SUBMISSION TO
THE WA INQUIRY INTO END OF LIFE
CHOICES

OCTOBER 2017
1. INTRODUCTION

- DwDTas is a separate organisation from Dying with Dignity WA (DWDWA). We have a close relationship through the national group of organisations, Your Last Right, with very similar purposes and objectives, but the views expressed in this submission are those of DwDTas alone.

- We expect that DWDWA and other individuals and organisations in WA will argue effectively the principles and the reasons for voluntary assisted dying legislation generally and will present to the Committee commonly available information and views, including on the most appropriate legislation for WA. Our aim is to provide information that may not otherwise be available to the Committee. The submission is relatively brief and we are happy to provide additional details on any matter.

- Like DWDWA, DwDTas is strongly committed to better end of life law and services to respond to the changes in medicine and society generally and that 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.

- Our submission focusses largely on Tasmanian voluntary assisted dying law reform, including the Tasmanian Voluntary Assisted Dying Bill 2016. We contributed to the large body of research that was undertaken to develop the first Bill in 2013 and the amendments to that Bill for the 2016 version. They are closest to the Canadian approach reflected in the judgement of the Canadian Supreme Court in February 2015 (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) and the principles based approach recommendations of the Canadian Medical Association (https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-dec-2015.pdf). The approach is as safe, if not safer, and more effective than the US model (eg Oregon) in providing a compassionate and workable voluntary assisted dying system in the Tasmanian environment.

- We have found that, when subjected to careful scrutiny - which we expect the Committee will provide - many of the opinions and claims made against voluntary assisted dying legislation have no basis in acceptable community attitudes to people at the end of their lives with terrible suffering and their wish to make decisions about their own lives in accordance with their own values. They also have no basis in facts and credible evidence, or plausible assumptions and arguments. What is missing from the claims and arguments is critically relevant and as important as what is there. We respect the right of everyone to their opinion on this issue and the right to express those views. However, good policy, as reflected in legislation, requires a high standard of information and analysis, including risk assessment and management.
2. DWDTAS INVOLVEMENT

- DwDTas has significant knowledge and understanding of the issues and a very extensive research database developed from our involvement over many 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 Tasmania¹*, and the resulting Bill, the *Voluntary Assisted Dying Bill 2013²*.

- DwDTas was very involved in these processes through representation of DwDTas by our President on the expert panel consulted on the 2013 Proposal and Bill. Margaret Sing was intensively involved in a personal capacity³ 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 do so for a Bill which will be introduced in the new Parliament after the next State election, due before March 2018.

3. TASMANIAN VOLUNTARY ASSISTED DYING BILL 2016

- 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 the most recent Bills:

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<th>SA (17 Nov 16)</th>
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<td>Third Reading</td>
<td>Second Reading</td>
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<td>No for</td>
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* Includes 2 Liberal MPs who abstained.

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

• **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.

• **In-depth research and comparisons:** An extensive amount of research and analysis and consultation was done for the development of the Tasmanian Bills. Our website includes a great deal of information particularly on the Canadian situation which we have found to be most relevant to the Australian situation because of our historical, cultural, medical and legal system similarities. An attachment provides a detailed comparison of the Tasmanian Bill with key overseas legislation and what was recommended in the Victorian inquiry into end of life choices. The comparison will be updated when debate on the Victorian Voluntary Assisted Dying Bill is finalised in the Legislative Council.

• **Principal aim of the Bill:** The principal aim of the Bill was 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 needed to be at the end of lives that would ever 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).

### 4. OBSERVATIONS

• We have been very disappointed in the standard of evidence and arguments about this issue in representations against voluntary assisted dying legislation both in Tasmania and elsewhere and in debates. We respect the right of everyone to their opinion on this issue and the right to express those opinions, but the soundness of the basis for those opinions varies even between those with high level qualifications and experience and between those with particular perspectives, eg people with disabilities.

• There are claims and arguments that cannot be regarded by the Committee as reliable or valid for its considerations because they fail to demonstrate sufficient knowledge and understanding of existing international legislation and legal practices and possible Australian law reform and instead promote inaccurate and distorted perceptions. There is also a lack of evidence that sufficient efforts have been made to gain better knowledge and to check facts and claims. This results in most claims and arguments against voluntary assisted dying promoting irrational fears based on inaccurate, out of date, distorted, illogical and unreasonable material that has little or no basis in reputable, quality evidence.
or soundly based considerations. Inaccuracies and distortions also occur because of major omissions of critically relevant data.

- We recommend a thorough fact check on representations because in our experience many inaccurate claims are made, and continue to be repeated even when they have been comprehensively refuted by thorough recent reviews, such as the Victorian inquiry into end of life choices and the many reviews overseas. (See our website for information.) We understand that very few people have any need to, or interest in, developing in-depth knowledge and understanding about voluntary assisted dying law reform. What we find disturbing, however, and important for the Committee to consider, is that many submissions have been made to all other inquiries, even by highly qualified and experienced individuals and organisations, that fail to demonstrate there has been attention to developing at least basic knowledge and understanding before commenting on these matters in a submission to a Parliamentary inquiry. There is also no acknowledgement of how limited their research has been, or the limited, if any, checking that has been done of the accuracy, reliability and validity of claims that have been taken from sources which they know or ought reasonably to know are not reliable (eg newspaper articles) or biased (eg only citing well-known opponents with known affiliations to particular religions or religious positions, such as Catholic websites such as the Anscombe Bioethics Centre and the European Institute of Bioethics).

- We believe that it is, at best, disrespectful of the Committee and the Parliamentary process and at worst, a deliberate attempt to mislead. Regardless of the intention of those making submissions, the worst outcome would be that the Committee is misled, and in turn, inadvertently, misleads your Parliamentary colleagues and the public by relying on poor material.

- These are key omissions and inconsistencies which we have noted and expect the Committee will confirm in the WA Inquiry:
  - In submissions and arguments opposed to voluntary assisted dying legislation, and in proposals for alternative approaches, there is an almost total absence of acknowledgement of the people that are at the end of their lives with intolerable and unrelievable suffering and an almost total absence of expressions of empathy and compassion. We find it unacceptable, and believe the Committee should also find it unacceptable, especially in submissions from Christian and medical individuals and organisations.
  - There is also a total absence of evidence of respect for self-determination and patient autonomy for people needing and wanting assisted dying and absence of respect for the principle of freedom of religion and belief. Particular religious beliefs are asserted as if they alone should prevail and be privileged in legislation, patient autonomy is treated as an optional extra and the benefits and disadvantages for the patient are as determined by someone other than the patient. The attitude seems to be ‘I know what’s best for you, even if I’ve never met you’.
  - There are also unacceptable attitudes expressed about people in particular groups who are labelled ‘vulnerable’. The attitudes are based on inaccurate, crude, demeaning, outdated and discriminatory stereotypes and the people are treated as if they are incapable of independent, competent decision-making and unlikely to choose assisted
dying unless coerced, manipulated or abused by families and doctors. This includes people who are elderly, have disabilities and are mentally ill.

➢ It is disappointing that there is little if any attention to the limits of palliative care to relieve all suffering and to the limits on the extent to which people’s wishes can be met as evidenced by the excellent national data through the Palliative Care Outcomes Collaboration project (University of Wollongong) (http://www.pcoc.org.au/). We also recommend to the Committee papers by Professor Michael Ashby, head of palliative care in Tasmania, who is supportive of voluntary assisted dying law reform, eg “The way we die: a view from palliative care” (http://www.austlii.edu.au/au/journals/QUTLawRw/2016/2.pdf)

➢ There is strong support and respect for people to protect their wishes and take responsibility for themselves through advance care directives that only come into operation when someone is no longer competent to express their wishes. But in many representations against VAD law reform there is no corresponding support and respect for competent people to take the same steps and responsibility if they are faced with the terrible situation when doctors and palliative care have run out of options to relieve their suffering.

➢ Assertions are often made without any basis in evidence or reasoned arguments and in numerous cases are contrary to the evidence that is available and reasonable assumptions, ie “it’s true because I say it is”. For example, the opinion is often expressed that doctors will no longer be trusted and the doctor/patient relationships will be adversely affected, even poisoned, if voluntary assisted dying is legalized. Not only is there no evidence of that happening after decades of carefully and thoroughly scrutinised assisted dying practice, there is also evidence to the contrary. For example, a European survey in 2008 by GfK research found that 91% of respondents trusted doctors in the Netherlands, the highest in Europe with Sweden. Belgium was not far behind with 88% of respondents trusting doctors. This compared to 82% in the UK.

➢ One of the most disturbing fallacies is that doctors don’t support voluntary assisted dying legislation. Yet the AMA survey of its members in 2016 found that: “More than half of respondents (52%) believe euthanasia can form a legitimate part of medical care and 45% believe the same for physician assisted suicide (Survey Questions 11 and 20)”. (From the AMA report: “Review of AMA Policy on Euthanasia and Physician Assisted Suicide: Member Consultation Report”. This is obtainable from the AMA on request.)

CONCLUSION

We believe the primary questions for the inquiry to address are:

1. Do you accept that:
   (a) there are people who have intolerable and unrelievable suffering as a result of incurable and irreversible medical conditions;
   (b) their doctors run out of options to improve their conditions and relieve their suffering adequately and to the satisfaction of the people concerned;
   (c) some of these people and their doctors accept that the only way their suffering is going
to be ended is through death;

(d) some of these people make competent, well-informed, voluntary requests for active intervention to achieve this end of suffering at a time and in a way which provides them with a better death than is otherwise available; and

(e) there are doctors who support this intervention and are prepared to provide assistance through lethal drugs?

2. How, as a community, can we respond with empathy, compassion and respect to the needs of people in this situation?

We believe the only acceptable response is the provision of an additional option, of doctor-provided voluntary assisted dying, within a regulated and monitored system that puts the needs of people with profound suffering at the heart of all considerations of requirements and processes.

END NOTES


3 Margaret Sing is a former senior public servant with over 30 years’ experience in policy and legislation development, implementation, management, review and assessment. This has been in a wide range of policy areas and in different capacities including senior public sector policy and management, Head of a Ministerial Office, member and Chair of bodies including the Local Government Board, member of the Social Security Appeals Tribunal and community lobby groups.
TASMANIAN VOLUNTARY ASSISTED DYING BILL 2016 – SUMMARY

BACKGROUND

- The Tasmanian Voluntary Assisted Dying Bill 2016 was moved in the House of Assembly on 17 November as a Private Member’s Bill. It will be debated sometime after Parliament sits again in March 2017. The Bill is available on the Tasmanian Parliament website.

- The co-sponsors of the Bill are Lara Giddings, former Premier and now MP for Franklin, and Cassy O’Connor, Leader of the Greens and MP for Denison. The Bill does not yet have a Liberal sponsor but we are hopeful there will be one before the debate.

- Last time a similar Bill was debated in October 2013, it was defeated at the Second Reading stage and was not debated in detail. It was supported by 12 MPs and voted against by 13. There are 9 new MPs since 2013.

- The new Bill has been based on a thorough reconsideration of the 2013 Bill in the light of comments at the time and information and evidence since then, including from Victoria, South Australia and Canada. (See Issues Paper 1, VAD – The Basics.) The requirements and processes are closest to the detailed proposal of the Canadian Medical Association in its policy document, “Principles-based Recommendations for a Canadian Approach to Assisted Dying”, based on the Canadian Supreme Court decision in Carter vs Canada.

- Because of its aims and provisions, the Bill is also consistent with the new policy of the Australian Medical Association (AMA) on what it calls “euthanasia and physician-assisted suicide”, particularly its focus on good quality end of life care, the right of all dying patients to receive relief from pain and suffering, even where this may shorten their life, and support for patients’ requests for assisted dying to be fully explored by doctors whose primary intention is to relieve suffering.

AIMS

- The principal aim of the Bill is to provide a last resort option for seriously ill competent adults and their doctors to end intolerable and unrelievable suffering through assisted deaths. The other aims are to prevent desperate suicides with devastating consequences; to provide comfort which can have a palliative effect when people know there may be an option for them if they end up with intolerable and unrelievable suffering and have no chance of recovery or relief; and to protect doctors, families and others from the risk and considerable fear of prosecutions for acts of compassion and kindness that may be regarded as criminal acts.

- The Bill establishes a doctor-safeguarded system of assisted dying, which is also safeguarded through an independent Registrar with significant powers and responsibilities to monitor and review all assisted deaths and report to Parliament annually.
KEY DETAILS

- **Eligibility:** as required in Section 10, a person eligible for an assisted death has to be an adult (18 or over), a Tasmanian resident and making requests voluntarily. The person has to be competent and have an eligible medical condition.

- **Informed decision:** The person must make an informed decision (S9(c)) to end their life and S12 sets out detailed requirements about the information to be provided by the primary medical practitioner.

- **Competent and voluntary:** Competent is defined in S3. The person must be able to make and communicate an informed decision and not be suffering from a mental condition that may cause their judgement to be impaired. In accordance with S14(2), if the primary medical practitioner reasonably suspects the person is not competent or is not making the request voluntarily, he/she must refer the person to a psychiatrist or psychologist for counselling and report to the primary doctor.

- **Eligible medical condition:** Under Section 11, the person:
  
  - has to be in 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
  
  - experiencing persistent suffering that is intolerable for the person as a result of their medical condition, or associated medical treatment, or complications resulting from them; and
  
  - there is no reasonably available medical treatment or palliative care options that would relieve the person’s suffering in a manner that is acceptable to them, taking into account both the treatment and any consequences of the treatment; and
  
  - must have no reasonable prospect of a permanent improvement in the medical condition.

- **Last resort:** At the time of the third request (S22), the primary medical practitioner and the person must agree they are satisfied that there are no relevant treatment options that will improve the person’s medical condition or relieve their suffering satisfactorily.

- **Three requests:** The person must initiate three requests, including an initial oral request (S13); a written request (S17) that must be witnessed by two witnesses that meet specified requirements; and a subsequent oral request. There must be 2 days between the first two, and at least 7 between the second two. There is provision for interpreters and signing by others under the direction of the person.

- **Doctors:** At least two registered medical practitioners, independent of each other, are voluntarily involved in the process. Their responsibilities at each stage of the process are specified in detail, including the safe control of the prescribed drugs and being present when they are administered.

- **Administration of the lethal drugs:** The person may self-administer through oral ingestion or activation of a medical device, or the primary medical practitioner may administer the drugs.

- **Monitoring, review, education and reporting:** Part 4 of the Bill covers the appointment of a Registrar and staff, functions and powers, reporting requirements and annual report to Parliament.

- **Immunities and offences:** The Bill includes details of immunities and liabilities in Part 3 and offences in Part 5.

Please consult the Bill for exact wording. More information will be contained in future DwDTas material or we can be contacted if you have specific questions.
All regulatory frameworks for doctor-provided voluntary assisted dying are working safely, regardless of the differences

As the Victorian inquiry and all other recent thorough reviews have shown, all the regulatory frameworks for doctor-provided voluntary assisted dying are 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.

Importance of establishing a framework that suits the culture and values 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, in different societies. The Victorian report makes the critically important point that “these 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) and “an assisted dying framework must reflect the values and culture unique to a particular jurisdiction. Certain elements of each framework are effective precisely because they reflect this uniqueness” (p217). [Our emphases] The Committee concluded that “any Victorian response must also be tailored to best fit with Victorian culture and values” (p210).

NEW TASMANIAN VOLUNTARY ASSISTED DYING BILL 2016

The new Tasmanian Voluntary Assisted Dying Bill 2016 was moved in the Parliament on 17 November 2016, and is to be debated after Parliament sits again from 7 March 2017. The date of the debate is not yet known.

The 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 organisations.

A DwDTas summary of the Bill provides a brief overview of the Bill, its aims and background information. This comparison is of key safeguards in the 2016 Tasmanian Bill with those in overseas legislation and the assisted dying framework recommended in the 2016 report of the Victorian inquiry into end of life choices. The detailed provisions of the Victorian Voluntary Assisted Dying Bill will not be known until later in the year. The Victorian Government has established an Expert Panel to finalise the Bill and, on 30 January 2017, issued a discussion paper, requesting feedback by 10 April 2017. Additional comparisons are available, including in the Tasmanian 2013 Proposal and in the report of the Victorian inquiry into end of life choices. Key safeguards that are compared in this analysis are: voluntariness, competence of the person making the request, informed decision, eligible medical condition, doctor safeguards, regulatory monitoring, scrutiny and reporting, type of assistance, age and waiting periods.
### LEGISLATION

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### VOLUNTARINESS

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<th>Victorian inquiry</th>
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<tr>
<td>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).</td>
<td>The patient’s request must be voluntary (§2(1)(a)).</td>
<td>The patient’s request must be “voluntary, well considered and repeated and is not the result of any external pressure” (§3(1)).</td>
<td>Individual right to die organisations in Switzerland have their own internal protocols for determining whether assistance will be provided. For example, the guidelines released by DIGNITAS state that “throughout the entire process of preparing an AS, DIGNITAS follows the rule that it is never DIGNITAS which initiates the next phase and further proceedings but that it is always and only the member’s own prompting which leads the entire process of the AS from one phase to the next, and the process will not move on until the member declares they are ready for the next step.”</td>
<td>“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.</td>
<td>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.</td>
<td>The request “must be completely voluntary, free of coercion”.</td>
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**Tasmanian Voluntary Assisted Dying Bill 2016**

**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 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).

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 patient must be capable of making and communicating health care decisions to their doctors (§1.01(3)). 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).

The patient's request must be "voluntary and carefully considered" (§2(1)(a)). Lewis and Black explain that “The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent.”

The patient must have capacity if their act is to be considered suicide. DIGNITAS' guidelines state that if there are concerns about the member's mental competence “or if there is a feeling that the member is obviously not making his/her decision free from external pressure but rather is being influenced by [someone else], the conversation will be continued by giving both DIGNITAS escorts the chance to speak with the member alone. If the doubts of both DIGNITAS escorts cannot be completely removed … then the AS will be cancelled.”

To obtain medical aid in dying, a patient must “be capable of giving consent to care” (§26(2)). (There is no specific requirement in this Act for the doctor to refer the patient for psychiatric or psychological assessment.)

The patient's request must be "voluntary and carefully considered" and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent.

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Capable of making decisions with respect to their health; (§241.2 (1)(b))
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))
(There is no requirement for the doctor to refer the patient for psychiatric or psychological assessment.)

Adult with decision making capacity about their own medical treatment. Patients whose decision-making capacity is in question due to mental illness must be referred to a psychiatrist for assessment.

Tasmanian Voluntary Assisted Dying Bill 2016

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. The only exceptions to this in other jurisdictions are limited ones in The Netherlands and Belgium but the provisions are very rarely used.

**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”.

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<th>Switzerland</th>
<th>Quebec, Canada</th>
<th>Canada</th>
<th>Victorian inquiry</th>
</tr>
</thead>
</table>
| 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)). | 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)). | Section 3.1 states that the patient’s decision must be “well considered.” 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). | Individual right to die organisations have their own guidelines. DIGNITAS’ guidelines state that after a request is made, DIGNITAS staff consider “whether the applicant can be given any immediate recommendations for possible alternatives with the hope of being able to continue life under better conditions.” | 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)) | 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)) | The request … Must be properly informed. The primary and secondary doctor must each properly inform the patient:  
- of the diagnosis and prognosis of their condition, as well as the treatment options available to them, including any therapeutic options and their likely results  
- of palliative care and its likely results  
- that they are under no obligation to continue with a request for assisted dying, and may rescind their request at any time  
- of the probable result and potential risks of taking the lethal drug. |

#### Tasmanian Voluntary Assisted Dying Bill 2016

S12 contains very detailed requirements on the information to be provided to the patient including those above for other legislation and the Victorian recommendation. For example, S12(2) - (f) all other reasonable treatment options available to the person including, but not limited to, palliative care.
<table>
<thead>
<tr>
<th></th>
<th>Terminal illness</th>
<th>Specified Timeframe</th>
<th>Specified suffering</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oregon</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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. (§1.01(12)).</td>
</tr>
<tr>
<td><strong>Netherlands</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Belgium</strong></td>
<td>No (except children)</td>
<td>No</td>
<td>Yes</td>
</tr>
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<td></td>
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<td>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.</td>
</tr>
<tr>
<td><strong>Switzerland</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>There is no requirement that the patient be terminally ill or suffering from a specified medical condition, or demonstrating a specified level of suffering. However, lethal medication must be supplied and dispensed in accordance with federal laws and doctors must operate “within the limits of accepted professional practice.”</td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<td>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)</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<td></td>
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<td></td>
<td>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) Canadian Health Dept advice – “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 only 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”</td>
</tr>
<tr>
<td><strong>Victorian inquiry</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<td></td>
<td>As the end of life (final weeks or months of life) and 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. Suffering as a result of mental illness only does not satisfy the eligibility criteria.</td>
</tr>
</tbody>
</table>

1 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.
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. Assisted dying should provide an option that can limit suffering at the very end of life, not a way to end life for those who are otherwise not dying. (p223)

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. (p224)

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. The reasons for the differences and the values underpinning the Tasmanian ‘last resort’ approach are to be covered in detail in Issues Paper 2.

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 poll16.

**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
   (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)]”.

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*insert footnote here*
<table>
<thead>
<tr>
<th>Oregon</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
<th>Canada</th>
<th>Victorian inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)). 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. 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. The patient must be informed about palliative care options in accordance with Section §2.01(c)(E).</td>
<td>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.” 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)). Lewis and Black explain that “[t]he consultation requirements are more stringent if the patient’s suffering is the result of a psychiatric disorder.”</td>
<td>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)). 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). 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). 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). 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. Lewis and Black explain that “[i]n Switzerland, there is no legal criterion that relates to the identity of the assistor: in the absence of selfish motives, any individual may in principle assist in the suicide of another.” While individual right to die organisations have their own guidelines, Lewis and Black explain that “[s]ince 2008, physicians in Zurich are required to meet the individual seeking suicide assistance in person on two occasions before a prescription is issued.”</td>
<td>The patient’s physician must “obtain the opinion of a second physician confirming that the criteria set out in section 26 have been met. The physician consulted must be independent of both the patient requesting medical aid in dying and the physician seeking the second medical opinion.” The physician consulted must consult the patient’s record, examine the patient and provide the opinion in writing. (§28(3))</td>
<td>medical practitioner means a person who is entitled to practise medicine under the laws of a province. 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. (§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 … (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); (f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent. 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 (a) are not a mentor to the other practitioner or responsible for supervising their work; (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 (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)) 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))</td>
<td>A request for assisted dying must be approved by a primary doctor and an independent secondary doctor. Each doctor must be properly qualified to make a professional diagnosis and prognosis regarding the patient’s specific condition. Each doctor must independently judge whether the person’s request satisfies all of the criteria outlined below. (p237)</td>
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</tbody>
</table>
Special note: The doctor safeguards in the Tasmanian Bill and in other regulated assisted dying systems are the most important guarantees of safe, effective legislation, particularly when backed up by the regulatory monitoring, scrutiny and reporting system.

Tasmanian Voluntary Assisted Dying Bill 2016

Doctors’ participation is entirely voluntary. Although the demands on doctors are significant, it must be remembered that assisted deaths are rare and a very small proportion of total deaths wherever such legislation exists.

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 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.
### REGULATORY MONITORING, SCRUTINY AND REPORTING

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oregon</strong></td>
<td>Section 3.11 sets out the reporting requirements to be undertaken by the Department of Human Services. 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].” The Department of Human Services is required to prepare an annual report on the operation of the Act (§3.11(3)).</td>
</tr>
<tr>
<td><strong>The Netherlands</strong></td>
<td>Regional review committees are established under Section 3 of the Act. 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: “If this committee finds that the physician did not act in accordance with the due care criteria, the case is referred to the Public Prosecution Service.” The review committees are required to provide an annual report on their activities (§17).</td>
</tr>
<tr>
<td><strong>Belgium</strong></td>
<td>The Belgian Act establishes a Federal Control and Evaluation Commission (§6). 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. The Commission is responsible for reviewing all cases of euthanasia to ensure they were undertaken in accordance with the Act (§8). If the Commission believes that the statutory criteria have not been met they will refer the case to the public prosecutor (§8).</td>
</tr>
<tr>
<td><strong>Switzerland</strong></td>
<td>The reporting requirement is that “assisted suicides must be reported to the local authorities as unnatural deaths.” Switzerland does not have Coroners which the Victorian inquiry report claims. The right to die organisations notify the police only – which prompts them, a state attorney (who leads the investigation into the case) and a local district doctor or one from the Institute of Forensic Medicine to come to the place of the assisted suicide. (Advice received from Silvan Luley, one of the managers of Dignitas.) Individual right-to-die organisations produce their own reports on their activities. Dignitas statistics can be accessed at <a href="http://www.dignitas.ch">http://www.dignitas.ch</a>.</td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td>“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) 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)</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>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. 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. (3) The Minister of Health must make regulations that he or she considers necessary (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 (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, (ii) the form, manner and time in which the information must be provided, (iii) the designation of a person as the recipient of the information, and (iv) the collection of information from coroners and medical examiners; (b) respecting the use of that information, including its analysis and interpretation, its protection and its publication and other disclosure; (c) respecting the disposal of that information; and (d) exempting, on any terms that may be specified, a class of persons from the requirement set out in subsection (1) or (2).</td>
</tr>
</tbody>
</table>
**Victorian inquiry**

1.5.1 Assisted Dying Review Board

The Assisted Dying Review Board is to review each approved request for assisted dying.

Membership of the Assisted Dying Review Board:
- a representative of End of Life Care Victoria
- a doctor
- a nurse
- a legal professional
- a community member.

The function of the Board will not be to approve or reject requests from patients to access assisted dying. That is the role of the primary doctor and independent secondary doctor in each case. Neither will the Board hear appeals from patients whose requests to access assisted dying have been rejected. The purpose of the Board is to ensure that doctors are complying with requirements of the assisted dying framework.

If the Board finds a breach of the assisted dying framework, it should forward its report to the appropriate authority. Depending on the nature of the breach, this may be Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency. Those bodies will then determine whether to investigate the case further.

The Board should report to Parliament on the operation of the assisted dying framework, including any trends it identifies and recommendations for improvement. For the purposes of increased transparency and accountability, during the first two years of operation these reports should be every six months. Following that the Board should report annually.

1.5.2 End of Life Care Victoria

The Government should establish a new entity to champion end of life care, and provide information and guidance on end of life care to health services, practitioners and the Victorian community.

End of Life Care Victoria will work closely with palliative care and other end of life care health practitioners and services to enhance and support the excellent work already being done in the Victorian health system. End of Life Care Victoria will aim to increase engagement with end of life care in the community and the health sector as a whole.

**Special note:** The doctor safeguards are reinforced by regulated monitoring, scrutiny and reporting, which vary significantly between jurisdictions.

**Tasmanian Voluntary Assisted Dying Bill 2016**

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.
### TYPE OF ASSISTANCE

<table>
<thead>
<tr>
<th>Oregon</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
<th>Canada</th>
<th>Victorian inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person must self-administer the lethal dose through oral ingestion. Doctor administration of the drugs is not permitted, even when there are complications. Both self and doctor-administration are legal.</td>
<td>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). Self-administration has been determined to be legal as well.</td>
<td>It is not a crime to assist another person’s suicide if the assistor does not have a selfish motive. The person must self-administer by taking the final act to administer the drugs. Doctor-administration, or administration by another person is not permitted.</td>
<td>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) Self-administration is not provided for in the law.</td>
<td>medical assistance in dying means (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (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.</td>
<td>Assisted dying should in the vast majority of cases involve a doctor prescribing a lethal drug which the patient may then take without further assistance. The singular exception is where people are physically unable to take a lethal drug themselves. In this case, a doctor should be able to assist the person to die by administering the drug.</td>
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**Special note:** The type of assistance which is legal varies between jurisdictions. Recent surveys have confirmed a preference for doctor-administration by doctors themselves and the public.  

**Tasmanian Voluntary Assisted Dying Bill 2016**

The Bill provides for both self-administration and doctor-administration (as under legal assisted dying everywhere but the US) 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.
### AGE

<table>
<thead>
<tr>
<th>Oregon</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
<th>Canada</th>
<th>Victorian inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient must be an adult aged 18 years or older (§2.01(1)).</td>
<td>Under the 2002 Dutch law, a patient aged between sixteen and eighteen years that &quot;may be deemed to have a reasonable understanding of his interests&quot; 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 &quot;may be deemed to have a reasonable understanding of his interests&quot; may also request euthanasia or assisted suicide, provided the parents and/or guardian give their consent (§2(3)).</td>
<td>Under the 2002 Belgian law, the patient had to have &quot;attained the age of majority or is an emancipated minor&quot; (§31)). An amendment to the law was made in February 2014, after very extensive community and Parliamentary debate, to allow that &quot;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.&quot; 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.</td>
<td>Lewis and Black explain that &quot;in Switzerland, children cannot have the required legal capacity to commit suicide, though the position for adolescents is unclear.&quot; Membership the right-to-die organisation DIGNITAS is only available for people “of legal age and full capacity of discernment.”</td>
<td>26. Only a patient who meets the following criteria may obtain medical aid in dying; (1) be of full age, …</td>
<td>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 …</td>
<td>An adult, 18 years and over</td>
</tr>
</tbody>
</table>

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**Tasmanian Voluntary Assisted Dying Bill 2016**

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

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13
WAITING PERIODS

<table>
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<tr>
<th>Oregon</th>
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<th>Victorian inquiry</th>
</tr>
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<tbody>
<tr>
<td>15 days between two oral requests and 48 hour period between written request and dispensing of the prescription</td>
<td>No</td>
<td>No, except for those whose deaths are not otherwise imminent there is a one month waiting period</td>
<td>Individual right to die organisations have their own guidelines.</td>
<td>No</td>
<td>10 days between written request and assisted dying (reduced from 15 in first reading Bill) “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))</td>
<td>No waiting periods.</td>
</tr>
</tbody>
</table>

The Committee recognises the need to guard against impulsive decisions by people experiencing extreme physical and emotional pain in the darkest hours of their lives. The Committee also believes that it is unreasonable to mandate an arbitrary cooling-off period that denies some people who would otherwise qualify to access this option at the end of life. … Doctors routinely assess whether medical treatment decisions are properly considered. As such, the Committee believes the best approach is to allow doctors to determine whether this criterion is established. (p228)

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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.
References


2 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.


4 DwDTas will be preparing more material to support and 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.


7 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.

8 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.”

9 Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 6.


12 The Oregon requirements are the same similar to those in other US States in these key criteria, but there are differences which should be noted in the particular legislation or court judgements.

13 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 not because it is believed that only those close to death should have access to assisted dying but 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 2015) 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.

14 Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 6. (Lewis and Black were commissioned to produce an expert briefing paper for the Commission on Assisted Dying on legal safeguards. Their report is titled ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’ and is available at
In this report Lewis and Black considered eight safeguards (the type of assistance; the person’s condition and/or experience of suffering; making the request for assistance; the age of the person requesting assistance; consultation and referral requirements; the identity of the assistor; due medical care; and the reporting and scrutiny of cases). To these eight safeguards we have also considered residency requirements, waiting periods, family notifications and the opportunity to rescind/revoke the request. We have separately considered mental capacity, voluntariness, informed decision making, and the written request which were considered by Lewis and Black under the heading ‘making the request for assistance’.


16 In the AMA poll (see note 21), 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 2016 Essential poll.

17 Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 7.

18 Ibid, p. 23.

19 Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 10.

20 Ibid.

21 This includes the 2016 AMA member survey (results of which are expected to be available publicly soon) and the international Economist poll in 2015.
