



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

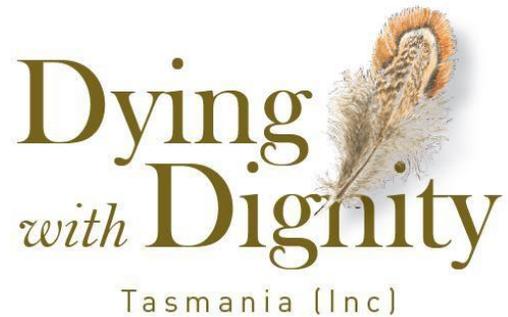
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Submission Cover Sheet

End of Life Choices in the ACT

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**SUBMISSION TO
THE INQUIRY INTO END OF LIFE CHOICES
IN THE ACT**

MARCH 2018

YOUR RIGHT TO CHOOSE

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1. OVERVIEW

- The aim of this submission is to provide information and perspectives that may not otherwise be included or given priority in submissions to the Committee.
- In our extensive experience with the detail of proposed voluntary assisted dying legislation in Tasmania, we have found there is generally very limited knowledge and understanding of the differences between the models of voluntary assisted dying legislation that currently exist, and very limited analysis of their relevance and suitability for the Australian situation, and the local differences in States and Territories. We have therefore made the main component of this submission a detailed comparison of voluntary assisted dying safeguards in the different models of legislation and the most recent Tasmanian Bill, the *Voluntary Assisted Dying Bill 2016*, which will form the basis of the next Bill in 2018-19. See Attachment 1, “Comparison of Voluntary Assisted Dying Safeguards”.
- Our submission is most relevant to the term of reference: “4. the applicability of voluntary assisted dying schemes operating in other jurisdictions to the ACT, particularly the Victorian scheme”. Its focus is on the models and details of voluntary assisted dying laws, rather than whether legislation is needed and can be made safe and effective. We believe the latter issue has been settled by all recent thorough reviews including the Victorian inquiry into end of life choices.
- We also expect that DwDACT and other individuals and organisations from the ACT and elsewhere in Australia will advocate effectively for the principles and evidence of the need for voluntary assisted dying legislation in the ACT and will present to the Committee relevant available information and views. We have made submissions on broader issues to the Victorian and WA inquiries into end of life choices that address these broad issues. They are available on the websites for those inquiries.
- DwDTas was intensively involved in the development of the Tasmanian Voluntary Assisted Dying Bills in 2013 and 2016. We provided much of the extensive research and analysis of the details of existing legislation and its implementation and worked closely with the proponents. This was combined with in-depth consideration of their applicability to the Tasmanian situation, taking into account the community’s views, the decentralised nature of the Tasmanian population which is the oldest of any State/Territory, and how to ensure legal voluntary assisted dying that is evidence-based, safe and workable.
- We argue that Canada provides the most relevant, appropriate and up-to-date model and approach for Australian legislation, not Oregon. Of particular relevance is the Canadian Supreme Court judgement in *Carter vs Canada* that led to the legislation. Our ongoing research has included material related to Canada that was not available to the Victorian inquiry. The Canadian medical aid in dying legislation was not passed at the time of the writing of the report of the inquiry, and there has been over 18 months of implementation which has revealed some issues.
- We applaud the historic passing of the Victorian *Voluntary Assisted Dying Act 2017*. Our comparison shows the similarities between the Act and other legislation, but also the differences. We understand the political pressures and considerations to get the first State voluntary assisted dying law passed, and congratulate all those involved in the massive

efforts needed for this achievement. We argue, however, that the legislation that was passed is not only the “most conservative in the world”, but is the most restricted, and unnecessarily so given the evidence and findings of all recent thorough reviews including the Victorian inquiry into end of life choices.

- The comparison supports our view that the Victorian scheme can be, and needs to be improved in a small number of areas to be more effective, consistent with the evidence from overseas and local patients’, community and doctors’ needs and views, but continue to be as safe.
- DwDTas is a separate organisation from Dying with Dignity ACT (DwDACT). We have a close relationship through the national group of organisations, Your Last Right, which all have very similar purposes and objectives, but the views expressed in this submission are those of DwDTas alone.
- Like other dying with dignity organisations, DwDTas is strongly committed to better end of life law and services to respond to the changes in medicine and society generally and which will enable people to achieve their wishes about the end of their lives. This includes, but is not limited to, voluntary assisted dying law reform. We support improved palliative care services. A major component of our activity has been the promotion, encouragement and provision of practical support for end of life and advance care planning. More information about the organisation, objectives, Committee, priorities and activities is available on our website. Also on our website is our detailed guide to end of life planning in Tasmania with the Tasmanian forms for advance care directives, appointing and Enduring Guardian and Enduring Power of Attorney.

2. TASMANIAN SITUATION

- There will be another voluntary assisted dying Bill put before the new Tasmanian Parliament elected at the State election on 3 March 2018.
- There are good reasons for our confidence that the new Bill will be passed and our expectation that it will be similar to the last Bill. There is a majority of members of the new House of Assembly who have expressed commitment in principle to voluntary assisted dying legislation, and the vast majority of those MPs voted for the last Bill/s or have advised DwDTas that they are likely to vote for A Bill similar to the last one. We believe there is a similar level of support in the Legislative Council, but that is still to be tested.
- DwDTas has advocated for voluntary assisted dying law reform in Tasmania for many years and has consistently supported principles- and evidence-based decision-making relying on the best quality information and analysis. We have significant knowledge and understanding of the issues and a very extensive research database developed from our involvement over recent years. This has included particularly intensive involvement in the development of the 2013 detailed proposal for a voluntary assisted dying Bill in Tasmania, *Voluntary Assisted Dying: A Proposal for Tasmania*, and the resulting Bill, the *Voluntary Assisted Dying Bill 2013*.
- DwDTas was very involved in these processes through representation of DwDTas by our President Margaret Sing on the expert panel consulted on the 2013 Proposal and Bill. She

was intensively involved in a personal capacity (as a former senior public servant with 40 years policy experience) in the small team that worked with the proponents, Lara Giddings, then Premier of Tasmania, and Nick McKim, then Leader of the Greens, to develop the model in the 2013 Proposal and Bill.

- DwDTas continued to work very closely with Lara Giddings and Cassy O'Connor for the 2016 Bill and will work with proponents for a Bill which will be introduced in the new Parliament.
- The Tasmanian Bills to date have been voted down largely on Party and factional grounds, not on the content of the Bills. That 2013 Bill narrowly failed to pass at the Second Reading stage. 12 MPs supported it and 13 voted against it at the Second Reading stage. No Liberal MPs voted for it.
- The *Voluntary Assisted Dying Bill 2016* was debated in the Tasmanian House of Assembly on 24 May 2017 and was defeated at the Second Reading stage in a vote of 16 – 8. The Bill was not debated in detail and the vote was largely on Party and factional grounds. All but one Liberal MP voted against it and three Labor Right faction MPs voted against it.
- Before the Second Reading vote, a vote was lost on an amendment to refer the Bill to a Parliamentary Committee inquiry. Seven Liberal MPs voted for the amendment, including the Premier and a number of MPs who expressed support in principle for the legislation.
- The voting pattern of MPs is similar across States with recent votes as this table shows:

Party	Victoria (20 Oct 17) Third Reading			Tasmania (24 May 17) Second Reading			SA (17 Nov 16) Third Reading		
	No for	No agst*	% for	No for	No agst	% for	No for	No agst	% for
ALP	38	6	86%	4	3	57%	16	9	64%
Liberal	4	25*	14%	1	13	7%	6	13	32%
National	1	7	12.5%						
Greens	2	0	100%	3	0	100%			
Independent	2	1	67%				1	1	50%
Total	47	37	55%	8	16	33%	23	23**	50%

* Includes 2 Liberal MPs who abstained.

** Vote was then lost on the casting vote of the Speaker.

(The table was prepared for our submission to the WA Inquiry in October 2017 and will be updated with more recent data including the NSW vote in November 2017.)

- **Terminology:** Tasmania was the first to use the term ‘voluntary assisted dying’ for a Bill. It is defined in the 2013 Proposal to include both self-administration and doctor-administration of assisted dying drugs. We continue to use the term to mean both. Subsequent Bills in Victoria and NSW have used the same name, but defined it to mean only self-administration of the drugs.
- **Principal aim of the Tasmania Bills:** The principal aim of the Bills has been to provide a last resort option for people at the end of their lives with intolerable and unrelievable suffering to end that suffering through an assisted death with their doctors’ help. To access an

assisted death, people need to be at the end of lives that would never again be free of intolerable and unrelievable suffering and of the debilitating effects of the advanced stages of serious incurable and irreversible medical conditions (eg S11). Both the people and their primary medical practitioner needed to agree there were no other relevant options to improve the person's medical condition or to relieve their suffering to the person's satisfaction (eg S22).

- **Most similar to Canadian approach:** Our website includes a great deal of information particularly on the Canadian approach which we have found to be most relevant to the Australian situation because of our historical, cultural, medical and legal system similarities. See in particular <http://dwdtas.org.au/current-situation-voluntary-assisted-dying-overseas/> including the section common fallacies and misunderstanding about existing legislation. We believe the Canadian approach is far preferable to the Oregon approach, which has provided the model for other US legislation. Canada was able to take into account information and analysis of the pros and cons of all other legislation in its long development and consideration process leading to its medical aid in dying legislation. It also had the advantage of the involvement and support of the Canadian Medical Association.

3. CONCLUSION

This submission is relatively brief and we are happy to provide additional details on any matter.

We congratulate the ACT Parliament for its initiative in holding this inquiry on this important social issue and wish the Committee well in its important work.

All regulatory frameworks for doctor-provided voluntary assisted dying are working safely, regardless of the differences

As the [Victorian inquiry into end of life choices](#) and all other recent thorough reviews have shown, all the regulatory frameworks for doctor-provided voluntary assisted dying are robust, working safely regardless of the differences between them. This is because they all have multiple safeguards but, in particular, are all doctor-safeguarded and have the additional safeguard of regulated oversight with careful monitoring, scrutiny and reporting. As the Victorian inquiry concluded: *The evidence is clear that assisted dying can be provided in a way that guards against abuse and protects the vulnerable in our community in a way that unlawful and unregulated assisted dying does not.*²

Importance of establishing a framework that suits the values and circumstances where the law is being introduced

The differences between assisted dying legal approaches reflect the significantly different cultures and history of law reform, and priorities given to particular principles and values, and the medical systems in different societies. The Victorian inquiry makes this critically important point: “[T]hese jurisdictions [with legal assisted dying] highlight the importance of establishing a framework that suits a particular jurisdiction’s medical and legal culture and of providing the appropriate safeguards within that framework” (p205). (See also page 217)

The framework must be workable in the circumstances in which it is being introduced as determined by rational risk assessment. Extra hurdles do not increase the safety - they decrease the effectiveness of the legislation. This is because they create unnecessarily onerous burdens on people who are at the end of their lives with intolerable suffering; create burdensome bureaucracy on doctors which is a disincentive to their participation and has a flow-on effect on people who want and would be eligible for assistance but cannot access it.

This analysis compares key safeguards in the Tasmanian [Voluntary Assisted Dying Bill 2016](#)³ with those in overseas legislation and the Victorian [Voluntary Assisted Dying Act 2017](#)⁴ passed on 29 November 2017. The Victorian legislation will not come into operation until mid-2019.

A new Tasmanian Bill, likely to be similar to the last one, will come before the newly elected State Parliament in 2018/9. The current situation, following the State election on 3 March 2018, is that a majority of the House of Assembly supports voluntary assisted dying legislation in principle. Also, the vast majority either voted for the *Voluntary Assisted Dying Bill 2016* or have indicated they are likely to vote for a similar Bill. We believe the support in the Legislative Council is similar.

The Tasmanian 2016 Bill provides a ‘last resort’ assisted dying option through a regulated doctor-safeguarded framework that includes strong safeguards, is workable and meets a number of aims. The Bill is based on thorough research and analysis of existing legislation and relevant proposals. There has also been thorough reconsideration of the *Voluntary Assisted Dying Bill 2013* in the light of the comments and concerns at the time of the 2013 debate and, since then, the significant reports, Parliamentary debates and policy by medical organisations⁵. A [DwDTas summary of the Bill](#)⁶ provides a brief overview of the Bill, its aims and background information.⁷ Additional comparisons are available, including in the [Tasmanian 2013 Proposal](#)⁸ and in the report of the Victorian inquiry into end of life choices.

LEGISLATION

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
<p><i>Death with Dignity Act 1994</i> Commenced operation 1997</p>	<p><i>Termination of Life on Request and Assisted Suicide Act 2002</i> Commenced operation 2002</p>	<p><i>Act on Euthanasia 2002</i> Commenced operation 2002</p>	<p><i>An Act respecting end of life care (2014)</i> Commenced operation December 2015</p>	<p><i>An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (2016)</i> Commenced operation June 2016</p> <p>As provided for in the Act, independent reviews are underway to report by December 2018 to the Government on the possible extension of the legislation to mature minors, advance requests and to requests where mental illness is the sole underlying medical condition. (§241.31 9.1(1)) ,</p>	<p><i>Voluntary Assisted Dying Act 2017</i></p>

AGE

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
<p>The patient must be an adult aged 18 years or older (§2.01(1)).</p>	<p>Under the 2002 Dutch law, a patient aged between sixteen and eighteen years that “may be deemed to have a reasonable understanding of his interests” may request euthanasia or assisted suicide. In these cases the parent and/or guardians must be consulted but do not have a veto on the final decision (§2(3)). Patients aged between twelve and sixteen and “may be deemed to have a reasonable understanding of his interests” may also request euthanasia or assisted suicide, provided the parents and/or guardian give their consent (§2(3)).</p>	<p>Under the 2002 Belgian law, the patient had to have “attained the age of majority or is an emancipated minor” (§3(1)).</p> <p>An amendment to the law was made in February 2014, after very extensive community and Parliamentary debate, to allow that “a child of any age can be helped to die, but only under strict conditions. He or she must be terminally ill, close to death, and deemed to be suffering beyond any medical help. The child must be able to request euthanasia themselves and demonstrate they fully understand their choice. The request will then be assessed by teams of doctors, psychologists and other care-givers before a final decision is made with approval of the parents.”⁹ It was expected that this provision would be very rarely used and this has turned out to be the case: the first and only death under the provisions occurred in September 2016, of a 17 year old.¹⁰</p>	<p>26. Only a patient who meets the following criteria may obtain medical aid in dying: (1) be of full age, ...</p>	<p>241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria: ... (b) they are at least 18 years of age ...</p> <p>Note that, as provided for in the Canadian Act, a review is under way related to requests by mature minors for medical assistance in dying. (See in ‘eligible medical condition’)</p>	<p>9(1)(a) the person must be aged 18 years or more</p>

Tasmanian *Voluntary Assisted Dying Bill 2016*

S10(1)(a) requires the person to be “an adult”.

ELIGIBLE MEDICAL CONDITION

	Terminal illness ⁱ	Specified Timeframe	Specified suffering	
Oregon¹¹	Yes	Yes	No	The Oregon (and other US) law allows a prescription for lethal drugs to be provided to people who have a terminal illness and who qualify for free federally funded palliative care. This occurs when someone has a prognosis, “within reasonable medical judgement” their death is expected within 6 months. ¹² (§1.01(12)).
Netherlands	No	No	Yes	The patient’s suffering must be “lasting and unbearable” (§2(1)(b)), and that there be “no other reasonable solution for the situation he was in” (§2(1)(d)). There is no requirement that the patient be diagnosed with a terminal illness.
Belgium	No (except children)	No	Yes	Section 3 states that “the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.” There is no requirement that the cause of the patient’s suffering be due to a terminal illness.
Quebec	No	No	Yes	To obtain medical aid in dying the patient must: 3. be at the end of life [undefined] 4. suffer from an incurable serious illness; 5. suffer from an advanced state of irreversible decline in capability; and 6. suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable.” (§26)
Canada	No	No	Yes	A person may receive medical assistance in dying if ... they have a grievous and irremediable medical condition. (§241.2 (1)(c)) A person has a grievous and irremediable medical condition only if they meet all of the following criteria: (a) they have a serious and incurable illness, disease or disability; (b) they are in an advanced state of irreversible decline in capability; (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining. (§241.2 (2)) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition, and report to Parliament within two years of the start of a review. (§9.1) <u>Canadian Health Dept advice</u> - (“People with a mental illness are eligible for medical assistance in dying as long as they meet all of the listed conditions. However, you are not eligible for this service if: you are suffering <u>only</u> from a mental illness; death is not reasonably foreseeable when considering all the circumstances of your medical condition; or a mental illness reduces your ability to make medical decisions”
Victoria	Yes ¹³	Yes ¹⁴	Yes	S9 (1) For a person to be eligible for access to voluntary assisted dying— ... (d) the person must be diagnosed with a disease, illness or medical condition that— (i) is incurable; and (ii) is advanced, progressive and will cause death ; [our emphasis] ⁱⁱ (iii) is expected to cause death within weeks or months, not exceeding 6 months [our emphasis] ⁱⁱⁱ ; and

ⁱ That is, an illness or condition that is likely to result in death. See for example, the definition in the South Australian *Consent to Medical Treatment Act 1995*.

ⁱⁱ This differs from the recommendation of the Victorian inquiry into end of life choices that the person must be “suffering from a serious and incurable condition” not the more restrictive requirement that it “will cause” the person’s death. See also Endnote 13.

ⁱⁱⁱ The inquiry’s recommendation was that the person must be “at the end of life (final weeks or months of life)” but did not specify the number of months. (See also Endnote 14)

				<p>(iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.</p> <p>9(4) Despite subsection (1)(d)(iii), if the person is diagnosed with a disease, illness or medical condition that is neurodegenerative, that disease, illness or medical condition must be expected to cause death within weeks or months, not exceeding 12 months [our emphasis]^{iv}</p> <p>9(2) A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the Mental Health Act 2014.</p> <p>9(3) A person is not eligible for access to voluntary assisted dying only because the person has a disability, within the meaning of section 3(1) of the Disability Act 2006.</p>
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Special notes:

1. ‘Eligible medical condition’ is the requirement that differs most between legislation because it is the section of the law most strongly related to the culture and fundamental principles, values and priorities of the place where the law is being introduced. As the Victorian inquiry report put it, an assisted dying framework must reflect “the values and culture unique to a particular jurisdiction”, including the medical and legal culture.
2. Contrary to the most common misunderstanding about assisted dying legislation:
 - “terminal illness” is not, and has never been, a requirement in European legislation – the key cultural value is compassionate ending of unbearable suffering; and
 - demonstrating suffering is not, and has never been, a requirement in Oregon and other US States – the key cultural value is individual autonomy.

Tasmanian *Voluntary Assisted Dying Bill 2016*

The approach taken in the Tasmanian Bill is supported by many public surveys and the 2016 AMA member survey¹⁵.

Because of the unreliability of prognoses, the Tasmanian Bill does not require them but considers people to be at the end of their lives if they meet the stringent medical requirements and the ‘last resort’ provision, ie they are at the end of lives that will never again be free of intolerable and unrelievable suffering and the devastating effects of the advanced stages of serious, incurable and irreversible medical conditions. The evidence from overseas shows that almost all those who choose and are provided voluntary assisted dying have unbearable suffering due to cancer, neuro-degenerative conditions, chronic heart disease and chronic pulmonary obstructive disease.

S11 - “For the purposes of this Act, an eligible medical condition –

- (a) is the advanced stages of a serious incurable and irreversible medical condition, whether caused by illness, disease or injury, **as diagnosed by a medical practitioner who has specialised qualifications, or experience, in diagnosing and treating the medical condition**; and
- (b) the person’s medical condition, or associated medical treatment, or complications resulting from the medical condition or treatment –
 - (i) is causing persistent suffering for the person that is intolerable for the person; and

^{iv} The Voluntary Assisted Dying Bill originally included 12 months for all conditions.

- (ii) there is no reasonably available medical treatment or palliative care options that would, having regard to both the treatment and any consequences of the treatment, relieve the person's suffering in a manner that is acceptable to the person; and
- (c) there is no reasonable prospect of a permanent improvement in the person's medical condition."

'Last resort' provision

S22 (2) and (3) provide the 'last resort' requirement. **S22(2)** states that the person's doctor "must discuss with the eligible person whether there are any relevant treatment options available that may adequately and to the satisfaction of the eligible person – (a) improve the eligible person's medical condition; or (b) relieve the eligible person's suffering". **S22(3)** requires the doctor to provide assisted dying only "If the eligible person and the eligible person's primary medical practitioner are satisfied there are no relevant treatment options available as discussed [under S22(2)]".

DOCTOR/NURSE¹⁶ SAFEGUARDS

<p>Oregon</p>	<p>The attending physician is defined as “the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease” (§1.01(2)).</p> <p>The attending physician must “refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily” (§3.01(d)). The consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient’s disease.</p> <p>Section 3.03 states that “if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counselling.” The request for assistance can only proceed once the counsellor determines that the patient is not suffering from depression.</p> <p>The patient must be informed about palliative care options in accordance with Section §3.01(c)(E).</p>
<p>The Netherlands</p>	<p>Under Dutch law only physicians can provide assistance with assisted suicide or voluntary euthanasia. The physician does not need to be the patient’s primary physician but it is required “that the physician must know the patient sufficiently well to assess whether the due care criteria are met.”</p> <p>The patient’s physician must consult another “independent physician who has seen the patient and has given his written opinion on the requirements of due care” (§2(1)(e)). As shown by the judgements and professional advice provided by the review committees, consultation requirements are expected to be more stringent if the patient’s suffering is the result of a psychiatric disorder.</p>
<p>Belgium</p>	<p>The role of the attending physician is not defined. However, the Act does state that the physician must have “several conversations with the patient spread out over a reasonable period of time” in order “to be certain of the patient’s constant physical or mental suffering and of the durable nature of his/her request” (§3(2)(2)).</p> <p>The patient’s physician must consult another physician who is required to review the medical record, examine the patient, confirm the patient’s constant and unbearable physical and mental suffering that cannot be alleviated (§3.2.3).</p> <p>The consulting physician must be independent of both the patient and the attending physician and be competent to give an opinion about the disorder in question (§3.2).</p> <p>If there is a nursing team that forms part of the patient’s regular care, the attending physician must discuss the patient’s request with the nursing team (§3.2.4).</p> <p>An additional requirement exists for patients who are “not expected to die in the near future” (§3.3). The physician must refer the person for examination and a report from a second independent physician who is a psychiatrist or a specialist in the person’s disorder.</p>
<p>Quebec</p>	<p>The patient’s physician must “obtain the opinion of a second physician confirming that the criteria set out in section 26 have been met.</p> <p>The physician consulted must be independent of both the patient requesting medical aid in dying and the physician seeking the second medical opinion.</p> <p>The physician consulted must consult the patient’s record, examine the patient and provide the opinion in writing. (§28(3))</p>
<p>Canada</p>	<p>medical practitioner means a person who is entitled to practise medicine under the laws of a province.</p> <p>nurse practitioner means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner - or under an equivalent designation - and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.</p> <p>(§241.2 (3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must ...</p> <p>(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);</p> <p>(f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent.</p> <p>The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) are independent if they</p> <p>(a) are not a mentor to the other practitioner or responsible for supervising their work;</p> <p>(b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death, other than standard compensation for their services relating to the request; or</p> <p>(c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity. (§241.2 (6))</p> <p>Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards. (§241.2 (7))</p>

Victoria	<p>10 (1) Each co-ordinating medical practitioner and consulting medical practitioner must—</p> <p>(a) hold a fellowship with a specialist medical college; or</p> <p>(b) be a vocationally registered general practitioner.</p> <p>(2) Either the co-ordinating medical practitioner or each consulting medical practitioner must have practised as a registered medical practitioner for at least 5 years after completing a fellowship with a specialist medical college or vocational registration (as the case requires).</p> <p>(3) Either the co-ordinating medical practitioner or each consulting medical practitioner must have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed.</p> <p>S7 A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—</p> <p>(a) to provide information about voluntary assisted dying;</p> <p>(b) to participate in the request and assessment process;</p> <p>(c) to apply for a voluntary assisted dying permit;</p> <p>(d) to supply, prescribe or administer a voluntary assisted dying substance;</p> <p>(e) to be present at the time of administration of a voluntary assisted dying substance;</p> <p>(f) to dispense a prescription for a voluntary assisted dying substance.</p> <p>In addition, under S17 the co-ordinating medical practitioner must not commence the first assessment (after the person's first request) unless the practitioner has completed approved assessment training. Under S26, the consulting medical practitioner must not commence a consulting assessment unless the practitioner has completed approved assessment training.</p> <p>18(2) If the co-ordinating medical practitioner is unable to determine whether the person's disease, illness or medical condition meets the requirements of the eligibility criteria, the co-ordinating medical practitioner must refer the person to a specialist registered medical practitioner who has appropriate skills and training in that disease, illness or medical condition.</p>
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Tasmanian Voluntary Assisted Dying Bill 2016

Safeguard of specialised diagnosis: Before a person commences the process for assisted dying, under **S11, Eligible medical condition**, he/she must have a diagnosis of their medical condition from “a medical practitioner who has specialised qualifications, or experience, in diagnosing and treating the medical condition”.

In **S3**:

- **medical practitioner** is defined as “a person who holds general registration under the *Health Practitioner Regulation National Law (Tasmania) 2010* in the medical profession”.
- Doctors’ participation is entirely voluntary:
 - **primary medical practitioner** “in relation to a person, means a medical practitioner who accepts primary responsibility for an assisted dying request made under this Act”
 - **secondary medical practitioner** “in relation to a person, means a medical practitioner who has accepted a referral in respect of the person from the person’s primary medical practitioner”.

Significant responsibilities of primary medical practitioner:

- There are many sections of the Bill that set out the responsibilities of the primary medical practitioner and the action that must be taken at each stage of the process to ensure that rigorous examination is undertaken of requests and only those persons who meet all the eligibility requirements receive an assisted

death, including referrals to other medical professionals. (See in particular **S14** for responsibilities after initial oral request, **S18** after written request, and **S22** after subsequent oral request.)

- The primary medical practitioner cares for and supports persons to the end of the process, including the delivery of the prescribed medication and being available to administer the medication or to support the person who is self-administering and, if there are complications, to assist as agreed (**S18(3)(c)**).
- The primary medical practitioner has the responsibility for the strict requirements for safe handling of medication.

Confirmation by independent second medical practitioner: A person cannot receive an assisted death until a secondary medical practitioner confirms the opinion of the primary medical practitioner on the key criteria of competence, voluntariness and eligible medical condition.

S18(3) [At the time of the written request], “if a person’s primary medical practitioner is satisfied that the person has made an eligible request, the primary medical practitioner must –

- (a) refer the person to a secondary medical practitioner for confirmation of the primary medical practitioner’s opinion that the person’s written request meets the requirements of section 10 (c) [competence], (d) [voluntariness] and (e) [eligible medical condition]”.

S19 sets out the responsibilities of a secondary medical practitioner who must be **independent** of the primary medical practitioner. **S19(1)** states that “A medical practitioner may only accept a referral [from a primary medical practitioner] if he or she is independent of the primary medical practitioner”. **S19(2)** sets out the requirements for independence. **S20** sets out the responsibilities of the primary medical practitioner on receipt of the written report from the secondary medical practitioner in the event that it supports or does not support the primary medical practitioner’s opinion.

Compared to other legislation and proposals, the Tasmanian Bill has much more specific and detailed provisions on the significant record keeping and reporting responsibilities of doctors under the legislation, and associated offences and penalties. These are significant additional safeguards related to the Registrar’s official monitoring, scrutiny and Parliamentary reporting. Detailed record requirements for the medical practitioner are set out in **S28** -

(1) A person’s primary medical practitioner is to record, or file, the following information or documents on the person’s medical records:

(a) the primary medical practitioner’s medical diagnosis of, and medical prognosis for, the person;

(b) each assisted dying request made by the person;

(c) each determination by the primary medical practitioner as to whether or not the person –

(i) is competent; or

(ii) is making an informed decision to end his or her life; or

(iii) is voluntarily making an assisted dying request;

(d) each written report provided to the primary medical practitioner under section 15;

(e) each written report provided to the primary medical practitioner under section 19(2);

(f) each time the primary medical practitioner –

(i) informed the person that he or she may rescind an assisted dying request made by the person; and

(ii) offered the person an opportunity to rescind an assisted dying request made by the person;

(g) the steps intended to be taken to fulfil the assisted dying request of the person, including a notation of the prescribed medication;

- (h) after the prescribed medication has been administered to the person, the steps taken to fulfil the assisted dying request of the person, including any steps taken by the primary medical practitioner, or that the primary medical practitioner is aware were taken, in respect of any complications that occurred after the administration of the prescribed medication;
- (i) a note by the primary medical practitioner that he or she has complied with all relevant requirements of this Act;
- (j) any other document or information as prescribed.

(2) A person's primary medical practitioner must send, to the Registrar, a copy of the records required to be kept in respect of the person under subsection (1) **as soon as practicable after the record is made, or filed**, under that subsection.

Penalty: Fine not exceeding 50 penalty units.

(3) No later than 14 days after the death of an eligible person in accordance with this Act, the eligible person's primary medical practitioner must –

- (a) ensure that a copy of each record required to be kept in respect of that eligible person under subsection (1) has been sent to the Registrar in accordance with subsection (2); and
- (b) send to the Registrar a copy of the notification given under section 35 of the Births, Deaths and Marriages Registration Act 1999 in respect of the eligible person; and
- (c) send to the Registrar a copy of any other information that the primary medical practitioner considers relevant. Penalty: Fine not exceeding 50 penalty units.

TYPE OF ASSISTANCE

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
<p>Person must self-administer the lethal dose through oral ingestion.</p> <p>Doctor administration of the drugs is not permitted, even when there are complications.¹⁷</p>	<p>Both self and doctor-administration are legal.¹⁸</p>	<p>Doctor administration is provided for in the law, defined as “intentionally terminating life by someone other than the person concerned, at the latter’s request” (§2).</p> <p>Self-administration has been determined to be legal as well.</p>	<p>Only doctor-administration is allowed.</p> <p>If all conditions are met, “medical aid in dying may be administered to a patient requesting it, the physician must administer such aid personally and take care of the patient until their death.” (§29)</p> <p>Self-administration is not allowed under the law.</p>	<p>Both self and doctor-administration are legal.</p> <p>medical assistance in dying means</p> <p>(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or</p> <p>(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.</p>	<p>Person must self-administer the poison or controlled substance or the drug of dependence to be supplied by the co-ordinating medical practitioner for the purpose of causing the person’s death. The exception is administration by the co-ordinating medical practitioner only if he/she “is satisfied that—</p> <p>(a) the person is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence”.</p> <p>The Act contains multiple relevant sections including Division 2, Voluntary Assisted Dying permits.</p>

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The Bill provides for both self-administration and doctor-administration of the drugs for assisted dying. **S24 - (1) ...** “prescribed medication may be administered to an eligible person by –

- (a) the eligible person; or
 - (b) the eligible person’s primary medical practitioner.
- (2) For the purposes of this Act, administration by the eligible person may include oral ingestion or the activation of a medical device that delivers the medication. (Protection is provided in **S31(2)(a)(i)** for someone “assisting with the preparation of medication or medical devices for the self-administration” which would all happen with the supervision of the primary medical practitioner.)
- (3) If an eligible person intends to self-administer prescribed medication, the eligible person’s primary medical practitioner must –
- (a) offer the eligible person a chance to rescind any assisted dying request made by the eligible person before dispensing the prescribed medication to the eligible person for self-administration; and
 - (b) remain on the same premises as the eligible person (but not necessarily within sight of the eligible person) until, and while, the eligible person self-administers the prescribed medication; and
 - (c) take any steps, as determined under section 18(3)(c), the primary medical practitioner considers necessary.

REGULATORY MONITORING, SCRUTINY AND REPORTING

Oregon	<p>Section 3.11 sets out the reporting requirements to be undertaken by the Department of Human Services.</p> <p>Section 3.11 also requires “any health care provider upon dispensing medication ... to file a copy of the dispensing record with the department [of Human Services].”</p> <p>The Department of Human Services is required to prepare an annual report on the operation of the Act (§3.11(3)).</p>
The Netherlands	<p>Regional review committees are established under Section 3 of the Act.</p> <p>For the physician to be protected by the legal defence provided by the 2001 Act, he or she must report the case to the municipal pathologist (§20(2)). The municipal pathologist is responsible for forwarding the file to the relevant review committee. The review committees are required to provide an annual report on their activities (§17).¹⁹</p>
Belgium	<p>The Belgian Act establishes a Federal Control and Evaluation Commission (§6).</p> <p>Section 5 states that “any physician who has performed euthanasia is required to fill in a registration form ... and to deliver the document to the Commission within four working days. Section 7 details the information the physician is required to provide about the patient.</p> <p>The Commission is responsible for reviewing all cases of euthanasia to ensure they were undertaken in accordance with the Act (§8).</p> <p>If the Commission believes that the statutory criteria have not been met they will refer the case to the public prosecutor (§8).</p>
Quebec	<p>“All information and documents in connection with a request for medical aid in dying, regardless of whether the physician administers it or not, including the form used to request such aid, the reasons for the physician’s decision and, where applicable, the opinion of the physician consulted, must be recorded or filed in the patient’s record.” (§31)</p> <p>The Act also provides for “a commission on end-of-life care” with the mandate to examine any matter relating to end-of-life care” (§35 - 42). “A physician who administers medical aid in dying must give notice to the Commission within the next 10 days and send the Commission, in the manner determined by government regulation, the information prescribed by regulation.” (§41)</p>
Canada	<p>Filing information - medical practitioner or nurse practitioner: 241.31 (1) Unless they are exempted under regulations made under subsection (3), a medical practitioner or nurse practitioner who receives a written request for medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.</p> <p>Filing information -pharmacist: (2) Unless they are exempted under regulations made under subsection (3), a pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.</p> <p>(3) The Minister of Health must make regulations that he or she considers necessary</p> <p>(a) respecting the provision and collection, for the purpose of monitoring medical assistance in dying, of information relating to requests for, and the provision of, medical assistance in dying, including</p> <p>(i) the information to be provided, at various stages, by medical practitioners or nurse practitioners and by pharmacists, or by a class of any of them,</p> <p>(ii) the form, manner and time in which the information must be provided,</p> <p>(iii) the designation of a person as the recipient of the information, and</p> <p>(iv) the collection of information from coroners and medical examiners;</p> <p>(b) respecting the use of that information, including its analysis and interpretation, its protection and its publication and other disclosure;</p> <p>(c) respecting the disposal of that information; and</p> <p>(d) exempting, on any terms that may be specified, a class of persons from the requirement set out in subsection (1) or (2).</p>
Victoria	<p>Part 9 provides for an Assisted Dying Review Board and sets out in detail the functions and powers, membership and procedure and reports.</p> <p>The Board is to consist of a Chairperson, a Deputy Chairperson (if appointed) and an unspecified number of members appointed by the responsible Minister.</p> <p>There are no specific qualifications for membership except as provided in 95(2): “A person is eligible for appointment as a member of the Board if the Minister is satisfied that the person has the appropriate knowledge and skills to perform all of the duties and functions of a member of the Board”. This is different from the recommendation of the Victorian inquiry into end of life choices that members include a doctor, a nurse, a legal professional and a community member. However, S100 states: “(1) Subject to the approval of the Minister, the Board may co-opt any person with special knowledge or skills to assist the Board in a particular matter. (2) A person who has been co-opted to assist the Board is to be considered to be a member of the Board until the period of co-option ends.”</p>

	<p>The functions and powers include monitoring, reviewing the exercise of any function or power under this Act, promoting compliance with the requirements of the Act, referring any issue identified by the Board in relation to voluntary assisted dying to relevant persons or bodies, (eg the Chief Commissioner of Police, the State Coroner or the Australian Health Practitioner Regulation Agency) conducting research, consulting, providing information, etc. For the first 2 years 6 monthly reports must be provided to parliament and thereafter annual.</p> <p>There are numerous requirements for the medical practitioners involved to provide reports or copies of forms to the Board, including:</p> <ul style="list-style-type: none"> • 21(2) Within 7 days after completing the first assessment, the co-ordinating medical practitioner must complete the first assessment report form and give a copy of that form to the Board. • 30(1) The consulting medical practitioner must— ... <ul style="list-style-type: none"> (b) complete the consulting assessment report form and give a copy of it to— <ul style="list-style-type: none"> (i) the Board; and (ii) the co-ordinating medical practitioner for the person. <p>(2) The consulting medical practitioner must give the copy of the consulting assessment report form to the Board within 7 days after completing the consulting assessment.</p>
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As well as being a doctor-safeguarded system, like other legal assisted dying, the Tasmanian Bill provides for the additional safeguard of a rigorous monitoring, scrutiny and reporting arrangement. The Tasmanian approach is for this to be done most effectively and safely through a Registrar with statutory powers.

Part 4 provides for the appointment of a Registrar with the following functions under **S33 (1)** -

- (a) review a death that occurs as a result of assistance provided under this Act, for the purpose of monitoring compliance with this Act;
- (b) investigate, report and make recommendations to the Minister on any matter relating to the operation or administration of this Act;
- (c) communicate to appropriate authorities any concerns the Registrar has about compliance or non-compliance with this Act;
- (d) distribute information, and provide education, relating to – (i) the functions of the Registrar; and (ii) the operation of this Act;
- (e) perform such other functions, or exercise such other powers, as may be prescribed.

General record requirements of the Registrar are covered in **S34** and an Annual Report to Parliament is required in **S35**.

S28 sets out the requirements for medical practitioners to record, file and submit reports including:

- (2) A person’s primary medical practitioner must send, to the Registrar, a copy of the records required to be kept in respect of the person under subsection (1) as soon as practicable after the record is made, or filed, under that subsection. Penalty: Fine not exceeding 50 penalty units.
- (3) No later than 14 days after the death of an eligible person in accordance with this Act, the eligible person’s primary medical practitioner must –
 - (a) ensure that a copy of each record required to be kept in respect of that eligible person under subsection (1) has been sent to the Registrar in accordance with subsection (2).

VOLUNTARINESS

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
The patient's request must be voluntary. Both the patient's doctors and the witnesses to the patient's written request are required to confirm that the request is being made voluntarily by the patient (§2.02, §3.01 (a) and §3.02).	The patient's request must be voluntary (§2(1)(a)).	The patient's request must be "voluntary, well considered and repeated and is not the result of any external pressure" (§3(1)).	"Before administering medical aid in dying the physician must (1) be of the opinion ... after...(a) making sure the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure.	241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria: [including] (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure	20 (1) The co-ordinating medical practitioner must assess the person as eligible for access to voluntary assisted dying if the co-ordinating medical practitioner is satisfied that— ... (c) the person is acting voluntarily and without coercion. There are very detailed requirements for the requests including Division 2 – First request; Division 5 – Written declaration and Division 6 – Final request ... The Written Declaration Form is included in Schedule 1 of the Act. Also in that form are sections for two Witness Declarations and Interpreter Declaration if necessary, which make clear what the requirements are. S8 requires that voluntary assisted dying must not be initiated by registered health practitioner. See also 18(1) in Competence section.

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S10(1) "For the purposes of this Act, an assisted dying request is an eligible request if the person making the assisted dying request – ... (d) is making the request voluntarily".

The greatest guarantee of voluntariness is that the person must initiate every one of the three requests - initial oral, written and subsequent oral – and advise the primary medical practitioner when the prescription is to be issued (**S23(1)(a)**). The person must also be offered numerous opportunities to rescind their request. The written request (**S17**) must be witnessed under **S17(3)(b)** by "at least two adults" one of whom needs to be independent (see **S17(4), (5) and (6)**).

The primary medical practitioner must be convinced that each request is voluntary. If in doubt, he/she must refer the person to a psychiatrist or a psychologist for counselling (**S14(2)**). The voluntariness must also be confirmed by a second medical practitioner. A person cannot receive an assisted death until a secondary medical practitioner confirms the opinion of the primary medical practitioner on voluntariness. (See section below on Doctor Safeguards).

COMPETENCE

Oregon ²⁰	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
<p>The patient must be capable of making and communicating health care decisions to their doctors (§1.01(3)).</p> <p>If either the attending or consulting physician are of the opinion that “the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement” they must refer the patient for counselling (§3.03).</p>	<p>The patient’s request must be “voluntary and carefully considered” (§2(1)(a)).</p> <p>It is practice for the attending physician to consult a psychiatrist if he or she suspects the patient is incompetent.</p>	<p>The patient must be “legally competent and conscious at the moment of making the request” (§3.1).</p>	<p>To obtain medical aid in dying, a patient must “be capable of giving consent to care” (§26(2)).</p> <p>(There is no specific requirement in this Act for the doctor to refer the patient for psychiatric or psychological assessment.)</p>	<p>Capable of making decisions with respect to their health; (§241.2 (1)(b))</p> <p>They give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (§241.2 (1)(e))</p> <p>(There is no requirement for the doctor to refer the patient for psychiatric or psychological assessment.)</p>	<p>9 (1) For a person to be eligible for access to voluntary assisted dying— ...</p> <p>(c) the person must have decision-making capacity in relation to voluntary assisted dying;</p> <p>Section 4 defines Meaning of decision-making capacity at some length</p> <p>18 (1) If the co-ordinating medical practitioner is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, the co-ordinating medical practitioner must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.</p>

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Under the Tasmanian Bill, the person has to be competent at the time of each request, in order for that request to be an eligible one.

Person must be competent

S10(1) “For the purposes of this Act, an assisted dying request is an eligible request if the person making the assisted dying request – ...
(c) is competent”

S3 (Interpretation) - competent, in relation to a person, means the person –

- (a) has the ability to make and communicate to health care providers, informed decisions in relation to the person’s medical treatment, including communicating through persons familiar with the person’s manner of communicating; and
- (b) is not suffering from a psychiatric or psychological disorder, or depression, to a degree that may cause the judgement of the person to be impaired.

S14(2) - “If the primary medical practitioner reasonably suspects that the person is not competent to make the initial oral request, or is not voluntarily making the initial oral request, he or she must refer the person for counselling and discuss with the person the reasons for the referral”. **S3** - “**counselling** means a consultation between a psychiatrist, or psychologist, and a person to determine, in the opinion of that psychiatrist or psychologist, whether or not the person – (a) is competent to make an assisted dying request; and (b) is making that request voluntarily”. **S15 and 16** - set out requirements to be met in relation to counselling and reporting. **S15(3)** “Nothing in this section prevents a person’s primary medical practitioner from referring the person to a psychiatrist, or psychologist or any other person, at any time, or for any reason, the primary medical practitioner thinks appropriate”.

INFORMED DECISION

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
<p>The patient must be making an informed decision and the attending physician is required to inform the patient of “his or her medical diagnosis, ... prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and palliative care” (§3.01(c)).</p>	<p>The request must be informed and the physician is required to “inform the patient about the situation he was in and about his prospects” (§2(1)(c)).</p>	<p>Section 3.1 states that the patient’s decision must be “well considered.”</p> <p>The physician must “inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences” (§3.2.1).</p>	<p>The patient’s physician must make “sure that the request is an informed one, in particular by informing the patient of the prognostic and of other therapeutic possibilities and their consequences” (§28(1)(b))</p> <p>The physician must make sure that such a decision is made freely and provide the person with all information needed to make an informed decision, in particular information about other therapeutic possibilities, including palliative care. ((§5)</p>	<p>They give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (§241.2 (1)(e))</p>	<p>If the co-ordinating medical practitioner is satisfied that the person requesting access to voluntary assisted dying meets all the eligibility criteria, the co-ordinating medical practitioner must inform the person about a range of matters set out in §19(1), including palliative care options available to the person and the likely outcomes of that care.</p> <p>In addition, under 19(2), the co-ordinating medical practitioner must, if the person consents, take all reasonable steps to fully explain to a member of the family of the person—</p> <p>(a) all relevant clinical guidelines; and</p> <p>(b) a plan in respect of the self-administration of a voluntary assisted dying substance for the purpose of causing death.</p>

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S12 contains very detailed requirements on the information to be provided to the patient including those above for other legislation. For example, **S12(2)** - (f) all other reasonable treatment options available to the person including, but not limited to, palliative care.

RESIDENCY

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
The patient must be a resident of Oregon (§2.01).	Residency is not mentioned in the Act but is effectively required in practice. ²¹	Residency is not mentioned in the Act but is effectively required in practice.	26(1) requires a person to be an insured person within the meaning of the Health Insurance Act (chapter A-29)	241.2 (1) A person may receive medical assistance in dying only if ... (a) they are eligible— or, but for any applicable minimum period of residence or waiting period, would be eligible—for health services funded by a government in Canada; ...	9(1)(b) the person must— (i) be an Australian citizen or permanent resident; and (ii) be ordinarily resident in Victoria; and (iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months;

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S10(1)(b) requires that a person be a Tasmanian resident. **10(2)** states: For the purposes of subsection (1)(b), evidence of a person’s Tasmanian residency may include, but is not limited to, evidence that the person currently –
 (a) holds a drivers licence issued under the Vehicle and Traffic Act 1999; or
 (b) is enrolled to vote in Tasmania.

WAITING PERIODS

Oregon	The Netherlands	Belgium	Quebec, Canada	Canada	Victoria
15 days between two oral requests and 48 hour period between written request and dispensing of the prescription	No	No, with the exception that for those whose deaths are not otherwise imminent there is a one month waiting period	No	10 days between written request and assisted dying “or—if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent— any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances” (§241.2 (3)(g))	38 A person's final request must be made— (a) subject to subsection (2), at least 9 days [∨] after the day on which the person made the first request; and (b) in any case, at least one day after the day on which the consulting assessment that assessed the person as eligible for access to voluntary assisted dying was completed. (2) Subsection (1)(a) does not apply if the co-ordinating medical practitioner for the person considers that the person's death is likely to occur before the expiry of the time period specified in that subsection, and this is consistent with the prognosis of the consulting medical practitioner for the person set out in the consulting assessment report form.

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There must be a minimum of 9 days between the initial request and the administration of drugs for an assisted death, including under **S17(2)** at least 48 hours between initial oral request and written request, and under **S21(2)(b)** at least 7 days between written request and subsequent oral request.

[∨] The Victorian inquiry recommended that there be no waiting periods.

Endnotes

¹ The original of this paper was dated January 2017, with an update in May 2017. At that time the Victorian information included only recommendations from the Victorian inquiry into end of life choices. This version in March 2018 includes information from the Victorian legislation, the *Voluntary Assisted Dying Act 2017*.

² As the Chair of the Victorian inquiry says in his foreword to the June 2016 report of the Victorian inquiry into end of life choices: “While these jurisdictions differ significantly in their assisted dying models, **what they all have in common is robust regulatory frameworks that focus on transparency, patient-centred care and choice**. We found **no evidence of institutional corrosion or the often cited ‘slippery slope’**. Indeed, the regulatory framework has been unchanged in Oregon, the Netherlands and Switzerland for many years.”

The same points are made elsewhere in the report, backed up by substantial evidence:

- Concerns raised in arguments against legalising assisted dying — such as the inability to implement and maintain effective safeguards — have not eventuated in jurisdictions where assisted dying is legal. The Committee did not find compelling evidence to support the negative consequences predicted by these claims. (p205)
- **The evidence is clear that assisted dying can be provided in a way that guards against abuse and protects the vulnerable in our community in a way that unlawful and unregulated assisted dying does not.** The Committee is satisfied, through its research into international jurisdictions, that assisted dying is currently provided in robust, transparent, accountable frameworks. The reporting directly from such frameworks, and the academic literature analysing them, shows that the risks are guarded against, and that robust frameworks help to prevent abuse. (p212)

See also the ABC Fact Check in November 2017 which refuted Paul Keating’s claim that the experience of assisted dying legislation in "overseas jurisdictions suggests the pressures for further liberalisation are irresistible" - <http://www.abc.net.au/news/2017-11-10/fact-check-do-assisted-dying-laws-lead-to-a-slippery-slope/9116640> .

³ Available at http://www.parliament.tas.gov.au/bills/Bills2016/pdf/73_of_2016.pdf

⁴ [http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/\\$FILE/17-061aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/$FILE/17-061aa%20authorised.pdf)

⁵ Particular attention has been given to the extensive consultative process, reports and parliamentary debates in Canada, including the reports, submissions, policies and advice of the Canadian Medical Association, eg [Principles-based Recommendations](#). The 2016 Tasmanian Bill is consistent with the new AMA policy even though the Bill was moved in the Parliament before the new policy and its report on the review and member survey was issued.

⁶ Available at <http://dwdtas.org.au/wp-content/uploads/2016/11/Tasmanian-VAD-Bill-Summary-29-November-2016.pdf> .

⁷ DwDTas has more material to support an informed, rational debate on this issue, to be added to the website and sent directly to MPs. We are happy to respond to specific queries at any time.

⁸ This information has been prepared by Margaret Sing, President, Dying with Dignity Tasmania. The information in these tables, other than the Quebec, Canada and Victorian inquiry details, is taken from Giddings, L and McKim, N, *Voluntary Assisted Dying: A Proposal for Tasmania*, Feb 2013 (obtainable at <http://dwdtas.org.au/wp-content/uploads/2013/05/Voluntary-Assisted-Dying-A-Proposal-for-Tasmania.pdf>). The original document includes additional tables comparing other provisions including Voluntariness, Written Request, Residency Requirement, Age of patient, Identity of the Attending Doctor, Family Notifications, Due Medical Care and Opportunity to Rescind Request. It also includes considerable additional detail on the similarities and differences between the legislation in different jurisdictions.

⁹ <http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/>

¹⁰ <http://www.rte.ie/news/2016/0917/817198-euthanasia/>

¹¹ The Oregon requirements are the same or similar to those in other US States in these key criteria, but there are some differences which should be noted in the particular legislation (Washington, Vermont, California, District of Columbia) or court judgements (Montana) which determine the legal conditions for voluntary assisted dying.

¹² The 6 month timeframe is included in the Oregon and other US States for a reason specific to the US situation that does not apply in Australia (or other countries). (See for example, the [Report of the Victorian inquiry into end of life choices](#), p223.) It is a requirement because the architects of the legislation wanted to be sure that people would not choose assisted dying merely because they could not afford palliative care. When people in the US have their doctor's prognosis of 6 months or less to live they are eligible for free access to palliative care (hospice) services through federal funding. This is obviously very important in the very expensive US health system. Consequently, 90.5% of those who have accessed assisted dying in Oregon have been enrolled for hospice care. (See [latest Annual Report for 2017](#)) However, it is also clear from the Oregon Annual reports that the prognoses are unreliable and some people live for a considerable period beyond 6 months. For example, the duration from first request to death ranges from 15 to 1009 days. In other words, at least one person (and maybe more) lived for nearly 3 years, despite their 6 month prognosis.

¹³ This represents a major difference between the recommendation of the Victorian inquiry into end of life choices and the final Act. The inquiry did not require the person to have a terminal illness – ie one that will cause the death of the person. The inquiry had adopted the approach of all jurisdictions other than the US, including Canada, that the person should be “suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable”. The restriction was recommended by the Victorian Government's Expert Panel without explanation or justification for the restriction. The requirement means that someone with a serious chronic but not terminal incurable condition (for example, a spinal condition) may not be eligible even though they meet all the other requirements including intolerable suffering. This was the situation for Kay Carter in Canada in the case that led to the Supreme Court judgement in February 2015. On our website we include two examples in the Tasmanian context – Elizabeth Godfrey and Joan Fitznead.

¹⁴ This also represents a major difference between the approach taken by the Victorian inquiry, and all legislation other than in the US, that a specific timeframe prognosis is not a reliable way to determine that someone is at the end of their life. The Victorian inquiry report states: “The Committee's view is that assisted dying in Victoria should be provided only to those who are at the end of life, as determined by a primary doctor and an independent secondary doctor. ... Doctors are best placed to assess whether a patient is at the end of life. The Committee trusts the judgement of doctors, specialists and health practitioners in determining whether a patient is at the end of life, according to the nature of their condition and its likely trajectory. The Committee believes that empowering doctors to make this assessment is preferable to allocating an arbitrary time limit based on factors that are not applicable to the Victorian context. For example, the six-month requirement specified in the Oregon framework which is based on access to hospice benefits is not applicable to the Australian context which provides universal health care” (p223-4).

Prognoses of months to live are notoriously unreliable and they have been generally rejected elsewhere (except the US where they are related to access to federal funding). An article by respected academic Professor Colleen Cartwright of Southern Cross University identifies these issues - <https://theconversation.com/the-six-month-amendment-could-defeat-the-purpose-of-victorias-assisted-dying-bill-87941> . A timeframe prognosis or an 'end of life' requirement was not included in the Canadian Supreme Court judgement in February 2015 that led to the national Canadian medical aid in dying legislation. The legislation was passed with a requirement added by the Government: 241.2 (2)(d) *their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining*. This requirement is to be legally challenged. It has been described as “one of the most confusing and controversial elements” of the legislation (see for example, <https://impactethics.ca/2017/07/28/in-a-nutshell-ii-ontario-court-decision-maid/>). It has been criticised chiefly because it could prevent people who would have been able to access medical aid in dying under the Supreme Court decision from doing so under the legislation (see for example <http://www.cbc.ca/news/politics/liberal-mps-call-for-changes-proposed-assisted-dying-1.3542505> and the views of the family of Kay Carter, the main person in the case decided by the Supreme Court - <http://www.cbc.ca/news/politics/doctor-assisted-suicide-bill-carter-family-speaks-out-1.3546472>).

The Victorian Coroner's evidence to the Victorian end of life choices inquiry is also critically important to this issue. The evidence was research done by the Coroners Office involving suicides of people who had “decline/deterioration in physical health due to incurable and irreversible conditions”. The Coroner specifically noted three different groups

– people diagnosed with terminal illness “expected to die within a specified period of time”; people with “incurable chronic disease that was not expected to cause death in the foreseeable future” (eg Huntington’s, Parkinson’s, MS, diabetes, MN, osteoarthritis) and people with “permanent physical incapacity and pain that could not be relieved as a result of injury”. The Victorian legislation will allow those in the first group to access voluntary assisted dying. A [DwDTas analysis](#) provides more details and links to the Coroners submissions and evidence at a hearing. See also Chapter 6 of the report of the Victorian inquiry.

¹⁵ In the AMA member survey, 91% of the AMA members who believed ‘euthanasia’ should be lawfully allowed for a competent adult supported it in the circumstances of “an incurable illness associated with unrelievable and unbearable suffering” and only 64% for the much narrower circumstances of a “terminal illness”. See also the details of successive Newspolls and Tasmanian EMRS polls in the [DwDTas paper on community support](#), as well as the more recent [2016 Essential poll](#) and the November 2017 [Roy Morgan poll](#).

¹⁶ Canada is the only jurisdiction that legally allows for nurse practitioners (NPs) to take part in the direct provision of medical assistance in dying.

¹⁷ Information on complications has, since mid-2010 been collected only when the physician or another health care provider is present at the time of death so the situation in a large number of cases is not known. Complications may include difficulty ingesting/regurgitated, seizures and regaining consciousness after ingesting DWDA medications. (Source: [Annual report for 2017](#).) One of the major issues in the US is the cost and accessibility of the most effective drugs. (See for example http://scienceline.org/2017/05/death-with-dignity/?utm_content=bufferfd4af&utm_medium=social&utm_source=facebook.com&utm_campaign=buffer and <http://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication>.)

¹⁸ As in all jurisdictions with both self and doctor-administration, doctor-administration is involved in the vast majority of instances. The [second interim report in Canada](#) comments that research has shown that “providers are less comfortable with self-administration due to concerns around the ability of the patient to effectively self-administer the series of medications, and the complications that may ensue” and “ although pharmacists can compound drugs for use in a self-administered assisted death, no drug commonly used for self-administration in international jurisdictions has been submitted for market approval in Canada, making access to these medications challenging in some communities”.

¹⁹ Annual Reports of the Review Committees are accessible at <https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports> .

²⁰ The Vermont legislation, *An act relating to patient choice and control at end of life*, May 2013, includes another alternative: “(8) The physician either verified that the patient did not have impaired judgment or referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker licensed in Vermont for confirmation that the patient was capable and did not have impaired judgment.”

²¹ The Dutch Ministry of Foreign Affairs advises that it is impossible for people to travel to the Netherlands to seek an assisted death ‘given the need for a close doctor-patient relationship. The legal procedure for the notification and assessment of each individual case of euthanasia requires the patient to have made a voluntary, well-considered request and to be suffering unbearably without any prospect of improvement. In order to be able to assess whether this is indeed the case, the doctor must know the patient well. This implies that the doctor has treated the patient for some time’. (Source: Lewis and Black, [The effectiveness of legal safeguards in jurisdictions that allow assisted dying](#). January 2012; p10)