

Voluntary assisted dying and telehealth: Commonwealth carriage service laws are putting clinicians at risk

A Commonwealth law poses legal risks for practitioners acting under state and territory voluntary assisted dying laws

November 2017 marked the start of a significant shift regarding voluntary assisted dying in Australia. After numerous reform attempts,¹ in a 4-year period, five states legalised voluntary assisted dying: Victoria, Western Australia, Tasmania, South Australia and Queensland (Box 1). A bill will be tabled imminently in New South Wales,² and the Australian Capital Territory and Northern Territory have renewed their push for reform.³

In the 2 years since the Victorian law commenced operation, widespread concerns have been raised about Commonwealth legislation that prohibits discussing suicide via a carriage service (electronic means of communication including telephone and internet).⁴⁻⁶ These offences — enacted when voluntary assisted dying was illegal — may criminalise activities otherwise lawful under state and territory legislation.

This article describes the problems caused by this Commonwealth law and its implications for clinicians and patients. It adds to calls for the Commonwealth Government to remove this “apparently unintended grey cloud”⁶ over clinicians providing voluntary assisted dying.

Telehealth can be important for patients seeking voluntary assisted dying

Voluntary assisted dying laws mandate a detailed “request and assessment” process. To illustrate, in Victoria, a patient seeking voluntary assisted dying must make at least three separate requests and be assessed as eligible by two independent medical practitioners.⁷ If the patient is found eligible and all safeguards have been complied with, the medical practitioner may prescribe a lethal substance to the patient for self-administration or (in more limited circumstances) the practitioner may administer it.

As other Australian jurisdictions have considered reform, a key issue has been ensuring access to voluntary assisted dying across geographically vast states.^{6,8,9} Travel may be difficult or impossible for some patients who are terminally ill and suffering intolerably. To facilitate more equitable access, provisions in WA and Tasmania expressly permit telehealth for some voluntary assisted dying consultations, provided audio-visual means are used where the practitioner and patient hear and see each other. While some argue telehealth is inappropriate given the seriousness of voluntary assisted dying, the expert panels that considered the form of the legislation in WA⁸ and Tasmania⁹ determined this was

a key part of implementation, and consistent with best practice in end-of-life care.

Telehealth is an important and increasingly ubiquitous part of health care, including end-of-life care.¹⁰ Catalysed by the coronavirus disease 2019 pandemic, the Commonwealth Government invested considerable resources into expanding telehealth services.¹¹ A member survey from the Royal Australasian College of Physicians reported that 75% of respondents thought telehealth improved accessibility of health care, and 87% supported retaining new telehealth items in the Medicare Benefits Schedule beyond the pandemic.¹² Whether telehealth is clinically appropriate for a particular patient or consultation for voluntary assisted dying is context-specific; however, Canadian and United States research suggests it can be effective.^{13,14} Formal requirements (such as assessing age and residency) and clinical requirements (including assessing capacity and voluntariness) can all be addressed through telehealth, particularly where doctors have been involved in the patient’s care before the request for voluntary assisted dying.¹³

The problem: Commonwealth carriage service offences

The Commonwealth *Criminal Code Act 1995* (the Code) sets out two complex offences regarding communicating about suicide over a carriage service (Box 2). The Code makes it an offence to use a carriage service to:

- counsel or incite suicide or attempted suicide; or
- promote or provide instruction on a particular method of committing suicide.

These offences were introduced in 2005 to combat pro-suicide chatrooms, and in response to Philip Nitschke’s efforts to promote suicide methods for the terminally ill.¹⁵

There is disagreement about whether and when health professionals who use a carriage service to discuss voluntary assisted dying will contravene these laws.^{6,15,16} One threshold issue is whether voluntary assisted dying meets the legal definition of “suicide”: in other words, “intentional self-killing”.^{15,16} There are strong arguments of logic why the two concepts are distinct, but a court has never ruled on whether voluntary assisted dying meets the legal meaning of suicide under the Code. Although some jurisdictional laws stipulate that voluntary assisted dying is not suicide, they cannot inform the interpretation of

Eliana Close 

Katrine Del Villar 

Lindy Willmott 

Ben P White 

Australian Centre
for Health Law
Research, Queensland
University of Technology,
Brisbane, QLD.

eliana.close@qut.
edu.au

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1 Status of voluntary assisted dying reforms in Australia, September 2021

	Jurisdiction	Legislative activity	Status
Voluntary assisted dying laws	Victoria	<i>Voluntary Assisted Dying Act 2017</i>	Passed November 2017, commenced 19 June 2019
	Western Australia	<i>Voluntary Assisted Dying Act 2019</i>	Passed December 2019, commenced 1 July 2021
	Tasmania	<i>End-of-Life Choices (Voluntary Assisted Dying) Act 2021</i>	Passed April 2021, due to commence by 23 October 2022
	South Australia	<i>Voluntary Assisted Dying Act 2021</i>	Passed June 2021, with a commencement date to be determined
	Queensland	<i>Voluntary Assisted Dying Act 2021</i>	Passed September 2021, due to commence on 1 January 2023
Other reform efforts	New South Wales	Independent Member of Parliament (MP) Alex Greenwich has prepared a bill and released it to MPs	Tabling of the bill in Parliament was planned for August 2021; however, sittings have been postponed due to the coronavirus disease 2019 pandemic
	Australian Capital Territory	Parliamentary inquiry into end-of-life choices (March 2019) Legislation is prohibited by the Commonwealth <i>Euthanasia Laws Act 1997</i>	MPs across parties have called on the Commonwealth government to restore the ACT's right to legislate on voluntary assisted dying
	Northern Territory	<i>Rights of the Terminally Ill Act 1995</i> (NT), repealed in 1997 by the Commonwealth <i>Euthanasia Laws Act 1997</i>	NT Country Liberal Party Senator Sam McMahon has introduced a bill to restore the NT's powers to legislate on voluntary assisted dying

2 Commonwealth carriage service offences

The Commonwealth *Criminal Code Act 1995* sets out two separate offences about suicide-related material over a carriage service: counselling or inciting suicide or attempted suicide; and promoting or providing instruction on a particular method of committing suicide.¹⁵ Currently, the maximum penalty for each offence is a fine of up to \$222 000 for an individual or \$1 110 000 for a corporation.¹⁵

Offence 1: Counselling or inciting suicide via a carriage service

- Section 474.29A(1) makes it an offence to use a carriage service to access, transmit, make available, publish or otherwise distribute suicide-related material (ie, any form of communication), where that material directly or indirectly counsels or incites (ie, actively encourages or urges) committing or attempting to commit suicide.
- The person must intend to use the material to counsel or incite committing or attempting suicide (or must intend that another person uses the material to do the same).
- To commit this offence, the person must actively encourage or urge the person to commit or attempt suicide, so it might be harder to prosecute than the "promoting or providing instruction" offence. While any communication would be context-specific, it would not be good medical practice to actively encourage or urge a patient to seek voluntary assisted dying. Note that if a health practitioner were actively trying to induce a patient into accessing voluntary assisted dying, this would also be an offence under state law: eg, *Voluntary Assisted Dying Act 2017* (Vic), section 85.

Offence 2: Promoting or providing instruction on a method of suicide via a carriage service

- Section 474.29A(2) makes it an offence to use a carriage service to access, transmit, make available, publish or otherwise distribute material (ie, any form of communication), where that material promotes or provides instruction on a particular method of committing suicide.
- The person must intend to use the material to either promote or provide instruction on a method of suicide, or intend that it be used by another person to commit suicide. This offence may be established more easily than the "counselling or inciting" offence, as providing information or instruction is a lower threshold.

Commonwealth statutes.¹⁵ This creates significant legal uncertainty.^{6,15}

State health departments have issued practitioner guidance to address this legal risk. The Victorian Government's guidance includes an expectation that all voluntary assisted dying consultations and assessments occur face to face.¹⁷ WA has adopted a more nuanced approach, instructing health professionals to avoid discussing information that relates to the act of administering a voluntary assisted dying substance over a carriage service.¹⁸ However, providing general or specific information about voluntary assisted dying is permissible,

provided it "does not advocate, encourage, incite, promote or teach about how to undertake the act of administration".¹⁸

Implications for doctors and patients

The Commonwealth Government has repeatedly indicated it has "no plans" to amend the Code,¹⁹ leaving significant barriers for patients and risks for health professionals.

Doctors in Victoria have reported the need to conduct all voluntary assisted dying consultations and assessments in person to be a critical implementation challenge.¹⁷

This poses an “immense burden”⁴ on very sick patients to travel or, if this is not possible, it requires doctors to travel large distances to see patients. There are currently limited specialists willing to participate in voluntary assisted dying,⁵ leaving patients in rural and remote areas with constrained access. In Victoria, the problem is particularly acute for those with motor neuron disease or respiratory conditions, where specialists who are willing to participate are concentrated in metropolitan areas.⁵

In its latest report, the Victorian Voluntary Assisted Dying Review Board commented that the carriage service offences adversely affect clinicians and patients.⁵ The Law Institute of Victoria, a peak legal body, is “deeply concerned about the lack of clarity and exposure for medical practitioners supporting the needs of patients, particularly in remote areas or extreme circumstances”.²⁰ The Australian Medical Association (which is opposed to voluntary assisted dying) has said medical practitioners are rightly concerned about potential prosecution.²¹

Law reform bodies have also identified concerns. The Queensland Law Reform Commission report accompanying its Voluntary Assisted Dying Bill 2021 stated: “It is inherently undesirable that health practitioners should be left under such an apparently unintended grey cloud”.⁶ The Tasmanian Expert Report noted this “could significantly curtail the use of telecommunications for [voluntary assisted dying] which has been an important part of ensuring regional access”.⁹

Solutions in the face of inaction by the Commonwealth

The Commonwealth Government’s refusal to remove this legal risk for doctors and associated patient burdens seems increasingly difficult to justify as voluntary assisted dying becomes lawful in more jurisdictions. By 2023, when Queensland’s legislation becomes operational, two-thirds of Australians will live in a jurisdiction where the practice is legal.²²

To resolve the uncertainty, the Commonwealth Government should amend the Code to clarify that suicide does not include voluntary assisted dying under state law. An alternative, although suboptimal, approach is for the Commonwealth Director of Public Prosecutions to issue guidelines barring prosecution of individuals acting lawfully under state or territory frameworks.

In the meantime, what should health practitioners involved in voluntary assisted dying (directly or indirectly) make of these laws? There are four key considerations.

First, providing general information about availability of voluntary assisted dying as a legal option is unlikely to contravene the Code because general discussions do not counsel or incite suicide, or promote or provide instruction about a method of suicide. Therefore, health practitioners can be reasonably confident discussing voluntary assisted dying as a legal option in general terms by telephone or internet.

Second, conducting an eligibility assessment via a carriage service is likely not to breach the Code, as this requires judgements about factors including residency,

prognosis and decision-making capacity, rather than inciting, encouraging or providing instruction about suicide.

Third, discussing the voluntary assisted dying medication protocol for self-administration and how death will occur could amount to providing instruction on a method of suicide (the second offence). These discussions could occur at any stage as part of a patient’s decision-making process. To minimise risk, health practitioners should have these discussions in person.

Fourth, voluntary assisted dying by practitioner administration cannot amount to suicide (unlike self-administration, it does not involve intentional self-killing) (del Villar K, White B, Close E, Willmott L. Voluntary assisted dying by practitioner administration is not suicide: a way past the Commonwealth Criminal Code? [unpublished article]). Therefore, if practitioner administration only is contemplated (eg, because the patient is physically unable to swallow the voluntary assisted dying substance), communication by telephone or internet will not infringe the Code.

Conclusion

Uncertainty about liability under the Code restricts the use of telehealth for voluntary assisted dying in practice, adversely impacting doctors, patients and their families. It has negatively affected implementation of voluntary assisted dying in Victoria and is likely to cast an even darker shadow in states such as WA and Queensland, with geographically dispersed populations.

Clinicians acting in accordance with lawful state processes and in good faith should not have to grapple with possible legal risk. The Commonwealth Government should act to protect practitioners and prioritise equitable access for those in rural and regional areas. As voluntary assisted dying reform spreads across the country, the calls to address this problem will, rightly, only grow louder and become more compelling.

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