in the voluntary assisted dying process	Coordinating practitioner role
Prescribing the voluntary assisted dying substance *(Note: Can only be done if the Voluntary Assisted Dying Board has granted a substance authority for the patient)*	• Before prescribing the substance, ensures the patient has a copy of the relevant hard-copy patient information booklet containing the required written information. • Writes a voluntary assisted dying substance prescription using the approved voluntary assisted dying prescription template as per the relevant protocol (refer to the NSW Voluntary Assisted Dying Prescription and Administration Handbook) and gives it to the VAD-PS. • Completes the ***Prescription Form*** and submits it to the Board via the Portal within five business days after writing the prescription. • If, after writing the prescription, the coordinating practitioner chooses to transfer the role of administering practitioner, identifies an eligible and willing practitioner to take over the role, completes the ***Administering Practitioner Transfer Form*** and submits it to the Board via the Portal within five business days after the transfer is accepted.
Administration of the voluntary assisted dying substance	If the patient has chosen practitioner administration and the coordinating practitioner has not transferred the role of administering practitioner, refer to the *7.1.3 Administering practitioner* section.
After the patient dies	• Unless practitioner administration has occurred (and a ***Practitioner Administration Form*** has been submitted to the Board), completes the ***Notification of Death Form*** and submits it to the Board via the Portal within five business days of becoming aware that the patient has died, whether by administration of a voluntary assisted dying substance or another cause.

7.1.2 Consulting practitioner

The consulting practitioner for a patient conducts a second eligibility assessment for the patient, called a consulting assessment.

To be eligible to act as a patient's consulting practitioner, all of the following criteria must be met. The medical practitioner must:

- Hold either:
  - Specialist registration, or
  - General registration and have practiced in the medical profession for at least 10 years
- Have completed approved mandatory training
- Not be a family member of the patient
- Not know or believe the practitioner is a beneficiary under a will of the patient or may otherwise benefit financially or in any other material way from the death of the patient other than by receiving reasonable fees for services as the patient's consulting practitioner

Table 4 provides a summary of the key roles of a consulting practitioner.

Table 4. Overview of consulting practitioner role

Step in the voluntary assisted dying process	Consulting practitioner role
Before accepting a referral for consulting assessment	• Registers to become an authorised voluntary assisted dying practitioner by completing the ***Practitioner Registration Form***, available on the *NSW Voluntary Assisted Dying Portal website* and completing mandatory training. Receives an outcome letter from NSW Ministry of Health indicating they are now an authorised practitioner.
Consulting assessment	• Receives a referral for consulting assessment from a patient's coordinating practitioner. • Informs the patient and their coordinating practitioner of acceptance within two business days. • Records details of the referral in the patient's medical record, including decision to accept or refuse (and if refused, the reason for refusal). • Completes the ***Consultation Referral Form*** and submits it to the Board via the Portal within five business days after deciding to accept or refuse the referral *(Note: By accepting the referral for consulting assessment, the practitioner becomes the patient's consulting practitioner).* • Independent of the coordinating practitioner's assessment, assesses the patient and decides whether they meet each eligibility criteria for access to voluntary assisted dying. • Refers the patient for opinion if they are unable to decide if the patient meets certain eligibility criteria. • If the patient is assessed as meeting the eligibility criteria, provides required information to the patient. • If the patient meets eligibility criteria and has understood the required information provided, assesses the patient as eligible to access voluntary assisted dying and informs the patient and their coordinating practitioner as soon as practicable. • If the patient does not meet all eligibility criteria or does not understand the required information provided, assesses the patient as ineligible to access voluntary assisted dying and informs the patient and their coordinating practitioner as soon as practicable. • Completes the ***Consulting Assessment Report Form*** and submits it to the Board via the Portal within five business days after completing the consulting assessment. • Gives a copy of the ***Consulting Assessment Report Form*** to the patient and their coordinating practitioner as soon as practicable.

7.1.3 Administering practitioner

The role of administering practitioner is only required in the voluntary assisted dying process if a patient has made a practitioner administration decision. The administering practitioner may be the patient's coordinating practitioner, or it may be another eligible practitioner. **By default, the coordinating practitioner will hold this role**. However, they can transfer it to another eligible practitioner after a prescription for a voluntary assisted dying substance has been written. If they intend to transfer the role, the coordinating practitioner should identify another eligible practitioner at the point of administration decision, and work with the patient and the practitioner to involve them in their care prior to administration.

To be eligible to act as a patient's administering practitioner, all of the following criteria must be met. The practitioner must:

- Be:
  - A medical practitioner who holds specialist registration, or
  - A medical practitioner who holds general registration and has practised in the medical profession for at least five years, or
  - A medical practitioner who is an overseas-trained specialist who holds limited or provisional registration, or
  - A nurse practitioner
- Have completed approved mandatory training
- Not be a family member of the patient
- Not know or believe the practitioner is a beneficiary under a will of the patient or may otherwise benefit financially or in any other material way from the death of the patient other than by receiving reasonable fees for services as the patient's administering practitioner

Table 5 provides a summary of the key roles of an administering practitioner.

Table 5. Overview of administering practitioner role

Step in the voluntary assisted dying process	Administering practitioner role
Before accepting the role of administering practitioner	• Registers to become an authorised voluntary assisted dying practitioner by completing the ***Practitioner Registration Form***, available on the *NSW Voluntary Assisted Dying Portal website*, and completing mandatory training. Receives an outcome letter from NSW Ministry of Health indicating they are now an authorised practitioner.
Supplying the voluntary assisted dying substance	• Receives a request from the patient for administration to be arranged, and organises: – A mutually acceptable time for administration to occur. – Supply of the voluntary assisted dying substance from the VAD-PS. • Receives the voluntary assisted dying substance from the authorised supplier.
Administration	• Administers the voluntary assisted dying substance to the patient in the presence of an eligible witness if: – The practitioner is satisfied at the time of administration that: • The patient has decision-making capacity in relation to voluntary assisted dying; and – The patient is acting voluntarily and not because of pressure or duress; and – The patient's request for voluntary assisted dying is enduring. • The witness considers that the patient's request for access appears to be free, voluntary and enduring.
After the patient dies	• Verifies the patient's death. • Completes the Medical Certificate of Cause of Death if a medical practitioner, or refers to previously planned process for its completion. • Completes the ***Practitioner Administration Form*** and submits it to the Board via the Portal within five days after administering the voluntary assisted dying substance. • Disposes of any unused or remaining voluntary assisted dying substance, immediately completes the ***Practitioner Disposal Form*** and submits it to the Board via the Portal within five business days after disposal.

8 First request

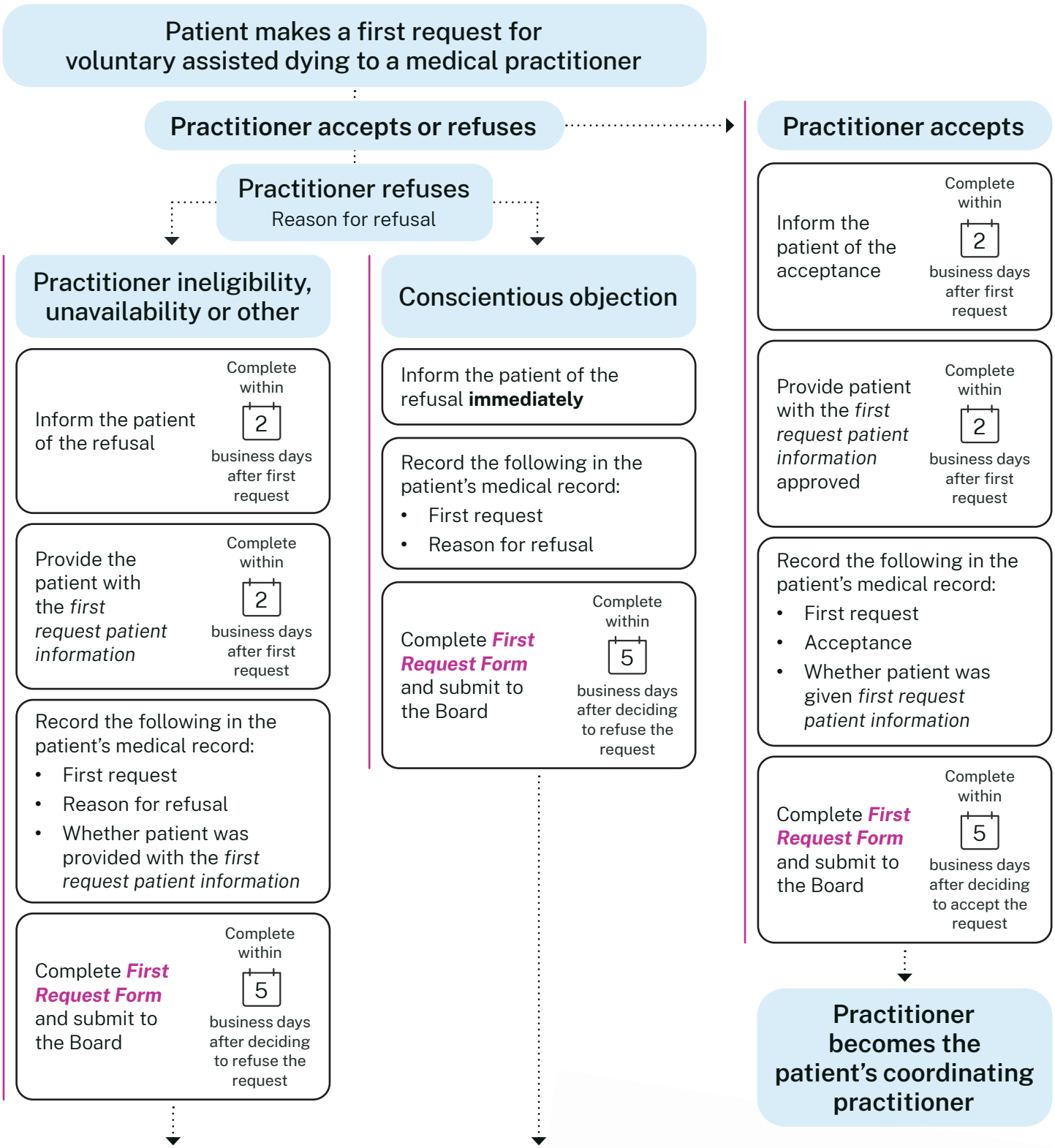
8

8.1 Overview

Making a clear and unambiguous first request to a medical practitioner is the first step for a patient in the voluntary assisted dying process. When a first request is made, the medical practitioner must decide whether to accept or refuse the request. If a first request is refused, the patient can make a first request to a different medical practitioner. As patients are unlikely to know which practitioners provide voluntary assisted dying services, they may make a first request to a medical practitioner who is not an authorised practitioner. For support in finding an authorised practitioner, patients can contact the *VAD-CNS*.

All medical practitioners have obligations under the Act when a patient makes a first request to them, even if they refuse the request. The medical practitioner who is an authorised practitioner who accepts a patient's first request becomes the coordinating practitioner for that patient. *Figure 2* outlines the steps in the first request.

Figure 2. Steps in the first request



8.2 Commonwealth Criminal Code

The first request may be conducted via telehealth where a face-to-face consultation is not practicable, and where telehealth is clinically appropriate.

However, if the patient or practitioner wishes to discuss anything relating to the following during the first request, to mitigate the risk of breaching the Criminal Code, this should occur face-to-face:

- potential risks of administering the voluntary assisted dying substance,
- a plan for the administration of the voluntary assisted dying substance.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

8.3 Step 1: Patient makes a first request

To start the process of voluntary assisted dying, the patient must make a first request for access to voluntary assisted dying to a medical practitioner.

The first request must be:

- Clear and unambiguous,
- Made during a medical consultation,
- Made in person or via telehealth if a face-to-face consultation is not practicable, and
- Made by the person seeking access to voluntary assisted dying.

A first request can be made using any method of communication the person uses, such as spoken language, sign language or alternative communication, or with the assistance of an interpreter. The medical consultation during which a first request can be made may be in a clinical setting (e.g., hospital or health clinic) or a non-clinical setting (e.g., in a patient's home).

No one can make a first request on behalf of another person. A first request cannot be made using an advance care directive as the person requesting voluntary assisted dying must have capacity throughout the process (see section *5 Voluntary assisted dying in the context of end of life care*).

8.3.1 Recognising a first request

Patients seeking access to voluntary assisted dying do not have to use the words "voluntary assisted dying" in their first request, as they may not be aware of the terminology or process involved. *Table 6* below outlines some examples of statements that patients could make to indicate they want to access voluntary assisted dying, and some examples that would not indicate a request for access.

Medical practitioners should confirm that a person who appears to be making a first request is in fact making a request for access, and not simply seeking further information about voluntary assisted dying.

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

- Carefully explore what the person is asking with curiosity, respect and in a patient-centred, non-judgmental 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.

8.3.2 What is not considered a first request

A first request must meet the criteria outlined above to be considered a first request. Examples of what is **not** considered a first request include:

- A request made to someone other than a medical practitioner or outside of a medical consultation.
- A request made by someone on behalf of someone else.
- A person asking general questions or expressing interest in voluntary assisted dying or seeking further information but not specifically requesting access to it themselves (*Table 6*).
- A request in an advance care directive.

All conversations about voluntary assisted dying need to be conducted with respect and consideration. In certain situations, a person who distinctly does not meet eligibility criteria for access, may raise questions or enquire about voluntary assisted dying. In these situations, practitioners are encouraged to respond to questions about voluntary assisted dying in a way that manages the person's expectations. For more information, see section *4.2 Responding to enquiries from ineligible patients before they make a first request*.

Table 6. Examples of patient statements

Example statements of a first request for voluntary assisted dying	Example statements that would not be considered a first request for voluntary assisted dying, but rather a request for information
"Can you help me end my life?"	"I want to die. What are my options?"
"I want you to help me to die."	"I'm tired of life. I've had enough."
"How can I get medication to end my life?"	"Can you tell me more about voluntary assisted dying?"
"Can I access euthanasia?"	"Does this hospital/facility provide voluntary assisted dying?"

8.4 Step 2: Medical practitioner decides whether to accept or refuse the first request

When deciding whether to accept or refuse a patient's first request, medical practitioners should consider:

- Their eligibility to act as a coordinating practitioner.
- Their ability to commit to the role of coordinating practitioner and assume the associated responsibilities.
- Their professional context and local policies and procedures of their local health district, facility or employer.

Information about eligibility and an overview of responsibilities of the coordinating practitioner can be found in *7 Practitioner participation in voluntary assisted dying*.

8.4.1 Refusing a first request

A medical practitioner may only refuse a patient's request for the following reasons:

- Are not eligible to act as the patient's coordinating practitioner,
- Have a conscientious objection to voluntary assisted dying or are unwilling to perform the required duties, or
- Cannot perform the required duties because they are unavailable or because of another reason.

If the medical practitioner refuses the first request, they must tell the patient that they refuse the request:

- Immediately, if the refusal is due to conscientious objection, or
- Within two business days if the refusal is due to any other reason.

If the medical practitioner is not eligible to be the patient's coordinating practitioner, they must immediately decide to refuse the first request. This includes if they are not an authorised practitioner, or if the practitioner:

- is a family member of the patient; or
- knows or believes that they:
  - are a beneficiary under a will of the patient; or
  - may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating or consulting practitioner for that patient.

Note: Medical practitioners who refuse a first request have additional responsibilities beyond informing the patient that they refuse the request. These requirements are detailed in the following sections 8.4, 8.5 and 8.6.

8.4.2 Accepting a first request

Unless the medical practitioner has a reason to refuse the patient's first request (see section 8.4.1), the practitioner must accept it. By accepting, they are agreeing to assume the role of coordinating practitioner for that patient, and to fulfil all the responsibilities of the coordinating practitioner (outlined in *7 Practitioner participation in voluntary assisted dying*).

If the practitioner decides to accept the first request, they must tell the patient that they accept within two business days of the first request.

8.5 Step 3: Medical practitioner provides the patient with required information

A medical practitioner must give the patient the *first request patient information* within two days of the first request, unless the practitioner refuses the first request due to conscientious objection. Medical practitioners who accept the request, or refuse the request for any reason other than conscientious objection must provide the information.

The practitioner can give the patient the information in physical or digital form and may send it electronically. The information is available at *https://www.health.nsw.gov.au/voluntary-assisted-dying/Pages/first-request-patient-guide.aspx*

8.6 Step 4: Medical practitioner documents the first request

8.6.1 Recording the first request in the medical record

Regardless of whether a first request is accepted or refused, the medical practitioner must record the first request in the patient's medical record, including:

- Whether the practitioner accepted or refused the request (and if refused, the reason for refusal)
- Whether the practitioner has given the patient the first request patient information (not applicable if the practitioner refused due to conscientious objection).

8.6.2 Notifying the Board of the first request

The medical practitioner who receives the first request must complete the ***First Request Form*** and submit it to the Board within five business days after deciding to accept or refuse the request.

This applies to all medical practitioners to whom a first request is made, regardless of whether the request was accepted or refused, the practitioner's eligibility or conscientious objection.

For authorised practitioners, the ***First Request Form*** is available on the Portal. For all other medical practitioners, the ***First Request Form*** is available on the Portal website, at www.nswvadportal.health.nsw.gov.au, where it can be completed and lodged to the Board.

9 First assessment

9

9.1 Overview

To be able to access voluntary assisted dying, a patient must be assessed as eligible by two medical practitioners independently. These independent assessments are the:

- first assessment, conducted by the coordinating practitioner; and
- consulting assessment, conducted by the consulting practitioner.

As the steps in the first assessment and consulting assessment are the same, step 1 and step 2 of the first assessment section are applicable to both the first and consulting assessments and the term 'medical practitioner' will be used to refer to both coordinating and consulting practitioners in this section.

Before the first assessment, the coordinating practitioner must have accepted the patient's first request. *Figure 3* outlines the steps in the first assessment.

Figure 3. Steps in the first assessment

Coordinating practitioner assesses patient against eligibility criteria

- Age: 18+
- Residency
- Medical criteria
- Decision-making in relation to voluntary assisted dying
- Request is voluntary, enduring and free from pressure or duress

Coordinating practitioner provides information to patient

If the coordinating practitioner is satisfied the patient meets all eligibility criteria, they must:

- Provide information under Section 28(1) and Section 28(4)
- Confirm patient understands information

Coordinating practitioner determines outcome of first assessment

- Advise patient of outcome as soon as practicable

Coordinating practitioner documents the first assessment

- Complete ***First Assessment Report Form*** and submit to the Board within 5 business days after completing the first assessment
- Provide a copy of the ***First Assessment Report Form*** to the patient as soon as practicable

9.2 Commonwealth Criminal Code

To mitigate the risk of breaching the Commonwealth Criminal Code, the first assessment should occur face-to-face. If an interpreter is required, the interpreter should also attend in person to avoid breaching the Commonwealth Criminal Code.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

9.3 Timeframe

There is no timeframe in which the first assessment must be completed. It can occur at any time after the first request, in line with the patient's preference, practitioner availability and other relevant factors e.g., the patient's prognosis. In practice, the first assessment may be conducted at the same time as the first request, providing that it is suitable in the circumstances. The coordinating practitioner does not need to submit the ***First Request Form*** before commencing the first assessment, but must submit it to the Board and be assigned as the patient's coordinating practitioner before they complete and submit the ***First Assessment Report Form***. Whilst no timeframes are legislated for this process it is important to recognise the importance of timely clinical appointments as requested by patients, due to the life-limiting nature of their disease.

9.4 Step 1: Medical practitioner assesses the patient's eligibility and refers to another assessor for opinion if required

To assess a patient's eligibility for access to voluntary assisted dying, a medical practitioner must make a decision about each eligibility criterion in section 16 of the Act. Medical practitioners must be satisfied they have accurately assessed a patient's eligibility to access voluntary assisted dying. Assessing a patient's eligibility will include reviewing any relevant documentation and may, among other things, include discussion with other members of the patient's treating team as per usual practice. This section is not a replacement for clinical judgment but provides suggestions that medical practitioners may find helpful on how to approach the assessment for each criterion.

9.4.1 Assessing whether the patient meets demographic eligibility criteria

Age requirements

To be eligible for access to voluntary assisted dying, the patient must be an adult (at least 18 years of age).

The medical practitioner must be satisfied that the patient is at least 18 years of age. If required to inform their decision, practitioners should sight and obtain copies of supporting documentation, such as a driver licence or Australian birth certificate.

Residency requirements

To be eligible for access to voluntary assisted dying, the patient must:

- be either an Australian citizen, be a permanent resident of Australia or, at the time of first request, have been resident in Australia for at least three continuous years; and
- have been ordinarily resident in NSW for at least 12 months at the time of first request.

Ordinarily resident is not defined in the Act. Factors that may be relevant to determining whether a person is ordinarily resident include whether they have lived in NSW for the past 12 months, whether the person's residential address is in NSW and whether the person has maintained a sufficient connection with NSW during the past 12 months. This does not mean that a patient cannot have spent any time outside NSW during the 12 months.

Where a longstanding relationship between the patient and their medical practitioner exists, it will likely be straightforward for the medical practitioner to determine eligibility against these criteria. If this is not the case, the medical practitioner should explicitly confirm with the patient and seek evidence of residency. They should also document in the patient's medical record any supporting documentation that informed their decision.

Examples of supporting documents that medical practitioners may use in making decisions about demographic eligibility criteria are shown in *Table 7*.

Table 7. Examples of documentation to support eligibility against demographic criteria

Demographic criterion	Examples of supporting documentation
Aged at least 18 years	• Australian passport • Australian birth certificate • NSW driver licence • NSW photo card • Other photo identification
Australian citizen; or	• The documents required to prove Australian citizenship depend on whether a patient was born overseas and when they were born. Further information is available at *https://www.passports.gov.au/getting-passport-how-it-works/documents-you-need/citizenship*
Permanent resident of Australia; or	• Proof of visa record from the person's electronic visa record (held on the Visa Entitlement Verification Online system)
Resident in Australia for at least three continuous years at time of first request	• Bank statements • Employment documentation • Medical records • Utility bills • Documentation from a rental agreement
Resident in NSW for at least 12 months at the time of first request	• Bank statements • Employment documentation • Medical records • Utility bills • Documentation from a rental agreement

Exemptions from NSW residency requirements

A person who has not been ordinarily resident in NSW for at least 12 months at the time of first request may still be eligible to access voluntary assisted dying in NSW if they are granted an exemption from this requirement by the Board.

If a person applies for an exemption from this criterion, the Board must grant the exemption if they are satisfied:

- the person has a substantial connection to NSW, and
- there are compassionate grounds for granting the exemption.

Examples of a substantial connection to NSW may include:

- a long-term resident in a place close to the NSW border and who works or receives medical treatment in NSW
- a person who has moved to NSW to be close to family for care and support due to their terminal illness
- a former NSW resident whose family resides in NSW.

It is important to note that the Board may only consider exemptions from the NSW residency requirement. The Act does not allow for exemptions from the requirement to be either an Australian citizen, permanent resident, or resident in Australia for at least three continuous years at the time of first request.

For information on how to apply for a residency exemption, see the *NSW Health website*.

9.4.2 Assessing whether the patient has an eligible disease, illness or medical condition

The medical practitioner must assess the patient's diagnosis and prognosis. They must also explore the patient's perception of the suffering they are experiencing because of their disease, illness or medical condition and the options available to alleviate their suffering. It is important to note that a patient can refuse medical treatment or symptom management and still access voluntary assisted dying.

To be eligible for access to voluntary assisted dying, the medical practitioner must be satisfied that the patient has at least one disease, illness or medical condition that:

- is advanced, progressive and will cause death, and
- will, on the balance of probabilities, cause death –
  - for a disease, illness or medical condition that is neurodegenerative – within a period of 12 months, or
  - otherwise – within a period of six months, and
- is causing suffering to the person that cannot be relieved in a way the person considers tolerable.

However, a patient is not eligible for access to voluntary assisted dying merely because the person has:

- a disability, or
- dementia, or
- a mental health impairment within the meaning of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020.*

Assessing a patient's eligibility will include reviewing any relevant documentation and may, among other things, include discussion with other members of the patient's treating team as per usual practice.

If, after this, the patient's coordinating or consulting practitioner is unable to decide whether the patient is diagnosed with a disease, illness or medical condition that meets the criteria outlined above, they must refer the person to a medical practitioner with appropriate skills and training for a determination in relation to the matter.

More information is available in *Table 9*.

Diagnosis

The coordinating 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 patient's medical condition.

Progressive indicates that the patient is experiencing an active deterioration that will continue to decline.

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:

- information obtained during 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 practitioner.

Prognosis

The eligibility criteria requires that the person's disease, illness or medical condition is expected to, on the balance of probabilities, cause death within a period of six months, **or** in the case of a disease, illness or condition that is neurodegenerative, within a period of 12 months.

The coordinating 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:

- information obtained during 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 practitioner.

During the final six or 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 a 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 further opinion where appropriate. *Appendix 1* 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 the eligible six-or 12-month period. 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 the eligible six-or 12-month period — for example, ceasing chemotherapy for managing cancer or ceasing non-invasive ventilation for chronic respiratory failure. Under these circumstances, the person's prognosis should be assessed in the context of their new treatment choice, and they may become eligible to access voluntary assisted dying where previously, they were not.

Suffering

A further requirement for accessing voluntary assisted dying is that the person's disease, illness or medical condition is causing suffering that cannot be relieved in a manner that the person considers tolerable.

Suffering has been defined as "the state of severe distress associated with events that threaten the intactness of the person" (Cassel, 1991) and as an "anguishing experience which can severely affect a person on a psychophysical and even existential level" (Bueno-Gomez, 2017). While it often occurs in the presence of pain, shortness of breath, or other symptoms, a person's experience of physical and psychological suffering can be the result of a range of interconnected factors:

- the disease, illness or 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 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 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.

The coordinating and consulting practitioner must explain all palliative and other treatment options. If not already in place, the coordinating and consulting practitioner should consider, with consent of the patient, a referral to the palliative care service to explore options for symptom control and end of life care planning.

9.4.3 Assessing decision-making capacity in relation to voluntary assisted dying

Medical practitioners frequently assess their patients' understanding of treatment options as part of standard clinical practice. Under NSW law, every person has the right to the presumption of capacity and this presumption is maintained within the Act (see point 2(a) and 2(b) below). However, a clinician must assess decision-making capacity as it specifically relates to voluntary assisted dying as outlined within the Act.

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 such as family, carers, cultural supports, education from healthcare teams. This may include the timely provision of written information in the person's primary language (where available)
- the time and context in which the decision is being made

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

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

The assessment of decision-making capacity specifically related to voluntary assisted dying is outlined in the Act and below:

1. For the purposes of the Act, a patient has decision-making capacity in relation to voluntary assisted dying if the patient has the capacity to:
   (a) understand information or advice about a voluntary assisted dying decision required under the Act to be provided to the patient, and
   (b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and
   (c) understand the matters involved in a voluntary assisted dying decision, and
   (d) understand the effect of a voluntary assisted dying decision, and
   (e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and
   (f) communicate a voluntary assisted dying decision in some way.
2. For the purposes of the Act, a patient is:
   (a) presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision, and
   (b) presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity.

Note: That a person may communicate their decision using speech, gestures, or other assisted communication means available to the patient, such as using symbol boards or sign language.

All adults are **presumed to have decision-making capacity** unless there is evidence otherwise. In good clinical practice, it should not be presumed that 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 or a history of trauma
- because the person makes a decision other people may not agree with.

Decision-making capacity can fluctuate, and a person may temporarily lose capacity and then later regain it, for example, due to:

- Medications (e.g., benzodiazepines, opioids or other sedatives)
- Delirium from intercurrent illness (e.g., infection or trauma)

When undertaking this assessment, the medical practitioner should ideally choose a time when the patient's symptom control is optimal, they are not overly tired and not experiencing adverse effects from medication. Equally, a patient has the right to be supported in decision-making. Examples of support include (but are not limited to):

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

The presence of ***depression*** in people who are at the end of life and experiencing suffering and a loss of hope is not uncommon. This does not mean the patient has lost decision-making capacity. If a coordinating or consulting practitioner believes the patient is depressed, they should carefully explore with the patient how this is affecting them, as part of the decision-making capacity assessment. If, after discussion with the patient, there are unresolved doubts, the coordinating or consulting practitioner must make a referral for determination of decision-making capacity.

The presence of ***cognitive impairment*** in people who are at the end of life and experiencing major physical illness is not uncommon. The fact that a person has cognitive impairment may, but does not necessarily, mean they do not have decision-making capacity in relation to voluntary assisted dying. If a coordinating or consulting practitioner believes the patient has cognitive impairment, they should carefully explore with the patient how this is affecting them, as part of the decision-making capacity assessment. If, after discussion with the patient, there are unresolved doubts the coordinating or consulting practitioner must make a referral for determination of decision-making capacity.

Other ***socially mediated factors*** that may impact a person's decision-making capacity in relation to voluntary assisted dying may need to be explored and considered in a similar manner to the examples above. Examples could include pressure, duress (expanded below), severe financial stress or lack of carer support or sufficient services.

The coordinating and consulting practitioner may find it useful to use a capacity and consent tool to guide discussions with the patient. While there are no validated tools specific to assessing decision-making capacity in relation to voluntary assisted dying, *Table 8* may be helpful in framing the assessment discussions.

Table 8. Assessing decision-making capacity in relation to voluntary assisted dying: possible approaches

Criterion	Patient's task	Medical practitioner's assessment approach	Questions for clinical assessment	Red flags – require further investigation
• Understand the information or advice about a voluntary assisted dying decision required to be given to the patient. • Remember the information or advice to the extent necessary to make a decision. • Understand the matters involved in, and the effect of, a decision. • Weigh up the factors mentioned above for the purposes of making a decision. • Communicate a decision in some way.	Understand their current health situation, their options and the decisions they are making. Grasp the fundamental nature of voluntary assisted dying and that it would lead to their death.	Encourage the patient to describe in their own words the following: • their medical condition • prognosis • treatment options • palliative care options • the nature of voluntary assisted dying and the fact it would lead to their death. Also encourage the patient to express their thoughts and decision making process around their medical condition and end of life choices.	Questions about health and treatment: • What is the problem with your health now? • How do you feel about your health now? • What are your treatment options? • What would happen if you are not treated for your health condition? • What are the benefits of palliative care? • What are the risks of palliative care? • What is voluntary assisted dying? • What would happen if you take the voluntary assisted dying substance? *(Pesiah et al., 2019)*	• Patient does not accept or remember their condition. • Patient is unclear about their medical condition or prognosis. • Patient fails to recount possible palliative care options. • Patient fails to recount treatment options and their consequences. • Patient fails to recount what would happen if they are not treated. • Patient cannot remember their choices or express them in a consistent way.

Medical practitioners may also wish to consult the NSW Health *Consent to Medical and Healthcare Treatment Manual* or the NSW Government *Capacity Toolkit* for an overview of the guiding principles of capacity and clinical assessments in decision-making capacity.

Referral for opinion on decision-making capacity

Assessing a patient's eligibility will include reviewing any relevant documentation and may, among other things, include discussion with other members of the patient's treating team as per usual practice

If, after this, the patient's coordinating or consulting. practitioner is unable to determine if the patient has decision making capacity in relation to voluntary assisted dying, they must refer the patient to a psychiatrist or another health practitioner who has appropriate skills and training to make a decision about the matter.

More information is available in *Table 9*.

9.4.4 Assessing whether a person has a request to access voluntary assisted dying and is acting voluntarily, without pressure or duress

Identifying pressure or duress

The medical practitioner must be satisfied that the patient is acting voluntarily and not because of pressure or duress and that their request for access to voluntary assisted dying is enduring. Time should be taken to discuss and understand the reasons why the patient is requesting access to voluntary assisted dying. These conversations will provide insight into the patient's concerns and why they think accessing voluntary assisted dying will address these concerns. The coordinating and consulting practitioner can ask the patient how they reached their decision, including what or who may have influenced them.

If a patient is requesting access to voluntary assisted dying because they are concerned that they are 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 and consulting practitioner should also seek to understand why the patient 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 struggles with their current situation. Such comments should also raise a 'red flag' to the coordinating or consulting practitioner to explore whether there may be any element of explicit or implicit coercion underlying the patient's request for voluntary assisted dying.

It is also relevant for the coordinating and consulting practitioner to recognise if the patient is being coerced or pressured not to access voluntary assisted dying. This will indicate that the patient is likely to need additional support and planning. The coordinating practitioner will need to be especially 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 firstly include talking with the patient on their own and, if appropriate and with the patient's consent, discussing with the family how they feel about the patient's decision to request access to voluntary assisted dying (along with observation and assessment of family dynamics). Discussion with members of the treating team about observations and conversations that they may have had with the patient, or their carers, family or friends may also provide useful insights into the motivation behind the patient's decision.

Indicators of possible pressure or duress that are often detected during a consultation with carers, family or friends present may include:

- excessive deferment by the patient to carers, family or friends for answers, reassurance or explanation
- carers, family or friends talking over the patient and answering on their behalf
- inconsistencies in the patient's answers to questions about their suffering, illness experience or voluntary assisted dying in general
- carers, family or friends threatening to withdraw care and support from the patient.

It may be necessary to talk with the patient 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 that the decision wasn't made freely and voluntary; the focus is on whether the person can make a decision free of intimidation, pressure or influence. Questions the coordinating and consulting practitioner could ask in their discussion with the patient include:

- Are you feeling any pressure from others to request voluntary assisted dying?
- Do you have or are there any significant financial concerns?
- Do you have any concerns about your family at the moment, during your illness, or after you die?
- Is there anything we need to know that you don't want your family to know?
- Tell me about your family/friends (may include partners, spouse, children, parents, siblings)?
  - Are they aware of your request for voluntary assisted dying?
  - How do they feel about it?
  - Do they support your decision?
- Is your GP aware of your request for voluntary assisted dying?
  - Does your GP support you having discussions about voluntary assisted dying?
- Are you feeling any pressure from others to not request 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, as would be normal clinical best practice. Additional information on the prevention and response to violence, abuse and neglect can be found on the *NSW Health website*.

If the coordinating or consulting practitioner is not satisfied the person's request for access to voluntary assisted dying is voluntary and free from pressure or duress, they must assess the person as ineligible for voluntary assisted dying.

Further information can be found in the following NSW Health Policy Directives:

- *Identifying and responding to abuse of older people*
- *Domestic Violence – Identifying and Responding*

Referral for opinion on voluntariness and pressure or duress

Assessing a patient's eligibility will include reviewing any relevant documentation and may, among other things, include discussion with other members of the patient's treating team as per usual practice.

However, the Act requires that where the coordinating or consulting practitioner cannot determine whether the person is acting voluntarily or whether the patient is or is not acting because of pressure or duress, they must refer the patient to a psychiatrist or another registered health practitioner or person who has appropriate skills and training to make a decision about the matter.

More information is available in *Table 9*.

9.4.5 Referral for opinion on certain eligibility criteria

A medical practitioner, other registered health practitioner or person who receives a referral for opinion on eligibility (as described in the previous section):

- Must not be a family member of the patient, or
- Must not be a person who knows or believes that they:
  - Are a beneficiary under a will of the patient, or
  - May otherwise benefit financially or in any other way from the death of the patient, other that by receiving reasonable fees for the provision of services in connection with the referral.
- Does not need to have completed mandatory training
- Does not need to be an authorised voluntary assisted dying practitioner
- Will need to be informed:
  - of the requirements of the voluntary assisted dying process, including the mandate for a formal report
  - that if a patient raises questions about the voluntary assisted dying process (including administration) during the referral assessment, these questions should be referred back to the patient's coordinating or consulting practitioner
  - that the referral assessment can be conducted virtually, if clinically appropriate.
- Will ideally have:
  - An understanding of the NSW voluntary assisted dying process
  - An understanding of the principles outlined in earlier sections in relation to:
    - Use of interpreters in voluntary assisted dying (see *section 4.3*)
    - Principles of clinician documentation (see *section 4.5 Documenting in the medical record)*

In line with good clinical practice, when a coordinating or consulting practitioner makes a referral for opinion on eligibility, they should explain the reason for the referral to the patient. The coordinating or consulting practitioner may adopt the decision of the medical practitioner, other health practitioner or other person to whom they have referred, or they may choose to rely on their own determination. If they do not accept the determination from the person whose opinion was sought, they should have robust reasons for their decision that are well documented. It is important that medical practitioners are able to recognise and act within their scope of experience and expertise.

Table 9 outlines when a referral for opinion on certain aspects of eligibility is mandatory under the Act.

Table 9. Referrals for opinion on eligibility during first assessment or consulting assessment

Event	Referral Pathway	Requirements
Coordinating or consulting practitioner is unable to decide whether patient has a disease, illness or medical condition that meets the eligibility criteria	The practitioner must refer to a medical practitioner who has appropriate skills and training to make a decision about the matter.	The medical practitioner who accepts the referral must: • Assess whether the patient meets eligibility criteria relating to their disease, illness or medical condition (see section *9.4.2 Assessing whether the patient has an eligible disease, illness or medical condition*). • Provide a clinical report outlining their decision to the referring coordinating or consulting practitioner. The referring coordinating or consulting practitioner: • May adopt the decision of the medical practitioner about the matter. • Must record the outcome of referral in the ***First Assessment Report Form***, and submit a copy of the report prepared by the medical practitioner whose opinion was sought.
Coordinating or consulting practitioner is unable to decide whether the patient currently has decision-making capacity in relation to voluntary assisted dying	The practitioner must refer to a psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter.	The registered health practitioner or other assessor who accepts the referral must: • Assess whether the patient has decision-making capacity as it relates to voluntary assisted dying (see section *9.4.4 Assessing decision-making capacity in relation to voluntary assisted dying*). • Provide a report to the referring coordinating or consulting practitioner outlining their opinion or recommendation about the eligibility criteria. The referring coordinating or consulting practitioner: • May adopt the decision of the practitioner about the matter. • Must record the outcome of referral in the ***First Assessment Report Form***, and submit a copy of the report prepared by the practitioner whose opinion was sought.
Coordinating or consulting practitioner is unable to decide whether the patient is acting voluntarily or is not acting because of pressure or duress	The practitioner must refer to a psychiatrist or another registered health practitioner or a person who has appropriate skills and training to make a decision about the matter.	The registered health practitioner or other person who accepts the referral must: • Assess, as requested, whether the patient is acting voluntarily and/or because of pressure or duress (see section *9.4.4 Assessing voluntariness and pressure or duress*). • Provide a report to the referring coordinating or consulting practitioner outlining their opinion or recommendation about the eligibility criteria. The referring coordinating or consulting practitioner: • May adopt the decision of the person about the matter. • Must record the outcome of referral in the ***First Assessment Report Form*** and submit a copy of the report prepared by the person whose opinion was sought.

9.5 Step 2: If eligible, medical practitioner provides patient with required information

If the medical practitioner decides that the patient meets all eligibility criteria, the Act specifies that they must inform the patient of certain matters. To mitigate the risk of breaching the Commonwealth Criminal Code, this should occur face-to-face.

Under section 28 of the Act, the medical practitioner must not only inform the person of the required information, but they must also be satisfied that the person **understands the information** to assess them as eligible for voluntary assisted dying.

The medical practitioner must inform the patient about:

- the patient's diagnosis and prognosis,
- the treatment options available to the patient that would be considered standard care for the disease, illness or medical condition with which the patient has been diagnosed and the likely outcomes of treatment,
- the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,
- the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing the patient's death,
- that the expected outcome of self-administering or being administered a voluntary assisted dying substance is death,
- the method by which a voluntary assisted dying substance is likely to be self-administered or administered,
- the request and assessment process, including the requirement for a written declaration signed by the patient, or a person on the patient's behalf, in the presence of two witnesses,
- that if the patient makes a self-administration decision, the patient must appoint a contact person,
- that the patient may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying,
- it is unlawful for a person to apply pressure or duress on the patient to request voluntary assisted dying or to continue the request and assessment process,
- that if the patient is receiving ongoing health services from a medical practitioner (the treating practitioner) other than the coordinating practitioner –
  - i. the patient is encouraged to inform the treating practitioner about the patient's request for access to voluntary assisted dying, and
  - ii. it is unlawful for the treating practitioner to withdraw other services the practitioner would usually provide to the patient or the patient's family and other close contacts because of the patient's request for access to voluntary assisted dying, and
  - iii. if the treating practitioner withdraws services mentioned in subparagraph (ii) — the matter should be the subject of a complaint to the Health Care Complaints Commission under the Health Care Complaints Act 1993,
- if the patient is a residential facility resident, whether permanently or not, the patient should inform the residential facility manager about their request for access to voluntary assisted dying.

The above information can be provided verbally to the patient during the assessment. It does not need to be provided to the patient in writing. A checklist of the information that must be provided to the person is available in the Resource Hub within the Portal. The coordinating and consulting practitioner may use this checklist as a prompt to ensure they have provided all the information required under section 28 of the Act.

Additional information to be discussed by the coordinating practitioner (not relevant for consulting practitioners)

In addition to providing the above information to the patient, the coordinating practitioner must take all reasonable steps to fully explain to the patient:

- all relevant clinical guidelines (e.g. describing how and when the voluntary assisted dying substance can be administered), and
- a plan in relation to the administration of a voluntary assisted dying substance.

If the patient consents, these discussions can also include a support person. While the inclusion of carers, family or friends in these discussions should be encouraged, it always remains the patient's choice as to who is involved. The coordinating practitioner should explore with the patient 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.

As the patient will not have made an administration decision at the point of first assessment, the discussion about clinical guidelines and a plan in relation to administration of a voluntary assisted dying substance will be broad and high-level at this stage of the process. These topics will then be covered in more detail at the in-person consultation in which the patient makes their administration decision. Details on planning for death are covered later in this Handbook (see *14.8 Planning for death*).

9.6 Step 3: Coordinating practitioner informs the patient of the outcome of the assessment

The patient must be assessed as eligible for access to voluntary assisted dying if the coordinating practitioner is satisfied the patient:

- meets all of the eligibility criteria, and
- understands the information provided to them (see *Step 2 of this section*).

If the coordinating practitioner is not satisfied about any of these matters, they must assess the patient as ineligible.

Regardless of whether the patient has been assessed as eligible or ineligible for access to voluntary assisted dying, the practitioner must:

- inform the patient of the outcome of the assessment as soon as practicable after the first assessment is completed; and
- provide the patient with a copy of the completed ***First Assessment Report Form*** as soon as practicable after the form is completed. *Note: that specific timeframes for completion of this form apply (see Step 4 of this section).*

9.6.1 Discussing the outcome with a person who is ineligible

It may be difficult for a person seeking to access voluntary assisted dying to accept that they are not eligible for the process. The practitioner should listen compassionately to the patient and, if possible and appropriate, discuss with the patient how their treating healthcare team may alleviate any physical symptoms or psychosocial and spiritual distress they may be experiencing. Based on the discussion, suitable referrals should be made, and the patient's care plan updated. Additional support from a specialist palliative care team may benefit the patient if one is not already involved in the patient's care.

If the patient agrees, it may be helpful to discuss their situation concerning voluntary assisted dying with their treating healthcare team and family. However, the patient's confidentiality and privacy must always be respected. If they do not wish others to be informed of their request to access voluntary assisted dying, this must be upheld. As part of explaining to the patient why they are ineligible the coordinating practitioner should address, if relevant, that the patient's eligibility may change if their circumstances change. For example, if the patient's prognosis changes they may then become eligible for voluntary assisted dying. If circumstances do change, the patient may commence the process again by making a new first request to the same medical practitioner or a different one.

- Relevant referrals for extra support may be required, to relevant healthcare workers such as a social worker, psychologist, or Aboriginal and Torres Strait Islander Health Worker, Practitioner, or Liaison Officer. In some circumstances details of crisis support services should be given (such as *Lifeline* or *Beyond Blue*).

9.7 Step 4: Coordinating practitioner documents the first assessment

The coordinating practitioner must complete the ***First Assessment Report Form*** and submit it to the Board via the Portal within five business days after completing the first assessment.

10 Consulting assessment

10

10.1 Overview

During the consulting assessment, the consulting practitioner must assess the patient independently of the coordinating practitioner. However, in making their assessment, the consulting practitioner may consider information prepared by or provided to them by the patient's coordinating practitioner, or any another registered health practitioner.

Figure 4 outlines the steps in the consulting assessment.

Figure 4. Steps in the consulting assessment

Coordinating practitioner refers to another eligible authorised practitioner for consulting assessment

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Authorised practitioner accepts the referral

- Authorised practitioner who receives the referral must complete ***Consultation Referral Form*** and submit to the Board within 5 business days after deciding to accept or refuse the referral
- By accepting the referral, the practitioner becomes the patient's consulting practitioner

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Consulting practitioner assesses patient against eligibility criteria

- Age: 18+
- Residency
- Medical criteria
- Decision-making in relation to voluntary assisted dying
- Request is voluntary, enduring and free from pressure or duress

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Consulting practitioner provides information to patient

If the consulting practitioner is satisfied the patient meets all eligibility criteria, they must:

- Provide information under Section 28(1)
- Confirm patient understands information

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Process map continues onto next page

Consulting practitioner determines outcome of consulting assessment

- Advise patient and coordinating practitioner of outcome as soon as practicable*

Consulting practitioner documents the consulting assessment

- Complete ***Consulting Assessment Report Form*** and submit to the Board within 5 business days after completing the consulting assessment
- Provide a copy of the ***Consulting Assessment Report Form*** to the patient and coordinating practitioner as soon as practicable

*If patient found to be ineligible by the consulting practitioner, the coordinating practitioner can refer for another consulting assessment.

10.2 Commonwealth Criminal Code

To mitigate the risk of breaching the Commonwealth Criminal Code, the consulting assessment should occur face-to-face. If an interpreter is required, the interpreter should also attend in person to avoid breaching the Commonwealth Criminal Code.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

10.3 Timeframe

There is no timeframe in which the consulting assessment must be completed. Coordinating practitioners need to consult with their patient to ensure that the patient is ready to take the next step in the process before making a referral for a consulting assessment.

10.4 Step 1: Coordinating practitioner refers patient for a consulting assessment

Coordinating practitioners need to make a referral to another authorised practitioner for the patient to have a consulting assessment. Only a medical practitioner who is eligible to be a consulting practitioner can take on this role for a patient and accept a referral. To identify an authorised practitioner who may be able to act as a consulting practitioner, in the first instance, the coordinating practitioner should contact their local voluntary assisted dying coordinator (or similar) if applicable. If local arrangements are unavailable, the coordinating practitioner should contact the *VAD-CNS* for assistance in identifying an authorised practitioner who may be able to act as a consulting practitioner. Medical practitioners who are not authorised voluntary assisted dying practitioners should not receive referrals for consulting assessments.

- A proforma for referring for a consulting assessment is available on the Portal, but its use is not mandatory. The information in the proforma can be used by the medical practitioner to complete the ***Consultation Referral Form*** in the Portal, and if they are accepting the role, they will be automatically assigned as the consulting practitioner for the patient.

If a referral for consulting assessment is not accepted by a medical practitioner, the coordinating practitioner can make a referral to a different medical practitioner.

10.4.1 Refusing a referral for consulting assessment

A medical practitioner must refuse the referral if the practitioner is not eligible to act as a consulting practitioner for the patient – for example, if they are a family member of the patient, or believe that they are a beneficiary under a will of the patient.

A medical practitioner may refuse a referral for a consulting assessment if they:

- Are unwilling to perform the required duties, or
- Are unable to perform the required duties because they are unavailable or because of another reason.

If the medical practitioner refuses the referral for consulting assessment, they must tell the patient and the patient's coordinating practitioner that they refuse the referral within two business days of receiving the referral.

If the referral is refused for any reason, under the Act the medical practitioner must document the referral in the patient's medical record, and notify the Board (see *Step 2 of this section*).

If the medical practitioner who is not an authorised practitioner receives a referral and they must refuse it, and if they have a conscientious objection to voluntary assisted dying, they must tell the patient and the patient's coordinating practitioner of the refusal immediately after receiving the referral.

10.4.2 Accepting a referral for consulting assessment

An eligible practitioner may choose to accept a referral for a consulting assessment. By accepting, they are agreeing to assume the role of consulting practitioner for that patient, and to fulfil all the responsibilities of the consulting practitioner (outlined in *7 Practitioner participation in voluntary assisted dying*).

If the practitioner decides to accept the referral for consulting assessment, they must tell the patient and the patient's coordinating practitioner that they accept the referral within two business days of receiving the referral.

10.5 Step 2: Medical practitioner documents the referral for consulting assessment

10.5.1 Recording the referral in the medical record

Regardless of whether a referral for a consulting assessment is accepted or refused, the medical practitioner must record the referral in the patient's medical record, as well as whether the practitioner accepted or refused the request (and if refused, the reason for refusal).

10.5.2 Notifying the Board of the referral

The medical practitioner who receives the referral for consulting assessment must complete the ***Consultation Referral Form*** and submit it to the Board via the Portal within five business days after deciding to accept or refuse the referral.

This applies to all medical practitioners who receive a referral for consulting assessment, regardless of whether the request was accepted or refused, or the practitioner's eligibility to act as the consulting practitioner for that patient.

10.6 Step 3: Consulting practitioner conducts a consulting assessment and refers for opinion if required

Before the consulting assessment, the consulting practitioner must have accepted the referral for consulting assessment.

The consulting practitioner is required to complete a consulting assessment, to independently assess the patient's eligibility for access to voluntary assisted dying. The process for a consulting assessment is similar to the process for a first assessment. Consulting practitioners should refer to the guidance in *Step 1* and *Step 2 of first assessment*.

Any referrals for opinion that were made by the coordinating practitioner may be used by the consulting practitioner to inform their assessment.

However, the consulting practitioner may make further requests for opinion to relevant persons as per *Step 1 of first assessment* if required (see *Table 9*).

10.7 Step 4: Consulting practitioner informs the patient and their coordinating practitioner of the outcome of the assessment

The patient must be assessed as eligible for access to voluntary assisted dying if the consulting practitioner is satisfied the patient:

- meets all of the eligibility criteria (see *Step 1 of first assessment*), and
- understands the information provided to them (see *Step 2 of first assessment*).

If the consulting practitioner is not satisfied about any of these matters, they must assess the patient as ineligible.

Regardless of whether the patient has been assessed as eligible or ineligible for access to voluntary assisted dying, the practitioner must:

- inform the patient and the patient's coordinating practitioner of the outcome of the assessment as soon as practicable after the consulting assessment is completed; and
- provide the patient and the patient's coordinating practitioner with a copy of the completed ***Consulting Assessment Report Form*** as soon as practicable after its completion. *Note: specific timeframes for completion of this form apply* (see *Step 5 of this section*).

10.8 Step 5: Consulting practitioner documents the consulting assessment

The consulting practitioner must complete the ***Consulting Assessment Report Form*** and submit it to the Board via the Portal within five business days after completing the consulting assessment.

10.9 Ineligible outcome of consulting assessment

10.9.1 Discussion regarding ineligibility of the consulting assessment

The discussion with a patient who is assessed as ineligible following a consulting assessment may be challenging, especially given that the person was assessed as eligible by the coordinating practitioner during their first assessment. The consulting practitioner will need to be clear when informing the patient of the assessment outcome that they have determined the patient is ineligible for voluntary assisted dying. The consulting practitioner should address, if relevant, that the patient's eligibility may change if their circumstances change. They should consider the risk to the patient from this disclosure, and ensure appropriate safety-netting and follow up will occur. For further guidance on managing conversations with patients who are assessed as ineligible, see *9.6 Discussing the outcome with a person who is ineligible*, within the first assessment section of this Handbook.

10.9.2 Managing disagreement on eligibility

There may be occurrences where the consulting practitioner has a different opinion to the coordinating practitioner's assessment regarding a patient's eligibility for voluntary assisted dying. Medical practitioners are expected to approach the issue with professional open communication.

Examples where this might happen, include:

- A patient has deteriorated in mental state and no longer has decision-making capacity.
- New information has come to light to suggest that the patient is making the decision to request voluntary assisted dying under duress.
- There is a change in the clinical scenario and hence prognosis, for example new staging scans conducted by the treating physician reveal an unexpectedly positive response to intercurrent treatment.
- There is a difference in opinion about prognosis. This is particularly relevant for diseases where there is limited knowledge about disease progression, or there are challenges with prognostication, such as in end stage renal disease, some haematological conditions, and some neurological syndromes.

The patient will have been directly notified by the consulting practitioner of the differences of opinion. In this situation, the coordinating practitioner should follow up with the patient and have a discussion to determine if they wish to continue seeking access to voluntary assisted dying. If they do, the coordinating practitioner may refer for another consulting assessment. However, the coordinating practitioner should consider reviewing the patient's eligibility prior to referring for an additional consulting assessment. It is important for the coordinating and consulting practitioners to work within their scope of expertise.

10.9.3 Referral for further consulting assessment if patient assessed as ineligible

If the consulting practitioner assesses the patient as ineligible for voluntary assisted dying, the patient's coordinating practitioner may refer the patient to another medical practitioner for a further consulting assessment. This must be done in consultation with and with consent from the patient.

11 Written declaration

11

11.1 Overview

The written declaration is the patient's second formal request in the voluntary assisted dying process. To make a written declaration, the patient must have been found eligible by the coordinating and consulting practitioner. A written declaration must be made in the presence of two witnesses, documented in the approved form and given to the coordinating practitioner. The written declaration is completed by the patient in the presence of two witnesses, and as such, this step of the voluntary assisted dying process must occur in person.

Figure 5 outlines the steps in the written declaration.

Figure 5. Steps in the written declaration

Coordinating or consulting practitioner gives the patient a copy of the ***Written Declaration*** form, downloaded from the Portal

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Patient completes the ***Written Declaration**** in the presence of two eligible witnesses who also sign the ***Written Declaration***

A person is an ineligible witness if they:

- know or believe they are a beneficiary under the patient's will or may otherwise benefit financially or in any other material way from their death
- are a family member of the patient
- are the patient's coordinating or consulting practitioner, or a family member or employee of the coordinating or consulting practitioner

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Patient gives the completed ***Written Declaration*** to the coordinating practitioner

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Coordinating practitioner documents the patient's ***Written Declaration***

- Submit a copy of the ***Written Declaration*** to the Board within 5 business days after receiving it from the patient
- Record the following in the patient's medical record:
  - The date the ***Written Declaration*** was made
  - The date it was given to the coordinating practitioner

*Written Declaration cannot be completed until after the consulting assessment in which the patient was found to be eligible.

11.2 Timeframe

A patient can make a written declaration at any time after the consulting assessment in which they were found to be eligible for voluntary assisted dying.

11.3 Step 1: Patient makes a written declaration

To make a written declaration, a patient must complete the approved ***Written Declaration***, sign the form in the presence of two eligible witnesses, and provide the completed form to their coordinating practitioner.

The patient's coordinating practitioner is responsible for providing the ***Written Declaration*** to the patient to complete. It can also be provided by the patient's consulting practitioner, or if a replacement form is required, by the VAD-CNS. The form can be downloaded and printed from the Portal, within the patient's record.

The Portal will pre-populate the form for each patient, for ease of completion by the patient and their witnesses. If a replacement copy is required, the VAD-CNS can email or post a copy of the form to the patient.

The written declaration states that the patient:

- Is making the declaration voluntarily, and
- Is not making the declaration because of pressure or duress, and
- Understands its nature and effect.

11.3.1 Completing the Written Declaration when a patient is able to sign

A ***Written Declaration*** should usually be signed physically. It can only be signed electronically if:

a) the patient is not able to physically sign the declaration, and

b) the patient generally uses a digitised signature to sign documents, and

c) signing the declaration by electronic means takes the form of the patient signing the declaration by using a digitised signature.

Each witness must sign the ***Written Declaration*** certifying that:

- the patient appeared to sign the declaration freely and voluntarily in their presence, and
- they are not knowingly an ineligible witness.

11.3.2 Completing the Written Declaration when a patient is unable to sign

If a patient is unable to sign the ***Written Declaration***, for example due to issues with manual dexterity, they may direct another person to sign on their behalf.

The person signing on behalf of the patient must:

- Be an adult (at least 18 years of age),
- Not be one of the two witnesses to the signing of the declaration, and
- Not be the coordinating or consulting practitioner for the patient.

In this situation, the witnesses to the signing of the ***Written Declaration*** must certify in writing in the declaration that:

- the patient making the declaration appeared to freely and voluntarily direct another person to sign the declaration
- the other person signed the declaration in the presence of the patient and the witness
- they are not knowingly an ineligible witness.

11.3.3 Witnesses to Written Declaration

Two eligible witnesses must be present at the time the patient makes their ***Written Declaration***. To be an eligible witness, the person must:

- Be an adult (at least 18 years of age)
- Not know or believe they are a beneficiary under a will of the patient making the declaration or may otherwise benefit financially or in any other material way from the death of the patient
- Not be a family member of the patient, meaning:
  - the person's spouse or de facto partner,
  - the person's parent or step parent, or a sibling of the person's parent or step parent,
  - the person's grandparent or step grandparent,
  - the person's sibling or step sibling, or a child of the person's sibling or step sibling,
  - the person's child or step child,
  - the person's grandchild or step grandchild
- Not be the coordinating or consulting practitioner for the patient
- Not be a family member or employee of the coordinating or consulting practitioner for the patient.

Best practice guidance regarding witnesses to a *Written Declaration*

Staff at health facilities where the coordinating practitioner works may be approached to be a witness to a ***Written Declaration***. If approached, staff members and the patient's coordinating practitioner should consider best practice guidance for choosing witnesses.

Best practice is to ensure that a witness is not in a position where they may be under influence of the coordinating practitioner. This may include:

- A direct report of the coordinating practitioner
- A staff member who could be under influence in another way e.g., significantly junior, or likely to be in a position working under the coordinating practitioner in a future role.

11.3.4 Use of an interpreter

Where an interpreter is required to complete the written declaration, the interpreter must certify on the original declaration (i.e. not a copy) that they provided a true and correct translation of any material translated during this step. This will require the interpreter to attend the signing of the ***Written Declaration*** in person, unless the original is sent via post for signature.

Coordinating practitioners may consider arranging an interpreter to attend a face-to-face consultation with the patient, in which the ***Written Declaration*** may be completed at the same time as the final request. Completing the ***Written Declaration*** in the presence of the coordinating practitioner may also be arranged to support any patient questions that may arise.

For more information on interpreters in the voluntary assisted dying process, see the section *4.3 Use of interpreters in the voluntary assisted dying process*.

11.4 Step 2: Coordinating practitioner documents the written declaration

11.4.1 Recording the written declaration in the medical record

When a patient gives their written declaration to their coordinating practitioner in the approved form, the coordinating practitioner must record the written declaration in the patient's medical record, including:

- The date the written declaration was made; and
- The date the written declaration was received by the coordinating practitioner.

11.4.2 Notifying the Board of the written declaration

The coordinating practitioner must submit a copy of the patient's ***Written Declaration*** to the Board via the Portal within five business days after receiving the declaration. The coordinating practitioner can give the original copy back to the patient.

12 Final request

12

12.1 Overview

A clear, unambiguous final request is the third formal request for access in the voluntary assisted dying process. The final request needs to be made by the patient to the patient's coordinating practitioner, and is the only step in the process with guidance on timeframes for the patient, outlined under *12.3 Timeframe*. The same principles apply to the final request as other steps in the process, in that the decision must be made voluntarily by a patient with decision-making capacity in relation to voluntary assisted dying, and without pressure or duress.

Figure 6 outlines the steps in the final request.

Figure 6. Steps in the final request

Patient makes a clear, unambiguous final request to the coordinating practitioner

Final request can only be made after the end of the designated period (unless there are grounds for exemption) and at least one day after the consulting assessment

Coordinating practitioner documents the final request

- Complete the ***Final Request Form*** and submit to the Board within 5 business days after final request
- Record the following in the patient's medical record:
  - The date of final request
  - If the final request was made before the end of the designated period, the reason for this

12.2 Commonwealth Criminal Code

The final request may be conducted via telehealth where a face-to-face consultation is not practicable, and where telehealth is clinically appropriate.

However, if the patient or practitioner wishes to discuss anything relating to the following during the final request, to mitigate the risk of breaching the Criminal Code, this should occur face-to-face:

- potential risks of administering the voluntary assisted dying substance,
- a plan for the administration of the voluntary assisted dying substance.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

12.3 Timeframe

The Act specifies two timeframes in relation to a final request.

First, the final request cannot be made until **at least one day after the consulting assessment**. For example, if a consulting assessment occurs on a Tuesday, the final request cannot be made until Wednesday, being one day after the date of consulting assessment.

The Act also specifies that the final request cannot be made until **after** the end of the 'designated period', which starts on the day of the first request and ends five days after that day. For example, if a patient makes a first request on the 1st of a month, the patient cannot make the final request until the 7th. This example is shown in the diagram below.

The Act does allow for the final request to be made before the end of the **designated period** if the coordinating practitioner believes that the patient is likely to die or to lose decision-making capacity in relation to voluntary assisted dying before the designated period has elapsed, and this is consistent with the opinion of the consulting practitioner. However, the final request still cannot be made until at least one day after the consulting assessment.

Subject to these two timeframes and if appropriate in the circumstances, the patient may make the final request at the same time as they provide the coordinating practitioner with their ***Written Declaration***. The coordinating practitioner does not need to submit a copy of the ***Written Declaration*** to the Board before the patient makes a final request, but must submit the Written Declaration to the Board before they submit the ***Final Request Form***.

Example of the designated period (timeframe). This example is used for illustrative purposes only, noting that a patient can take as much time as they want to move through the process.

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1 July	2 July	3 July	4 July	5 July	6 July	7 July
First request made					Consulting assessment must occur at least one day before the final request is made	Final request can be made from this date onwards

Key: Pink shading indicates the duration of the designated period in this example.

12.4 Step 1: Patient makes a final request

The final request must be:

- Clear and unambiguous, and
- Made in person or via telehealth if a face-to-face consultation is not practicable.

Similarly to a first request, a final request must be made by the person seeking access to voluntary assisted dying and can be made using any method of communication the person uses, such as spoken language, sign language or alternative communication. No one can make a final request on behalf of another person and an advanced care directive cannot replace a final request. The final request can be made in a clinical setting (e.g., hospital or health clinic) or a non-clinical setting (e.g., in a patient's home).

12.5 Step 2: Coordinating practitioner documents the final request

12.5.1 Documenting the final request in the medical record

The coordinating practitioner must record the final request in the patient's medical record, including:

- The date the patient made the final request; and
- If the final request was made before the end of the designated period (*12.3 Timeframe*), the reason for this.

12.5.2 Notifying the Board of the final request

The coordinating practitioner must complete the ***Final Request Form*** and submit it to the Board via the Portal within five business days after the date the patient makes the final request.

13 Final review

13

13.1 Overview

Conducting a final review is the final step in the request and assessment portion of the voluntary assisted dying process. The coordinating practitioner completes the final review to ensure the process has been followed in line with the Act in relation to that patient.

The final review requires the coordinating practitioner to:

- Review all consulting assessment report forms and the ***Written Declaration***, and
- Complete the ***Final Review Form***

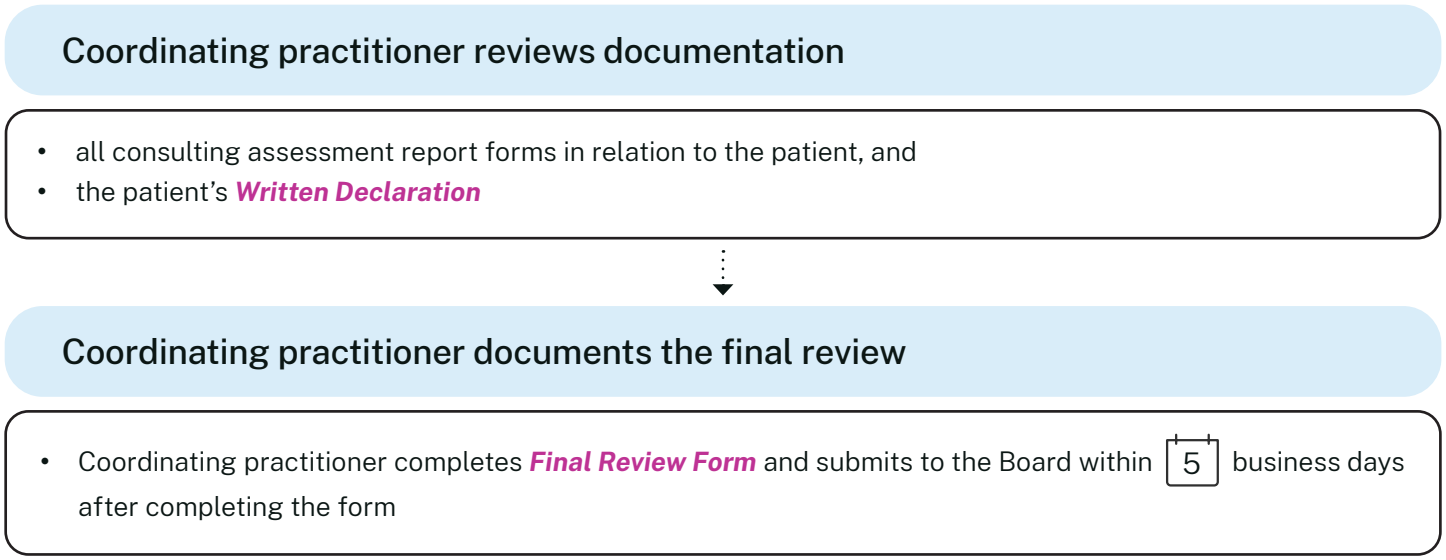
The coordinating practitioner must certify on the ***Final Review Form*** that:

- The request and assessment process has been completed in accordance with the Act; and
- They are satisfied the patient's request is enduring, the patient has decision-making capacity, and the patient is acting voluntarily and not because of pressure or duress.

When completing the final review, the coordinating practitioner must consider any decision made by the Supreme Court about a decision made during the patient's request and assessment process. For more information on Supreme Court decisions, see *20 Supreme Court Applications*.

Figure 7 outlines the steps in the final review.

Figure 7. Steps in the final review



13.2 Commonwealth Criminal Code

The final review may be conducted without contact with the patient. However, if the coordinating practitioner has reason to contact the patient during the course of the final review, they should follow guidance with respect to complying with the Commonwealth Criminal Code.

If the patient or practitioner wishes to discuss anything relating to the following during the final review, to mitigate the risk of breaching the Criminal Code, this should occur face-to-face:

- potential risks of administering the voluntary assisted dying substance,
- a plan for the administration of the voluntary assisted dying substance.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

13.3 Timeframe

The final review must be conducted on receiving a patient's final request. Although there is no timeframe stipulated in the Act in which the final review must occur, in practice this should be done as soon as practicable. This is particularly important as the coordinating practitioner must be satisfied at the time of final review that the patient has decision-making capacity. Therefore, if there is a significant delay between final request and final review, an additional consultation with the patient may be required.

13.4 Step 1: Coordinating practitioner conducts the final review

As above, the coordinating practitioner must review all consulting assessment report forms in relation to the patient and the patient's ***Written Declaration***.

Coordinating practitioners should be aware that the validity of the request and assessment process for a patient is not affected by:

- A minor or technical error in a document under this Act, or
- The failure of a person to provide a form within the time required under this Act.

Examples of what may be considered a minor or technical error include:

- Incorrect spelling on one or more forms.
- Incorrect date on a form, where the true date complies with the timeframes specified under the Act.

To correct an error discovered at any point during the process, or for further guidance when determining the validity of the process due to an error, practitioners should contact the Board Secretariat, at *MOH-VADBoardSecretariat@health.nsw.gov.au*

13.5 Step 2: Coordinating practitioner submits the Final Review Form to the Board

The coordinating practitioner must complete the ***Final Review Form*** and submit it to the Board via the Portal within five business days.

14 Administration decision

14

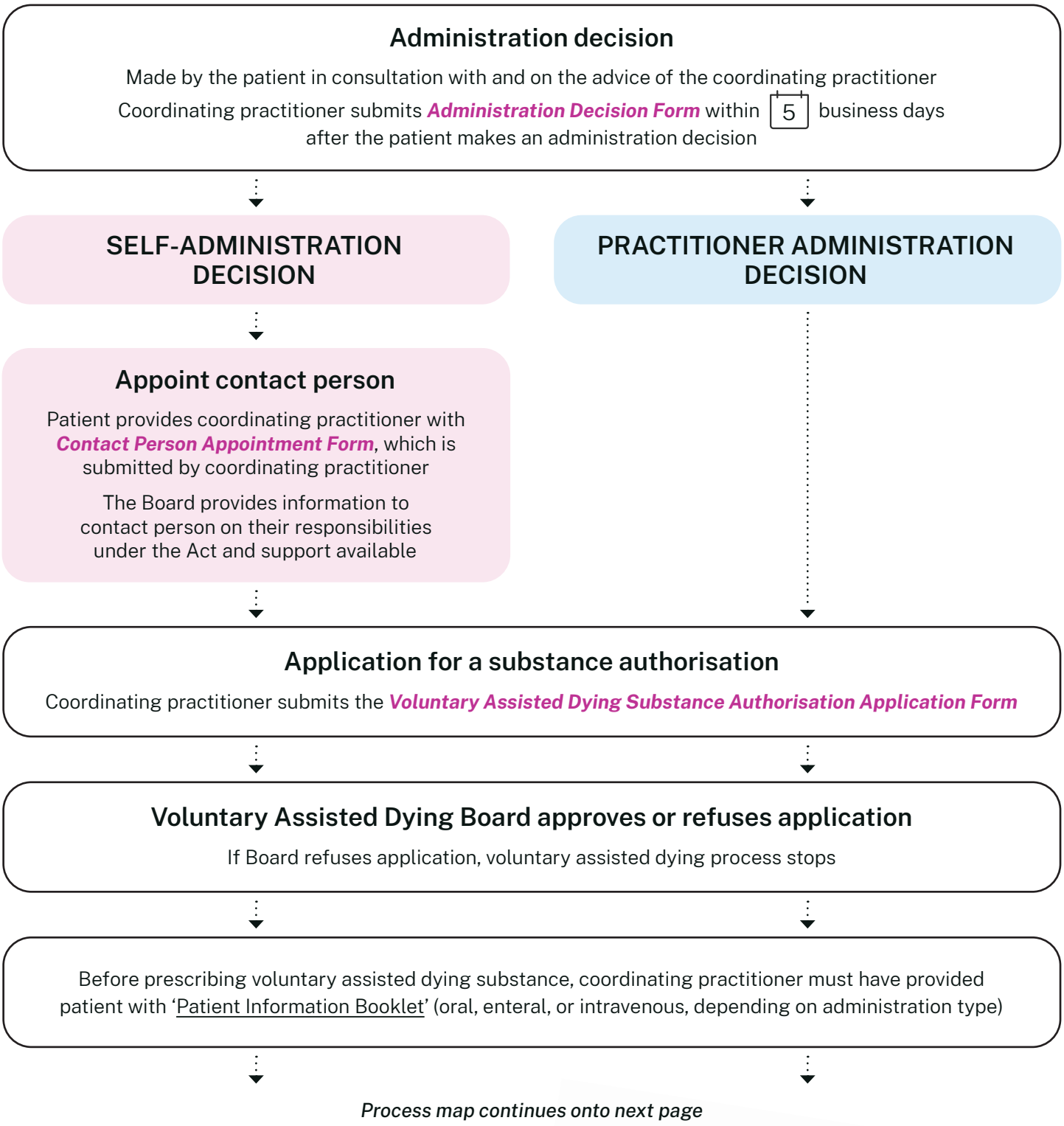
14.1 Overview

After the coordinating practitioner has completed the final review, the patient can make an administration decision. An administration decision must be made before the coordinating practitioner applies to the Board for a voluntary assisted dying substance authorisation.

This section of the Handbook should be read in conjunction with the NSW Voluntary Assisted Dying Prescription and Administration Handbook (the Prescription and Administration Handbook). Only practitioners who have successfully completed mandatory training have access to this information.

Figure 8 outlines the process of administration of the voluntary assisted dying substance, from the point of administration decision, through to through to self or practitioner administration.

Figure 8. Administration of the voluntary assisted dying substance



Process map continues onto next page

Coordinating practitioner prescribes voluntary assisted dying substance

Contacts the NSW Voluntary Assisted Dying Pharmacy Service (Pharmacy Service)

Provides prescription to Pharmacy Service

Submits the ***Prescription Form*** within 5 business days after prescribing the substance

Pharmacy Service supplies substance to:

Patient, contact person or agent of the patient, only after patient requests supply

The relevant 'Patient Information Booklet' is again provided in writing and the process explained face-to-face

Self-administration

After death, contact person notifies coordinating practitioner

Pharmacy Service supplies substance to administering practitioner

Practitioner administration

After death, the administering practitioner submits ***Practitioner Administration Form*** which is signed by a witness present at the administration, within 5 business days after administering the substance

14.2 Commonwealth Criminal Code

To mitigate the risk of breaching the Commonwealth Criminal Code, the administration decision and associated discussions (such as making a detailed plan for administration) in this step of the process should occur in person. If an interpreter is required, the interpreter should also attend in person to avoid breaching the Commonwealth Criminal Code.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

14.3 Timeframe

There is no timeframe in which a patient must make an administration decision. The patient may choose to make an administration decision at any time after the final review, in line with their preference and other relevant factors. However, it must be made before a coordinating practitioner applies to the Board for a substance authorisation for the patient.

14.4 Step 1: Patient makes an administration decision in consultation with the coordinating practitioner

The administration decision must be:

- Clear and unambiguous, and
- Made in **person** before the patient's coordinating practitioner.

An administration decision must be made by the patient and can be made using any method of communication the person uses, such as spoken language, sign language or alternative communication. No one can make an administration decision on behalf of the patient.

The administration decision is to be made in consultation with and on the advice of the patient's coordinating practitioner. The administration decision may be to:

- Self-administer a voluntary assisted dying substance. This is known as a **self-administration decision**, or,
- Decide that a voluntary assisted dying substance will be administered to the patient by the patient's administering practitioner. This is known as a **practitioner administration decision**.

The Act allows for a patient to choose either self-administration or practitioner administration based on the most suitable choice for that patient.

When discussing and advising on an administration decision, the coordinating practitioner should consider all factors relevant for that patient, including:

- Physical ability to self-administer (see Prescription and Administration Handbook for more details);
- Patient preference for either self or practitioner administration (including potential patient concerns or fears);
- Other individual contextual factors of that patient and their family.

As part of the administration discussion and decision, the practitioner should provide the patient with a hard copy of the Patient Information Booklet relevant to their administration decision (oral self-administration, oral practitioner administration, enteral self-administration, enteral practitioner administration or intravenous). Although the information will be provided in writing, coordinating practitioners should go through the information in the Patient Information Booklet with the patient during the in-person consultation.

14.4.1 Self-administration decision

Self-administration means that the patient ingests the prescribed substance by swallowing it, or via another enteral route, such as a percutaneous endoscopic gastrostomy (PEG). Under the Act, the patient can be assisted to prepare (for example, mix) the substance by either the contact person or an agent of the patient (see *Appendix 2*). However, the contact person or agent are not authorised to administer the prescribed substance.

14.4.2 Practitioner administration decision

Practitioner administration most often involves an administering practitioner administering the voluntary assisted dying substance intravenously, however it can also include assisting the patient with ingestion either orally, or via another enteral route. Patients may choose practitioner administration for a range of reasons, and under the Act they do not have to meet any criteria to be eligible to choose practitioner administration over self-administration.

If the patient makes a practitioner administration decision, the coordinating practitioner is by default the administering practitioner.

If the patient's coordinating practitioner is unable or unwilling to be the patient's administering practitioner, they can transfer the role to another person eligible to be an administering practitioner (refer to the *7 Practitioner participation in voluntary assisted dying* section for administering practitioner eligibility criteria). However, this cannot occur until after the patient's prescription for the voluntary assisted dying substance has been written and submitted to the VAD-PS.

When considering practitioner administration as an administration option, coordinating practitioners should ensure the patient is aware of who would act as the administering practitioner, so they can make an informed decision. For example, if the coordinating practitioner intends to transfer the role of administering practitioner, they should:

- discuss this with the patient,
- identify a person who is eligible to be the patient's administering practitioner, and
- make a shared decision regarding the process for involving the administering practitioner in the patient's care before the time of administration.

Details on how to transfer the role of administering practitioner can be found in the section on *21.1 Transferring a practitioner role*.

14.5 Step 2: Coordinating practitioner documents the administration decision

14.5.1 Documenting the administration decision in the medical record

The coordinating practitioner must record the administration decision in the patient's medical record. The Act does not stipulate specific details to be captured in the medical record. Coordinating practitioners should follow usual best practice guidance and local policies with relation to record-keeping.

It is recommended (at a minimum) that the coordinating practitioner records:

- The administration decision (self-administration or practitioner administration),
- The date of administration decision,
- Considerations that were part of the decision to either self-administer or be administered a voluntary assisted dying substance, and
- Whether an interpreter was used.

14.5.2 Notifying the Board of the administration decision

The coordinating practitioner must complete the ***Administration Decision Form*** and submit it to the Board via the Portal within five business days after the date the patient makes an administration decision.

14.6 Step 3: Patient appoints a contact person (following a self-administration decision only)

This step is only relevant where a self-administration decision has been made. It is not required where a patient has made a practitioner administration decision.

14.6.1 Contact person requirements

A person who has made a self-administration decision must appoint a contact person, who:

- Is an adult (at least 18 years of age)
- Consents to the appointment and agrees to carry out the role of a contact person for the patient, and
- Signs the ***Contact Person Appointment Form***.

The contact person may be the person's coordinating practitioner, consulting practitioner or another registered health practitioner, or it might be someone else, for example, a family member.

The contact person is authorised to:

- Receive the prescribed substance from an authorised supplier,
- Possess the prescribed substance,
- Prepare the prescribed substance for self-administration by the patient,
- Supply the prescribed substance to the patient,
- Give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer.

Note: In NSW, the substance will be supplied directly to the patient in most instances. Where it is appropriate, supply may be to the contact person.

The contact person is not authorised to administer the prescribed substance.

Under the Act, the contact person for a patient must:

- Return any unused or remaining voluntary assisted dying substance to an authorised disposer as soon as practicable and not later than 14 days after either:
  - The patient dies, or
  - The patient revokes a self-administration decision (and the substance has already been supplied)
- Notify the patient's coordinating practitioner if the patient dies, whether as a result of self-administering the voluntary assisted dying substance or from another cause.

The coordinating practitioner should take reasonable steps to ensure the contact person is aware of their responsibilities under the Act and advise them to refer any questions to the coordinating practitioner or the VAD-CNS. They should also inform the contact person that the Board will provide written instructions on their legal obligations after they are notified of their appointment.

The responsibilities of a contact person are significant, and failure to comply with the obligations carries penalties under the Act (e.g., maximum penalty of 12 months' imprisonment for failure to give unused or remaining substance to an authorised disposer within 14 days of a revocation decision or the patient's death). It is therefore vital that the contact person is aware of the supports in place to help them to fulfil this role.

14.6.2 Appointing a contact person

When a contact person has been identified, a patient must complete the ***Contact Person Appointment Form***, and provide the completed form to their coordinating practitioner. The coordinating practitioner does not need to be present at the appointment of a contact person.

Patients can obtain a copy of the form from their coordinating practitioner. Coordinating practitioners can download the ***Contact Person Appointment Form*** from the Portal and provide it to a patient in hard copy or electronically. If the patient needs a replacement form, they can contact the VAD-CNS.

If the patient accessing voluntary assisted dying is unable to complete the Contact Person Appointment Form, they may direct another person to complete it on their behalf, provided the person is:

- an adult (at least 18 years of age); and
- not the person to be appointed as the contact person.

A person who completes a Contact Person Appointment Form on behalf of the patient making the appointment must do so in the patient's presence.

14.6.3 Notifying the Board of the contact person

The coordinating practitioner must submit a copy of the ***Contact Person Appointment Form*** to the Board via the Portal within five business days after receiving the form. This must be submitted before the application for a substance authorisation is submitted to the Board.

14.6.4 Board to provide contact person with information

Within five days of receiving a ***Contact Person Appointment Form***, the Board will send the contact person information to:

- Explain the requirements to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer within legislated timeframes, and
- Outline the support services available to help the contact person comply with their requirements under the Act.

14.6.5 Changing the contact person

A patient may revoke the appointment of a contact person, or a contact person may refuse to continue in the role of contact person, at any time before the voluntary assisted dying substance is administered.

If a patient chooses to revoke the appointment of the contact person:

- The patient must inform the person that they are revoking their role as contact person,
- The person ceases to be the contact person for the patient upon being informed of the patient's decision to revoke their appointment,
- The patient must inform their coordinating practitioner,
- The patient must appoint another contact person and submit a new ***Contact Person Appointment Form*** to their coordinating practitioner.

If the contact person decides to refuse to continue in the role of contact person:

- The person must inform the patient of the decision not to continue as contact person,
- The person ceases to be the contact person for the patient upon notifying the patient of their refusal,
- The patient must inform their coordinating practitioner,
- The patient must appoint another contact person and submit a new ***Contact Person Appointment Form*** to their coordinating practitioner.

The coordinating practitioner must submit the new ***Contact Person Appointment Form*** to the Board via the Portal.

14.7 Revoking an administration decision

A patient can choose to revoke their administration decision at any time. The decision to revoke a self-administration or practitioner administration decision must be:

- clear and unambiguous, and
- communicated to:
  - the coordinating practitioner if the patient is revoking a self-administration decision, or
  - the administering practitioner if the patient is revoking a practitioner administration decision. *Note: In this case, the administering practitioner must also inform the patient's coordinating practitioner of the decision.*

The decision to revoke an administration decision must be made by the patient themselves and can be communicated to the coordinating practitioner or administering practitioner using any method of communication the person uses, such as spoken language, in writing, sign language or alternative communication, or with the assistance of an interpreter. The revocation does not need to be communicated during a medical consultation.

14.7.1 Documenting the revocation of administration decision in the medical record

The coordinating or administering practitioner notified of the patient's decision to revoke the administration decision must record the revocation in the patient's medical record.

The Act does not stipulate specific details to be captured in the medical record. Practitioners should follow usual best practice guidance and local policies with relation to record-keeping.

It is recommended (at a minimum) that the practitioner records:

- Date the patient notified the practitioner of the revocation of administration decision;
- Whether or not an interpreter was used.

14.7.2 Notifying the Board of a revocation of administration decision

The coordinating practitioner or administering practitioner who is informed by a patient of their decision to revoke an administration decision must complete the ***Revocation Form*** and submit it to the Board via the Portal within five business days after being informed of the revocation.

14.7.3 Returning unused substance after a revocation decision

If an administration decision is revoked after the voluntary assisted dying substance has already been supplied, it must be:

- Returned by the patient's contact person to an authorised disposer as soon as practicable and not later than 14 days after the revocation decision (if a self-administration decision is being revoked), or
- disposed of by the administering practitioner as soon as practicable (if a practitioner administration decision is being revoked).

14.7.4 Making a new administration decision after a decision is revoked

If a patient revokes an administration decision, they are able to make a new administration decision without needing to restart the voluntary assisted dying process.

A patient may choose to change their administration decision at any time, including after the Board has already granted them a substance authority. In this case, the coordinating practitioner does not need to apply for a new substance authorisation.

If a patient changes from a self-administration decision to a practitioner administration decision, the coordinating practitioner:

- Must notify the Voluntary Assisted Dying Board of the new decision by completing and submitting a new ***Administration Decision Form*** (after completing the ***Revocation Form***).
- Can issue a new prescription for the voluntary assisted dying substance, after any unused substance from the self-administration decision has been returned by the contact person to an authorised disposer.

If a patient changes from a practitioner administration decision to a self-administration decision, the coordinating practitioner:

- Must notify the Voluntary Assisted Dying Board of the new decision by completing and submitting a new ***Administration Decision Form*** (after completing the ***Revocation Form***).
- Must submit the patient's ***Contact Person Appointment Form*** to the Board.
- Can issue a new prescription for the voluntary assisted dying substance, after any unused substance from the practitioner administration decision has been disposed of by the administering practitioner.

14.8 Planning for death

Discussions between the patient and the coordinating practitioner about planning for death may occur many times throughout the voluntary assisted dying process. It is important to ensure that the patient, and any other people they wish to have involved at their death, are prepared and informed about the patient's values, wishes, and needs that may arise at this time. It is also important to discuss what dying might look like to someone present at that time.

Access to voluntary assisted dying may provide a patient with some control over the time of their death, however, given their diagnosis of a life-limiting condition, preparations should occur for death regardless of whether the substance is ever prescribed or administered.

It is recommended that the coordinating practitioner discuss with the patient their values and wishes around dying. Some people may lose capacity whilst undertaking the voluntary assisted dying process. This would mean the person was no longer eligible for voluntary assisted dying. Therefore, it is important to ensure that the person's wishes are known in preparedness, regardless of the mechanism of death.

14.9 End of life care planning

Preparation for any end of life care trajectory should ideally involve completion of any financial and advance care planning documentation and discussion. This may include but is not limited to:

- Appointing an enduring power of attorney
- Appointing an enduring guardian
- Completing and lodging a Will
- Completing an advance care directive (noting that this cannot be used as a request for access to voluntary assisted dying)
- Ensuring where possible that resuscitation plans are completed in local health district systems
- Ensuring goals of care for unexpected events are clearly defined and discussed with family, carers and the patient's medical team
- Considering timing of deactivation of implantable defibrillation devices should be discussed
- Considering funeral arrangements
- Considering whether the patient wishes to be an organ and tissue donor (see *14.10 Organ and tissue donation*), or a body donor (noting that body donation programs are available at many universities across NSW):

These steps should be taken early, to ensure that if the patient loses capacity at any stage during the voluntary assisted dying process, there is guidance, and people appointed to act on the person's behalf. More information on planning for end of life can be found on the *NSW Government website*.

It is important to note that the patient must complete the voluntary assisted dying process themselves. Neither an enduring guardian nor an advance care directive can be used to complete the voluntary assisted dying process. If the patient loses capacity, voluntary assisted dying is no longer possible, and death will occur as a natural process.

The content of discussions on planning for death will vary according to a range of factors, but the following subheadings may provide some useful considerations in planning for death.

Place of death

Establishing with the patient where they would like to die is an important aspect of end of life care. It is recommended that the coordinating practitioner talks to the patient about their preference for place of death whether the voluntary assisted dying substance is administered or not. When a voluntary assisted dying substance is to be administered, it would be imperative to have these discussions with the patient.

When discussing the location of administration of the substance, the following places within the borders of NSW are potential options for patients:

- At home
- At family or friend's homes
- Residential facility
- Hospital
- Hospice
- On country

If the person wishes to die in a residential facility, or healthcare establishment such as a hospital, the patient should discuss that with the facility manager or the health entity. It is recognised that some private facilities or faith-based organisations may not actively participate in voluntary assisted dying. Further guidance on rights and obligations under the Act is available in the *NSW Voluntary Assisted Dying Private Entity Guidance*.

Connections

Relationships with family and friends can be more challenging when people approach the end of their life. There may be social and familial connections that the patient would like to discuss or have further support put in place. Patients and families can often decrease stress and worries if people are preparing and talking about death prior to it occurring. Some of the questions that may arise at this time that should be addressed by the coordinating practitioner or through referral to support services may include:

- Has the patient disclosed the decision for voluntary assisted dying with family and friends?
  - Is there any conflict about this decision?
- Are there relationships that are estranged or cause friction?
- Are there people that the patient would like to say goodbye to, and have they considered doing this?
- Does the patient have any concerns about dying and leaving things left unsaid?
- Are there any significant relationships with medical or healthcare teams that the patient is concerned about?
- Is there anything worrying the patient that support services can help with?
- Does the person have responsibility for children, dependents or pets, and if so what considerations or plans will be required to put in place for them?

Referrals to support services are available in NSW, including counselling, mental health support, social workers and pastoral care. Referrals should occur via normal health pathways.

Symptom burden

The patient may or may not be engaged with a palliative and end of life care service. Ensure that any pain or other symptoms causing the patient distress are addressed, and if necessary and not already engaged, the patient should be referred to a palliative care service. Further advice on simple symptom management for patients can be found on the *Caresearch* website.

Values and wishes

Establishing goals and wishes for a patient approaching end of life will allow for individualised and patient-centered care. Across our multicultural society, values and wishes may vary greatly.

Some prompts that may be useful for discussion about values and wishes include:

- What is important to you as a person?
- What brings you joy?
- Who are the people you want or don't want around during these times?
- Are there important cultural beliefs that need to be addressed?
- Do you have any religious needs?
- Are there spiritual/cultural or religious elders you want involved in this process?
- Are there rituals or practices that should be followed?
- Are there pets that should be visiting or around?
- Is there music or television that is important to you, that should be playing during this time?
- What are favourite foods or drinks that you might wish to eat or drink in the days before death?
- Are there photos, personal belongings or trinkets that should be present at or near the time of death?

Dying and death as a process

Patients approaching the end of life will often become increasingly fatigued, spend less time out of bed, and be less interested in eating and drinking. These are all normal parts of dying. Voluntary assisted dying means that some patients may be able to choose the date and time of their death. There are several important points that should be discussed with all patients preparing for death, especially in the context of voluntary assisted dying. Ensure that any discussions remain patient-centered, and family and friends are only included with the patient's consent.

Points to consider include:

- Who will be present at the time of administration of the voluntary assisted dying substance?
  - Ensure the people with the patient are prepared for what death will look like, the signs and symptoms that may be expected, and timeframes in which death may occur.
- Who will complete the verification of death, or life extinct process?
  - How is that person able to be contacted and who will contact them?
- Who will complete the Medical Certificate of Cause of Death?
  - How is that person able to be contacted and who will contact them?
  - The Death Certification Arrangements for Expected Home Death form, appended to the NSW Health Policy Directive *Verification of death and medical certificate of cause of death*, can be completed in advance. This form will allow a funeral home to remove the person from their home after verification of death, with the assurance that a medical officer will complete the Medical Certificate of Cause of Death within 48 hours.
- In case of an adverse or emergency event what actions should be taken to support the patient and family?
  - Normal emergency response services will be available.
- If the person dies at home or in a facility without a mortuary, which funeral director will be responding?
  - Guidance and discussion should occur about timeframes to keep someone at home after death.
  - It is legal to keep people at home for up to five days in NSW, but patients and families may need to be informed of the potential need for cooling strategies (e.g., air conditioning or cooling beds).
- Explaining to the patient (and chosen others) that the Medical Certificate of Cause of Death and the formal death certificate produced by NSW Births Deaths and Marriages will have different wording. The formal death certificate will not show that a voluntary assisted dying substance was administered.

14.10 Organ and tissue donation

Organ and tissue donation may be a possibility for some patients that choose voluntary assisted dying. In general, however, patients with metastatic or haematological malignancies or aged over 75 years will not be suitable for solid organ donation, although tissue donation (eyes, musculoskeletal tissue, cardiovascular tissue, and skin) may still be possible in many cases.

Where a patient makes an enquiry about organ and tissue donation during the voluntary assisted dying assessment process it is recommended that the request be responded to respectfully and courteously, however detailed discussions regarding organ and tissue donation should be deferred until the patient has completed the final review by the coordinating practitioner. In NSW, the NSW Organ and Tissue Donation Service is the state-wide body which coordinates organ and tissue donation. If a patient has received a substance authorisation for voluntary assisted dying and enquires about the possibility of donation, the coordinating practitioner should contact the NSW Organ and Tissue Donation Service. For patients that are hospital in-patients, contact with the local Donation Specialist Nurse can be made via the hospital switchboard, and for patients that are in the community a Donor Coordinator can be contacted via 02 8566 1700. Donation specialists are available at any time during the assessment process if further information is needed regarding potential donation suitability.

Where a patient is clearly unsuitable to donate, it may be useful to have this information early so that this can be explained to the patient, they can be thanked for their generosity and the matter can then be closed.

For solid organ donation to proceed, the voluntary assisted dying administration will need to occur within a hospital setting. Coordination of this involves many complex variables and would need to be considered well before the planned time of death. These matters will be principally the responsibility of the Donation Specialist Nurse. For tissue donation to proceed, death can occur in the home or hospital. Tissue recovery can occur up to 24 hours post declaration of death.

Detailed discussion about the process of organ and tissue donation, particularly solid organ donation, is likely to include some details about the voluntary assisted dying substance, and as such, could put the practitioner in danger of breaching the criminal code. These discussions should be referred to the NSW Organ and Tissue Donation Service who can have preliminary discussions over the phone, before having further detailed discussions with the patient in person.

If donation for research purposes is an end of life care wish for the patient, this should be discussed with university research programs.

15 Applying for a substance authorisation

15

15.1 Overview

After a patient has made an administration decision, the coordinating practitioner can apply to the Board for a substance authorisation for the patient. The Board considers and either approves or refuses each application.

If the application is approved, the Board grants a Voluntary Assisted Dying Substance Authority, which permits the coordinating practitioner to write a prescription for a voluntary assisted dying substance for that patient. A patient is only able to access the voluntary assisted dying substance if the Board has issued a substance authority.

15.2 Commonwealth Criminal Code

Applications for a substance authorisation will almost always be completed without requiring additional contact with the patient. However, if the coordinating practitioner has reason to contact the patient during the course of applying for a substance authorisation, they should follow guidance with respect to complying with the Commonwealth Criminal Code.

If the patient or practitioner wishes to discuss anything relating to the following during this step, to mitigate the risk of breaching the Criminal Code, this should occur face-to-face:

- potential risks of administering the voluntary assisted dying substance,
- a plan for the administration of the voluntary assisted dying substance.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

15.3 Timeframe

There is no timeframe within which the coordinating practitioner must apply to the Board for a substance authorisation. However, the application can only be made after the request and assessment process is complete, the patient has made an administration decision and the patient has appointed a contact person (if they have made a self-administration decision). Consideration should be given to the timelines of the application given the life-limiting condition of the patient.

15.4 Step 1: Coordinating practitioner applies to the Board for a voluntary assisted dying substance authorisation

With consent from the patient, the coordinating practitioner can apply to the Board for a substance authorisation. To apply, the coordinating practitioner must complete the ***Voluntary Assisted Dying Substance Authorisation Application Form*** and submit it to the Board via the Portal.

15.5 Step 2: Board assesses application and notifies the coordinating practitioner of the outcome

The Board will consider and decide to either approve or refuse each application for a voluntary assisted dying substance authorisation as soon as practicable after receiving the application.

The Board must approve an application unless:

- They have not received all the documents relating to the request and assessment process, or
- They suspect the requirements of the Act have not been met.

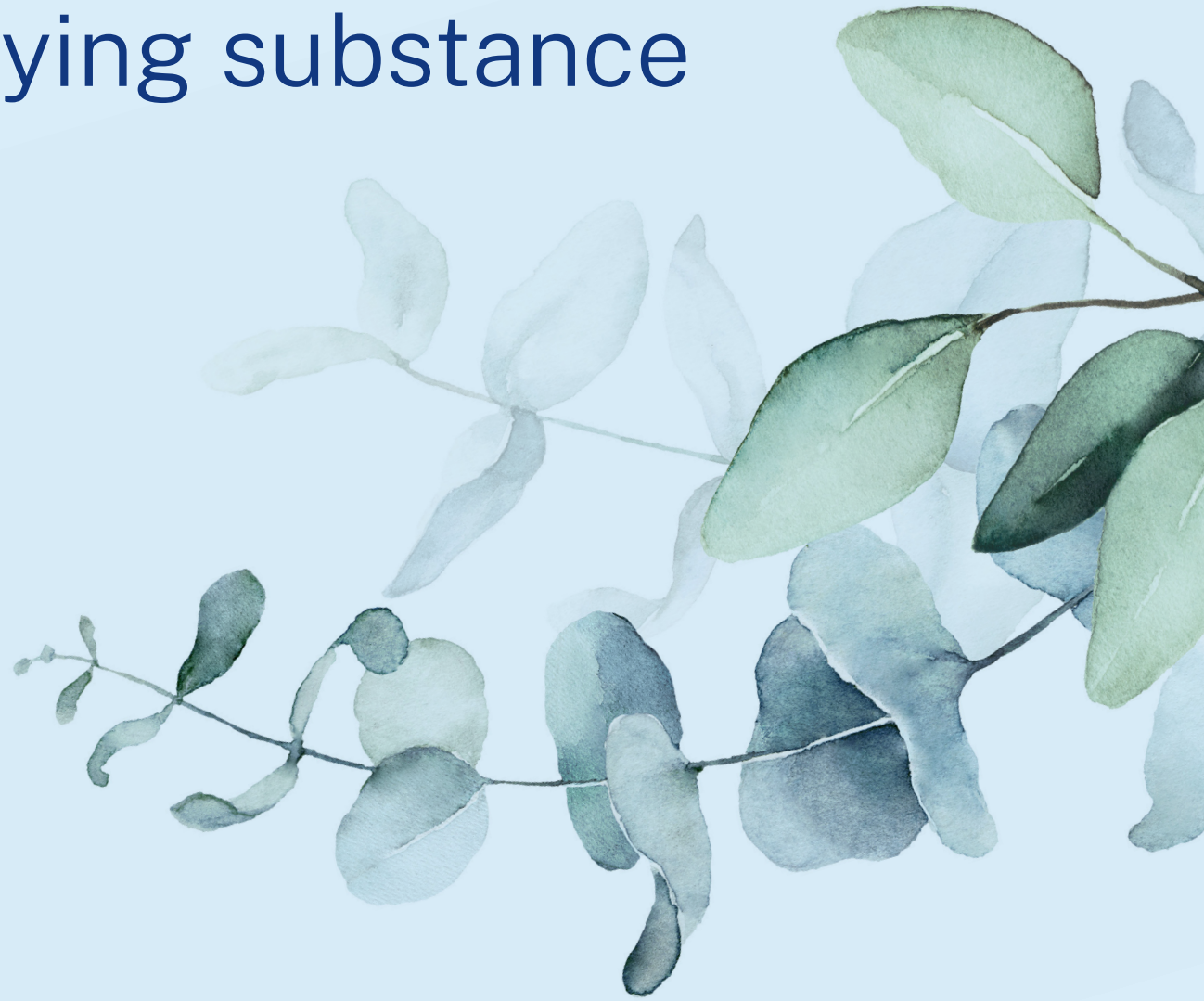
If an application is refused, the Board must notify the coordinating practitioner in writing of the refusal, and the reasons for the refusal, within two business days of making their decision.

If the Board approves an application, they must grant a substance authority for that patient as soon as practicable after the decision has been made. The coordinating practitioner will receive a notification of the Board's decision, and if approved, the substance authority for the patient will be available in the Portal. The substance authority does not specify the administration decision of the patient, so it does not differ depending on administration type.

15.6 Step 3: Coordinating practitioner advises the patient of the outcome of the application

It is the coordinating practitioner's responsibility to advise the patient of whether the Board has approved the application (and a substance authority has been issued) or refused it, and the next steps. If the application has been refused, the coordinating practitioner should advise the patient of the reason for refusal and discuss the options for the ongoing care and support of the patient.

16 Prescribing the voluntary assisted dying substance



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16.1 Overview

Once the Board has issued a substance authority for a patient, the coordinating practitioner can write a prescription on the approved voluntary assisted dying prescription template. The prescription must be sent directly to the VAD-PS. **The prescription does not go to the patient**.

This section of the Handbook should be read in conjunction with the Prescription and Administration Handbook. Only practitioners who have successfully completed mandatory training have access to this information.

16.2 Commonwealth Criminal Code

To mitigate the risk of breaching the Commonwealth Criminal Code, any provision of information or instruction to the patient about administration should not be provided over a carriage service and should be provided in-person or by provision of hard copy documents. This includes the information outlined in Step 1 below.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

16.3 Timeframe

The prescription process can only commence after an administration decision has been made and the Board has issued a Voluntary Assisted Dying Substance Authority in relation to the patient. Further, if the patient has made a self-administration decision, the coordinating practitioner cannot prescribe the voluntary assisted dying substance until they have submitted the patient's completed ***Contact Person Appointment Form*** to the Board via the Portal.

The coordinating practitioner has six months to prescribe the voluntary assisted dying substance (or 12 months for neurodegenerative conditions) under that substance authority. The prescription will be valid for 6 months from the date the prescription is written.

16.4 Step 1: Before writing prescription, coordinating practitioner provides patient with written information

Before writing the prescription, the coordinating practitioner must have provided the patient with specified information in writing which is contained in the Patient Information Booklet relevant to their administration decision (oral self-administration, oral practitioner administration, enteral self-administration, enteral practitioner administration or intravenous).

16.4.1 Written information for a patient who has chosen self-administration

Before prescribing the voluntary assisted dying substance for self-administration, the coordinating practitioner must have provided the following information to the patient in writing in accordance with the Act. This relevant information is all contained in the Patient Information Booklet (oral self-administration) or Patient Information Booklet (enteral access device self-administration).

- the Schedule 4 poison or Schedule 8 poison, or combination of poisons, constituting the substance,
- that the patient is not under an obligation to obtain the substance,
- that the patient is not under an obligation to self-administer the substance,
- how to dispense the substance,
- that the substance must be stored –
  - in a locked box that complies with the requirements stated in section 79 of the Act, and
  - otherwise in accordance with the information provided by the authorised supplier who supplies the substance
- how to prepare and self-administer the substance,
- the method by which the substance will be self-administered,
- the expected effects of self-administration of the substance,
- the period within which the patient is likely to die after self-administration of the substance,
- the potential risks of self-administration of the substance,
- that, if the patient decides not to self-administer the substance, the patient's contact person must give the substance to an authorised disposer for disposal,
- that, if the patient dies, the patient's contact person must give any unused or remaining substance to an authorised disposer for disposal.

16.4.2 Written information for a patient who has chosen practitioner administration

Before prescribing the voluntary assisted dying substance for practitioner administration, the coordinating practitioner must have provided the following information to the patient in writing in accordance with the Act. This relevant information is all contained in the Patient Information Booklet (Intravenous), Patient Information Booklet (Oral practitioner administration) or Patient Information Booklet (Enteral access device practitioner administration).

- the Schedule 4 poison or Schedule 8 poison, or combination of poisons, constituting the substance,
- that the patient is not under an obligation to have the substance administered,
- how the substance will be dispensed,
- the method by which the substance will be administered,
- the expected effects of administration of the substance,
- the period within which the patient 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 patient's contact person must give any prescribed substance received by the patient, the contact person or an agent of the patient, to an authorised disposer for disposal.

Some of this information is likely to have been provided in the form of the relevant Patient Information Booklet during the consultation where the administration decision was made to best inform the patient's decision.

At this stage of the voluntary assisted dying process, the coordinating practitioner will have had many conversations with the patient, including their individual circumstances and the administration decision that best suits that person.

16.5 Step 2: Coordinating practitioner prescribes the voluntary assisted dying substance

The coordinating practitioner must prescribe the voluntary assisted dying substance in accordance with the instructions and protocols in the Prescription and Administration Handbook. This document includes details of what the prescription must include and importantly an approved voluntary assisted dying template will help ensure practitioners meet these requirements. Importantly, the prescription must not be in the form of a medication chart or on the prescriber's usual prescription stationery.

The coordinating practitioner should contact the VAD-PS to discuss the specific considerations of the case before writing the prescription. The coordinating practitioner is also encouraged to contact the VAD-PS for advice about completing the prescription, and once written, notify them of the incoming prescription.

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 the VAD-PS without causing delay. Any adjuvant medications required by the patient must also be prescribed and sent to the VAD-PS.

The prescription for the voluntary assisted dying substance and adjuvant medications can be given to the VAD-PS either:

- in person
- via registered post
- via courier
- via electronic prescription with special prescription details as outlined in the Prescription and Administration Handbook.

The prescription must not be given to the patient.

16.6 Step 3: Coordinating practitioner notifies the Board of the prescription

The coordinating practitioner must complete the ***Prescription Form*** and submit it to the Board via the Portal within five business days after prescribing a voluntary assisted dying substance.

16.7 Step 4: Coordinating practitioner informs the relevant persons that the prescription has been written

16.7.1 Self-administration

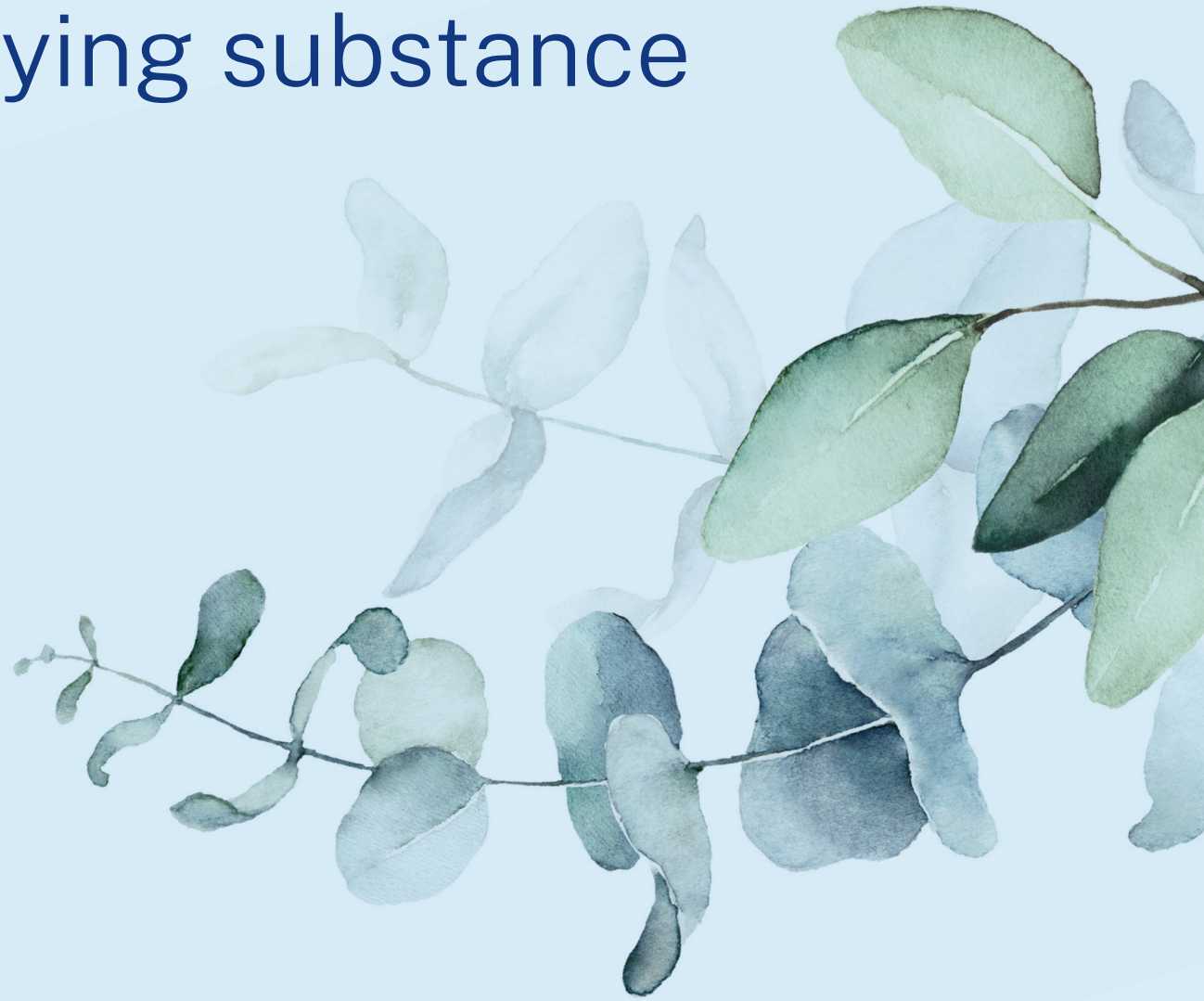
The coordinating practitioner must provide the patient with the contact details for the VAD-PS and advise them to contact the VAD-PS when they are ready to arrange delivery of the voluntary assisted dying substance. If the person is unable to contact the VAD-PS, a contact person or agent of the patient can do this on their behalf.

16.7.2 Practitioner administration

The coordinating practitioner must advise the patient when they have prescribed the substance and advise the patient to contact their administering practitioner when they are ready to arrange a time for administration. When a date and time has been planned for administration to occur, the administering practitioner must contact the VAD-PS to arrange delivery or collection of the voluntary assisted dying substance.

If the coordinating practitioner has transferred the role of administering practitioner, they must also notify the administering practitioner that the prescription has been written.

17 Supplying the voluntary assisted dying substance



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17.1 Overview

Supply of the voluntary assisted dying substance, and any adjuvant medications, is to be initiated at the request of the patient. This is to ensure the process remains voluntary and patient-directed. The VAD-PS will not supply the voluntary assisted dying substance until a request for supply is received either from the patient, their contact person or agent (for self-administration) or from the administering practitioner (for practitioner administration).

The supply arrangements differ, depending on whether the substance is for self-administration or practitioner administration.

The authorised supplier (at the VAD-PS) must not supply the voluntary assisted dying substance until they have confirmed:

- the authenticity of the prescription, and
- the identity of the person who issued the prescription, and
- the identity of the person to whom the substance is to be supplied.

This section of the Handbook should be read in conjunction with the Prescription and Administration Handbook. Only practitioners who have successfully completed mandatory training have access to this information.

17.2 Commonwealth Criminal Code

Any provision of information or instruction about administration should not be provided over a carriage service and should be provided in-person or by provision of hard copy documents. This includes the information outlined below to be provided to a patient who has made a self-administration decision, upon supply of the voluntary assisted dying substance.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

17.3 Timeframe

Supply will only occur after the patient requests this, which should be:

- For self-administration:
  - The patient contacting the VAD-PS themselves, or
  - Via the patient's contact person or an agent of the patient (where the patient is not able to contact the VAD-PS e.g., the patient cannot communicate via phone)
- For practitioner administration: via the patient's administering practitioner.

17.4 Supply of the substance to recipient

17.4.1 Supply of the substance for self-administration

A pharmacist employed by the VAD-PS will supply the substance to the patient. In exceptional circumstances where the VAD-PS cannot supply the substance to the patient, the substance will be supplied to the patient's contact person or an agent of the patient.

The pharmacist will counsel the patient on the safe use of the substance in a face-to-face consultation, and must provide them with hard-copy written information at the same time. This written information is all contained within the relevant Patient Information Booklets and includes:

- that the patient is not under an obligation to self-administer the substance,
- that the substance must be stored –
  - in a locked box that is made of steel, not easily penetrable and locked using a lock of sturdy construction
  - otherwise in accordance with other requirements provided by the authorised supplier,
- how to prepare and self-administer the substance,
- that, if the patient decides not to self-administer the substance, the patient's contact person must give the substance to an authorised disposer for disposal,
- that, if the patient dies, the patient's contact person must give any unused or remaining substance to an authorised disposer for disposal not later than 14 days after the day on which the patient dies,
- details of the place where any unused or remaining substance may be given to an authorised disposer for disposal.

In the exceptional case where the recipient is not the patient, the pharmacist must, when supplying the prescribed substance, advise the recipient to give the relevant Patient Information Booklet to the patient.

The patient will be provided with a substance kit. This kit contains the voluntary assisted dying substance, adjuvant medications (if prescribed), a copy of the patient's substance authority, contact details of the coordinating practitioner and VAD-PS, instructions for the authorised disposer, and a drug waste container for use by an authorised disposer.

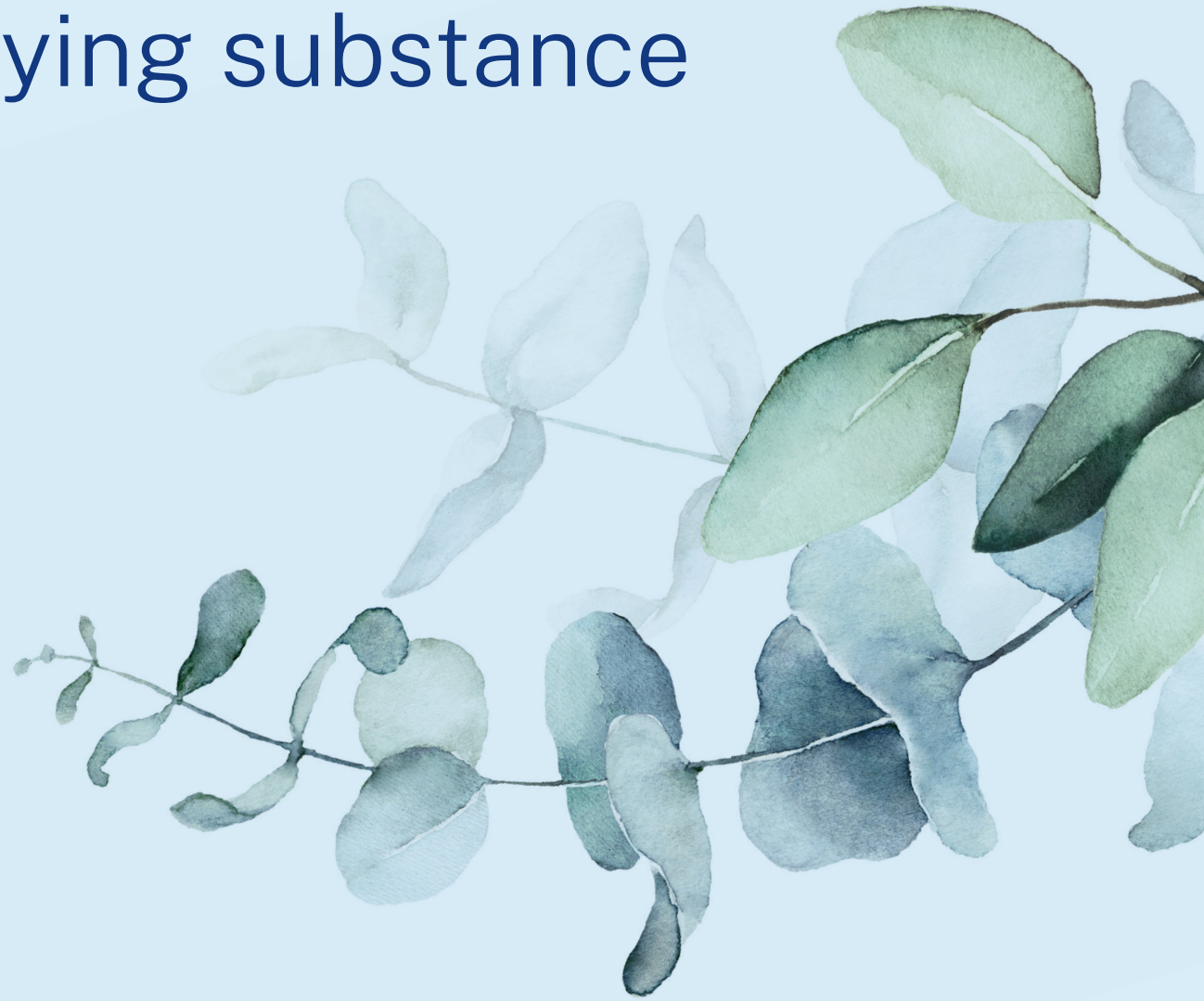
17.4.2 Supply of the substance for practitioner administration

The administering practitioner will make a plan driven by the patient for when the practitioner will administer the voluntary assisted dying substance. When a date and time has been confirmed, the administering practitioner must contact the VAD-PS to arrange supply of the substance.

The administering practitioner can collect the substance from the VAD-PS or the VAD-PS can organise delivery.

Once supplied, the administering practitioner will be responsible for the safe storage of the substance in accordance with the guidance provided in the Prescription and Administration Handbook until patient administration.

18 Administering the voluntary assisted dying substance



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18.1 Overview

A voluntary assisted dying substance can only be administered if:

- The patient has made an administration decision that has not been revoked,
- A contact person has been appointed (for self-administration decisions only),
- The Board has issued a substance authority for the patient,
- A prescription has been written and the voluntary assisted dying substance for that patient has been supplied,
- All associated information on the voluntary assisted dying substance and administration details have been provided to the patient, and
- For practitioner administration only, the administering practitioner is satisfied that the patient has decision-making capacity in relation to voluntary assisted dying.

This section of the Handbook should be read in conjunction with the Prescription and Administration Handbook. Only practitioners who have successfully completed mandatory training have access to this information.

18.2 Commonwealth Criminal Code

Any provision of information or instruction about administration should not be provided over a carriage service and should be provided in-person or by provision of hard copy documents.

Further information can be found in the section *4.1 Implications of the Commonwealth Criminal Code Act 1995*.

18.3 Timeframe

18.3.1 Self-administration

Once the kit has been supplied to a patient who has elected to self-administer the substance they can decide when to administer the substance, as there is no timeframe within which the substance must be administered.

18.3.2 Practitioner administration

Supply of the practitioner administration kits should occur on or close to the planned day of administration. Therefore, if supply occurs and the patient chooses to change their date of administration, the substance may need to be returned, disposed of and re-supplied. In this event, the VAD-PS can discuss this with the administering practitioner.

18.4 Self-administration

If a patient has chosen self-administration, the contact person or an agent can assist them to prepare the substance but cannot administer the substance to the patient.

Self-administration can occur at a time and place of the patient's choice, such as a home, hospital or residential aged care facility, but it must take place in NSW. Coordinating practitioners should discuss the patient's detailed plan for administration before the substance is prescribed (see section *4.8 Planning for death* for further details on what this discussion could include).

The patient information booklet provided to the patient before the voluntary assisted dying substance is prescribed, and when the substance is supplied, contains detailed information and instructions on self-administration. If the patient is no longer able to self-administer the substance at any stage, they can contact their coordinating practitioner to change their administration decision. If the patient revokes a self-administration decision after they have been supplied the voluntary assisted dying substance, it is the legal responsibility of the contact person to return any unused voluntary assisted dying substance to an authorised disposer.

If the patient or their family or contact person has questions, they can contact their coordinating practitioner or the VAD-PS (contact details are provided in the Patient Information Booklet).

18.4.1 Witnesses to self-administration of a voluntary assisted dying substance

There is no legal requirement for a witness to be present during self-administration, so the patient may choose to do this alone, or in the presence of others. However, patients should be encouraged to not self-administer alone.

Many patients may choose to have friends, family or carers present when they self-administer a voluntary assisted dying substance. Discussing end of life choices and plans for administration with friends and family can be very difficult for patients. Coordinating practitioners should encourage patients to have these discussions and should support the patient in these conversations if requested. While some family and friends may find the experience of being present at the patient's death comforting, others may find this confronting and may not wish to be present. Coordinating practitioners should ensure that the patient's family and friends are aware of what they can expect during and after administration, and ensure they are well-supported and connected with appropriate support where required. Coordinating practitioners may also ask a patient to keep them informed about their plans to administer the substance.

Some patients may choose to ask a healthcare worker, such as their coordinating practitioner or another person involved in their care, to be present when they self-administer a voluntary assisted dying substance. However, it is up to the individual healthcare worker as to whether or not they want to do this. Under section 130 of the Act, a person who is present when another person self-administers a substance in accordance with the Act is protected from liability.

Under the Act, the contact person must inform the coordinating practitioner that the patient has died, whether as a result of self-administration or not.

18.5 Practitioner administration

Practitioner administration of a voluntary assisted dying substance must occur in the presence of an eligible witness, and can only occur if at the time of administration:

- the administering practitioner is satisfied that the patient:
  - has decision-making capacity in relation to voluntary assisted dying,
  - is acting voluntarily and is free from pressure or duress, and
  - has an enduring request for voluntary assisted dying.
- the witness considers that the patient's request for access appears to be free, voluntary and enduring.

An interpreter may be required to satisfy the above requirement.

Practitioner administration of the voluntary assisted dying substance and any adjuvant medication may be via intravenous administration, orally or via an enteral access devices (e.g., PEG/PEJ/NGT/NJT). An appropriate kit will be supplied depending on the chosen route of administration. Prior to practitioner administration of a voluntary assisted dying substance, the administering practitioner should make a detailed plan with the patient, including agreeing on a suitable time, date and location (within NSW) for administration, as well as the presence of an eligible witness (see section on *14.8 Planning for death*).

The VAD-PS will provide the administering practitioner with information and instructions on administering the substance. If the administering practitioner has questions, they should contact the VAD-PS.

18.5.1 Witnesses to a practitioner administration of a voluntary assisted dying substance

A person is eligible to witness a practitioner administration of a voluntary assisted dying substance if they are:

- an adult (at least 18 years of age),
- not a family member of the administering practitioner, and
- not employed or engaged under a contract for services by the patient's administering practitioner.

Best practice is to ensure that a witness is not in a position where they may be under the influence of the administering practitioner. This may include:

- A direct report of the administering practitioner
- A staff member who could be under the influence in another way e.g., significantly junior, or likely to be in a position working under the administering practitioner in a future role.

See *Appendix 1* for examples of witnesses.

The witness to administration must certify, by signing on the ***Practitioner Administration Form***, that:

- the patient's request for access to voluntary assisted dying appeared to be free, voluntary and enduring, and
- the administering practitioner administered the prescribed substance to the patient in the presence of the witness.

When planning for practitioner administration of a voluntary assisted dying substance, the administering practitioner must ensure the witness is aware of what they can expect during and after administration. They must also ensure that the witness is aware of their requirements, including that they must sign the ***Practitioner Administration Form*** after the patient's death.

The administering practitioner and witness should stay with the patient until the patient dies.

If requested or required, other healthcare workers may attend a practitioner administration, and may support the administering practitioner (for example, with intravenous lines). However, only the administering practitioner for the patient is allowed to administer the voluntary assisted dying substance. Under section 130 of the Act, a person who is present when a person is administered a substance in accordance with the Act is protected from liability.

19 After the patient dies

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19.1 Overview

Preparing for after death is an important part of the preparation for administration of a voluntary assisted dying substance. Ensuring that plans are made well in advance of the administration of the substance will enable the patient and others to understand the plan and process for care after death.

Regardless of whether each patient has chosen self-administration or practitioner administration of the voluntary assisted dying substance, the broad steps for verification and completion of the Medical Certificate of Cause of Death are the same. However, these steps may occur within different timeframes, depending on whether there is a medical practitioner present at the bedside at the time of death.

19.2 Verification of death

Verification of death is the clinical examination that must occur to confirm that life is extinct. This can be completed by demonstrating the following assessment after five minutes of continued cessation of cardiorespiratory function:

- Absence of pupillary responses to light, and
- Absence of response to central painful stimulus, and
- Absence of a central pulse on palpation, and
- Absence of heart sounds on auscultation, and
- Absence of respiratory effort.

Where available, a medical practitioner should conduct the verification of death assessment. In cases where there is no medical practitioner available to verify death, registered nurses, registered midwives, and qualified paramedics can do this. The NSW Health *Verification of death and medical certificate of cause of death* Policy Directive provides a Verification of Death form that can be used for this purpose.

If there is no medical practitioner present at the time of the death, normal processes within the area and district for verification of deaths should be followed. The coordinating practitioner should have made plans in conjunction with other healthcare workers and the patient for normal procedures to occur, for example the GP, community nurses or NSW Ambulance may provide this service in regional areas.

When the patient has died, it is important to allow the people present privacy and time alone with the person if they wish prior to verification as a mark of respect to the patient. This may only be a brief time; however, this time should be protected.

19.3 Completion of the Medical Certificate of Cause of Death

The Medical Certificate of Cause of Death must be completed by a medical practitioner. This may be the patient's coordinating practitioner, administering practitioner (if a medical practitioner), GP by prior arrangement, or a medical officer in attendance in a facility such as a hospital or hospice. Planning for who should complete this legal document should be made in advance of the day of death (see *14.8 Planning for death*).

The Medical Certificate of Cause of Death must be completed within 48 hours of the death. This happens for all deaths, not only those where the patient has been administered a voluntary assisted dying substance.

Where a patient has died after administration of a voluntary assisted dying substance, the medical practitioner must identify in the Medical Certificate of Cause of Death:

(a) that the medical practitioner knows or reasonably believes the patient self-administered, or was administered, a voluntary assisted dying substance in accordance with this Act, and

(b) the disease, illness, or medical condition with which the person had been diagnosed that made the person eligible to access voluntary assisted dying.

If a medical practitioner who is not an authorised practitioner completes the Medical Certificate of Cause of Death, the same steps apply for completing the certificate. They must also notify the Voluntary Assisted Dying Board via the ***Notification of Death Form*** (see section on notification of death – *19.4.1 Self-administration*).

It is important to inform the patient and people responsible for the person after death that the Medical Certificate of Cause of Death will state that a voluntary assisted dying substance was administered, however the final death certificate from the NSW Registry of Births Deaths and Marriages will only record the underlying disease, illness or medical condition and not voluntary assisted dying.

The NSW Health *Verification of death and medical certificate of cause of death* Policy Directive provides a form (Death Certification Arrangements for Expected Home Death) that can be completed in advance of a patient's death. If completed, this form allows a funeral home to remove the person from their home after verification of death, with the assurance that a medical officer will complete the Medical Certificate of Cause of Death within 48 hours.

Where a patient has died from the administration of a voluntary assisted dying substance in accordance with the Act, the death is not routinely reportable to the Coroner.

19.4 Notification of death

19.4.1 Self-administration

The contact person must notify the coordinating practitioner if the patient dies, whether as a result of self-administering the prescribed substance or from some other cause. When notified by the contact person of the patient's death (whether from voluntary assisted dying or another cause), the coordinating practitioner must complete the ***Notification of Death Form*** and submit it to the Board via the Portal within five business days of becoming aware of the patient's death.

If a medical practitioner who is not an authorised practitioner completes the Medical Certificate of Cause of Death, they must also notify the Voluntary Assisted Dying Board via the ***Notification of Death Form***. Practitioners who are not authorised practitioners can access the ***Notification of Death Form*** on the Portal website, at www.nswvadportal.health.nsw.gov.au, where it can be completed and lodged to the Board.

19.4.2 Practitioner administration

The administering practitioner must complete the ***Practitioner Administration Form***, which requires input and a signature from the witness to administration.

Within five business days after administering the voluntary assisted dying substance, the administering practitioner must submit a copy of the ***Practitioner Administration Form*** to the Board via the Portal.

If a patient dies from practitioner administration, completion of the ***Notification of Death Form*** by the coordinating practitioner or administering practitioner is not required.

19.5 Disposal of unused or remaining voluntary assisted dying substance

19.5.1 Self-administration

If a patient who has chosen self-administration dies after the voluntary assisted dying substance has been supplied, the contact person must, as soon as practicable and not later than 14 days after the day on which the patient dies, give any unused or remaining substance to an authorised disposer. The information the Board provides to the contact person will provide details of how to do this.

19.5.2 Practitioner administration

The administering practitioner must dispose of any unused or remaining voluntary assisted dying substance as soon as practicable after the patient's death, complete the ***Practitioner Disposal Form*** immediately after disposal and submit a copy to the Board via the Portal within five business days after disposal.

Disposal of any voluntary assisted dying substance must be done in accordance with requirements of the *Poisons and Therapeutic Goods Act 1966*.

19.6 Death prior to administration of a voluntary assisted dying substance

If at any time during the voluntary assisted dying process before the administration step, the coordinating or administering practitioner becomes aware that the patient has died, the coordinating practitioner or administering practitioner must complete the ***Notification of Death Form*** and submit it to the Board via the Portal within five business days after becoming aware of the patient's death. If the patient has already made an administration decision and a contact person has already been appointed (required for self-administration only), further instruction on steps to be taken are outlined below.

19.6.1 Death prior to self-administration

If the patient has died prior to taking the voluntary assisted dying substance:

- The contact person must notify the coordinating practitioner of the patient's death.
- The contact person must return the unused substance (if it has already been supplied) to an authorised disposer as soon as practicable and not later than 14 days after the patient's death. The contact person will have the information provided to them about how and where to do this and the VAD-PS will work with them to facilitate the return of the substance to an authorised disposer.
- The authorised disposer will safely dispose of the unused or remaining substance as soon as practicable. The authorised disposer who disposes of the substance is responsible for completing and submitting the ***Authorised Disposal Form*** via the NSW Voluntary Assisted Dying Portal within **five business days** of disposal.
- The coordinating practitioner must complete the ***Notification of Death Form*** and submit it to the Voluntary Assisted Dying Board via the NSW Voluntary Assisted Dying Portal within **five business days** of becoming aware of a patient's death.

19.6.2 Death prior to practitioner administration

In the event that the patient dies prior to practitioner administration:

- The administering practitioner must dispose of the substance in accordance with the *Poisons and Therapeutic Goods Act 1966* if it has already been supplied to them.
- The administering practitioner must complete the ***Practitioner Disposal Form*** immediately upon disposal, and submit a copy of it to the Voluntary Assisted Dying Board via the NSW Voluntary Assisted Dying Portal within **five business days** after disposal. Comprehensive instructions regarding administration and destruction are available in the Prescription and Administration Handbook which practitioners will receive after successful completion of this online module.
- The coordinating or administering practitioner must complete the ***Notification of Death Form*** and submit it to the Voluntary Assisted Dying Board via the NSW Voluntary Assisted Dying Portal within **five business days** of becoming aware of a patient's death. If they are not the same person, the coordinating and administering practitioner should notify one another when they become aware of a patient's death prior to administration and determine which practitioner will submit the ***Notification of Death Form***, as it only needs to be submitted once.

19.7 Bereavement support

After any death it is normal for a person to experience grief and bereavement. Grief is a natural and normal response to loss. Community supports are important, and the coordinating practitioner should encourage those connections. Some people may require further supports and the coordinating practitioner should ensure that family and friends of the deceased person have the contact details of normal local bereavement services and NSW services such as *Griefline*.

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.

19.7.1 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.

The following links and resources may be useful in supporting the patient's carers, family, friends as part of bereavement support.

Table 10. Bereavement support

Griefline supports anyone experiencing grief, providing access to free telephone support.	Telephone: 1300 845 745, Monday to Friday (8:00 am – 8:00 pm) or access the website *https://griefline.org.au/*
Grief Australia can help family, friends and carers deal with the death of a loved one and put them in touch with appropriate support groups.	Telephone: 1800 642 066, Monday to Friday (9:00 am – 5:00 pm) or access the website *www.grief.org.au*
Palliative Care NSW provides the NSW community with a palliative care information and promotes provision of quality palliative care.	Contact: *info@palliativecarensw.org.au* or +61 2 8076 5600 Recommended links: • *Griefline* – free counselling and support service • *MyGrief App* – an online resource for grief and bereavement support
Carers NSW provides fact sheets in multiple languages on bereavement.	Telephone: 02 9280 4744 or access the website *www.carersnsw.org.au*
Lifeline can provide crisis support to anyone who is need of immediate help to deal with emotional distress.	Telephone: 13 11 14, (any time day or night) or access the website *www.lifeline.org.au*

Receiving support, in addition to providing support, is key for those practitioners participating in the voluntary assisted dying process. Self-care should be a priority for practitioners who choose to deliver voluntary assisted dying services. Practitioner self-care and the NSW Voluntary Assisted Dying Community of Practice are discussed in *22 Healthcare worker self-care and support*.

20 Supreme Court applications

20

Appealing a decision

The Supreme Court can, on application, review decisions made by the coordinating practitioner, consulting practitioner or the Voluntary Assisted Dying Board that impact a person's eligibility to access voluntary assisted dying.

Examples of decisions that can be reviewed include:

- Whether the patient has been ordinarily resident in New South Wales for a period of at least 12 months,
- Whether the patient has decision-making capacity in relation to voluntary assisted dying,
- Whether the patient is acting voluntarily,
- Whether the patient is acting because of pressure or duress,
- A decision of the Board to refuse an application for a Voluntary Assisted Dying Substance Authority for a patient.

An application can be made by:

- The patient,
- A person appointed as the patient's agent in writing or by means the Supreme Court considers satisfactory, or
- Another person with sufficient and genuine interest in the rights and interests of a patient in relation to voluntary assisted dying.

An application for Supreme Court review of a decision will result in suspension of the voluntary assisted dying process. For example, if the Board has issued a substance authority for a patient and the prescription for the voluntary assisted dying substance has been written, the VAD-PS must not supply the voluntary assisted dying substance until the review application is decided. A practitioner will still be able to access the patient's record within the Portal and download already submitted forms, however they will not be permitted to create or submit any new forms while the application is suspended.

The coordinating practitioner, consulting practitioner and administering practitioner will be given notice of any review applications, and the outcome of those applications.

Supreme Court overturning medical practitioner's decision

The Supreme Court can overturn a medical practitioner's decision relating to the patient's eligibility to access voluntary assisted dying in a Court order.

If the patient is eligible to access voluntary assisted dying based on a decision of the Supreme Court, the coordinating practitioner can continue with the voluntary assisted dying process in accordance with a Court order, or choose to transfer the role of coordinating practitioner (see *21.1 Transferring a practitioner role*).

21 Other considerations

21

21.1 Transferring a practitioner role

21.1.1 Transferring the coordinating practitioner role

The coordinating practitioner may transfer the role of coordinating practitioner at either the patient's request or on their own initiative. The coordinating practitioner for a patient may transfer the role to another authorised medical practitioner if the consulting practitioner has assessed the patient as eligible for access to voluntary assisted dying and the other authorised medical practitioner accepts transfer of the role.

A practitioner must inform the original coordinating practitioner whether they accept or refuse the transfer of the role within five business days after the request. It is recommended that the original coordinating practitioner check that the other practitioner is eligible, available and would be able to accept the transfer of the role.

If the medical practitioner accepts the transfer of the coordinating practitioner role

If the medical practitioner accepts the transfer of the coordinating practitioner role, the original coordinating practitioner must:

1. Inform the patient of the transfer
2. Record the transfer in the patient's medical record
3. Complete the ***Coordinating Practitioner Transfer Form*** and submit it to the Board via the Portal within five business days of acceptance of the transfer.

If the medical practitioner refuses transfer of coordinating practitioner role

If the medical practitioner refuses and the coordinating practitioner role still needs to be transferred, a second consulting assessment is required. The coordinating practitioner can refer the patient to another authorised medical practitioner for the second consulting assessment (this follows the same process of referring for a consulting assessment (see *10 Consulting assessment*).

On accepting a second consulting assessment, the previous consulting assessment that determined the patient as eligible becomes void.

If the second consulting assessment finds the patient eligible for access to voluntary assisted dying, then that consulting practitioner can be asked to become the coordinating practitioner. The role can be transferred to the second consulting practitioner if they accept.

If the second consulting assessment finds the patient not eligible for access to voluntary assisted dying, the coordinating practitioner role cannot be transferred. If the patient wishes to continue the voluntary assisted dying process, the coordinating practitioner will need to refer the patient for a further consulting assessment.

21.1.2 Transferring the administering practitioner role

If a practitioner administration decision is made, the coordinating practitioner will automatically become the administering practitioner. However, if the patient's coordinating practitioner is unable or unwilling to be the patient's administering practitioner, they can transfer the role to another person eligible to be an administering practitioner that accepts transfer of the role. This transfer can only occur after the patient's prescription for the voluntary assisted dying substance has been written and submitted to the VAD-PS.

The process of transferring the role of administering practitioner after prescription of the voluntary assisted dying substance is as follows:

1. The original administering practitioner must identify another authorised practitioner who is eligible to act as an administering practitioner for the patient
2. If the new practitioner accepts the transfer of the role, the original administering practitioner must inform the patient:
    - That the role of administering practitioner has been transferred to the new practitioner, and
    - Of the new practitioner's name and contact details.
3. The original administering practitioner must document the transfer of the role:
    - In the patient's medical record, and
    - By completing the ***Administering Practitioner Transfer Form*** and submitting it to the Board via the Portal within five business days after accepting the transfer.

If the role of administering practitioner is transferred after the prescribed substance has been supplied to the original administering practitioner, the original practitioner can supply the substance directly to the new administering practitioner. The administering practitioner must notify the VAD-PS that this has occurred.

Circumstances may arise where the coordinating practitioner has not intended to transfer the role of administering practitioner, but needs to transfer the role due to unforeseen circumstances e.g., practitioner unavailable at patient's requested time. The original administering practitioner (the coordinating practitioner) should let the patient know, identify a person eligible to be the patient's new administering practitioner and take steps to involve the new administering practitioner in the patient's care.

21.2 Considerations for patients in private entities

Private entities, including private residential facilities and private health facilities, have obligations under the Act. These are outlined in the *NSW Voluntary Assisted Dying Private Entity Guidance*.

Private entities may be required to take reasonable steps to facilitate transfer of a person to and from a place where voluntary assisted dying services can be provided.

All decisions to transfer a person must be based on an appropriate clinical risk assessment:

- in a private residential facility – by the person's coordinating practitioner, or another medical practitioner nominated by the person if the coordinating practitioner is not available
- in a private health facility – by the person's treating clinician on behalf of the entity that owns or operates the private health facility, in consultation with the person's coordinating, consulting or administering practitioner.

In making decisions about the reasonable steps that may be taken to facilitate transfer of a person accessing voluntary assisted dying, the practitioner or the entity must have regard to the following matters:

- whether the transfer would be likely to cause serious harm to the person
- whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying
- whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying
- whether the place to which the person is proposed to be transferred is available to receive the person
- whether the person would incur financial costs due to the transfer.

22 Healthcare worker self-care and support

22

22.1 Self-care

Caring for patients at the end of life can be extremely rewarding, but it can also be emotionally challenging. Practitioners must manage the needs and expectations of patients, families, and colleagues but they must also attend to self-care as an essential part of participating in the voluntary assisted dying process.

Even in Australian states where it has been legalised for several years, voluntary assisted dying is a relatively uncommon practice. Practitioners might want to consider how to manage their own feelings and their unique workplace stressors, which may include:

- Practitioners' own reactions to, and experiences of, supporting a planned death
- Local community views around voluntary assisted dying
- Varying views on voluntary assisted dying within the workplace
- Isolation in rural or remote areas
- Differing levels of organisational support.

These factors can all come together to challenge practitioners.

It is widely recognised that health professionals provide the best care to their patients when they are experiencing their own optimal wellness.

Some resources that may be useful to support medical and nurse practitioners are listed in the tables below.

Table 11. Mental health and wellbeing support resources

Resources	Contact
Employee Assistance Programs	All NSW Health staff can access the Employee Assistance Service for free, confidential counselling. You can access this service 24/7. Other organisations may offer similar programs for staff.
CRANAplus Bush Support Line	The *Bush Support Line (1800 805 391)* is open to all health workers and their families in rural, remote, and isolated communities. Callers will be connected with a psychologist experienced in the rural and remote sector.
Hand-n-Hand Peer Support	*Hand-n-Hand* is a free, confidential peer support for health professionals in Australia and New Zealand.
Beyond Blue	Information and support to help individuals experiencing anxiety and depression. Call 1300 224 636 *www.beyondblue.org.au*
Lifeline	24/7 crisis support and suicide prevention Call 13 11 14 *www.lifeline.org.au*
Black Dog Institute	*The Essential Network (TEN) for Health Professionals* offers a range of resources for health professionals, including on managing burnout, self-guided mental health check-ups, confidential sessions with clinical psychologist or psychiatrist.
Australian Centre for Grief and Bereavement (Grief Australia)	*Grief Australia* provides a range of education, training, research and professional service options for those working in the area of grief and bereavement.
Palliative Care Australia	*Self-Care Matters* is a resource to support health professionals providing palliative care. *https://palliativecare.org.au/resources/self-care-matters*
CareSearch Palliative Care Knowledge Network	*CareSearch Palliative Care Knowledge Network* provides palliative care evidence and tools for health professionals including self-care strategies.

Table 12. Additional resources for medical practitioners

Resources	Contact
Royal Australian College of General Practitioners (RACGP) Support Program	The *RACGP's GP support program* is a free service offered to foster a culture of self care amongst GPs. The service is available to all RACGP members who are registered medical practitioners at locations across Australia, including in regional and remote areas. Support is offered via telephone counselling or through wellbeing resources and self-help tools. The service provides members with professional advice in range of areas including as: • Grief and bereavement • Depression, anxiety and stress • Conflict and communication Call 1300 361 008 during business hours to make an appointment.
Royal Australasian College of Physicians (RACP)	The *RACP* website has a number of wellbeing resources. The RACP also offers a support service for members offering professional and confidential counselling service. Call 1300 687 327 to make an appointment.
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	The *RANZCP* website has a number of wellbeing resources. The RANZCP also has a member support program offering professional and confidential counselling service to members. Book online at *RANZCP* or call 1300 687 327 to make an appointment.
Australian College of Rural and Remote Medicine (ACRRM)	The *ACRRM* website has a number of wellbeing resources.
DRS4DRS	*DRS4DRS* supports health and wellbeing for doctors and medical students across Australia and offers confidential support services.
Doctor's Health NSW	Doctor's Health NSW offers a 24/7 Support Line (02 94376552) which is a confidential services that connects doctors and medical students to experienced doctors to discuss health and wellbeing matters.

Table 13. Additional resources for nurse practitioners

Resources	Contact
Nurse and Midwife Support	24/7 National Support service for nurses and midwives providing access to confidential advice and referral (1800 667 877).
Australian College of Nurse Practitioners	The Australian College of Nurse Practitioners offers mentorship and peer support for nurse practitioners. Contact *admin@acnp.org.au* for more information.

22.2 NSW Voluntary Assisted Dying Communities of Practice

Connecting with others who are providing voluntary assisted dying services to patients and families can help manage some challenging aspects of this work experienced by health professionals. These include managing a sense of isolation, especially for rural and remote practitioners, and navigating differing views about voluntary assisted dying amongst professional, institutional, and wider communities.

A community of practice supports practitioners by providing an inclusive forum that can offer practical and emotional support, as well as opportunity to learn from one another and seek guidance from senior practitioners with experience in palliative and end of life care and managing complex deaths.

The VAD-CNS hosts two communities of practice.

The first community of practice, chaired by an Access Service Visiting Medical Officer, is specifically for authorised practitioners (medical and nurse practitioners). This offers a means to continually improve practice through interactive case-based discussions, mentoring, structured education, and confidential peer support.

The other community of practice is for a broader network of health professionals active in voluntary assisted dying services or interested in doing so. It provides a forum to connect across the state, to share and learn from their experiences, and offer peer support. This is co-chaired by the VAD-CNS and local health district membership.

22.3 Education and training

Eligible practitioners who have registered to become an authorised voluntary assisted dying practitioner will undergo checks to confirm they are eligible to provide voluntary assisted dying services. After successful completion of these checks, practitioners will be given access to *Mandatory training to become an authorised voluntary assisted dying practitioner*, on My Health Learning. Once practitioners have passed the online exam, they will be provided with the Prescription and Administration Handbook and associated documentation via the post, which they will need to confirm they have read and understood, in order for training to be considered complete.

Once mandatory training has been successfully completed, authorised practitioners will continue to have access to the online training module so they can refer to it as required, for example, as a refresher to revisit key concepts.

23 NSW Voluntary Assisted Dying Support Services

23

Northern Sydney Local Health District hosts the NSW Voluntary Assisted Dying Support Services that support voluntary assisted dying activity across NSW and respond to enquiries about voluntary assisted dying from the wider community. The services comprise three inter-linked operational services:

- NSW Voluntary Assisted Dying Care Navigator Service (VAD-CNS)
- NSW Voluntary Assisted Dying Access Service, providing outreach medical support
- NSW Voluntary Assisted Dying Pharmacy Service (VAD-PS)

These services are integrated, multidisciplinary and provided by senior nurses, social workers, counsellors, pharmacists, a clinical lead (medical), Visiting Medical Officers/Staff Specialists, and administration officers.

23.1 NSW Voluntary Assisted Dying Care Navigator Service

The NSW Voluntary Assisted Dying Care Navigator Service (VAD-CNS) provides the NSW community with a state-wide point of contact in relation to voluntary assisted dying. This service:

- Provides consistent and accurate information about voluntary assisted dying and how to access voluntary assisted dying in NSW
- Liaises with patients, families, carers, authorised practitioners, healthcare workers or others involved with those seeking information about or access to voluntary assisted dying
- Supports individuals throughout the voluntary assisted dying process
- Includes an outreach medical support capability to support equity of access to voluntary assisted dying across NSW
- Supports implementation, development, and evaluation of voluntary assisted dying services in NSW.

The VAD-CNS is staffed by trained, experienced nurses and allied health professionals, such as social workers and counsellors, taking calls from:

- Patients and their families
- Doctors and other health practitioners
- Local health district teams, hospitals, and health and aged care facilities
- community organisations and interested members of the public who want more information about voluntary assisted dying.

23.1.1 Contacting the NSW Voluntary Assisted Dying Care Navigator Service

The VAD-CNS is open from Monday to Friday (excluding public holidays).

To speak to Care Navigator support staff or the Access Service, please contact the Call Service between Monday to Friday, 8:30am to 4:30pm on 1300 802 133 or email at *NSLHD-VADCareNavigator@health.nsw.gov.au*

23.2NSW Voluntary Assisted Dying Pharmacy Service

The NSW Voluntary Assisted Dying Pharmacy Service (VAD-PS) provides state-wide access to voluntary assisted dying substances for eligible patients and has been established to:

- Employ and train pharmacists to fulfill the role of authorised suppliers under the Act
- Provide expert pharmaceutical information, advice and support for eligible patients, their caregivers, as well as coordinating and administering practitioners
- Provide centralised procurement, preparation and dispensing of the voluntary assisted dying substances, adjuvant medicines and administration equipment
- Provide outreach medication delivery services to enable equitable access to voluntary assisted dying substances across NSW
- Liaise with health practitioners and healthcare workers who may be involved in the provision of services to patients accessing voluntary assisted dying substances
- Facilitate the safe return and disposal of unused or remaining voluntary assisted dying substance by authorised disposers.

23.2.1 Contacting the NSW Voluntary Assisted Dying Pharmacy Service

The VAD-PS contact details are outlined in the Prescription and Administration Handbook.

24 References

24

Legislation

Disability Inclusion Act 2014 (NSW).

Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW).

Websites

Australian College of Nurse Practitioners (2023) About Nurse Practitioners. ACNP.
https://www.acnp.org.au/about-nurse-practitioners

Journal articles and discussion papers

Bueno-Gomez, N. (2017). Conceptualizing pain and suffering.
Philosophy, Ethics and Humanities in Medicine, 12(7), 1-11. https://doi.org/10.1186/s13010-017-0049-5

Kurtz, S.M. (2002). Doctor-Patient Communication: Principles and Practices.
Canadian Journal Neurological Science. 29(2) S23-S29.
https://www.cambridge.org/core/services/aop-cambridge-core/content/view/23808049F33114BFA988142C35910AA8/S0317167100001906a.pdf/doctorpatient_communication_principles_and_practices.pdf

Paget, L., P. Han, S. Nedza, P. Kurtz, E. Racine, S. Russell, J. Santa, M. J. Schumann, J. Simha, and I. Von Kohorn. (2011).
Patient-Clinician Communication: Basic Principles and Expectations. National Academy of Medicine.
https://nam.edu/perspectives-2011-patient-clinician-communication-basic-principles-and-expectations/

Pesiah C, Sheahan L and White B. (2019). Biggest decision of them all – death and assisted dying: capacity assessments and undue influence screening. *Internal Medicine Journal*, 49(6), 792-796.

Webb, W., Mitchell, T., Snelling, P. & Nyatanga, B. (2020). Life's hard and then you die: the end-of-life priorities of people experiencing homelessness in the UK. *International Journal of Palliative Nursing*, 26(3), 120-132. DOI:10.12968/ijpn.2020.26.3.120.

Books

Silverman JD, Kurtz SM, and Draper J. (2005). *Skills for Communicating with Patients* (2nd ed.).
Radcliffe Publishing (Oxford).

Cassell EJ. (1991). *The nature of suffering and the goals of medicine*. Oxford University Press (New York) 31.

25 Appendices

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Appendix 1

Table 1. Resources to assist with prognostication

Please note that the below resources may be useful as a generic guide but are not definitive.

Tool/resource/paper	Contains	Additional information
Australia-modified Karnofsky Performance Status Scale Abernethy AP, et al. 2005. *"The Australia-modified Karnofsky Performance Status (AKPS) Scale: a revised scale for contemporary palliative care clinical practice."* BMJ Palliative Care 4:7.	Measures the patient's overall performance status or ability to perform their activities of daily living.	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.
Charlson Comorbidity Index Charlson ME, et al. 1987. *"A new method of classifying prognostic comorbidity in longitudinal studies: Development and validation".* Journal of Chronic Diseases 40(5): 373-83.	Validated tool which quantifies a person's burden of disease and mortality risk.	Internationally validated, disease specific, and easy to use using information from clinical notes.
CareSearch review collection – Prognosis CareSearch. 2023. *"CareSearch review collection - Prognosis".* Last modified September 2023.	Collection of systematic reviews relating to prognostication.	
Supportive and Palliative Care Indicators Tool (SPICT) The University of Edinburgh. *"SPICTTM: Supportive and Palliative Care Indicators Tool."* Last modified 2022.	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.	
The Gold Standards Framework Thomas K, et al. 2011. *"The GSF Prognostic Indicator Guidance 4th edition".* Last modified October 2011.	Guidance to help health practitioners with earlier identification of adult patients who are nearing the end of their life and may need additional support.	Relatively succinct tool with information and specifics about individual medical conditions. Uses the surprise question.
The surprise question van Lummel, EV, et al. 2022. *"The utility of the surprise question: A useful tool for identifying patients nearing the last phase of life? A systematic review and meta-analysis".* Palliative Medicine 36(7), pp. 1023–1046.	Asks *"Would I be surprised if this patient died in the next 12 months?"* to identify patients at high risk of death who might benefit from palliative care services.	High specificity and sensitivity.

Appendix 2

Table 1. Non-authorised practitioner roles in the voluntary assisted dying process

Role	Description of responsibilities and requirements	Eligibility requirements	Examples of people who could act in this role
Agent of the patient	An agent of a patient is a person who acts on behalf of the patient. An agent of the patient is authorised to – (a) receive the prescribed substance from an authorised supplier, and (b) possess the prescribed substance for the purpose of supplying the substance to the patient, and (c) prepare the prescribed substance for self-administration by the patient, and (d) supply the prescribed substance to the patient. If a patient is receiving care at a health establishment or residential facility that does not provide access to voluntary assisted dying at the facility, an agent of the patient may also have a role in communicating with the establishment or facility about the patient's request to access the voluntary assisted dying process.	The Act does not outline eligibility criteria for an agent of the patient. However, where a patient requires an agent to undertake a specific task in the voluntary assisted dying process, coordinating practitioners should support patients to select an appropriate person to act in this role.	Examples of people who may be suitable to act in this role include: • An adult family member or friend of the patient • A carer • The patient's coordinating or consulting practitioner
Contact person *(role only applicable for self-administration)*	The contact person is authorised to: • Receive the prescribed substance from an authorised supplier, • Possess the prescribed substance, • Prepare the prescribed substance for self-administration by the patient, and • Supply the prescribed substance to the patient. The contact person for a patient must: • Return any unused or remaining voluntary assisted dying substance to an authorised disposer as soon as practicable and not later than 14 days after either: – the patient dies, or – the patient revokes a self-administration decision (and the substance has already been supplied). • Notify the coordinating practitioner if the patient dies, whether as a result of self-administering the prescribed substance or from some other cause.	The contact person must: • Be an adult (at least 18 years of age) • Consent to the appointment and agree to carry out the role of a contact person for the patient, and • Sign the ***Contact Person Appointment Form***	Examples of people who may be suitable to act in this role include: • An adult family member or friend of the patient • A carer • The patient's coordinating or consulting practitioner

Role	Description of responsibilities and requirements	Eligibility requirements	Examples of people who could act in this role
Witness to the ***Written Declaration***	The patient must complete their ***Written Declaration*** in the presence of two eligible witnesses. The witnesses provide independent verification that the ***Written Declaration*** was signed freely and voluntarily by the person requesting access to voluntary assisted dying.	A witness to a ***Written Declaration*** must: • Be an adult (at least 18 years of age), • Not know or believe they are a beneficiary under a will of the patient or may otherwise benefit financially or in any other material way from the death of the patient, • Not be a family member of the patient, • Not be the coordinating or consulting practitioner of the patient, and • Not be a family member or employee of the coordinating or consulting practitioner of the patient.	Examples of people who may be suitable to act in this role include: • A friend or neighbour of the patient who is not a beneficiary under the patient's will Staff at health facilities where the coordinating practitioner works may be approached to be a witness to a written declaration. If approached, staff members and the patient's coordinating practitioner should consider best practice guidance for choosing witnesses. Best practice is to ensure that a witness is not in a position where they may be under influence of the coordinating practitioner. This may include: • A direct report of the coordinating practitioner • A staff member who could be under influence in another way e.g., significantly junior, or likely to be in a position working under the coordinating practitioner in a future role.

Role	Description of responsibilities and requirements	Eligibility requirements	Examples of people who could act in this role
Witness to practitioner administration of a voluntary assisted dying substance ***(role only applicable for practitioner administration)***	An eligible witness must be present when the administering practitioner administers the voluntary assisted dying substance to the patient. The witness must certify in the ***Practitioner Administration Form*** for the patient that – (a) the patient's request for access to voluntary assisted dying appeared to be free, voluntary and enduring, and (b) the patient's administering practitioner administered the prescribed substance to the patient in the presence of the witness.	The witness to practitioner administration must: • Be an adult (at least 18 years of age), • Not be a family member[1] of the administering practitioner, and • Not be employed or engaged under a contract for services by the patient's administering practitioner.	Examples of people who may be suitable to act in this role include: • An adult family member or friend of the patient (including immediate family i.e. parent, sibling, spouse) • A carer • An adult neighbour of the patient • A healthcare worker who is not in a position of influence by the administering practitioner *Note: Best practice is to ensure that a witness is not in a position where they may be under influence of the coordinating practitioner. This may include:* • A direct report of the coordinating practitioner • A staff member who could be under influence in another way e.g., significantly junior, or likely to be in a position working under the coordinating practitioner in a future role.

[1]*Note: Family member, of a person, means any of the following –*

(a) the person's spouse or de facto partner,

(b) the person's parent or step parent, or a sibling of the person's parent or step parent,

(c) the person's grandparent or step grandparent,

(d) the person's sibling or step sibling, or a child of the person's sibling or step sibling,

(e) the person's child or step child,

(f) the person's grandchild or step grandchild.

Appendix 3

Summary of key forms in the voluntary assisted dying process

This summary does not cover all forms that may be required for a patient to complete the voluntary assisted dying process.

Form	Person responsible for submission	Maximum timeframe for submission
First Request Form	Any medical practitioner to whom a first request is made	Within 5 business days after deciding to accept or refuse a first request
First Assessment Report Form	Coordinating practitioner	Within 5 business days after the completion of the first assessment
Consultation Referral Form	Any authorised practitioner who receives a referral for consulting assessment	Within 5 business days of deciding to accept or refuse a referral for a consulting assessment
Consulting Assessment Report Form	Consulting practitioner	Within 5 business days after the completion of the consulting assessment
Written Declaration	Coordinating practitioner	Within 5 business days after receiving it from the patient
Final Request Form	Coordinating practitioner	Within 5 business days of receiving a final request

Form	Person responsible for submission	Maximum timeframe for submission
Final Review Form	Coordinating practitioner	Within 5 business days of completing the final review
Administration Decision Form	Coordinating practitioner	Within 5 business days after patient makes an administration decision
Contact Person Appointment Form *Note: only applicable for patients who have made a self-administration decision*	Coordinating practitioner	Within 5 business days after receiving it from the patient or contact person
Prescription Form	Coordinating practitioner	Within 5 business days after prescribing a voluntary assisted dying substance for the patient
Authorised Supply Form	Authorised supplier	Within 5 business days after supplying the substance
Practitioner Administration Form *Note: only applicable for patients who undergo practitioner administration*	Administering practitioner	Within 5 business days of the substance being administered to the patient

Form	Person responsible for submission	Maximum timeframe for submission
Authorised Disposal Form *Note: only applicable where an authorised disposer disposes of a voluntary assisted dying substance*	Authorised disposer	Within 5 business days after disposing of the substance
Practitioner Disposal Form *Note: only applicable where an administering practitioner disposes of a voluntary assisted dying substance*	Administering practitioner	Within 5 business days after disposing of the substance
Notification of Death Form *Note: only applicable for self-administration, or where the patient has died from another cause*	• Coordinating practitioner, or • Administering practitioner, or • Any other medical practitioner completing an MCCD for a patient they know or believe self-administered a voluntary assisted dying substance	Within 5 business days after becoming aware of the patient's death

NSW GOVERNMENT