

LEGISLATIVE OPTIONS TO ADDRESS INSTITUTIONAL OBJECTIONS TO VOLUNTARY ASSISTED DYING IN AUSTRALIA

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Voluntary assisted dying is being considered by parliaments and law reform bodies across Australia. Although individual conscientious objection is routinely considered in these deliberations, an institution's desire to object to providing voluntary assisted dying has received very little attention. After briefly considering the concept of institutional objection in voluntary assisted dying, this article examines the available (albeit limited) Australian evidence on this practice. Institutional objection is happening in Victoria (where voluntary assisted dying is lawful) and is likely to occur in other Australian states. The article proposes that regulation is needed and presents three models for parliaments and law reformers to consider. The first is 'conscientious absolutism', which grants institutions unrestricted ability to object to voluntary assisted dying. The second

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is a 'compromise or reasonable accommodation' model, which aims to accommodate both institutional objection and a person's wish to access voluntary assisted dying. Different balances can be struck; we propose a model that prioritises a patient's interests. The third model is 'non-toleration', which would refuse to allow an institution to object at all. While there can be debate about the optimal model, the issue of institutional objection to voluntary assisted dying must be addressed.

I INTRODUCTION

After decades of unsuccessful attempts to legalise voluntary assisted dying ('VAD'),¹ the past few years have witnessed a flurry of reform activity in Australia. In Victoria, the *Voluntary Assisted Dying Act 2017* (Vic) ('*Victorian VAD Act*') commenced operation in June 2019. Western Australia largely followed the Victorian model and its *Voluntary Assisted Dying Act 2019* (WA) is due to commence operation on 1 July 2021. As this article was being published, Tasmania also passed its *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) which is anticipated to commence in 2022. A VAD Bill has been introduced in South Australia,² one will be considered in Queensland in May 2021,³ and New South Wales is likely to see such a Bill tabled in 2021 as well.⁴

Reflecting the contested nature of VAD legislation, such laws almost universally contain provisions to respect conscientious objections by individual health professionals. Both the Victorian and Western Australian laws state that a health professional has a right to refuse involvement with any aspect of the VAD process.⁵ A more controversial issue, which has received limited consideration in Australia, is whether an *institution* should be able to prohibit access to VAD or any VAD-related activities (which include eligibility assessments and providing

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- 1 A detailed discussion of attempts at law reform in Australia is available in: Lindy Willmott et al, '(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics' (2016) 39(1) *University of New South Wales Law Journal* 1. See also further Bills in Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42(6) *Australian Health Review* 616.
 - 2 Voluntary Assisted Dying Bill 2020 (SA).
 - 3 The Queensland Premier referred the issue to the Queensland Law Reform Commission to draft a Bill for the Government's consideration: Queensland Law Reform Commission, *Queensland's Laws Relating to Voluntary Assisted Dying* (Terms of Reference, 2020) <https://www.qlrc.qld.gov.au/_data/assets/pdf_file/0004/651379/vad-tor.pdf>. See also Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (Consultation Paper No 79, October 2020) <https://www.qlrc.qld.gov.au/_data/assets/pdf_file/0003/658506/qlrc-wp-79-2020.pdf>.
 - 4 Michael Koziol, 'Fresh Bid to Legalise Assisted Dying Set to Test NSW Government', *The Sydney Morning Herald* (online, 13 December 2020) <<https://www.smh.com.au/politics/nsw/fresh-bid-to-legalise-assisted-dying-set-to-test-nsw-government-20201209-p56m2t.html>>.
 - 5 *Voluntary Assisted Dying Act 2017* (Vic) s 7 ('*Victorian VAD Act*'); *Voluntary Assisted Dying Act 2019* (WA) s 9.

information about VAD) within its facility.⁶ The Victorian and Western Australian Acts are silent on this issue. However, this is important because institutions that object have the power to significantly curtail individuals' ability to access what is a lawful medical service.⁷ When this occurs for reasons of conscience, this is problematic, particularly when these institutions are the sole providers of specialist end-of-life care in a particular geographic area.⁸ This effectively creates barriers to access and the impact on patients can be extreme; those who are eligible for VAD are already experiencing intolerable suffering and such institutional objections can compound this.

Although the Victorian and Western Australian Acts do not address institutional objection, it is possible for legislation to regulate it. The Voluntary Assisted Dying Bill 2019, a model Bill that was recommended by the Queensland parliamentary inquiry considering VAD as the proposed basis for reform,⁹ contains such a provision.¹⁰ A proposed amendment to regulate institutional objections was also debated, though ultimately not passed, in the Legislative Council of Tasmania during debate on the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas).¹¹

During the debates in Tasmania, many parliamentarians expressed grave concern that institutions (particularly residential aged care facilities) would create unjustified barriers for individuals who were approaching the end of their lives, suffering intolerably, and seeking VAD. For example, Ms Forrest stated: 'I am really struggling with why we would require someone to be moved from their home because an organisation's policy was that they did not want to be involved in the matter'.¹² Indeed, several politicians expressed surprise that institutions

6 See, eg, Philip Shadd and Joshua Shadd, 'Institutional Non-Participation in Assisted Dying: Changing the Conversation' (2019) 33(1) *Bioethics* 207; LW Sumner, 'Institutional Refusal to Offer Assisted Dying: A Response to Shadd and Shadd' (2019) 33(8) *Bioethics* 970.

7 See, eg, Sumner (n 6) 971.

8 See, eg, Udo Schuklenk, 'Conscience-Based Refusal of Patient Care in Medicine: A Consequentialist Analysis' (2019) 40(6) *Theoretical Medicine and Bioethics* 523; Sumner (n 6) 971.

9 Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying* (Report No 34, 31 March 2020)

<<https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf>> ('Queensland Parliamentary Report'). In Recommendation 1, the Committee recommended the Queensland Government use a draft voluntary assisted dying ('VAD') Bill written by two of the authors as the basis for legalising VAD in Queensland. For the model Bill, see: Ben White and Lindy Willmott, 'A Model Voluntary Assisted Dying Bill' (2019) 7(2) *Griffith Journal of Law and Human Dignity* 1, 15–43.

10 White and Willmott (n 9) 36.

11 The amendment proposed by Dr Bastian Seidel would require institutions that object to VAD to transfer a patient to a healthcare facility that does not object: Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 2 (Bastian Seidel). Note also that clause 19(3) in the (defeated) Death with Dignity Bill 2016 (SA) addressed institutional objection to VAD. This clause indicated that an institution could refuse to provide VAD, but if it did so it must ensure the refusal is brought to the attention of individuals before being admitted, and if the person had already entered the institution without being aware of the objection, arrange a transfer.

12 Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 5 (Ruth Forrest).

could legally prevent health professionals from entering facilities for this purpose.¹³

This article explores how institutional objections to VAD in Australia are currently regulated, the potential consequences of such objections, and possible legislative responses. We commence by examining the concept of institutional objection, including a comparison with conscientious objection by individuals. We then outline how institutional objection is regulated in Victoria (by policy), evidence of the impact of such objection on individuals in Victoria, and likely outcomes in other parts of Australia if VAD is enacted. We also consider the recent Canadian experience to identify potential outcomes of institutional objections. We conclude by offering some regulatory options to govern institutional objection for parliaments and other bodies deliberating on VAD reform.

II THE CONCEPT OF INSTITUTIONAL CONSCIENTIOUS OBJECTION¹⁴

Conscientious objection in medicine can refer to a desire not to participate in providing a healthcare service based on concerns to ‘preserve or maintain moral integrity’.¹⁵ It is conceptually distinct from non-participation based on clinical judgment – that to provide a particular treatment would not be in accordance with good medical practice.¹⁶ It is also to be distinguished from pragmatic reasons for non-participation, based on lack of expertise, financial or technological resources.¹⁷

13 See, eg, Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 5–6 (Ruth Forrest), 10 (Meg Webb), 15–16 (Bastian Seidel).

14 This article does not consider institutional objections made on the basis of institutional capacity (eg, not having the required human resources or equipment). We do briefly note here, though, that such objections may be difficult to sustain as VAD does not require specialised equipment or human resources that cannot be brought into a facility.

15 Mark R Wicclair, ‘Conscientious Objection in Medicine’ (2000) 14(3) *Bioethics* 205, 213. See generally Morten Magelssen, ‘When Should Conscientious Objection Be Accepted?’ (2012) 38(1) *Journal of Medical Ethics* 18; Sara Fovargue and Mary Neal, ‘“In Good Conscience”: Conscience-Based Exemptions and Proper Medical Treatment’ (2015) 23(2) *Medical Law Review* 221, 222. See also Stephen Smith, who defines conscience from an individual perspective as ‘an internal mental process focused on an inward-looking choice to engage in particular behaviour on the basis of a moral value’: Stephen W Smith, ‘The Responsibilities of Conscience in Healthcare Decisions: Moving Towards a Collaborative Framework’ (2020) 79(1) *Cambridge Law Journal* 120, 124. While these authors defend the right to conscientiously object on the basis of preserving moral integrity, others frame the issue in terms of harm to the doctor and the health service: see, eg, Julian Savulescu, ‘Conscientious Objection in Medicine’ (2006) 332(7536) *British Medical Journal* 294.

16 See Fovargue and Neal (n 15) 224–5; Smith (n 15) 129; Nadia N Sawicki, ‘Mandating Disclosure of Conscience-Based Limitations on Medical Practice’ (2016) 42(1) *American Journal of Law and Medicine* 85, 91–2.

17 Shadd and Shadd (n 6) 208, 211.

While an individual's right to conscientiously object is traditionally recognised in law and policies,¹⁸ it is more contentious whether an institution itself can have a 'conscientious objection'. Individuals are self-evidently moral agents, and possess human rights, including the right to freedom of religion, thought and conscience.¹⁹ The status of institutions is less clear. Some argue there is no basis for an institution to have such an objection, as 'bricks and mortar' cannot have moral beliefs as people do.²⁰ Others consider a healthcare institution to be more than just a building, and view it as 'a group of people organized according to a series of roles and relationships designed to deliver the social good of healthcare'.²¹ According to this view, institutions may have a distinctive mission, ethos and moral values, and should be recognised as having a conscience.²² A middle ground, advanced by Wicclair, is to argue that while hospitals do not possess a conscience like individuals do, they could still justify claims to refuse a service on the basis of their identity and integrity. Nevertheless, they have obligations to prevent harm to patients, promote health and respect autonomy, which can outweigh identity or integrity-based claims.²³

Institutional objections to VAD may be made by a range of different institutions, including hospitals, residential aged care facilities and other long-term care facilities, and hospices or other short-term care facilities.²⁴ Institutions may object to participating in VAD on at least three levels: 1) VAD administration; 2) eligibility assessments; and 3) providing information or referring individuals to facilitate VAD.²⁵ Firstly, an institution may not wish to have administration of

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- 18 Wicclair, 'Conscientious Objection in Medicine' (n 15). For the contrary view, that an individual health practitioner should not be able to object on conscientious grounds, see Savulescu (n 15) 294; Julian Savulescu and Udo Schuklenk, 'Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception' (2017) 31(3) *Bioethics* 162, 165.
- 19 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 18. See also Sumner (n 6) 972.
- 20 Daphne Gilbert, 'Faith and/in Medicine: Religious and Conscientious Objections to MAiD' (2020) 43(2) *Dalhousie Law Journal* 1, 38. Gilbert argues that under Canadian law, religious institutions do not have the right to refuse to offer medical assistance in dying ('MAiD': the Canadian term for VAD), a publicly-funded and legal health service. See also George J Annas, 'At Law: Transferring the Ethical Hot Potato' (1987) 17(1) *The Hastings Center Report* 20, 21: 'Hospitals are corporations that have no natural personhood, and hence are incapable of having either "moral" or "ethical objections" to actions. ... [H]ospitals don't practice medicine, physicians do'. Sumner (n 6) says it is 'debatable' whether institutions can have conscience rights: at 972 n 14.
- 21 Shadd and Shadd (n 6) 208.
- 22 See Cameron Flynn and Robin Fretwell Wilson, 'Institutional Conscience and Access to Services: Can We Have Both?' (2013) 15(3) *American Medical Association Journal of Ethics* 226, 227; Daniel P Sulmasy, 'What Is Conscience and Why Is Respect for It So Important?' (2008) 29(3) *Theoretical Medicine and Bioethics* 135; Kevin W Wildes, 'Institutional Identity, Integrity, and Conscience' (1997) 7(4) *Kennedy Institute of Ethics Journal* 413, 416. In New Zealand, a court has held that institutions may have 'an entrenched moral ethos through which it operates' and have a right to freedom of conscience: *Hospice New Zealand v A-G* [2020] NZHC 1356, [103] (Mallon J). Mallon J held that there is nothing in the *End of Life Choice Act 2019* (NZ) that requires institutions to offer VAD: at [103]–[117], [214].
- 23 Mark R Wicclair, 'Conscientious Refusals by Hospitals and Emergency Contraception' (2011) 20(1) *Cambridge Quarterly of Healthcare Ethics* 130.
- 24 See Shadd and Shadd (n 6) 208.
- 25 Carpenter and Vivas note three types of individual objection to VAD: objection to administration, objection to participation in consultation and assessment, and, less commonly, objection to providing a direct referral. Travis Carpenter and Lucas Vivas, 'Ethical Arguments Against Coercing Provider

VAD occur in its facility.²⁶ It may achieve this by forbidding its staff or outside health professionals from administering or prescribing VAD medication to patients, and/or it may prohibit individuals themselves from taking it in the facility. Secondly, an institution may prohibit consultations or eligibility assessments for VAD occurring within the facility, whether conducted by staff or outside health professionals.²⁷ Thirdly, an institution may refuse to refer a patient to other institutions or health professionals who provide VAD services or object to providing information about VAD.

A common basis for institutional objection is religious belief. The Catholic Church has made prominent statements on VAD, with its most recent pronouncement concluding that ‘euthanasia ... is an intrinsically evil act’,²⁸ and that complicity by ‘[a]ny formal or immediate material cooperation in such an act is a grave sin against human life’.²⁹ This is significant as Catholic hospitals and institutions (eg, hospices and long-term care facilities) provide a significant proportion of end-of-life care in Australia.³⁰ Other religions, including Judaism and Islam, have expressed the same viewpoint.³¹ This has led some religious organisations to refuse to permit VAD assessments or administration in their

Participation in MAiD (Medical Assistance in Dying) in Ontario, Canada’ (2020) 21 *BMC Medical Ethics* 46:1–5, 1–2. Institutional objections may also extend to a refusal to allow individuals to complete paperwork relating to VAD onsite: see, eg, Jennie Russell, ‘Paralyzed, Terminally Ill Man Had to Sign Assisted-Dying Papers in Bus Shelter’, *CBC News* (online, 2 November 2018)

<<https://www.cbc.ca/news/canada/edmonton/convenant-health-assisted-dying-edmonton-1.4888114>> (‘CBC Coverage of Bob Hergott’); Jennie Russell, ‘Unassisted Death’, *CBC News* (online) <<https://newsinteractives.cbc.ca/longform/unassisted-death>> (‘CBC Coverage of Doreen Nowicki’).

26 See, eg, the case of a Victorian patient discussed below: Eswaran Waran and Leeroy William, ‘Navigating the Complexities of Voluntary Assisted Dying in Palliative Care’ (2020) 213(5) *Medical Journal of Australia* 204.

27 In Victoria, some institutions (such as facilities run by Catholic Health Australia, discussed below) have indicated that they will refuse to participate in assessment or administration of VAD.

28 Congregation for the Doctrine of the Faith, ‘*Samaritanus Bonus: On the Care of Persons in the Critical and Terminal Phases of Life*’ (Letter, 22 September 2020) 8

<http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html>. This position is also reflected in Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* (2001). The Code states in its section on euthanasia: ‘It is never permissible to end a person’s life (whether that decision is made to relieve a patient’s suffering by euthanasia, to comply with the wishes of the family, to assist suicide, or to vacate a bed)’; at 46 [5.20].

29 Congregation for the Doctrine of the Faith (n 28) 9 (emphasis omitted).

30 The South Australia End of Life Choices Report notes that approximately 13% of palliative care in Australia is provided in Catholic hospitals, and in South Australia the Catholic Church is the largest provider of private palliative care beds: Joint Committee on End of Life Choices, Parliament of South Australia, *Report of the Joint Committee on End of Life Choices* (Report, 13 October 2020) 12.

31 Rhiannon Shine, ‘Voluntary Euthanasia Legislation Leaves WA’s Religious Communities Debating Doctrine and Death’, *ABC News* (online, 10 August 2019) <<https://www.abc.net.au/news/2019-08-10/where-do-different-religions-stand-on-voluntary-euthanasia/11399138>>; Jewish Care, ‘Voluntary Assisted Dying’ (Position Statement, April 2019).

facilities.³² They may, however, be willing to provide information about VAD, refer to an external source of information,³³ or facilitate a transfer of care.³⁴

Institutional objections need not be grounded in religion.³⁵ An example of this is an objection based on an institution's philosophy of palliative care, which for some³⁶ (but not others)³⁷ warrants a strict separation from VAD. For other institutions, objections to VAD may be grounded in their view about the purpose of medicine; namely, to promote health and preserve life, rather than to take life.

III EXISTING EVIDENCE ABOUT LAW AND POLICY RESPONSES

A Victoria

The *Victorian VAD Act* is silent on institutional objection.³⁸ Instead, the Department of Health and Human Services ('DHHS') has addressed this issue using a series of policy documents aimed directly at institutions.³⁹ The DHHS

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- 32 Catholic Health Australia, 'Our Enduring Commitment to End of Life Care: Catholic Health and Aged Care Services in Australia' (Report, February 2019) ('CHA Taskforce Document'); Catholic Health Australia, 'CHA VAD Response Taskforce: Clinical Governance Recommendations' (Report, February 2019) ('CHA Clinical Governance Recommendations'); Catholic Health Australia, 'Catholic Health and Aged Care Services Response to the "Voluntary Assisted Dying Act"' (Media Statement, 19 June 2019) ('CHA Media Statement'); Jewish Care (n 31).
- 33 Jewish Care (n 31).
- 34 CHA Media Statement (n 32) 1.
- 35 Andrew McGee, 'Voluntary Assisted Dying: Should Conscientious Objection Be Unconditional?' (2020) 50(2) *Journal of Pharmacy Practice and Research* 117, 118.
- 36 Australian and New Zealand Society of Palliative Medicine, 'The Practice of Euthanasia and Physician-Assisted Suicide' (Position Statement, September 2020); Waran and William (n 26) 205. This position was also advanced by Hospice New Zealand in *Hospice New Zealand v A-G* [2020] NZHC 1356, [18] (Mallon J).
- 37 Palliative Care Australia, 'Palliative Care and Voluntary Assisted Dying' (Position Statement, September 2019) ('PCA Position Statement'). The PCA Position Statement also draws a distinction between VAD and palliative care, but suggests palliative care practitioners may decide whether to be involved in VAD.
- 38 Conscientious objection is addressed in section 7 of the *Victorian VAD Act 2017* (Vic), but this is limited to registered health practitioners. Section 7 indicates registered health practitioners may refuse to: provide information; participate in the request and assessment process; apply for a VAD permit; supply, prescribe, or administer the medication; be present at the time of administration; or dispense a VAD prescription. The *Victorian VAD Act 2017* (Vic) does not specify whether the health practitioner must refer the patient or disclose their conscientious objection.
- 39 Department of Health and Human Services, State Government of Victoria, 'Voluntary Assisted Dying Model of Care Pathways for Health Services' (Guidance, January 2019) <<https://www2.health.vic.gov.au/~media/Health/Files/Collections/Policies%20and%20guidelines/VVA D%20Model%20of%20care%20pathways%20for%20health%20services>> ('DHHS Model of Care Pathways'); Department of Health and Human Services, State Government of Victoria, 'Preparing for Voluntary Assisted Dying: *Voluntary Assisted Dying Act 2017*' (Guidance, 24 April 2019) <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/preparing-for-voluntary-assisted-dying>>; Department of Health and Human Services, State Government of Victoria, 'Voluntary Assisted Dying Guidance for Aged Care Providers' (Guidance, 17 April 2019) <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-guidance-aged-care-providers>>; Department of Health and Human Services, State Government of Victoria, 'Voluntary Assisted Dying Safety and Quality Guidance for Health Services' (Guidance, January 2019); Department of Health and Human Services, State Government of Victoria, 'Health Service Participation in Voluntary

instructs health services to assess their capacity to provide VAD, and determine whether it is congruent with their ‘staff or service mix’ and the health service’s values.⁴⁰ The guidance indicates that ‘most health services will fall into one of three high-level pathways’:⁴¹

- Pathway A: Single service – Health services that are willing and able to provide VAD within their facilities;
- Pathway B: Partnership service – Institutions that can provide access to some elements of VAD but require assistance from existing external partnerships and referral pathways;⁴² and
- Pathway C: Information and support service – Health services that either choose or are not able to provide VAD, including those that do not provide end-of-life care. The DHHS guidance indicates that organisations who adopt Pathway C ‘will be able to provide’ support and information about VAD and ‘[a]ll health services should be prepared to respond to requests for information about, or access to, voluntary assisted dying’.⁴³

The DHHS guidance characterises institutional objection both as a matter of conscience and as a matter of self-governance.⁴⁴ It suggests an institution that objects to VAD will typically fall under Pathway C.⁴⁵ A health service is not obliged to refer the patient to a VAD provider, but must not ‘inhibit a person’s

Assisted Dying’ (Guidance, August 2018)

<<https://www2.health.vic.gov.au/~media/Health/Files/Collections/Factsheets/V/VAD-health-service-participation>> (‘DHHS Health Service Participation’); Department of Health and Human Services, State Government of Victoria, ‘Health Service Policy Guidance for Voluntary Assisted Dying’ (Guidance, 12 June 2019)

<<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-service-policy-guidance-for-voluntary-assisted-dying>>. All Department of Health and Human Services policy documents aimed at institutions can be found here: ‘Health Services Information’, *Department of Health and Human Services, State Government of Victoria*, (Web Page)

<<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-services-information>>.

40 DHHS Model of Care Pathways (n 39) 3. See also DHHS Health Service Participation (n 39) 1.

41 DHHS Model of Care Pathways (n 39) 9.

42 For example, partnering with general practitioners to conduct VAD assessments.

43 DHHS Model of Care Pathways (n 39) 3, 9.

44 The DHHS Model of Care Pathways (n 39) document invites institutions to assess their staff or service mix and their organisational values. It states: ‘After assessing the capacity of their service to provide voluntary assisted dying, a health service may determine they do not have the appropriate staff or service mix to provide access to voluntary assisted dying, or that providing access to voluntary assisted dying would not be consistent with the values of the health service’: at 3. See also Shadd and Shadd (n 6). Cf Sumner (n 6).

45 The DHHS Model of Care Pathways (n 39) document states that Pathway C ‘is likely to include health services that do not provide care to people who are at the end of their life as well as health services that have chosen not to provide voluntary assisted dying’: at 9. Note, however, that Pathway B may apply depending on the nature of the objection (eg, if the objection extends only to providing access to VAD and does not include the provision of information or eligibility assessment). For example, an aged care facility might choose to partner with general practitioners to provide VAD assessments but object to their residents consuming the VAD medication onsite.

access to treatment’.⁴⁶ Additionally, health services should inform the patient ‘as soon as practicable that they will not assist them’⁴⁷ and health professionals (in accordance with professional codes of conduct) must not use their objection to ‘impede access to treatments that are legal’.⁴⁸ The policies strongly suggest (but do not require) that organisations nominate a VAD contact, but if no one is designated, organisations may direct patients to the Statewide Care Navigator Service (‘VAD Navigators’), which can provide information, support and referrals.⁴⁹

On its face, the DHHS policy position suggests, at a minimum, that objecting institutions should provide information and support to those seeking VAD, and should consider how to provide ‘compassionate person-centred care’ to those who request information or access to VAD.⁵⁰ However, the policies allow latitude for institutions to depart from this, with the DHHS indicating that ‘[h]ealth services may adapt the care pathways’.⁵¹

Some organisations have created specific policies stating that they will not permit access to VAD. For example, Catholic Health Australia (‘CHA’), the largest non-governmental grouping of hospitals and aged care providers in Australia, will not provide VAD in its facilities.⁵² Their taskforce document in response to the *Victorian VAD Act* does not explicitly mention referral, but indicates that organisations under the CHA umbrella ‘will not facilitate or participate in assessments’ for the purpose of VAD.⁵³

46 DHHS Health Service Participation (n 39) 1.

47 Ibid.

48 DHHS Model of Care Pathways (n 39) 6. The DHHS Model of Care Pathways document puts forward this language from the Medical Board of Australian Code of Conduct. It also addresses nursing and pharmacy professional codes of conduct.

49 Department of Health and Human Services, State Government of Victoria, ‘The Statewide Voluntary Assisted Dying Care Navigator Service’ (Fact Sheet, September 2019) <<https://www2.health.vic.gov.au/Api/downloadmedia/%7B443D45A2-9F81-4BCB-9D3A-EE3B36FD3306%7D>> (‘DHHS VAD Care Navigators’).

50 DHHS Model of Care Pathways (n 39) 3.

51 Ibid 7.

52 CHA Taskforce Document (n 32). This statement was contributed to by CHA member organisations: Calvary Health Care; Cabrini; Mercy Health; St John of God; St Vincent’s Health; and Vita Maria Catholic Homes (‘VMCH’). See also CHA Media Statement (n 32).

53 CHA Taskforce Document (n 32) 2. It appears that at least some organisations under the Catholic Health umbrella will facilitate referrals or transfers of care. The CHA Media Statement (n 32) that accompanied the commencement of the *Victorian VAD Act 2017* (Vic) indicates that ‘[e]ach of our services has a system in place that will respond respectfully and compassionately to any questions about “VAD”. This includes coordinating transfer of care to other providers if a patient/resident wishes to seek “VAD”. We will not impede access to the provision of “VAD” elsewhere’: at 1. Note, also, that guidance has been issued by the Australian Medical Association in its broad statement on conscientious objection in medicine. The statement also addresses institutional objection and may inform Victorian health providers’ responses. It states that institutions may object to providing certain services, and if this occurs the institution should visibly inform the public so potential patients can seek care elsewhere. It indicates that where a patient admitted to an institution requests VAD, doctors should still be allowed to refer the patient to a VAD provider outside the facility. In other words, the organisation should not limit its staff from making appropriate referrals. This guidance is likely to pose difficulties for religious organisations that would seek to limit VAD referrals: see ‘Conscientious Objection: 2019’, *Australian Medical Association* (Web Page, 27 March 2019) [3.1]–[3.2] <<https://ama.com.au/position-statement/conscientious-objection-2019>>.

To date, evidence of how VAD is operating in practice is limited. Waran and William describe a transfer of care due to an institutional objection to VAD.⁵⁴ A 53-year-old woman sought VAD for metastatic breast cancer, but after she was assessed as eligible, she required admission to a palliative care unit to manage her worsening symptoms. Since the woman could not return home, she sought to take the VAD substance in the unit but was refused because of the organisation's policy against providing VAD.⁵⁵ She was then referred to another site within the same health service, which also objected. She was eventually transferred to a third venue in the service and was able to take the VAD substance on her preferred date. In describing the case, the authors emphasise the position taken by the DHHS: there is no duty for a health service to refer a patient, but health services must not actively inhibit a patient's access. It is not clear from the article whether the original palliative care unit facilitated the referral or used the VAD Navigators.

There has also been a media report of institutional objection where a patient in a Catholic hospice was not permitted to take delivery of their VAD substance after pharmacists were refused entry to the premises.⁵⁶ As a result, the patient needed to be transported out of the hospice and to a hospital where they were then able to receive their VAD substance. In addition, although not an institutional objection of the type discussed in this article, that media report also described a decision by a large palliative care service to decline to certify deaths of patients who had died at home from VAD. Although at this early stage there is only anecdotal evidence that institutional objection is occurring in Victoria, given that there is no legislative requirement for institutions to permit access or make a referral, and that the government policy confirms this, we anticipate that institutions will continue to object to VAD.

B Other Australian Jurisdictions

There is no reason to believe the situation in relation to institutional objections will be different in other Australian states if and when VAD legislation is enacted. Some religious institutions have adopted a position at a national level, so institutions affiliated with these entities can reasonably be expected to have similar objections.⁵⁷

54 Waran and William (n 26).

55 Waran and William (n 26) describe that the policy was also grounded in 'the need to minimise misperceptions' about the role of the palliative care unit: at 204. The Royal Australasian College of Physicians ('RACP') statement on VAD was cited to justify this stance, which recommends 'voluntary assisted dying must not be seen as part of palliative care': Royal Australasian College of Physicians, 'Statement on Voluntary Assisted Dying' (Position Statement, November 2018) 2 (emphasis omitted).

56 Melissa Cunningham, "'Discriminatory and Unethical': Palliative Care Service Criticised Over Failure to Verify Euthanasia Deaths', *The Age* (online, 17 April 2021) <<https://www.theage.com.au/national/discriminatory-and-unethical-palliative-care-service-criticised-over-failure-to-verify-euthanasia-deaths-20210415-p57jif.html>>.

57 See, eg, CHA Clinical Governance Recommendations (n 32); CHA Taskforce Document (n 32).

As mentioned, the VAD legislation in Western Australia is silent on whether a non-participating institution must refer or facilitate transfer of a patient who wishes to access VAD. The Catholic Church is committed to ensuring Catholic hospitals, aged care facilities and palliative care facilities in Western Australia remain ‘VAD free spaces’,⁵⁸ suggesting they will permit neither VAD assessment nor administration. Anglican, Jewish and Muslim leaders in Western Australia have also expressed opposition to VAD.⁵⁹ It is anticipated that healthcare and aged care facilities run by these religious institutions may well prohibit the assessment or administration of VAD, or provision of information about VAD, or referrals out occurring within their facilities.

In Queensland, members of the Presbyterian Church, the Anglican Church, the Baptist Church and the Catholic Church all expressed their opposition to VAD before the parliamentary inquiry.⁶⁰ Similarly, in Tasmania, CHA has stated that Catholic hospitals and aged care facilities will not provide VAD prescriptions nor administer a lethal injection.⁶¹ They will also not allow external providers to enter the facility to conduct VAD consultations, and will not be making specific referrals to non-objecting institutions.⁶²

It seems, however, that some institutions which object to VAD on the ground of conscience will refer individuals to a central government coordination and referral agency, rather than provide a direct referral to a known VAD provider.⁶³

58 Don Sproston, ‘Euthanasia in Western Australia’ (Speech, 2019 Australian Catholic Youth Festival, 8 December 2019) <http://perthcatholic.org.au/Our_Archdiocese-Bishop-Speeches_Statements_and_Letters-2019-Speech_Euthanasia_in_Western_Australia.htm>.

59 Shine (n 31). However, not all religious institutions in Western Australia are opposed to VAD. The Buddhist Council expressed support for the legislation, and the Uniting Church has put forward a resolution to allow VAD assessment and administration to occur within its facilities: see, eg, Synod of the Uniting Church in Western Australia, ‘Proposal 9: Voluntary Assisted Dying Task Group’ (Policy Proposal, September 2020) <<https://unitingchurchwa-startdigital.netdna-ssl.com/wp-content/uploads/2020/09/VAD-Task-Group-3.pdf>>.

60 Queensland Parliamentary Report (n 9) 50. Similar views were expressed by religious groups to other parliamentary inquiries: see, eg, Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report No 174, June 2016) 213 <https://www.parliament.vic.gov.au/file_uploads/LSIC_pF3XBb2L.pdf>; Select Committee on End of Life Choices in the ACT, Parliament of the Australian Capital Territory, *End of Life Choices in the ACT* (Report, March 2019) 89–90 <https://www.parliament.act.gov.au/_data/assets/pdf_file/0004/1334992/9th-EOLC-Report.pdf>.

61 This includes the four hospitals run by Calvary Healthcare and around nine aged care facilities operated by Southern Cross Care in Tasmania: Marilyn Rodrigues, ‘Peak Health Group Rejects Dying Bill’, *Catholic Weekly* (online, 17 September 2020) <<https://www.catholicweekly.com.au/peak-health-group-rejects-dying-bill/>>.

62 Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 15 (Bastian Seidel). The Anglican Church has also publicly voiced its opposition to VAD: Sue Bailey, ‘Two Churches Have Strongly Opposed an Assisted Dying Bill Being Prepared for Parliament’, *The Advocate* (online, 22 September 2019) <<https://www.theadvocate.com.au/story/6399252/assisted-dying-proposal-rebuffed-by-churches/>>.

63 In Victoria, the Department of Health and Human Services established a Statewide Voluntary Assisted Dying Care Navigator Service to provide this referral function: DHHS VAD Care Navigators (n 49). In the first year of the *Victorian VAD Act 2017* (Vic), this service provided support to 613 people (the data does not state whether these supports were a result of institutional objections): Voluntary Assisted Dying Review Board, ‘Report of Operations: January–June 2020’ (Report, 31 August 2020) 5

C Some Illustrative Canadian Examples

Allowing institutional objections to VAD can sometimes result in patients being transferred seamlessly and painlessly to another institution, community space, or home for assessments and provision of VAD. However, as the longer Canadian experience with VAD has shown,⁶⁴ it can also result in indignity, extreme pain, and loss of access. There is insufficient scope here to report all such reported cases, but those described below are illustrative.⁶⁵

Two cases that resulted in indignity were Doreen Nowicki and Bob Hergott. Doreen Nowicki was a woman in her late 60s with advanced motor neurone disease.⁶⁶ She was living in a continuing care facility run by a Catholic provider. She was taken from her bed with a mechanical lift, put in a wheelchair, and brought out of the facility to benches situated across the street (off the property) for her VAD eligibility assessment. This was intensely distressing for her. Bob Hergott, a 72-year-old man also with motor neurone disease, had to leave the hospital where he had been an in-patient for five years, cross the street in the rain to a bus shelter, and meet the two witnesses required as he signed his form requesting VAD.⁶⁷

An institutional objection can also result in extreme pain to the patient. Ian Shearer was an 87-year-old man with spinal stenosis.⁶⁸ His pain medications were reduced to ensure he would have decision-making capacity following the transfer. The ambulance was more than three hours late. The time waiting for the ambulance was increasingly painful and the trip across the streets of Vancouver was agonising.

Institutional objections have also resulted in limitations or removal of access. Gerald Wallace was an 80-year-old man with pancreatic cancer in a rural hospital run by a Catholic organisation.⁶⁹ He was prevented from accessing VAD and died

<https://www.bettersafecare.vic.gov.au/sites/default/files/2020-08/VADRB_Report%20of%20operations%20August%202020%20FINAL_0.pdf>. The *End of Life Choice Act 2019* (NZ) has mandated the creation of a support and referral group in its legislation: at s 25.

64 As noted above, in Canada, VAD is referred to as ‘medical assistance in dying’ (‘MAiD’), but we use the term VAD in this section for consistency with the rest of the article.

65 We do not have full information on the scope of the problem as the data is not collected in all jurisdictions. However, in Alberta, a province that collects and publishes data on this issue, between 17 June 2016 and 30 April 2020 (noting, though, that the website states it is current as of April 2020 but actually only includes data up to end of 2019), 125 patients were transferred from faith-based (109) or non-participating (16) sites to a participating facility or the patient’s home. This data suggests that 10% of VAD deaths in Alberta follow a transfer from a faith-based site: ‘Data & Statistics: Medical Assistance in Dying’, *Alberta Health Services* (Web Page, 28 February 2021) <<https://www.albertahealthservices.ca/info/Page14930.aspx>>.

66 CBC Coverage of Doreen Nowicki (n 25).

67 CBC Coverage of Bob Hergott (n 25).

68 Tom Blackwell, ‘BC Man Faced Excruciating Transfer after Catholic Hospital Refused Assisted-Death Request’, *National Post* (online, 27 September 2016) <<https://perma.cc/DE36-V9TA>>.

69 Jennie Russell, ‘Camrose Man Died in Pain after Covenant Health Hindered Access to Assisted-Dying Services, Son Says’, *CBC News* (online, 1 December 2018)

in pain. Additionally, Horst Saffarek, an elderly man whose lungs were failing, was admitted to a Catholic hospital.⁷⁰ He was found eligible for VAD but the hospital refused to allow it to be provided on their premises. He had to be transferred to a city more than an hour away, but he died before he was able to access VAD.

IV THREE POSSIBLE MODELS OF LEGAL REGULATION

The limited evidence in Australia about institutional objection, as discussed in Part III(A) and (B), reveals that some institutions in Victoria are currently objecting to VAD in various ways and this is likely to occur in other states that legalise VAD. These objections, as also shown in the longer Canadian experience, can adversely affect individuals who are eligible for VAD but cannot access it in such institutions. Governments exploring VAD reform must consider this issue and the appropriate regulatory response, whether that is prohibiting institutions from conscientiously objecting, not restricting this ability in any way, or a compromise of these two extremes. Ultimately, a government's position will depend on how it balances institutional and individual interests. At the heart of this decision is how best to weigh an individual's ability to access VAD against an institution's desire not to permit access to VAD within its facility.⁷¹

This balancing exercise has been subject to extensive debate⁷² and there is not scope in this article to engage further with those arguments. Instead, our goal is to describe possible regulatory models that chart three broad options, and briefly observe the implications of each model for institutional and individual interests.

The three regulatory responses proffered draw on Wicclair's terminology in relation to conscientious objection by individuals,⁷³ and are framed as:

- 'conscience absolutism' – permitting institutional objections without limit;
- 'compromise or reasonable accommodation' – permitting institutional objections but imposing limits on them; and
- 'non-toleration' – institutional objections are not permitted.

But before considering these three options, we raise two threshold issues. The first is whether a regulatory response should comprise of legislation or policy. We propose that legislation is optimal (which would allow for accompanying policy), and regulatory responses in Part IV(B) and (C) below are framed accordingly. Policy alone is a weaker form of regulation with less coercive force.

<<https://www.cbc.ca/news/canada/edmonton/camrose-man-died-in-pain-after-covenant-health-hindered-access-to-assisted-dying-services-son-says-1.4927739>>.

70 'Should Catholic Hospitals Have to Provide Access to Medically Assisted Dying?', *CBC Radio* (online, 11 January 2018) <<https://www.cbc.ca/radio/thecurrent/the-current-for-january-11-2018-1.4481312/should-catholic-hospitals-have-to-provide-access-to-medically-assisted-dying-1.4482372>>.

71 Flynn and Wilson (n 22) 228–9.

72 See Carpenter and Vivas (n 25); Flynn and Wilson (n 22); Gilbert (n 20); Shadd and Shadd (n 6); Sumner (n 6).

73 Mark R Wicclair, 'Preventing Conscientious Objection in Medicine from Running Amok: A Defense of Reasonable Accommodation' (2019) 40(6) *Theoretical Medicine and Bioethics* 539.

While a policy approach is often appropriate to regulate aspects of healthcare, we consider this is not the case where the proposed policy response conflicts with deeply-held views of the target of regulation (here, institutions). The stronger normative and coercive force of law is more likely to be needed here, particularly if an individual citizen is seeking to rely on it to compel an institution (often large and well-resourced) to comply with regulation.⁷⁴ Further, a legislative approach ensures any changes occur only with the transparency and public accountability of parliamentary consideration.

The second threshold point we make is that, regardless of which regulatory response is adopted, it should require organisations to disclose their objections publicly.⁷⁵

A ‘Conscience Absolutism’

The first regulatory option is for legislation to enshrine the ability of an institution to object. The model gives all weight to an institution’s position on VAD and no weight at all to the patient’s interests, and enables institutions that effectively have a monopoly on the provision of specialist services to bar individuals from accessing legally-available health services.⁷⁶

Such an approach would bestow greater powers on institutions to object than individuals, upon whom law and ethics in medicine traditionally impose at least some compromise or accommodation duties – eg, providing information or effective referral.⁷⁷ Allowing absolutism for institutions could effectively deprive eligible people of access to VAD, even more so than objections by individual health professionals. While changing doctors is not straightforward, it generally remains possible, whereas for a person unable to move from an institution, absolutism is a veto on that person’s ability to access VAD.⁷⁸ Even if a person was able to move, they may require the cooperation or assistance of the institution to facilitate the transfer, which absolutism would allow them to withhold.

74 We note it would be possible, however, to design a policy response which may nevertheless be effective in ensuring compliance by institutions – eg, if linked to accreditation or funding requirements.

75 A provision requiring such disclosure was included in the Voluntary Euthanasia Bill 2016 (SA) clause 21(3)(a). We do not propose this disclosure being a ground for refusing access to VAD. Rather, we consider the utility of such a provision is to help avoid situations, where possible, of a person finding out subsequent to their admission or residence that the facility objects to access to VAD.

76 See, eg, Schuklenk (n 8).

77 It is worth noting that while the *Voluntary Assisted Dying Act 2019* (WA) section 20(5) requires conscientiously objecting health professionals to provide certain information to their patients, the *Victorian VAD Act 2017* (Vic) s 7 imposes no accommodation duties on doctors who conscientiously object.

78 Sumner (n 6) 972.

B ‘Compromise or Reasonable Accommodation’ of Institutional Objection

This section outlines how legislation could present a ‘compromise or reasonable accommodation’ model for institutional objection to VAD. Such an approach recognises that institutional objections to VAD will occur and allows them, but aims to regulate them to ensure as little impact on the person seeking VAD as possible, while still permitting some degree of institutional objection. This need not imply legislative endorsement of these objections; the focus is instead on creating processes to facilitate a person’s access to VAD where objections occur. Two of the authors included a clause in their model VAD Bill which aimed to address this by requiring the objecting institution to arrange a transfer if requested.⁷⁹ However, in light of the impacts of institutional objections on patients in practice, as described earlier in the article, more may be needed to better support access to VAD when institutions object.

While there are various compromise models that could be designed, in our view, all compromise models should, at a minimum, require institutions to provide information about VAD and facilitate effective referral to a VAD provider. This obligation does not require an objecting institution to endorse VAD, or to be involved with its assessment or administration. Although some organisations may consider that providing information or directly referring to a VAD provider makes them complicit in the activity to which they object,⁸⁰ a workable alternative is to connect individuals with a central coordination service (such as the VAD Navigators in Victoria).⁸¹ Therefore, our discussion below focuses on the two other aspects of VAD provision that institutions may object to: conducting VAD assessments and administration.

A final general point is that this compromise or reasonable accommodation category is very broad: legislation could be drawn to require either very little compromise or a great deal of compromise from objecting institutions. The below approach is one put forward for consideration which weighs the balance between individual and institution in favour of the person seeking access to VAD. As explained below, we have struck the balance in favour of the patient when the institutional objection will unduly compromise the patient’s interests. This is because the patient, who is close to death and intolerably suffering, is in a vulnerable position.

1 Nature of Provision: No New Rights for Institutions; Creates Process Only

Under this model, legislation should provide that ‘nothing in this section creates a right for an institution to refuse to provide access to VAD’. This addresses concerns raised in the Tasmanian debates⁸² that legislatively regulating this issue

79 White and Willmott (n 9) 36. See also Voluntary Euthanasia Bill 2016 (SA) cl 21(3)(b). Such a clause was also reflected in amendments proposed in Tasmania to its *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas): see Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 2 (Bastian Seidel).

80 Congregation for the Doctrine of the Faith (n 28) 8, 14.

81 This is also the position that has been adopted in Alberta and Quebec, Canada: Gilbert (n 20) 9.

82 See, eg, Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 10 (Meg Webb).

might be seen as implicit recognition of institutional objections and conscience rights.⁸³ Further, the provision should be framed as establishing a process to ensure a person's access to VAD is not unreasonably denied. For example, it could state: 'An institution wishing to refuse a person's request to access VAD within a facility must follow the process outlined in this section'.

2 *Would the Patient's Interests Be Unduly Compromised by Requiring Access to VAD Outside the Facility?*

One way to accommodate both an institution's objection and a person's desire to access VAD is for VAD assessments and administration to occur outside the facility. This could occur by transferring a person's care or residence to another, non-objecting, institution. However, it is also possible for VAD to occur without a formal transfer. For instance, a person in a residential aged care facility may remain living there but, if well enough to do so, may leave the facility for VAD assessments and then again attend elsewhere to take the VAD medication at a time of their choosing. Determining when this should be required would depend both on establishing criteria to assess the impact on the patient's interests, and identifying who would decide whether these criteria were met.

To address the undesirable consequences for persons seeking VAD outlined above, this criteria could include that it is not appropriate for an institution to refuse access to VAD where:

- that would cause harm to the person (eg, this could be pain or a deterioration of their condition from the required transfer);
- that would prejudice a person's access to VAD (eg, the transfer logistics to another institution mean a person is likely to lose capacity or die first; or pain medication required to manage the transfer means they are likely to lose capacity);
- that would cause undue delay (and thereby extended intolerable suffering) in accessing VAD; or
- access to VAD is not reasonably possible at another institution (eg, another institution will not accept a transfer or the institution is the only facility in the district that could manage the patient in their condition).

Given the criteria (which are medical in nature or at least involve navigating the health system), we consider it appropriate that whether they are met is decided by a doctor. We would propose a doctor who is chosen by or acceptable to the patient. A doctor employed by an objecting institution may not be free to adopt a position contrary to the institution, although we note that a patient might choose to nominate a doctor working in an objecting institution if they considered that doctor was independent.

83 This provision would not, of course, create a right or duty to provide VAD.

This may raise issues if the objecting institution considers that granting permission for this doctor to meet with the person is facilitating access to VAD and so is inconsistent with the institutional objection. However, failing to allow this access to the facility by the doctor could preclude a person's access to VAD altogether, so this is required to appropriately balance institutional and individual interests.

3 *Obligations Where Access to VAD Will Occur Outside the Objecting Institution*

Where the criteria above mean that access to VAD will occur outside the objecting institution, the institution must offer and take reasonable steps to facilitate this access. For instance, this may require supporting a transfer of the care or residence of the person to a place at which VAD can be assessed or provided by a doctor who does not have a conscientious objection to VAD.

Further, a person must not experience financial detriment because of such a transfer, which could in some instances have financial implications for a person so serious as to create an unconscionable or insurmountable barrier. This detriment could range from the cost of transport between institutions through to costs due to complex financial arrangements associated with entry into and exit from a residential aged care facility. Because the need for a transfer arises from the institution's objection, the legislation should provide that no financial detriment will occur as a result.

4 *Obligations Where Access to VAD Will Occur Inside the Objecting Institution*

Where the criteria above mean that access to VAD will occur inside the objecting institution, the legislation should provide that access must be permitted by the institution. This is based on a person's claim to access VAD outweighing an institution's objection, when both outcomes cannot be achieved. Not taking this approach would effectively mean that a person who is unable to be reasonably transferred or leave the institution for periods to access VAD would be prevented from accessing VAD by an institution that is objecting.

The legislation should state that an objecting institution will be required to permit a person to access VAD within the institution and will take reasonable steps to allow this where transfer is not possible or unduly harms the person's interests. This may include permitting existing staff (who are willing) to be involved in conducting VAD assessments or administering the VAD medication to this person, or allowing other doctors to visit the person onsite and provide the assistance required. The institution would also not be allowed to impede a person self-administering VAD medication onsite.

C 'Non-Toleration' of Institutional Objection

Under this model, legislation would prohibit an institution from preventing access to VAD on the basis of an objection. The provision could be framed broadly

and prohibit an institution from impeding access of a person seeking VAD.⁸⁴ For clarity, it may be desirable for the legislation to specify that the institution could not prohibit entry to its facility of any health professional for the purpose of discussing VAD with a patient, assessing eligibility for VAD, or providing VAD. The institution also could not prohibit a patient from self-administering a VAD substance.

Under this approach, VAD would be available to all eligible individuals who wish to access it, not just for those for whom transfer would be problematic (as canvassed above). This model gives the strongest recognition of the three approaches to the right of an individual to access VAD despite an institution's objection.

V CONCLUSION

This article aims to highlight an important, but largely neglected, aspect of the VAD debate in Australia: objections by institutions when a person seeks lawful access to VAD. Patients and residents being cared for or residing in such institutions may effectively be denied access to VAD or have to overcome significant barriers to access it. There is evidence of institutional objection in Australia, and experience in Canada demonstrates the impact these objections can have on individuals who wish to access VAD and are experiencing intolerable suffering.

This article proposes three possible legislative models to regulate institutional objection. One is conscientious absolutism: legislation that enshrines the ability of an institution to object and imposes no limitation on that right. This model will have adverse outcomes for some individuals, particularly those who are unable to transfer from that facility, as they are effectively deprived of choice, unable to move, and without access to VAD. This prioritises the institutional position at the expense of the individual. At the other end of the spectrum, non-toleration, where an institution is prohibited from exercising an objection in any circumstances, the individual is prioritised even if the institution may be in a position and willing to transfer their care.

The middle ground, the 'compromise or reasonable accommodation' model, is a legislative option worthy of consideration. It does not grant absolute priority to either the institution or the individual seeking VAD, but seeks to accommodate both. The specific compromise model proposed in this article, however, does prioritise the individual if both positions cannot be reasonably accommodated.

Parliaments and law reform bodies considering VAD reform must consider the issue of institutional objection, and select a policy position on how to balance the

84 A stricter version would be to require institutions to employ staff capable of and willing to be involved in the provision of VAD.

desire of an institution to determine what practices are permitted within their facilities and the interests of an individual seeking access to VAD, a lawful medical service. As argued above, this should not be left to policy alone and is an issue that should be explicitly addressed in VAD legislation.