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23 October 2017

Joint Select Committee on End of Life Choices
Legislative Assembly
Parliament House
PERTH WA 6000

Dear Ms Sanderson

Silver Chain Group appreciates the opportunity afforded by the Joint Select Committee on End of Life Choices to contribute to the *Inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices*.

For over three decades, Silver Chain has worked in partnership with WA Health to deliver comprehensive in-home palliative care services across metropolitan Perth to over 3,000 individuals annually. Of these 3,000 individuals, over 74% are supported to die in their place of choice – their own homes. Having seen the benefits of that arise from the provision of high quality palliative care, Silver Chain advocates strongly for access to quality palliative care for all people nearing the end of their life, and would like to note the following:

- Each year, tens of thousands of people who are approaching the end-of-life are cared for and die in a place that does not reflect their choice or fully meet their end-of-life care needs. Most people who die do so in two of the least preferred places — hospitals and residential aged care.
- More community-based palliative care services are needed to enable more people who wish to die at home to do so.
- End-of-life care in residential aged care needs to be better resourced and delivered by skilled staff, so that its quality aligns with that available to other Australians.

However, Silver Chain acknowledges that even with increased access to palliative care services, there may still be exceptional instances where individuals do not experience an adequate alleviation of their suffering, and may choose to consider assisted dying. Silver Chain's submission focuses on the organisation's understanding of the issues surrounding assisted dying, an issue that has been debated recently both internally within the organisation, and nationally, with the recent introduction of the *Voluntary Assisted Dying Bill* into Victorian Parliament.

Yours sincerely

Dr Christopher H McGowan
Chief Executive Officer

23 October 2017

INQUIRY INTO END OF LIFE CHOICES: SILVER CHAIN GROUP SUBMISSION

1 BACKGROUND

Silver Chain Group (Silver Chain) is a not-for-profit organisation which delivers services to over 84,000 clients annually in Western Australia, South Australia, Queensland, New South Wales and Victoria, making it one of the largest providers of in-home health and community care in Australia. Founded in 1905, Silver Chain is a values-based organisation which is committed to its purpose and mission of delivering high value care to enable people to remain in their own homes.

For over three decades, Silver Chain has worked in partnership with WA Health to provide home-based, multidisciplinary, 24/7 support metropolitan Perth for a cohort of individuals who have reached the end-of-life, and who wish to die in their own homes. Silver Chain's Hospice Care Service (HCS) provides care for an average of 680 clients per day. On any given day, HCS clients receive care from a multidisciplinary team of specialist nurses, medical consultants, General Practitioners, allied health professionals, social workers, counsellors and chaplains, care aides and volunteers. Silver Chain's HCS is recognised nationally and internationally for the excellence of its service and its outcomes. These outcomes are based on the ongoing support and contribution of the service to the national benchmarking collaborative, Palliative Care Outcomes Collaboration (PCOC). Current PCOC data for the HCS shows:

- All clients referred to HCS are seen within 24 hours of the client being ready to receive care.
- HCS clients who enter the unstable phase have a change of care plan that is proven to work within three days, 97% of the time
- Over 74% of patients are able to die at home.

To put the HCS' 74% death at home rate in perspective, in Australia while 70% of people indicate that they would like to die at home, only 14% actually achieve this¹.

The outcomes achieved and evolution of the HCS has enabled consecutive WA governments to continue a policy position in regards to primary investment in community for palliative care. This investment has supported an outcome where it remains the case that WA has the lowest number of publicly funded inpatient palliative care beds per head of population. This is furthermore exemplified by WA also having nationally the lowest number of employed Palliative Medicine Specialists per head of population, at a rate which is significantly lower than that of NSW (0.8 FTE in NSW per 100,000, compared 0.5 FTE per 100,000 in WA²).

2 INTRODUCTION

Silver Chain supports the work being undertaken by the Joint Select Committee on End of Life Choices to elevate the conversation around death, dying and end of life choices, and their efforts to place individuals at the centre of decision making about their treatment and care options. As one of the largest in-home health and social care providers in Australia, and the largest provider of in-home palliative care services in Western Australia, Silver Chain has long monitored the debate and evidence around end of life choices.

¹ Swerissen, H. and Duckett, S. (2014). *Dying Well*. Grattan Institute. Melbourne, Australia.

² Australian Institute of Health and Welfare. (2014). *Palliative care services in Australia 2014*. Retrieved from <http://www.aihw.gov.au/publication-detail/?id=60129548894>

For most patients at the end of life, the provision of high quality palliative care can alleviate suffering and improve quality of life. However, timely access to such services varies greatly across Australia. Of the approximately 150,000 Australians who currently die each year, more than half will do so in a hospital bed³. A substantial proportion of those deaths are expected and could have been managed in a home setting, where, if given the choice and access to appropriate care, at least 70% of Australians wish to die⁴. Given the demonstrated benefits of palliative care, there has been considerable research seeking to answer the question *how many people need palliative care?* Traditional palliative care estimates have been largely focussed on cancer, but the continuing increase in people living with and dying of chronic conditions has meant clinicians, researchers and policy makers have had to take a much broader approach.

The first notable work in relation to this question, being one of the first studies to consider conditions other than cancer, was undertaken in Australia in 2005⁵, where the determination was made that 37% of those that die would have benefitted from provision of palliative care. This work has since been enhanced by research published in 2014^{6,7} where the estimate increased to a minimum of 63% of all deaths benefitting from palliative care. Palliative Care Australia has estimated that 90% of cancer patients and half of non-cancer patients could benefit from palliative care services⁸. Based on this estimate, approximately 100,000 people who die each year in Australia would require and benefit from palliative care. Many healthcare professionals and patient advocates, regardless of their stance on the emotionally charged issue, hope the recently reignited national debate over physician-assisted suicide will boost awareness and use of palliative care and hospice care⁹.

However, Silver Chain acknowledges that even with increased access to palliative care services, there may still be exceptional instances where individuals do not experience an adequate alleviation of their suffering, and may choose to consider assisted dying.

3 NATIONAL AND INTERNATIONAL FRAMEWORKS

3.1 The Australian context

Currently in Australia, requests for assisted dying are relatively uncommon. Of the approximately 50,000 palliative care patients referred to Australian hospitals annually, less than 1% of those with advanced illness referred have a sustained desire for assisted dying¹⁰.

To date, there have been many attempts to pass legislation around assisted dying. From 16 June 1993 until late 2016, 51 Bills had been introduced into Australian parliaments dealing with legalising assisted dying¹¹. Despite these numerous attempts, until last week the only success in this space had been the *Rights of the Terminally Ill Act 1995* (NT), which was enacted in the Northern Territory, but a short time later overturned by the controversial Euthanasia Laws Act 1997 (Cth).

³ Australian Institute of Health and Welfare (2014). *Risk factors, diseases and deaths: Deaths*. Retrieved from <http://www.aihw.gov.au/deaths/>

⁴ Swerissen, H. and Duckett, S. (2014). *Dying Well*. Grattan Institute.

⁵ Rosenwax, L., McNamara, B., Blackmore, A.M. and Holman, C.D. (2005). Estimating the size of a potential palliative care population. *Journal of Palliative Medicine*, 19 (7), pp. 556-62.

⁶ Murtagh, F.E.M., Bausewein, C., Verne, J., Groeneveld, E.I., Kaloki, Y.E., Higginson, I.J. (2014). How many people need palliative care? A study developing and comparing methods for population-based estimates. *Palliative Medicine*, 28 (1), pp.49-58.

⁷ In this study researchers considered a more detailed categorisation of palliative care–relevant conditions, including dementia and stroke.

⁸ Swerissen, H. and Duckett, S. (2014). *Dying Well*. Grattan Institute. Melbourne, Australia.

⁹ Schencker (2015). Assisted-suicide debate focuses attention on palliative, hospice care. *Modern Healthcare*, Vol. 45 (20), pp 22-5.

¹⁰ Hudson et al. (2015). Legalising physician assisted suicide and/ or euthanasia: Pragmatic implications. *Palliative and Supportive Care*, Vol. 13 (5), pp 1399-1409.

¹¹ Willmott, L., White, B.P., Stackpoole, C., Purser, K. and McGee, A. (2016). (Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics. *University of New South Wales Law Journal*, 39 (1), pp. 1-46.

The *Rights of the Terminally Ill Act 1995* operated between July 1996, and March 1997, allowing for the legal provision of assisted dying for the terminally ill in the NT. During this time, seven patients made formal use of the Act; with four patients dying under the Act¹².

On 20 October 2017, after a lengthy inquiry¹³, the *Voluntary Assisted Dying Bill* passed 47 votes to 37 in Victoria, after a conscience vote. The Bill will now go to the 40-member Upper House for debate in a fortnight. If it successfully passes the Victorian Upper House, the Bill will allow terminally ill people over the age of 18, in severe pain and with only a year to live will be able to access lethal drugs. The Bill has been described as the most conservative assisted dying regime in the world.

A range of key industry stakeholders have developed position statements around assisted dying, which have been summarised under Appendix 1.

3.2 The international context

Assisted dying and euthanasia laws, regulations and practices vary widely from country to country, and across various definitions (see section 4). For example voluntary euthanasia is legal in some countries. Non-voluntary euthanasia is illegal in all countries. Involuntary euthanasia is also illegal in all countries and is usually considered murder. In some countries there is a divisive public controversy over the moral, ethical, and legal issues of euthanasia. Passive euthanasia is legal under some circumstances in many countries. Active euthanasia however is legal or de facto legal in only a handful of countries and is limited to specific circumstances and the approval of medical professionals. In some countries such as Nigeria, Saudi Arabia and Pakistan, support for active euthanasia is almost non-existent.

A summary of the regulations and practices in countries where some form of assisted dying is currently practiced legally has been included under Appendix 2.

4 UNDERSTANDING END OF LIFE PRACTICES

As a provider of palliative care services, Silver Chain has invested time and effort in understanding the various definitions of the multitude of practices that are applied nationally and internationally at the end of life. It is important to understand these definitions and the differences between them in order to provide patients and their families/ carers with the information necessary for them to make informed decisions and choices around their medical treatment and care needs at the end of life.

4.1 Defining and classifying end of life practices

The words “euthanasia”, “assisted suicide” and “assisted dying” are often used interchangeably. However, they are different and, in the law, they are treated differently.

Euthanasia is a deliberate, intentional act of one person to end the life of another person in order to relieve that person’s suffering. The term euthanasia is often used in different ways:

- *Voluntary euthanasia*: Euthanasia is performed at the request of the person whose life is ended, and that person is competent. For example, a doctor injects a competent patient, at their request, with a lethal substance to relieve that person from physical pain.

¹² Kissane, D.W., Street, A. and Nitschke, P. (1998). Seven deaths in Darwin: Case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *The Lancet*, Vol. 352 (9134), pp. 1097-1102.

¹³ Legal and Social Issues Committee (2016). *Inquiry into end of life choices: Final report*. Parliament of Victoria, PP No 174, Session 2014-16.

- *Non-voluntary euthanasia*: Euthanasia is performed and the person is not competent. For example, a doctor injects a patient in a post-coma unresponsive state (sometimes referred to as a persistent vegetative state) with a lethal substance.
- *Involuntary euthanasia*: Euthanasia is performed and the person is competent but has not expressed the wish to die or has expressed a wish that he or she does not die. For example, a doctor injects a competent patient who is in the terminal stage of a terminal illness such as cancer with a lethal substance without that person's request.
- *Active euthanasia*: Involves taking deliberate steps, often entailing the use of lethal substances or forces such as administering a lethal injection, to end a patient's life.
- *Passive euthanasia*: Occurs when a patient's death is brought about by an omission – when treatments necessary for the continuance of life are withheld or withdrawn.
- *Indirect euthanasia*: Providing treatment (usually to reduce pain) that has the side effect of speeding the patient's death. A justification along these lines is formally called the doctrine of double effect.

Assisted suicide is any act that intentionally helps another person kill themselves, for example by providing them with the means to do so, most commonly by prescribing a lethal medication.

Physician-assisted suicide occurs where a person requests a doctor to assist them in committing suicide, for example, a doctor provides a person with a prescription to obtain a lethal dose of drugs.

Assisted dying is a term usually used in the US and the UK to mean assisted suicide for the terminally ill only. *Voluntary assisted dying* is the language adopted by the Victorian Government, and is generally taken to mean voluntary assisted suicide, for the terminally ill only, and has been adopted by Silver Chain for the purpose of this submission.

Related concepts include:

- *Terminal sedation*: This refers to the practice of sedating a terminally ill competent patient to the point of unconsciousness, then allowing the patient to die of her disease, starvation, or dehydration.
- *Withholding/withdrawing life-sustaining treatments*: When a competent patient makes an informed decision to refuse life-sustaining treatment, there is virtual unanimity in state law and in the medical profession that this wish should be respected.
- *Pain medication that may hasten death*: Often a terminally ill, suffering patient may require dosages of pain medication that impair respiration or have other effects that may hasten death. It is generally held by most professional societies, and supported in court decisions, that this is justifiable so long as the primary intent is to relieve suffering.

Interventions such as terminal sedation and treatment withdrawal may be used in the delivery of palliative care, with the informed consent of patients, meaning the line between voluntary assisted dying and palliative care can become blurred. It is therefore important to clarify that the aim of palliative care differs significantly from that of voluntary assisted dying:

- *Palliative care* aims to improve the quality of life of patients with life-threatening illness through the prevention and alleviation of suffering through the identification and treatment of pain and other physical, emotional, social and spiritual concerns. Palliative care also encompasses the provision of support for patients' family and carers.

4.2 Assisted dying and palliative care

As a provider of palliative care services, Silver Chain is well aware of the divergent views within the health sector and the broader community around the relationship between assisted dying and palliative care, and whether the two concepts should be closely linked, or held as distinct and separate. Arguments in favour of including assisted dying within a palliative care context include:

- With regard to the role of palliative care providers in decision making around assisted dying, it is illogical that physicians can hold a position of complete non-involvement. Palliative care patients commonly wish to discuss options for end-of-life care, which means palliative care providers become a key source of information about the law¹⁴.
- There is evidence from other countries to suggest that assisted dying would not be seen as an alternative to palliative care. For example, societal debates in Belgium were intense before assisted dying legislation was passed in 2002, however advocates always supported palliative care and never presented assisted dying as an alternative¹⁵. The Belgian model ensured that from the beginning, there were shared staff and connections between palliative care and assisted dying, allowing the two practices to co-exist.
- The model described above was largely emulated in Quebec, Canada¹⁶. In Belgium, there were few professional stances suggesting that palliative care and the allowing of legalisation legalising assisted dying was antagonistic, and therefore no evidence base for the concern that the drive to legalise assisted dying would interfere with the development of palliative care services in the country¹⁷.
- Furthermore, a substantial proportion of Belgian caregivers seem to consider assisted dying as a medical act, which is in line with their commitment to palliative care. In 2003, the Federation of Palliative Care Flanders (FPCF) officially embraced assisted dying as an option within palliative care. The FPCF stated that “*palliative care and [assisted dying] are neither alternatives nor antagonistic [...] [Assisted dying] may [...] be part of palliative care [...]. Caregivers are fully entitled to ethical limitations, but they must be expected to state these limitations candidly, clearly and above all in due time*”¹⁸.
- The rejection of assisted dying by palliative care groups has serious practical consequences to palliative care practice. “*If [assisted dying] is excluded from palliative care and carried out only in settings that are less competent for end of life care, patients who desire the possibility of [assisted dying] will tend to shun professional palliative care and hence may not receive optimal end of life care*”¹⁹.
- In Australia and many other countries, the overwhelming majority of patients with a life-threatening illness are not seen by specialist palliative care physicians²⁰. Studies indicate that Oregon's *Death with Dignity Act* has led to improvements in palliative and hospice care. In a 2001 paper, 30% of Oregon doctors who responded to a 1999 survey said they had increased the number of patients they referred to hospice after voters approved the legislation²¹.

¹⁴ Belanger et al. (2016). G01-B A Qualitative Study of Palliative Care Physicians' Roles in Decision Making About Euthanasia. *Journal of Pain and Symptom Management*. Vol 52 (6) pp e56.

¹⁵ Bernheim et al. (2008, April 19). Development of Palliative care and legalisation of euthanasia: antagonism or synergy? *British Medical Journal*. Vol 336, pp 864-867.

¹⁶ Ibid

¹⁷ Ibid

¹⁸ Bernheim et al. (2017). Casting Light on an Occultation in the IAHPCC Position Paper on Palliative Care and Assisted Dying”. *Journal of Palliative Medicine*, Vol 20 (2017), pp 1- 2.

¹⁹ Ibid

²⁰ Hudson et al. (2015). Legalising physician assisted suicide and/ or euthanasia: Pragmatic implications. *Palliative and Supportive Care*. Vol 13 (5), pp 1399-1409.

²¹ Schencker (2015) Assisted-suicide debate focuses attention on palliative, hospice care. *Modern Healthcare*. Vol 45 (20), pp 22-25.

- In the Netherlands, assisted dying legislation strongly boosted the development of palliative care²².

Arguments against the inclusion of assisted dying within palliative care include:

- Many patients and families are already reluctant to involve palliative care in their treatment out of the mistaken fear of what that means^{23,24}. Fernandes²⁵ and De Lima et al²⁶ comment that allowing an exception to society's long-standing prohibitions against assisted dying or directly causing another's death is immoral and would severely erode trust in clinicians.
- The World Health Organisation definition of palliative care regards dying as a normal process and emphasises that palliative care never intends to hasten nor postpone death, going on to say that assisted dying is in direct conflict with this definition²⁷.
- The International Association for Hospice and Palliative Care (IAHPC) endorsed the majority position on assisted dying, stating that it is doctrinally incompatible with the very foundations of palliative care²⁸. As cited in De Lima et al²⁹, *"The IAHPC believes that practices of [assisted dying] violate the bond of trust within the profession of medicine, which is essential to the physician patient relationship. In states and countries where [assisted dying is] legal, the IAHPC agrees that palliative care units should not be responsible for overseeing or administering these practices as doing so would place the professionals, their staff and, in some cases their patients and families, in untenable positions. [...] Palliative Care Australia, states that euthanasia and assisted suicide should not be part of palliative care practice and that 'palliative care physicians should not be gatekeepers in accessing this service. A separate approval, monitoring, and oversight body or organisation is required and should be put in place"*
- Other countries have followed with the same idea. *"In the Netherlands assistance for "self-chosen death of the elderly" is provided by counsellors, removing it from the medical domain because it is an existential problem... In Oregon... assisted dying need not be physician assisted, thereby freeing doctors to focus on high quality palliative care³⁰"*.
- In the Australian context, the society representing doctors working in palliative care has recently moved from a position of silence on the issue of legalisation, to one of opposition. In addition, a 2016 review³¹ identified that a number of palliative care groups have deliberately distanced themselves from the issue in the stance known as 'studied neutrality.'

²² Berheim et al. (2017). Casting Light on an Occulations in the IAHPC Position Paper on Palliative Care and Assisted Dying". *Journal of Palliative Medicine*, Vol 20 (2017), pp 1- 2.

²³ Herx (2015). Commentary: Physician-assisted death is not palliative care. *Current Oncology*. Vol 22 (2), pp 82-83

²⁴ Hudson et al. (2015). Legalising physician assisted suicide and/ or euthanasia: Pragmatic implications. *Palliative and Supportive Care*. Vol 13 (5), pp 1399-1409.

²⁵ Fernandes (2015). Assisted dying is a threat to the ethics of palliative nursing. *International Journal of Palliative Nursing*. Vol 21 (9), pp 421-422.

²⁶ De Lima, et al. (2017). International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician Assisted Suicide. *Journal of Palliative Medicine*. Vol 20 (1), pp 8-14.

²⁷ Ibid

²⁸ Berheim et al. (2017). Casting Light on an Occulations in the IAHPC Position Paper on Palliative Care and Assisted Dying". *Journal of Palliative Medicine*, Vol 20 (2017), pp 1- 2.

²⁹ De Lima, et al. (2017). International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician Assisted Suicide. *Journal of Palliative Medicine*. Vol 20 (1), pp 8-14.

³⁰ Hudson et al. (2015). Legalising physician assisted suicide and/ or euthanasia: Pragmatic implications. *Palliative and Supportive Care*. Vol 13 (5), pp 1399-1409.

³¹ Sheahan (2016). Exploring the interface between 'physician assisted death' and palliative care: cross sectional data from Australasian palliative care specialists. *Internal Medicine Journal*. Vol 46 (6), pp 443-51.

- Some evidence points to the notion that palliative care specialists in Australasia are largely opposed to legalisation of assisted dying, particularly physician assisted dying³². *“Professional ethical codes for physicians have clarified that ending life is not part of the tasks of a physician. The AMA states assisted dying is fundamentally incompatible with the physician’s role as a healer, and would be difficult or impossible to control, and would pose serious societal risks^{33”}.*

5 SILVER CHAIN’S POSITION

In May 2017, Silver Chain held a workshop with key internal stakeholders as a step towards clarifying the organisation’s position around assisted dying. As a provider of palliative care services, Silver Chain has provided terminal sedation and has withheld/ withdrew life-sustaining treatments. Both interventions only occur with the informed consent of a competent patient. However, the organisation has agreed to make a distinction between these interventions and providing the means for an individual to end their own life, for example, the provision of a prescription for a lethal medication. Based on this agreement, and the views of Silver Chain staff and stakeholders, if laws in relation to voluntary assisted dying were to be passed in a State in which the organisation operates, the organisation would not seek to become a provider of voluntary assisted dying services. If a Silver Chain client was to request such a service, the organisation would provide advice and provide a referral to a provider of such services. The logistical implications of this position would largely be determined by the legislative scope of any State Bill or Act.

However, the organisation is committed to supporting patient choice, and recognises assisted dying as a legitimate option for those nearing end of life where supporting legislation exists. Therefore, Silver Chain would offer its end of life care and support to all individuals, as well as providing bereavement services to their families and carers, regardless of how they may choose to live out their last days of life.

Silver Chain will continue to strongly advocate for access to quality palliative care for all people nearing the end of their life, again irrespective of their position on assisted dying. The organisation would value the opportunity to be an active participant in future conversations and debate around end of life choices, and will actively support the efforts of State, Territory and Federal Governments to improve end of life care for all Australians through:

- Increased community-based palliative care services, to enable more people who wish to die at home to do so.
- Better resourcing of end-of-life care in residential aged care, so that its quality aligns with that available to other Australians.
- Increased funding for palliative care education and support. This includes additional palliative care specialist trainee positions, and enhanced remuneration for general practitioners and nurses involved in community palliative care.

³² Ibid

³³ De Lima, et al. (2017). International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician Assisted Suicide. *Journal of Palliative Medicine*. Vol 20 (1), pp 8-14.

APPENDIX 1: INDUSTRY STAKEHOLDER POSITIONS ON ASSISTED DYING

The Australian and New Zealand Society of Palliative Medicine (ANZSPM)

- The Palliative Medicine discipline does not include the practice of euthanasia or assisted suicide.
- Euthanasia is not; withholding or withdrawing treatments that are not benefitting the patient, treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, or palliative sedation for the management of refractory symptoms.
- ANZSPM endorses the World Medical Association Resolution on Euthanasia, which states that "... euthanasia is in conflict with basic ethical principles of medical practice."
- ANZSPM opposes the legalisation of both euthanasia and assisted suicide.

Palliative Care Australia (PCA)

- Euthanasia and physician assisted suicide are not part of palliative care practice.
- Declining or withdrawing aspects of treatment is acceptable if it aligns with the informed wishes of the patient. This does not constitute euthanasia or physician assisted suicide.

Australian Medical Association (AMA)

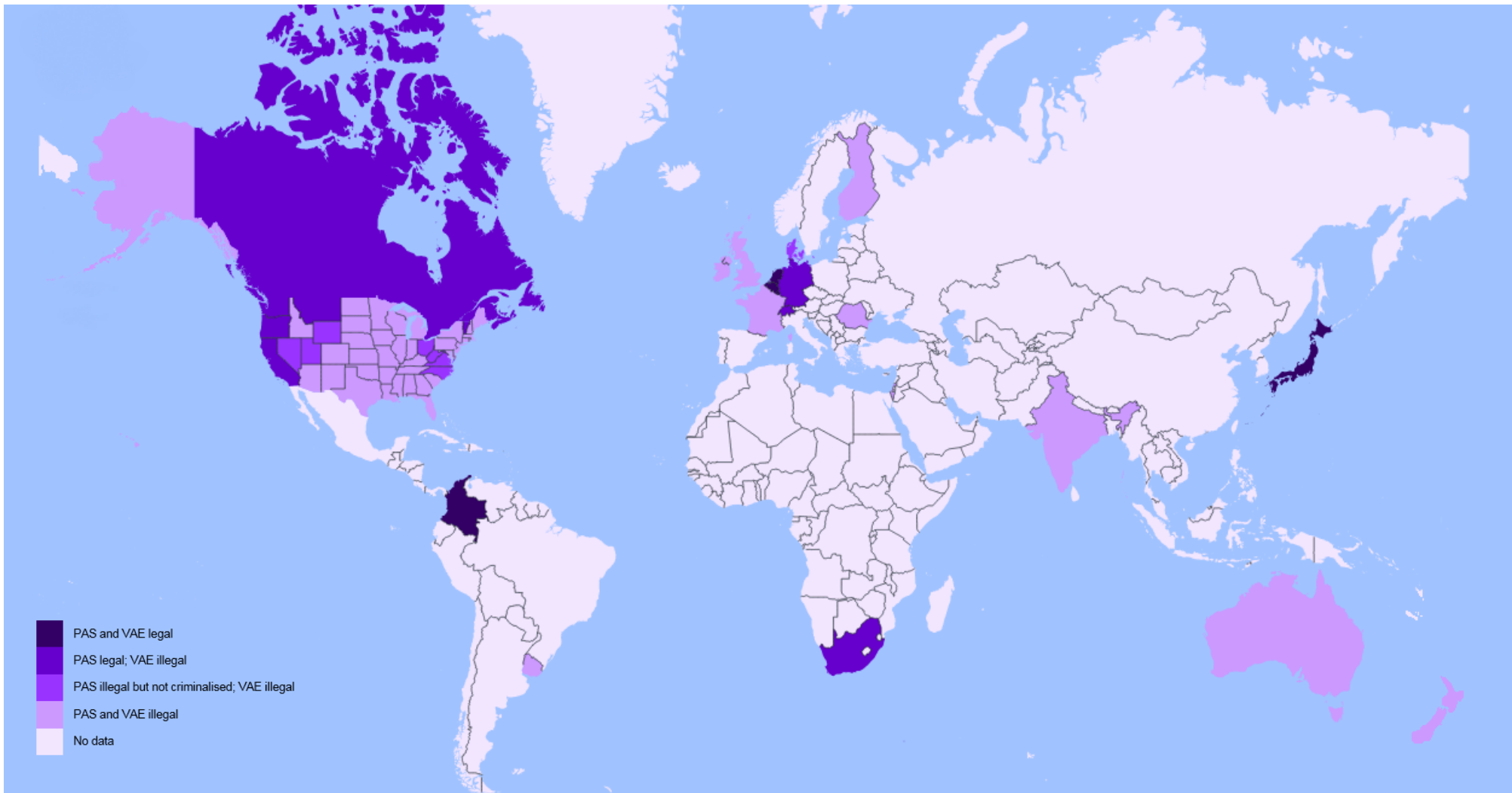
- Doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.
- If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

- The need for psychiatric assessment and treatment should be considered for patients who request physician-assisted suicide of their doctors.
- A body must be established to provide support for doctors assisting terminally ill adults to die
- Medical practitioners are able to abstain from providing services or advice.

The Royal Australasian College of Physicians (RACP) and the Royal Australasian College of General Practitioners (RACGP) currently do not have a formal position on euthanasia or assisted suicide.

APPENDIX 2: INTERNATIONAL ASSISTED DYING REGULATIONS



COUNTRY	LEGALISATION PROCESS	CONDITIONS	STATISTICS
Physician assisted suicide (PAS) and voluntary assisted euthanasia (VAE) legal			
Belgium	The Belgian Parliament legalised VAE in 2002 and extended the law to include terminally ill children in 2014.	Patients must experience constant and unbearable suffering, either mental or physical, their condition must be incurable and they must make their request in writing. For children, patients must be conscious of their decision and understand the meaning of euthanasia must have the approval of their parents.	Between 2007 and 2014, the rate of euthanasia in Belgium increased from 1.9 to 4.6% of deaths. This relates to increases in both the number of requests (from 3.5 to 6.0% of deaths) and the proportion of requests granted (from 56.3 to 76.8% of requests made) ³⁴ .
Colombia	Colombia's Constitutional Court ruled in 1997 that physicians cannot be criminally liable for VAE involving terminally ill patients. The ruling was delayed until guidelines were approved by the Colombian Congress in 2015.	Patients cannot be minors and must have a terminal illness and be competent. If they are unconscious family members or proxies must present audio, video, or written proof of desire for VAE.	
Japan	The Japanese government has no official legislation on PAS or VAE. However, two local court cases in 1962 and 1995 have provided a legal framework and a set of conditions for their legality (though both cases found that the physicians violated those conditions).	Patients must be terminal and suffering from unbearable physical pain that cannot be controlled by other measures.	
Luxembourg	Luxembourg's parliament adopted legislation in 2009 approving PAS and VAE by a vote of 30 to 26.	Competent patients suffering unbearable physical or psychological pain with no prospect of improvement have, upon written request (possibly by proxy), the option of voluntary active euthanasia after receiving the approval of two doctors and a panel of experts. No nationality requirements are attached to the law.	Between January 2013 and December 2014, 15 people were euthanised in Luxembourg, with the majority of deaths occurring in hospital. Three patients died at their residential care facility, and one person died at home.

³⁴ Chambaere, K., Vander Stichele, R., Mortier, F., Cohen, J. and Deliens, L. (2015). Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium. *The New England Journal of Medicine*, 372, pp. 1179-1181

COUNTRY	LEGALISATION PROCESS	CONDITIONS	STATISTICS
Netherlands	Dutch legislation, the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", in 2002 legalized PAS and VAE. More detail can be found here . Specific guidelines cover euthanasia and infants .	Patients must reside in the Netherlands. Requests must be voluntary, their suffering must be lasting and unbearable, they must be aware of their prospects and have no other reasonable solution, and they must receive consultation of at least two physicians. Minors may request euthanasia at 12, but require parental consent until 16, when parental involvement, but not necessarily consent is required.	Around 5,500 deaths, 3.7% of all deaths, in the Netherlands in 2015 were due to euthanasia ³⁵ . This figure represents an increase of 4% of deaths due to euthanasia compared to 2014.
PAS legal; VAE illegal			
Canada	The Canadian Supreme Court ruled in Carter v. Canada, 2015, that the criminal code prohibiting assistance in death violated the Canadian Charter of Rights and Freedoms.	The government is in the process of crafting and passing legislature to codify regulations. Each province is developing guidelines, which overlap around the supreme court ruling which requires that patients are competent, with a medical condition that causes intolerable enduring suffering.	During 2015-2015, there were 970 medically assisted deaths in Canada. Between June-December 2016, medically assisted deaths accounted for less than 0.6% of all deaths in Canada ³⁶ .
Germany	Germany's legislature passed a bill in 2015 permitting some types of assisted suicide.	Assistance must be provided out of altruistic motives and not conducted on a business basis, but there is not a comprehensive legal framework. Assisted suicide is legal as long as the lethal drug is taken without any help, such as someone guiding or supporting the patient's hand.	
Switzerland	Switzerland's Criminal Code, in effect since 1942, legislatively permits assisted suicide via Article 115.	The law does not require that a physician be involved or that one be a Swiss national. The law requires that one's motives in assistance not be selfish. Switzerland has tolerated the creation of organisations such as Dignitas and Exit, which provide assisted dying services for a fee.	In 2014, the Swiss Federal Statistical Office recorded 742 cases of euthanasia for persons residing in Switzerland. This corresponds to 1.2% of all deaths. Compared to the previous year, it is 26% more, and has been increasing steadily since 2008 ³⁷ .

³⁵ Government of The Netherlands: Regional Euthanasia Review Committees. (2016). *Annual Report 2015*. Retrieved from <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>

³⁶ Government of Canada (2017). *Interim update on medical assistance in dying in Canada June 17 to December 31, 2016*. Retrieved from <https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html>

³⁷ Government of Switzerland: Federal Statistical Office (2016). *Cause of death statistics 2014 - Assisted suicide (suicide) and suicide in Switzerland*. Retrieved from <https://www.bfs.admin.ch/bfs/en/home/statistics/catalogues-databases/publications.assetdetail.1257-1400.html>

COUNTRY	LEGALISATION PROCESS	CONDITIONS	STATISTICS
South Africa	In a 2015 legal case, Pretoria's High Court ruled in favour of doctor assistance to end life. The decision is being appealed and a new ruling could reverse the status of physician assisted suicide in South Africa.		
U.S: California	The California legislature, in an "extraordinary session" called by the Governor, introduced The "End of Life Option Act" in 2015. It was signed into law by Gov. Jerry Brown and is in effect as of June 9th, 2016. See the California Medical Association's guidelines .	Patients must be California residents 18 or older. They must have decisional capacity and a terminal disease with 6 months or less to live, agreed upon by two doctors. They must make two verbal requests at least 15 days apart and a written request witnessed by two adults and be able to self-administer prescribed drugs.	
U.S: Colorado	Colorado voters approved Proposition 106 that authorizes the medical practice of aid in dying.	Patients must be an adult, a Colorado resident; terminally ill with six months or less to live; mentally capable of making their own healthcare decisions; fully informed of all care options, including pain management and palliative care, and be able to take the medication themselves. Two physicians must determine the person has condition impairing their ability to make decisions and is free from undue influence or coercion, and must offer the person multiple opportunities to take back the request for aid in dying medication.	
U.S: Montana	The Montana Supreme Court ruled in <i>Baxter v. Montana</i> in 2009 that nothing in the state law prohibited doctors from honouring a terminally ill patient's request to prescribe medication to hasten the patient's death.	Because this was a Supreme Court ruling, Montana does not have a regulatory framework. The ruling does shield physicians prescribing lethal medication for terminally ill, mentally competent patients that have requested it in writing.	
U.S: Oregon	Oregon voters approved the "Death with Dignity Act" (DWDA) in 1994. It survived a ballot initiative challenge in 1997 to come into law, as well as other challenges through legislation, congress, and federal courts. Read the act's requirements .	Patients must be Oregon residents 18 or older. They must have decisional capacity and a terminal disease with six months or less to live, agreed upon by two doctors. They must make two verbal requests at least 15 days apart and a written request witnessed by two adults, and be able to self-administer prescribed drugs. Prescribing physicians must inform patients of alternatives and request that patients notify next of kin.	In Oregon in 2015, there were 35,598 deaths. Of these deaths, 132, or 0.39%, were reported as physician-assisted suicide ³⁸ . Between 1997 – 2015, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications ³⁹ .

³⁸ Emanuel E.J., Onwuteaka-Philipsen B.D., Urwin J.W. and Cohen J. (2016). Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *The Journal of the American Medical Association*, 216 (1), pp. 79-70.

³⁹ Oregon Public Health Division (2016). Oregon Death with Dignity Act: 2015 Data Summary. Retrieved from <http://www.worldrtd.net/sites/default/files/newsfiles/Oregon%20report%202015.pdf>

COUNTRY	LEGALISATION PROCESS	CONDITIONS	STATISTICS
U.S: Vermont	The Vermont legislature passed "The Vermont Patient Choice and Control at the End of Life Act" in 2013 and the law went in to effect immediately.	As above.	Between May 2013 and May 2016, physician reporting forms have been completed for 24 people, according to the Department of Health
U.S: Washington	Washington voters approved the "Washington Death with Dignity Act" in 2008, which went into effect in 2009.	Patients must be Washington residents 18 or older. They must have decisional capacity and a terminal disease with 6 months or less to live, agreed upon by two doctors. They must make two verbal requests at least 15 days apart and a written request witnessed by two adults, and be able to self-administer prescribed drugs.	In Washington in 2015 there were 166 reported cases of physician-assisted suicide (equating to 0.32% of all deaths in Washington in that year) ⁴⁰ .

⁴⁰ Washington State Department of Health (2016). 2015 Death with Dignity Act Report: Executive Summary. Retrieved from <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>