

VOLUNTARY ASSISTED DYING

A PROPOSAL FOR TASMANIA

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FOREWORD

In June 2010 we announced that we would be working together to prepare a Private Member's Bill to allow for voluntary assisted dying for terminally ill Tasmanians. We did so at that time because we believed that there was a compelling case for law reform in this area. As we demonstrate through this Consultation Paper, the case for legalising a form of voluntary assisted dying has continued to strengthen since our announcement to develop a new Bill, and we have good reason to believe that the case in support of law reform will only continue to grow. As legislators we believe that the law in this area has not kept up with changes in medical practice, social values or the views of the vast majority of the community. It is time for change.

We believe it is important and necessary for the Parliament to enact legislation that fully demonstrates the compassion we all feel for people who are suffering in extremely difficult circumstances at the end of their lives. We know of too many terrible experiences for people at the end of their lives who have not found current care and treatment options to be effective and who have clearly and voluntarily expressed a wish to have their suffering cut short, even if it hastens their death. We do not believe it is acceptable to allow the current situation to continue when there are such substantial negative effects for those patients who are dying in prolonged suffering that cannot be relieved adequately and for whom there are no other effective care or treatment options.

Assisted dying legislation and other legal provisions have now been in place in a number of overseas jurisdictions for many years and have been proven to be safe, responsible and supported by the vast majority of the population, including the medical profession. We can now have great confidence in the safeguards included in those laws because of the substantial evidence that is produced on an annual basis that demonstrates the workability of the laws in place in those jurisdictions. In addition, a number of comprehensive reviews have also been undertaken which confirms the successful design and implementation of the laws. Major reviews also show how we can learn from overseas experiences and improve on their approaches. Our proposed model has been designed to suit the Tasmanian situation and includes both the best of the safeguards and provisions in place from existing legislation as well as new provisions to further reduce any potential risks. In every example of overseas legislation, the operation of the law has been very intensively monitored and scrutinised, as will be the case in Tasmania. This is to ensure that any issues in the operation of the legislation can be responded to quickly and the law can stay relevant and reflect community sentiment.

The Tasmanian Parliament has considered the issue of voluntary assisted dying on a number of occasions, through Committee investigations and reports and debates on specific voluntary assisted dying Bills. However, whereas the previous debates have been largely theoretical in nature on whether there should be law reform, in this paper we focus on the practical question of what kind of legislation could provide a safeguarded system of voluntary assisted dying for the terminally ill in Tasmania that reflects the views and expectations of the vast majority of the community. Through our research and consideration of this issue we have concluded that law reform is best done through specific voluntary assisted dying legislation that achieves careful, limited and responsible change.

We know that the limited change we are proposing will not go as far as some people will want but we believe that the model we are putting forward is the most responsible approach.

We also appreciate that there are some people who are strongly opposed to voluntary assisted dying law reform and will not accept any form of assisted dying. We respect their views and the model we propose will protect their right to not access an assisted death or, if they are doctors, to not provide assisted dying.

Others have clearly expressed concern about the potential risks in any legislation developed for Tasmania and allege that deficiencies exist in legislation already in place overseas. We have given these concerns a great deal of consideration and we have not been able to find any sound evidence that there is a heightened risk for people who may be vulnerable due to their age, disability, mental illness or isolation as a result of assisted dying legislation that has been enacted elsewhere. Many claims against overseas laws are based on inaccuracies and unscholarly information, whereas in-depth examination of good quality evidence, including the data published in the annual reports on the operation of specific assisted dying laws, shows these fears to be unfounded. We do not believe it is logical or reasonable to assume that vulnerable people would be at risk in Tasmania if a safeguarded voluntary assisted dying law were in place here.

Any debate on voluntary assisted dying is going to be difficult, but as elected representatives we believe it is our responsibility to take on the challenging questions of reform to ensure that our laws in this area are contemporary, transparent and in-line with community expectations. Voluntary assisted dying is a complex issue that evokes strong emotions and generates intense debate. It is an issue on which political parties grant their members a conscience vote, and for good reason. It is in this context – as private members, not as members of the Tasmanian Government, the Australian Labor Party or the Tasmanian Greens – that we release this paper and that we will be seeking to introduce voluntary assisted dying legislation into the Tasmanian Parliament.

The views expressed in this paper are our own. However, we would like to thank Professor Margaret Otlowski (Dean, Faculty of Law, University of Tasmania), Professor Michael Ashby (Clinical Director of Palliative Care, Department of Health and Human Services), Ms Lisa Warner (Public Guardian), Ms Margaret Sing (President, Dying with Dignity Tasmania) and Reverend Carol Bennett (Uniting Church) for their advice and feedback on this paper.

We want to ensure that as far as possible our proposal reflects broad views within the community. We hope that as many Tasmanians as possible will tell us what they think about our proposal and whether it meets their needs based on their experiences and views.

Lara Giddings MP and Nick McKim MP

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I. ABOUT THE CONSULTATION PAPER AND THE CONSULTATION PROCESS

1.1 CONSULTATION PAPERS

Two papers have been released for consultation:

- a long and detailed paper that sets out our proposed model, associated issues and accompanying information, arguments and analysis in more detail; and
- a short paper which primarily presents our proposed model in a condensed form.

1.2 CONSULTATION PROCESS

We invite responses to this Consultation Paper with comments on any issue related to our proposal for a model of voluntary assisted dying for Tasmania. Responses need to be received by close of business, Friday 15 March 2013. Responses should be sent to GPO Box 123, Hobart, Tasmania 7001 or emailed to premier@dpac.tas.gov.au.

A number of specific consultation questions are included throughout Section 5 and in a consolidated list in Appendix 4. These questions do not represent an exhaustive list, but are questions that we are specifically interested in seeking feedback on. We also welcome your feedback on any other aspect of our proposed model.

Our main interest is in the views of Tasmanians and it is therefore important that we are able to identify which responses come from Tasmanians. We request that your response includes your name and mailing address. You are not required to provide that information for your response to be considered, but if it is not provided the response will be regarded as from a non-Tasmanian. We intend to provide a copy of all submissions received to the Parliamentary Library. Please indicate on your response if you would like your name and/or address withheld.

Additional hard copies of the paper can be obtained by contacting 6233 3464 or emailing premier@dpac.tas.gov.au. The paper can also be downloaded at <http://www.premier.tas.gov.au/> or <http://mps.tas.greens.org.au/>.

After we have considered the responses to this paper it is our intention to introduce a Bill into the Tasmanian Parliament during 2013.

2. THE CASE FOR VOLUNTARY ASSISTED DYING LAW REFORM

2.1 WHY 'VOLUNTARY ASSISTED DYING'?

There are a range of different definitions used to cover the variety of forms of assisted dying, and many definitions are dependent on a specific context. The Joint Standing Committee on Community Development's 'Report on the *Dying with Dignity Bill 2009*' used the following definitions:

- *Active voluntary euthanasia*: where medical intervention takes place, at a patient's request, in order to end the patient's life.
- *Passive voluntary euthanasia*: where medical treatment is withdrawn or withheld from a patient, at the patient's request, in order to end the patient's life.
- *Passive in/non voluntary euthanasia*: where medical treatment or life-support is withdrawn or withheld from a patient, without the patient's request, in order to end the patient's life.
- *Active in/non voluntary euthanasia*: where medical intervention takes place, without the patient's request, in order to end the patient's life.
- *Physician-assisted suicide*: suicide using a lethal substance prescribed and/or prepared and/or given to a patient by a doctor for self-administration for the purpose of assisting the patient to commit suicide.
- *Double effect*: the administration of drugs (such as large doses of opioids) with the intention of relieving pain, but foreseeing that this might hasten death even though the hastening of death is not actually intended.¹

In this paper we use the term 'voluntary assisted dying' to mean medical intervention, at the request of an eligible patient, with the intention of causing the patient's death in order to end their suffering. This intervention could be undertaken by the patient themselves (as in cases of 'self-

administered assisted dying'), or by the doctor (as in cases of 'doctor-administered assisted dying').

2.2 INCREASING SUPPORT FOR VOLUNTARY ASSISTED DYING LEGISLATION

Since the inquiry and debate on the *Dying with Dignity Bill 2009* there has been a significant increase in the public discourse on voluntary assisted dying legislation in Tasmania, elsewhere in Australia and overseas. What has been most striking in this discourse is the consistent and majority expression of support for voluntary assisted dying legislation as a compassionate and responsible response to the suffering of a patient at the end of their lives. This conclusion has also been reached in a number of recent extensive and thorough reviews and, in one case, a comprehensive and carefully argued judicial judgement.

In Tasmania, as in Australia generally, community opinion in favour of voluntary assisted dying has increased steadily over the last 20 years and remains at a very high level. The opinion poll results in support of voluntary assisted dying have been consistent no matter how the question has been asked.²

We believe that as parliamentarians, we need to look at all proposals for legislative reform on their merits and take into account a wide range of matters, including community opinion. We agree with Professor Margaret Otlowski who argues that:

... reliance upon public support for the legalisation of active voluntary euthanasia can never, of itself, be sufficient justification for reform of the law. Public opinion may quite possibly be misguided or misinformed, or may have failed to take into account the full implications of legalisation. Before

*the case for reform is made out, it must be shown that the consequences of legalisation have been considered, and that no harm is likely to result to society or its members if active voluntary euthanasia is legalised.*³

We also share her conclusion that:

*Within these confines, however, public opinion should be recognised as having some role in shaping the law, indicating, as it does, prevailing morality and the needs of the community. After all, ultimately, the law must serve the community and it must therefore be responsive to real social needs ... Thus while evidence of community support for legalisation of active voluntary euthanasia would not of itself be decisive, it would undoubtedly be a relevant factor in determining the appropriateness of legalisation.*⁴

In this Consultation Paper we have drawn on the evidence and information included in the various reviews released in 2011 and 2012. These reviews include that of the Royal Society of Canada, the Commission on Assisted Dying in the United Kingdom, the select committee report undertaken by the National Assembly of Québec and the judicial decision in *Carter v. Canada*. We have also noted the interesting report by the think-tank Australia 21 released in November 2012 entitled 'How should Australia regulate voluntary euthanasia and assisted suicide?'. While this report sets out the different arguments for and against voluntary assisted dying, it does not reach any conclusions as to what reform, if any, government should take.

What is very clear from all these thorough reviews is:

- The consistency of the findings and recommendations in favour of law reform and that this reform is best done through specific legislation, providing for voluntary assisted dying in limited and prescribed circumstances, with multiple safeguards and within carefully monitored processes.
- The thoroughness of the examination of the claims and arguments for and against legislation from many different specialist perspectives.

- The rejection of the assertion that voluntary assisted dying cannot be responsibly and safely provided to eligible patients because there is now overwhelming evidence to the contrary.

The reviews we have considered in this paper have been conducted by, and have drawn on, a wide range of respected and specialist expertise coupled with very extensive information gathering and consultation processes. This expertise has covered the fields of law, medicine (including palliative care), religion, philosophy, ethics, and politics.

This Consultation Paper draws on evidence presented in the various reviews and they are cited where appropriate. In undertaking this work we have not had the resources to replicate the comprehensive reviews that have been completed elsewhere around the world. But nor do we believe that would have been necessary. The campaigns for and against voluntary assisted dying legislation are international ones, with clear links and alliances across countries, and patterns of repeated claims and arguments.

The most recent major reviews have been undertaken in Canada and the United Kingdom and some of the findings of those reviews are specific to the medical, social and cultural environments that apply in those jurisdictions. However, the claims and arguments for and against voluntary assisted dying examined in those reports have been the same, or are very similar, to the claims and arguments we have heard made in a Tasmanian context.

A notable point raised in a number of these recent reports and in recent editions of peer reviewed journals is that those with the most direct experience of voluntary assisted dying (and therefore the most understanding of how this practice actually operates) overwhelmingly support it. We have also noted that support for voluntary assisted dying has been expressed by those who originally opposed a change in the law, before seeing first-hand how such a law can operate safely and compassionately.

The most telling examples of this include:

- The Royal Dutch Medical Society representative, Gert van Dijk, who gave

evidence to the Commission on Assisted Dying that “Here [the Netherlands], 84 per cent of physicians have either performed it [self-administered assisted dying or doctor-administered assisted dying] or are willing to do so. Current law is supported by 92 per cent of the population and so it has wide public support and I think that is very important.”⁵

- In a letter to the British Medical Journal published in June 2012, Professor Sam H Ahmedzai, a Professor of Palliative Medicine at the University of Sheffield with over 27 years experience in hospice and hospital palliative medicine explained how he had shifted in his opposition to physician-assisted suicide (self-administered assisted dying) after witnessing first-hand its safe and compassionate operation in Oregon and the Netherlands. While acknowledging that he remained sceptical about ‘euthanasia’ (doctor-administered assisted dying), Professor Ahmedzai commented that his travels to Oregon, where he had the opportunity to meet with doctors, nurses, patients and their families, patient advocates, pharmacists and hospice volunteers, he was constantly given the message that “assisted suicide has coexisted very well with palliative care.”⁶ Of his experiences in the Netherlands, Professor Ahmedzai explained that:

... it was clear to me that the decisions to agree to euthanasia or offer palliative sedation were taken at a very advanced stage, when life was nearly at the end anyway but the patient wanted to die or be put in oblivion before they experienced the final level of suffering. In both cases it seemed a very natural and caring extension of good palliative care to allow the dying patient to die at the time of their choosing.

... It is unreasonable, inhumane and patronising of British palliative care to insist that a few people should suffer extreme distress and indignity because society ‘values their lives’ - regardless of how meaningless those lives have become to their owners. It is inconsistent of British palliative care to trumpet about how it enables personal choices about place of terminal care, but to deny patients the choice of the timing of death. It is contradictory of British palliative care to take an opposing stance

to assisted suicide in the name of ‘protecting the vulnerable’, but sees one of its important roles as helping people to withdraw from life-sustaining treatments such as chemotherapy or blood transfusions, as this is thought to be more consistent with the hospice view of a ‘good death’. It is hypocritical of British palliative care to deny patients the opportunity to die at the time and manner of their choosing, but to take it on itself to decide when to increase sedation or withdraw fluids, acts which will of course ultimately lead to an ‘assisted death’ – but on the doctors’ and nurses’ terms.”⁷

- The judicial decision, *Carter v Canada*, released in June 2012 included the following quote from Ann Jackson, the former Executive Director of the Oregon Hospice Association, who initially voted against the *Oregon Death with Dignity Act* (ODDA) and also advocated for its repeal, but now argues:

Today I would vote in favour of physician-assisted dying [self-administered assisted dying], and “yes” if the ODDA were on the ballot. I am convinced that physician-assisted dying can be, and is, practiced responsibly in Oregon, and the ODDA was very well crafted. I can say this based on my personal experience and on the basis of my knowledge of the data that is now regularly published by the Oregon Health Authority. I am satisfied that the bar is high enough that people who are clinically depressed, for instance, and whose judgement is questionable are not likely to seek it or obtain it. The bar is, however, not so high, that motivated terminally-ill Oregonians are unduly deterred or restricted from participation. The safeguards in place are not merely meaningless obstacles.”⁸

Through our research we have seen that people can and do change their views based on their own personal experience of seeing someone, often a loved one, die over a prolonged period with unacceptable levels of unrelievable suffering. During this consultation, we would be very interested to hear from Tasmanians who have changed their views on voluntary assisted dying and why you have done so.

2.3 PRINCIPLES AND VALUES

Whatever our beliefs and views about voluntary assisted dying legislation, we believe there are some key principles and values on which we can all agree. These principles and values are:

- The value and importance of a tolerant democratic society and the rights and freedoms it provides for all of us when it comes to making decisions about matters involving our fundamental beliefs; and
- The importance of compassion for those who are nearing the end of their lives, particularly for those who have a medical condition that is going to shorten their lives and even more so if their medical condition is causing major suffering.

These are the principles and values that underpin our commitment to developing voluntary assisted dying legislation. Death and dying are a natural part of life, so it is in keeping with the principles and values of a tolerant and open democratic society that people should be able to apply their own personal beliefs and values to their death and dying in accordance with the law.

PERSONAL AUTONOMY

Consistent with the first principle is the frequently used argument for law reform that individuals in a society such as ours should have the right to decide for themselves what they do with their lives. While proponents of voluntary assisted dying uphold the principle of protection of the right to life, they also argue that “a competent terminally ill patient seeking a quick painless death does not represent any harm to others in society and in the absence of such a threat the state does not have the right to subjugate the individual’s autonomy.”⁹

We believe that those arguing against voluntary assisted dying law reform have failed to substantiate perceived threats to society as a whole, to ‘vulnerable’ groups, to the role of the doctor or to doctor-patient relationship (for more on this see Section 3).

Bartels and Otlowski, writing on this subject from a legal perspective, argue that there currently exists an inconsistency in the law “... which permits a patient to induce an earlier death by refusing treatment (passive euthanasia), yet categorically prohibits a patient from seeking active assistance. Indeed, many philosophers have argued that there is no morally relevant difference between passive and active euthanasia and that the current legal position which permits passive euthanasia but prohibits active euthanasia is fundamentally flawed.”¹⁰

A COMPASSIONATE RESPONSE TO SUFFERING: CHOOSING THE MANNER AND TIMING OF ONE’S DEATH

For many people, self-determination means having greater control over the manner and timing of their death, particularly in response to a medical condition that leaves the patient with what they consider to be a poor quality of life. From our research we believe that individuals are increasingly valuing quality, rather than quantity, of life. Thus it is argued that individuals “should be able to decide at what point the *quality* of their lives is too poor for them to want to continue living.”¹¹

Debbie Purdy, a prominent voluntary assisted dying advocate in the United Kingdom who is suffering from primary progressive multiple sclerosis, explained to the Commission on Assisted Dying:

I want to be in control of my life, and that means I want to be able to live as long as I can, but I want to be able to choose what quality of life is liveable; I don’t want somebody else to tell me that ‘the quality of your life’s ok, what are you complaining about?’ I want to be able to make those choices myself. I want the help and support to make it.¹²

In the Commission on Assisted Dying’s report, the British Humanist Association argues that:

Individuals should be allowed to decide on such personal matters for themselves; if someone in possession of full information and sound judgement

*decides that her continued life has no value, her wishes should be respected ... To postpone the inevitable against the wishes of an individual with no intervening benefit is not a moral act. We believe that a compassionate society is one which respects and upholds in law people's right to choose to have an assisted death if that is their considered and expressed wish.*¹³

The theme of 'a compassionate response to suffering' was further elaborated in the Commission's report by Ms Purdy who argued "As a civilised society, are we really saying that you have to live out your three weeks however much pain you're in and however much the people you love have got to see you suffering ... Rather than ending it earlier?"¹⁴

We firmly believe that legislation for voluntary assisted dying would provide a compassionate response and recognition that sometimes there are no other adequate options available to terminally ill patients who, against their wishes, are experiencing a prolonged period of great suffering at the end of their lives. Many people will find sufficient relief in palliative care, by refusing or withdrawing from treatment they find unacceptable (such as treatment with too many side-effects) or terminal sedation, but not all. We have not seen any other proposed solutions to this issue that are practical or likely to be effective at relieving all the suffering experienced by those at the end of their lives.

We agree with Dr Simon Longstaff, a respected ethicist who heads the St James Ethics Centre in Sydney, who says:

*I do not know of any system of belief (religious or otherwise) that promotes suffering as a good thing. Indeed, I would go so far as to say that suffering is universally regarded as an evil. Even those who think that we might grow through our suffering do not argue that the suffering is, in itself, good. Given this, I think we have a positive obligation to limit suffering. Unfortunately, there are some times when the only way to end suffering is with the death of a person. In those circumstances, I think we should allow a person to choose death.*¹⁵

We do not believe that the current situation is sustainable. Nor do we think it is acceptable that people at the end-of-life just have to 'put up' with

their suffering, because there is only a 'few' of them or on the basis of unfounded speculation about what might happen to others.

We are also very concerned that some people are taking their own lives ahead of time while they still can without implicating their loved ones and that this sometimes occurs by very unsatisfactory means and without medical support. There is also clear evidence that doctors and family members are acting out of compassion and helping terminally ill patients to achieve an assisted death. However, without legal and professional guidance and oversight, this practice is clandestine, with all the problems that result from that kind of practice. Those doctors who aid terminally ill patients put themselves at risk of prosecution and professional sanction if their actions are discovered.

Having the option of accessing an assisted death can provide a sense of reassurance to terminally ill patients, even if they ultimately do not make that choice. In the judicial decision, *Carter v Canada*, Ann Jackson, the former Executive Director of the Oregon Hospice Association explained:

*I have also seen the positive impact the ODDA has on patients in palliative care who, in the end, do not use their prescription. For these patients, it provides peace of mind that they have an option in the event of a worst case scenario. I have also seen the positive impact of merely a promise of a prescription on Oregonians who are well, on those who are newly diagnosed with life-threatening diseases or conditions, on family members and loved ones.*¹⁶

In a similar vein, Barbara Glidewell, former Hospital Ombudsman from Oregon has explained that "many patients want to obtain the medication in case their worst fears materialise such as loss of dignity and intolerable suffering."¹⁷ In this sense, Glidewell explains that the prescription acts as a "back-up plan" to act on if they need it. And with the evidence from Oregon showing that only 64 per cent of patients who receive a prescription actually take the medication, "having ready access to the medication may provide psychological comfort even if it is never used."¹⁸

2.4 HISTORY OF THE ISSUE IN TASMANIA

In 1998 the House of Assembly Community Development Committee held an inquiry into the need for voluntary euthanasia legislation in Tasmania. The Committee concluded that, on the evidence available to them at that time, voluntary euthanasia should not be decriminalised because “legislation could not adequately provide the necessary safeguards against abuse.”¹⁹ Since 1998 a number of laws providing for self-administered assisted dying and/or doctor-administered assisted dying have been enacted in overseas jurisdictions and the intense scrutiny on the operation of these laws has provided a vast amount of evidence that shows that this conclusion is no longer valid. These laws, which will be outlined in Section 4, continue to demonstrate that effective safeguards can be achieved and maintained.

In May 2009, Nick McKim tabled the *Dying with Dignity Bill 2009* in the House of Assembly. The Bill allowed for terminally ill patients who were experiencing intolerable pain and suffering to request the assistance of a doctor to end their lives. On 18 June 2009, the House of Assembly voted to send the Bill to the Joint Standing Committee on Community Development for investigation. The Committee issued its final report in October 2009 and concluded that the *Dying with Dignity Bill 2009*:

- ... does not provide an adequate or concise framework to permit voluntary euthanasia/physician assisted suicide.
- ... has been described as containing insufficient safeguards or for having too many safeguards to enable a sufferer seeking assistance to end their life.²⁰

The Committee did not include any recommendations in their report as to how the Parliament should progress this Bill. Instead, they focused predominantly on a number of technical issues with the wording and structure of the Bill.²¹ Incidental matters given consideration by the Committee included palliative care, end-of-life care, current practices, public support and arguments for and against voluntary assisted dying. Unlike the 1998 Committee, which found that

voluntary euthanasia should not be decriminalised, the 2009 Committee made no comment about this. Bartels and Otlowski observed that while the Committee’s final report noted a number of issues and difficulties with the Bill, “they related predominantly to issues of terminology and did not resolve the substantive issues as to the desirability or otherwise of a law to permit voluntary euthanasia.”²²

Following the report from the Joint Standing Committee on Community Development, the *Dying with Dignity Bill 2009* was brought on for debate in the House of Assembly in November 2009 where it was defeated 15 votes to 7 with two Members absent. Some Members of Parliament said that while they supported voluntary euthanasia in principle, they held reservations about the workability of the model presented in the Bill.

In light of strong and increasing support for voluntary assisted dying within the community, as well as concerns that the law is condoning an existing and unregulated practice,²³ we believe the law as it currently stands is out of touch with public opinion and community expectations.

Under Sections 153 to 162 of the *Tasmanian Criminal Code Act 1924*, all forms of homicide are illegal, including when the death of someone suffering from a terminal illness is hastened (§154(d)). Under Section 163 it is illegal to aid another person to kill themselves. Under Section 53(a) it is also illegal to consent to be killed.

Yet people in our community are suffering at the end of their lives and, in an attempt to address that suffering in a humane manner, a form of assisted dying is already occurring, but without the safeguards and appropriate regulation that can be provided through legislation. During both the 1998 and 2009 Tasmanian Parliamentary inquiries into voluntary assisted dying, evidence was given that around Australia, including in Tasmania, voluntary and involuntary euthanasia was being practised.²⁴

In 2004 the complex nature of voluntary assisted dying was highlighted when the Tasmanian Supreme Court refused to jail John (Stuart) Godfrey for assisting his mother to die. Mr Godfrey’s mother was aged 88 at the time of her

death and had been suffering from incontinence, severe muscular pain and chronic back pain. She was also allergic to morphine and had been told by her doctor that she could no longer live independently and required institutionalised care.²⁵

In his sentencing comments, Justice Peter Underwood noted that "... the decision Mrs Godfrey made to end her life was a rational one, and viewed objectively, soundly based." The crime was "an act of last resort" that was "motivated solely by compassion and love."²⁶ Justice Underwood also commented that:

... although aiding suicide is a crime, attempting to commit suicide has not been a crime in this State for almost fifty years. Curiously, it might be said that those who wish to end their life but are physically unable to do so, are discriminated against by reason of their physical disability.²⁷

We are concerned that such cases demonstrate that Tasmania's laws against aiding suicide are no longer considered applicable in all circumstances, and that "this dysfunctionality in the operation of the law is a powerful reason for change, and can only be addressed through some kind of legislative reform which overrides current criminal law prohibitions."²⁸

In the absence of leadership from parliaments on this matter, the courts have been left to define public policy. Writing on this issue from a US perspective in the late 1990s when Bills for voluntary assisted dying were before 10 state legislatures, Assistant Professor Russell Korobkin explained that "The right to die ... is a matter for the people and their legislatures, not courts, to debate and resolve."²⁹ While judgements such as that handed down in the Godfrey case in Tasmania have demonstrated a leniency in the sentences imposed on offenders of these crimes, only specific voluntary assisted dying legislation can provide the necessary safeguards for patients, their families and medical practitioners. Only parliaments can deliver that change.

2.5 CURRENT PRACTICES IN END-OF-LIFE CARE

In the contemporary medical treatment of patients suffering at the end of their lives, the principle of the 'double effect' has arisen out of "established medical ethics [which] permit a doctor to administer medication or other treatment with the intention to relieve suffering even if it is 'foreseen' that the patient's life may be shortened as a side-effect of the treatment."³⁰ Both the 1998 and the 2009 parliamentary reports found that this practice was occurring in Tasmania. We also note the Australian Medical Association's (AMA) position statement on end-of-life care which explains that:

... if a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide:

- *not initiating life-prolonging measures*
- *not continuing life-prolonging measures*
- *the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.³¹*

We recognise that many commentators acknowledge that this form of end-of-life management "has become an established part of medical practice and is relatively uncontroversial."³² What is controversial is when action is undertaken by a doctor with the explicit intention of hastening a patient's death, either with the patient's request (and in the absence of specific assisted dying legislation) or without that patient's request.

There are clear indications that in Australia (and elsewhere in jurisdictions that do not have specific voluntary assisted dying legislation) the law "has not prevented the practice of euthanasia or the intentional ending of life without the patient's consent."³³ There are also clear indications that in Australia doctors are making "medical end-of-life decisions explicitly intended to hasten the patient's death without the patient's request."³⁴ We will return to this issue in relation to the 'slippery slope' argument used by opponents of voluntary assisted dying legislation in Section 3.2.

Both the 1998 and 2009 Tasmanian parliamentary reports cited the 1997 study by Kuhse et al titled 'End-of-life Decisions in Australian Medical Practice'. The data collected through this survey showed that "Australia had a significantly higher rate of intentional ending of life without the patient's consent, both through the administration of drugs and by withholding or withdrawing treatment, than in the Netherlands."³⁵ The data showed that:

- 30.9 per cent of deaths were the result of a 'double effect' decision where medication such as opioids were administered to alleviate pain in such large doses that they had a probable life shortening effect;
- 1.8 per cent of all Australian deaths were the result of active voluntary euthanasia;
- 3.5 per cent of deaths were the result of active involuntary euthanasia; and
- 28.6 per cent were the result of passive voluntary or involuntary euthanasia.³⁶

Kuhse's study showed that "in 30% of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient's life, of which 4% were in response to a direct request from the patient."³⁷ A similar study was referenced in the final report from the Commission on Assisted Dying in the United Kingdom. In 2009, a UK survey of 2,869 doctors who had treated a patient that had died in the previous year was undertaken. The results of the survey showed that "17.1 per cent of deaths had involved a 'double effect' decision. In 15.1 per cent of these deaths the doctor reported 'knowledge of probable or certain hastening of end of life' and in 2 per cent of the deaths the doctor reported 'partly intending to end life'."³⁸

The 1998 Parliamentary Committee made a number of findings about practices in end-of-life care in Tasmania at that time. The Committee noted that:

... In some cases patients had difficulty ensuring that their wishes would be respected in regard to their medical treatment when they became incompetent. ... [And] there is evidence to suggest that abuses of the current prohibition on active

*voluntary euthanasia do occur and Tasmania may not be immune to such abuses.*³⁹

The 1998 Committee also noted that "whilst the extent of active voluntary euthanasia may be contested there is sufficient evidence including anecdotal accounts given by witnesses to the Committee to suggest that it is a current practice."⁴⁰ Indeed, a former nurse who gave evidence to the Committee explained that:

*Whether admitted openly or not, practitioners constantly make decisions in care setting that end lives ... Often without consultation, practitioners will decide who will be resuscitated, rehabilitated, given antibiotics or narcotics, and whose life machine will be turned off and at what time.*⁴¹

In her evidence to the 1998 Committee, Tasmanian academic Professor Margaret Otlowski highlighted the inconsistency between the law and contemporary medical practice. Otlowski submitted that:

*Despite the strict legal prohibition of the practice, with the threat of the most serious criminal liability (i.e. for murder) the reality of the matter is that not infrequently, requests for active voluntary euthanasia are made by patients, and a significant proportion of doctors are responding to such requests.*⁴²

Otlowski further argued that "It is unsatisfactory to have a situation where it is commonly known that the law is being breached by the medical profession, yet breaches are usually ignored or pass unpunished."⁴³

This kind of anecdotal evidence was repeated during the course of the 2009 Committee:

Ms O'CONNOR - Dr McGushin, at one point in your testimony we you (sic) were talking about how medical practitioners administer palliation to the terminally ill and ... there are situations where out of compassion and only out of compassion medical practitioners may increase the dosage of a palliative drug, knowing that relief will be provided but also that death will be hastened. Do you accept that that does happen?

Dr McGUSHIN - Yes, I accept that that happens and I do it all the time and so do other doctors. But that is not what we are actually talking about

because the primary intention is not to end that person's life, it is to relieve their symptoms.

Ms O'CONNOR - But in administering the elevated level of that drug you are doing so in the full knowledge that it is likely to hasten the sufferer's death.

*Dr McGUSHIN - I have no problem with that at all, it is good palliative care.*⁴⁴

While we recognise that many doctors are comfortable with using palliative sedation as an end-of-life treatment option for some patients, our concern remains that this practice can occur without the clear consent of the patient. One of our aims in releasing this paper is to encourage conversations between patients and their families and doctors around what an individual's end-of-life expectations are. For those patients and doctors who are comfortable with current end-of-life practices we are not proposing that they be forced to choose or participate in any form of voluntary assisted dying. But for those patients and their doctors who are supportive of voluntary assisted dying, we want to ensure that there is legislation in place to regulate and control this practice, and to provide safeguards for patients, doctors and families.

The empirical evidence suggests that there are greater risks in a legal system that prohibits voluntary assisted dying but it still occurs anyway in an unregulated and opaque manner, than in jurisdictions that have made voluntary assisted dying legal. For example, as long as voluntary assisted dying remains illegal, "doctors will feel inhibited in discussing these issues with their colleagues in an open way, and consequently will not be able to benefit from constructive critique or support from their professional peers. In turn, this jeopardises the quality of medical decision-making in this area."⁴⁵

Legalising voluntary assisted dying in Tasmania will allow us to establish a legal framework through which medical choices relating to the end-of-life decisions of competent, terminally ill patients can be made, reviewed and regulated. Otlowski argues that "if active euthanasia is in fact being practised, it is imperative that these decisions are based upon the patient's choice rather than the idiosyncratic views of individual doctors ... [and a]

more permissive but regulated legal environment" will allow us to protect and respect the end-of-life preferences of terminally ill patients and provide protection to the doctors who assist them.⁴⁶

2.6 PALLIATIVE CARE AND ADVANCE CARE PLANNING

PALLIATIVE CARE

Palliative care is the "specialised care and support provided for someone living with a terminal condition. Palliative care also involves care and support for family members and carers. Palliative care is provided in a sensitive way, taking into account individual and family uniqueness, cultural and spiritual beliefs and lifestyle patterns."⁴⁷ A patient who is receiving palliative care will have an active, progressive and far-advanced terminal illness from which there is little or no prospect of cure. Palliative care aims to achieve the best quality of life for the patient, while also ensuring family members and carers are supported and provided with necessary information.⁴⁸

The World Health Organisation explains that "Palliative care begins from the understanding that every patient has his or her own story, relationships and culture, and is worthy of respect as a unique individual."⁴⁹ People requiring palliative care have differing needs and not everyone requires the same level of care during the course of their illness. For many palliative care patients, their local community is the preferred place of care. Admission to a specialised palliative care inpatient unit only occurs for short periods of time such as for symptom management or during the final stage of illness.

Palliative care in Tasmania is provided through a mix of specialist palliative care beds, as well as palliative care services in the community. This includes specialists working with their general medical practice colleagues and other primary health professionals, as well as through admissions

to rural hospitals which allows patients to continue to receive care in their local community.

Our support for voluntary assisted dying legislation does not in any way lessen our support for palliative care and we can find no evidence that voluntary assisted dying legislation has had any negative impact on the continuing development of palliative care services in jurisdictions that have adopted such a law. Justice Smith in the judgement *Carter v Canada* concluded:

My review of the evidence regarding Oregon, the Netherlands and Belgium suggests that in those jurisdictions, legalization of assisted death has not undermined palliative care; on the contrary, palliative care provision has been improved since legalization by some measures.⁵⁰

We do not believe it is logical or reasonable to assume that voluntary assisted dying legislation would cause any reduction in either the commitment to, or the delivery of, palliative care services in Tasmania. Voluntary assisted dying is different from palliative care, and we believe competent patients who are suffering from a terminal condition should have the option to voluntarily hasten their death when palliative care and other treatment options are not effective in meeting their needs and wishes.

We agree with the conclusions of the Québec National Assembly's Select Committee on Dying with Dignity that "palliative care is the best answer to the suffering of most end-of-life patients. However, we also recognize it has its limitations."⁵¹ The Québécoise Committee gave the issue of palliative care a great deal of attention throughout its consultations and in its final report. Some of their conclusions naturally relate specifically to the situation in Québec, but much of the information, observations and conclusions are also relevant to the situation here in Tasmania. We agree with them that:

... universal access to palliative care would certainly reduce the number of requests for help to die, but we are convinced it would not eliminate them all. ... we believe that palliative care, no matter how good it may be, cannot alleviate all the suffering of end-of-life persons.⁵²

The Québécoise Committee further explained:

First, some pain is extremely difficult to alleviate and, in rare cases, impossible to completely control, at least not by keeping the person conscious. While palliative sedation is an option, it does not suit everyone. Some people prefer to remain alert until the end, even if it means terrible pain, so they can be with their loved ones. Others have trouble with the idea that the only option available to ease their pain is to induce an indefinite coma. Still others cannot fathom subjecting their families to the pain of sitting by their bedside while they lie unconscious, waiting for days or weeks.

Then there are the physical symptoms of some diseases that are hard to control and even to describe: uncontrollable vomiting, terminal agitation, delirium and hallucinations, death rattle caused by the inability to cough and faecal vomiting due to intestinal obstruction.

The medication required to ease the pain can sometimes have undesirable side effects that can only be controlled with other medication. This pharmacological spiral can therefore keep patients from the death they would have wanted. Lastly, palliative care offers little relief to patients with degenerative diseases, who can be prone to all kinds of suffering such as a choking sensation and the fear of choking to death.

Physical pain at the end of life is often accompanied by psychological suffering that can be even more intense. Worse yet, the psychological pain can outlast the physical pain because 'Once the pain is controlled, that's when you see the immense, senseless suffering emerge'. The stories we heard from families about the agony of a loved one shook us to the core, as did the accounts of people suffering from a degenerative disease, who shared with us the anxiety they were feeling about their inevitable decline.

Because of its intensity and complexity, this suffering is difficult, if not impossible, to fully relieve.⁵³

These findings from Québec echo evidence provided by Professor Michael Ashby to the inquiry into the *Dying with Dignity Bill 2009* and which is quoted in the Joint Standing Committee's final report:

Modern palliative care has evolved over the last three decades and a great deal of knowledge and expertise has been gained about how we look after people who are dying. There is almost always something that can be done to improve a person's symptom control, emotional, spiritual and psychological well-being. However, palliative care has limitations and it must be acknowledged that the best efforts of multi-disciplinary palliative care services do not always provide patients with what they wish or need. Skilled palliative care can nearly always make a difference for the better, but may be challenged by symptoms such as refractory cancer pain, fatigue, loss of function and independence.⁵⁴

The reports and accompanying transcripts of evidence from the Québec National Assembly's Select Committee, the Commission on Assisted Dying and our own Tasmanian Parliamentary committees all include heart-wrenching stories of people suffering at the end-of-life because their symptoms could not be relieved adequately by palliative care, no matter how good that care is and no matter how skilled and well intentioned the doctors, nurses and other medical staff are. These stories echoed the experience of Tasmanian Robert Cordover who suffered from Motor Neurone disease and whose situation and suffering was highlighted in the debate on the *Dying with Dignity Bill 2009*.⁵⁵

Since the middle of the twentieth century we have witnessed many significant advancements in medical treatment and technology, from the development of life-saving equipment such as ventilators and heart-lung machines to procedures and treatments such as organ transplants and chemotherapy. These advancements have not only improved the capacity of medical professionals to diagnose and treat patients, but also extend a patient's life through mechanical or artificial means. Professor Penney Lewis remarks that:

Physicians' attitudes characterized by 'a worry about malpractice, a zest for technology, a deep-seated moral belief in the need to prolong life, and the pressure of families and others, still often lead to overtreatment and an excessive reliance on technology.' The result may be that dying has become, in some cases, longer and more difficult. 'An inadvertent and unintended side effect of

*medicine's growing effectiveness is that the dying process has been elongated. ... for those who are suffering greatly ... it has become harder and harder to die.*⁵⁶

ADVANCE CARE PLANNING

Through an advance care plan or directive a patient can clearly explain their wishes with regard to medical treatments that they consent to or wish to refuse, as well as their preferences for future care in the event of incapacity. The Royal Australian College of General Practitioners explains that medical science breakthroughs:

*... have created their own dilemmas, especially when the treatments may be of limited or no benefit to the patients. Doctors and families can find themselves having to decide for the patient when to withhold or withdraw life-sustaining treatments when the patient can no longer communicate their own decision. Advance care planning enables a patient's wishes and views to influence this discussion and decision.*⁵⁷

Advance care planning is closely linked with the principle of patient autonomy and the principle of consent. By putting in writing, preferably in a legally binding document, the individual's wishes for medical treatment in the event of incapacity "advance care plans help to ensure that the norm of consent is respected should the patient become incapable of participating in treatment decisions."⁵⁸

It is recommended that an advance care plan (otherwise known as an Advance Care Directive) in Tasmania be registered as part of an Enduring Guardianship with the Guardianship and Administration Board. In an Enduring Guardianship document, a person can give directions to the enduring guardian about their future medical wishes. These directions are referred to as 'conditions', and provided "the conditions are clear, lawful, and practically possible to carry out, they are binding on your enduring guardian and must be respected."⁵⁹ The Office of the Public Guardian 'Enduring Guardianship Infosheet' provides the following examples of conditions that could be included in an Enduring Guardianship:

- *I direct my guardian to consult my friend (name) on any important decisions about my health and welfare.*
- *If I require long-term care in a facility outside my home, I would prefer to live close to my brother, (name).*
- *When my guardian assumes his or her role, I direct my guardian to notify my relative (name, address) of the nature of my illness.*
- *Because of my religious beliefs I do not wish to receive a blood transfusion or blood products under any circumstances.*
- *I would like life-prolonging treatments to be commenced and continued, including Cardio Pulmonary Resuscitation (CPR), while they are medically appropriate and remain in my best interests.*
- *If I am acutely ill and unable to communicate responsively with my family and friends and it is reasonably certain that I will not recover, I want to be allowed to die naturally and to be cared for with respect for my dignity. I do not want to be kept alive by extraordinary or overly burdensome treatments that might be used to prolong my life. If any of these treatments have been started, I request that they be discontinued. However, I do want palliative care that includes medications, and other treatments to alleviate suffering and keep me comfortable, and to be offered something to eat or drink.*
- *I am a registered organ donor and would like to donate my eyes, liver and any other organs that can be used.*⁶⁰

By including an advance care directive that specifically deals with health and medical treatment preferences in a registered Enduring Guardianship, an individual can have comfort and peace of mind that their wishes are known and clearly stated. This ensures that the doctors and nurses providing care will respect the individual's wishes and relieve some of the decisions that would otherwise be made by family members or carers.

There has been some take-up of Enduring Guardianships, supported by a community engagement process undertaken by the Office of

the Public Guardian. There are now over 14,000 registered Enduring Guardianships in Tasmania.⁶¹ In its 2010-11 Annual Report the Office of the Public Guardian urged:

*Much more public debate and education about end of life issues ... It is important to encourage everyone to make their wishes known for end of life care, so that those around them will have the authority and confidence to stop medical treatment that is not working, and re-direct care to comfort, quality and dignity goals. Both Enduring Guardianship and Advance Directives are important tools to ensure that patient's wishes are carried out, and that the dying process is not drawn out in a way which benefits no one, mis-uses health resources, and fails to address the real needs of the patients, their families and carers.*⁶²

Under our proposed model for voluntary assisted dying in Tasmania we are not recommending that an assisted death could be accessed through any form of advance request. Given that we are also proposing that only competent patients would be able to access an assisted death, an enduring guardian would not be able to make a request for an assisted death on behalf of a person they are acting for. However, an Enduring Guardianship document containing medical treatment preferences will continue to be an important tool for individuals to ensure their treatment preferences around palliative care and the withdrawal or withholding of treatment are understood and carried out in the event of incapacity.

2.7 CONCLUSION

After very thorough consideration and advice, we are convinced that there are a number of arguments which together provide a compelling case for voluntary assisted dying law reform through legislation such as we propose.

Modern medicine has made great advances, but the downside is that it can keep some of us alive beyond our wishes and beyond any quality of life that we find acceptable. Some of us will be unfortunate enough to have illness or disease that

is not only incurable and is going to cut short our lives, but which also involves great suffering that cannot be relieved adequately, no matter how skilled and caring the medical and palliative care professionals are.

We believe that there are a number of negative effects caused by not having a legal option for terminally ill patients at the end of their lives who want assistance from their doctors to die, and who make a voluntary, informed, consistent and persistent request for assistance. These negative effects impact directly on the dying patient, their loved ones, and their doctors. Indeed, when laws do not keep up with social and cultural changes these negative consequences also impact on the community as a whole.

We firmly believe that parliamentarians have a responsibility to act unless there are compelling grounds not to, such as evidence of major negative effects for some individuals, groups of patients, or for the community more generally. However, evidence shows that consistently expressed fears about voluntary assisted dying law reform have been found in practice to be unjustified and vulnerable groups have not been put at increased risk where voluntary assisted dying law reform has been achieved.⁶³ This evidence will be discussed in more detail in Section 3 of this paper.

Our society has changed significantly in many ways over the past decades. We now all have greater

expectations about the kinds of choices we can make about our own lives. Attitudes towards rights and freedoms and the value of 'quality of life' have also changed, as has medical treatment options, especially at the end-of-life. We know that the vast majority of the population want a legal option for assisted dying in addition to the current legal right to refuse treatment or withdraw from treatment. No matter how the question is asked, in reputable opinion polls the result is consistently and overwhelmingly in support of a last resort option for the patient's doctor to be legally able to provide assistance to help the patient die.⁶⁴

So long as the practice of euthanasia occurs in an unregulated environment, patients remain at risk of being abused. We believe that having legislation to regulate voluntary assisted dying would provide safeguards for both patients and doctors, and would reduce the level of non-voluntary euthanasia. The aim of voluntary assisted dying legislation is not to replace the role of palliative care or other treatments in providing care for the terminally ill at the end-of-life. Rather, we consider it a compassionate option for the small number of terminally ill patients for whom palliative care cannot relieve all their pain and suffering.

3. THE CASE AGAINST VOLUNTARY ASSISTED DYING LAW REFORM

3.1 ISSUES

We have given very serious and in-depth consideration to the case against voluntary assisted dying legislation and have found a number of issues with the nature and quality of claims and arguments used to support that case. In general, we are disappointed with the quality of claims and arguments and have found that many of them do not meet the standards required by parliamentarians when considering legislative reform.

We recognise and understand that many people feel very strongly about this issue and we respect their right to express their own views on this matter. However, in a pluralistic democratic society such as ours, parliamentarians must make decisions on the basis of good quality information that meets standards of accuracy, relevance and intellectual credibility. That is, information used to inform a debate must be reliable and valid. It must also be up-to-date and as comprehensive as possible. Arguments need to be based on good quality information, as well as on reasonable assumptions and logical and well-considered conclusions.

Some claims made by those opposed to voluntary assisted dying law reform relate to legitimate concerns about potential risks. We have taken these concerns into account in the development of the safeguards and provisions included in our proposed model. These safeguards and provisions include the need for checks to occur before assisted dying is provided rather than depending solely on retrospective monitoring (see Section 5.17).

However, we have found that there are many claims and arguments against voluntary assisted dying legislation which, when subjected to careful scrutiny, do not meet the requirements of accuracy, relevance and intellectual credibility. These claims and arguments also fail to acknowledge the risks and disadvantages in the

current system where voluntary assisted dying is forbidden, but still occurs. We have been unable to find any satisfactory substantiation of the repeated claims that voluntary assisted dying legislation constitutes a threat to society as a whole, to people in vulnerable groups (such as people with a disability or the elderly), to the role of the doctor, or to the doctor-patient relationship.

Section 3.2 of this paper sets out the main arguments against voluntary assisted dying law reform. However, there are a number of other claims and arguments against this reform which we have noted in our research and have rejected as unreliable or invalid. These claims fall into three main groups:

1. Claims for which no supporting evidence is provided and:
 - despite considerable efforts, no supporting evidence can be found;
 - there is substantial reliable evidence to the contrary;
 - there appear to be underpinning assumptions and beliefs that are not reasonable or generally accepted; or
 - the conclusions are not logical or reasonable.
2. Claims which are dependent on poor quality information, including:
 - information, particularly from the 1990s but also pre-2009, that is now well out of date and does not reflect any of the changes that have occurred following legislative reform and recent reviews;
 - information based on inaccurate and irrelevant data;
 - ‘cherry-picking’ of information in a piecemeal way providing a distorted picture;

- the absence of critically relevant information – what is missing is often more important than what is included;
 - use of numbers or percentages in ways that present a misleading impression; and
 - unsubstantiated anecdotes.
3. Claims dependent on major errors in reasoning including:
- perceived ‘cause and effect’ when no such relationship exists;
 - misunderstandings about or misrepresentations of the views of those who support voluntary assisted dying reform, including ‘straw man’ arguments;
 - argument against people supporting voluntary assisted dying reform rather than focusing on their information and arguments (‘ad hominem’ arguments);
 - contradictions and inconsistencies in arguments;
 - dependence on negative, demeaning and unsubstantiated stereotypes, particularly of elderly people and people with disabilities, but also of doctors and family members of those seeking voluntary assisted dying; and
 - dependence on unreliable and biased sources, including citing only those people of the same religious persuasion and views.

Whether claims and arguments that fit into these categories are due to genuine mistakes, carelessness in research or deliberate attempts to mislead, the outcome is the same: they provide very poor quality material on which to base consideration of legislation. On this issue, claims are made that the vast majority of people would find preposterous by any standard and not just the higher standards required for decisions on our laws.

3.2 ARGUMENTS AGAINST REFORM

Opponents of voluntary assisted dying predominantly use these main arguments against law reform:

- the sanctity of human life;
- the ‘slippery slope’ argument and the subsequent threats, especially to ‘vulnerable’ people, but also to society as a whole;
- it is inconsistent with the role of the doctor and it will have a negative impact on the doctor-patient relationship; and
- it is unnecessary because palliative care provides an adequate solution. The information and arguments against this claim are set out in Section 2.6 of this paper.

SANCTITY OF HUMAN LIFE

Those opposed to voluntary assisted dying legislation often premise their arguments on the notion that all human life is sacred, a gift from God, and that only God can take life away. Those who oppose reform from this particular religious viewpoint believe that there are no circumstances that can justify the deliberate and sanctioned taking of life.

However, this view is not held by all people who have a religious belief or affiliation. It is also the case that, in the pluralistic and secular society in which we live, it is important that the beliefs of all individuals be respected and tolerated. As Bartels and Otlowski explain, it is “... inappropriate to allow the beliefs of some individuals to dominate the law or to impinge on the freedoms of others. Only if the legal prohibition on active voluntary euthanasia is removed will everyone be able to live according to their own convictions: those who oppose voluntary euthanasia could reject it for themselves, while those who are in favour of the practice would not be forced to live against their convictions.”⁶⁵

THE 'SLIPPERY SLOPE' ARGUMENT

The 'slippery slope' argument holds that the legalisation of voluntary assisted dying would inevitably lead to a range of negative consequences, particularly for the most vulnerable in the community. The 1998 Parliamentary Committee report explained the 'slippery slope' argument as:

- *The acceptance of voluntary euthanasia for the terminally ill would lead to acceptance of voluntary euthanasia for non-terminal conditions;*
- *The acceptance of voluntary euthanasia will lead to involuntary euthanasia;*
- *The weaker members of society would be made more vulnerable through a diminishing of the value of human life and a subtle pressure would be brought to bear making the 'choice to die' a 'duty to die';*
- *Economic burdens both personal and social would encourage the euthanasia option for the weak and vulnerable;*
- *Suicide would become more prevalent in society as death is established as a 'quick fix' solution;*
- *Medical ethics and trust in doctors would diminish.*⁶⁶

We can be confident on the basis of the evidence now available to us, and which was not available to the 1998 inquiry, that these phenomena have not eventuated where legalised voluntary assisted dying has been enacted.

The idea of a 'slippery slope' depends on a number of false assumptions, such as the belief that there will be "no plausible halting points between the initial commitment to a premise, action or policy and the resultant bad outcome."⁶⁷ The Royal Society of Canada Expert Panel's report on end-of-life decision-making provides a detailed, erudite discussion on the general concepts involved in the 'slippery slope' approach.⁶⁸ The Royal Society's report concluded that the 'slippery slope' arguments "are, in almost all cases, *logically invalid*."⁶⁹ The report also states "Some slippery-slope arguments that can be found in the literature

about assisted dying are good examples of fear-mongering rather than of a realistic assessment of the risks that might accompany the decriminalization of assisted dying."⁷⁰

Importantly we note that there is no sound evidence that 'slippery slope' effects have eventuated. Indeed, the research demonstrating that 'slippery slope' effects have not been realised in those jurisdictions that have legalised voluntary assisted dying is considerable. This has remained the case even after many years of legalised voluntary assisted dying. We are convinced there is no good reason to assume that 'slippery slope' effects will occur in Tasmania given the range of safeguards and provisions that will necessarily be built in to legislation here. We believe that we can confidently expect that Tasmanian doctors will behave ethically and with professional due care in carrying out requests for voluntary assisted dying, and the monitoring and reporting mechanisms we propose will provide the means to ensure this is the case.

In relation to the issue of the impact on people in 'vulnerable' groups, a 2007 study by Battin et al asked the question "If physician-assisted suicide (PAS) and/or voluntary active euthanasia were legalised, would this disproportionately affect people in 'vulnerable' groups?"⁷¹ Using the data available in the annual reports on the operation of the Oregon and Dutch systems, the researchers analysed whether vulnerable groups of patients (such as the elderly or minors, people from racial or ethnic minorities or people with a physical disability) were over-represented in the statistics of patients who received an assisted death in those jurisdictions.

In response to the concerns that elderly people would be at risk, the research showed that in Oregon "Persons aged 18-64 were over three times more likely than those over age 85 to receive assisted dying ... [and] In the Netherlands, rates of assisted dying were lowest in the people over 80."⁷² The research concluded that "there is no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying – concerns that death in this way would be practiced more frequently on persons in vulnerable groups."⁷³ We recognise the concerns that opponents of voluntary assisted dying have

that “the small number of people who would likely to benefit from assisted dying legislation did not justify the risk to the much larger number of potentially vulnerable people.”⁷⁴ However, the evidence is not there to support the view that vulnerable people have been put at risk when voluntary assisted dying legislation has been introduced.

Bartels and Otlowski strongly argue that debates about a ‘slippery slope’ are flawed because they are starting “from an assumption that because euthanasia is presently prohibited, it does not occur.”⁷⁵ However, as has been explained in Section 2 of this paper, there is “incontrovertible evidence” that assisted dying is already occurring.⁷⁶ Bartels and Otlowski suggest that if “the practice were brought into the open, carefully regulated and subject to professional and public scrutiny, this would provide greater protection from abuse than retaining the current prohibition.”⁷⁷

Indeed, one of the key arguments used to justify the ‘slippery slope’ hypothesis is the incidence of doctors using drugs with the intention of ending a patient’s life without the patient’s explicit request. This practice would only be **caused** by voluntary assisted dying legislation if it **only** occurred in those places with such legislation. This is certainly not the case as this practice occurs in Australia and in many other countries that do not have specific voluntary assisted dying legislation (see Section 2). It is also the case that the incidence of the practice of intentionally ending a patient’s life without the patient’s explicit request has dropped significantly in the Netherlands and Belgium following the enactment of their legislation in 2002. Appendix 6 of this paper details information on the decrease that has occurred in the Netherlands from a high of 0.8 per cent per annum in 1990 (approximately 1000 deaths) to 0.4 per cent in 2005 (approximately 550 deaths) and to a low of 0.2 per cent in 2010.⁷⁸

THE ROLE OF THE DOCTOR

The third main argument against voluntary assisted dying centres on the role of the doctor. This argument holds that “it should never be a doctor’s job to kill. His or her obligation is to cure, to palliate and to care, not to end a patient’s life.”⁷⁹

The Hippocratic Oath is often referred to as the basis for this view, although for very good reasons it has been replaced by codes such as the Australian Medical Association’s Code of Ethics.⁸⁰ The Hippocratic Oath is an oath that requires allegiance to ancient Greek gods, refers only to male doctors and forbids surgery: it is clearly not a relevant model for 21st century medical care and treatment.

Through our research we have noted that there are indications an increasing number of doctors accept that, in some circumstances, it is ethical and good professional practice to agree to a request from a patient for assistance to die.⁸¹ It is recognised that the aim to ‘do no harm’ is not always achievable. Many medical procedures and treatments have side effects, some of them quite serious. A doctor has the responsibility to weigh up the benefits versus harm before recommending treatment. But it is the patient who, if competent to do so, must make the final decision as to which treatment, or no treatment, is a greater benefit and a lesser harm. A terminally ill patient with intolerable suffering may decide for themselves, on the basis of consultation and advice, that a peaceful assisted death is a far lesser harm than being forced to endure unrelievable suffering, or having to resort to violent methods of suicide as some terminally ill patients currently do.

A further fear expressed about the role of the doctor in a legislated system of voluntary assisted dying is the damage that could be caused to the relationship of trust between a doctor and his or her patient, should a doctor actively participate by providing assistance. We are not aware of any evidence that this damage has occurred as a result of voluntary assisted dying legislation that has now been in place for many years. In fact, there are indications that it has not occurred. For example, according to a survey in 2008, public trust in doctors in the Netherlands was at 91 per cent, amongst the highest in Europe, with Belgium not far behind at 88 per cent.⁸²

We believe that under a legislated model of voluntary assisted dying no doctor should ever be compelled to provide assistance against his or her conscience. However, those who choose to do so will be able to provide that assistance most responsibly within a carefully regulated and

safeguarded environment which provides the best professional and legal guidance.

We remain concerned about the risks of allowing assisted dying to occur in an unregulated environment. As Otlowski argues, not only is there a “very real risk of abuse if the law condones what is an unregulated practice. Because of the present criminality of the practice of active euthanasia, doctors may engage in the practice without necessarily consulting the patient, motivated by benevolent paternalism, and in the belief that they are acting in the patient’s best interests.”⁸³ One of our aims for proposing this model for voluntary assisted dying legislation is to encourage frank and open conversations that will improve provision of information and communication between the doctor and patient around end-of-life expectations. We believe this will improve, not erode, the doctor-patient relationship. Indeed, we note the comments of Ann Jackson in the judicial decision in *Carter v Canada* who explained:

*Until 2008, when I retired from the Oregon Hospice Association, I met with front-line hospice workers twice a year to discuss their experiences. Whether they supported or did not support the concept of physician-assisted dying or the ODDA, it is clear to me that conversations with patients and families and other health care professionals about death and dying had improved significantly once the ODDA, literally, put the topic on the table. When one can respond openly to a request for help in dying, the likelihood of successfully addressing fears or reasons behind the request is much greater.*⁸⁴

A Tasmanian doctor, Dr Keith Arthur, made a similar and important point in his evidence to the inquiry into the *Dying with Dignity Bill 2009*. Dr Arthur explained the great need for open conversations and the provision of information to patients:

Almost universally, all the patients who have requested euthanasia from me have withdrawn their request once I am able to ease their suffering or even the fear that they may suffer. Patients are reassured once they understand I have their comfort as a priority, that I will listen to them, inform them as best I can about options available,

*and promise to involve them in any decision making.*⁸⁵

3.3 CONCLUSION: WHAT DOES THE EVIDENCE SHOW?

In general, we are disappointed with the quality of claims and arguments against voluntary assisted dying legislation and have found that many of these claims and arguments do not meet the standards that should be required by parliamentarians when considering legislative reform. Specifically there has been a failure to substantiate perceived threats to society as a whole, to ‘vulnerable’ people, to the role of doctors, and to the doctor-patient relationship.

Some claims relate to legitimate concerns about potential risks. These concerns have been responded to through the incorporation of specific safeguards in the various voluntary assisted dying laws. Similar or the same safeguards and provisions are also included in our proposed model.

It is important that we learn from the experience of legalised voluntary assisted dying which has been in place in Oregon since 1997, the Netherlands and Belgium since 2002 and Washington since 2008. The evidence we have available on how these regimes are working is increasing every year. This allows observers to better understand the risks and how they can be mitigated and, in particular, to be assured that vulnerable people in those jurisdictions are not disproportionately represented in the statistics of patients who choose an assisted death.

Fifteen years of evidence from Oregon in the United States suggests that having the option of an assisted death has provided reassurance to terminally ill patients. And from the data released each year we can see clearly that not every patient provided with a prescription actually takes the medication to end their lives. In 2012, 115 prescriptions for lethal medication were issued but only 77 took the medication.⁸⁶

There is also evidence that “Those who received physician-assisted dying ... appeared to enjoy comparative social, economic, educational, professional and other privileges.”⁸⁷ The work of the Commission on Assisted Dying included interviews with experts in the Oregon, Switzerland, the Netherlands and Belgium which confirmed this conclusion, explaining that “the broad consensus among those interviewed ... was that it is not vulnerable people who lack capacity or who are experiencing pressure from others who are actually having assisted deaths ... it is usually the better educated, more articulate people who are able to access an assisted death.”⁸⁸

Findings such as this are understandable because the requirements that must be met to access voluntary assisted dying are considerable and the processes are necessarily demanding. It is illogical and unreasonable to trust the stereotype of the rapacious relative being able to manipulate their terminally ill family member through these processes and to an in-voluntary assisted death.

In debates about voluntary assisted dying legislation, the impact that any law change would have on vulnerable groups is a frequently cited concern. We recognise and acknowledge fears expressed by opponents of voluntary assisted dying with regard to the possible risks posed to vulnerable groups. We recognise that close and constant attention must be given to the operation of laws that allow for any form of voluntary assisted dying and have made provision for this in our proposed model. We have sought to improve safeguards as a result of learning from overseas experience and based on a well-founded assessment of the risks. We are convinced that after intense scrutiny, researchers have conclusively shown that there is “no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.”⁸⁹

4. VOLUNTARY ASSISTED DYING LEGISLATION IN PRACTICE

4.1 KEY SIMILARITIES AND DIFFERENCES

Voluntary assisted dying legislation is currently in place in Oregon (1997), the Netherlands and Belgium (2002), Washington State (2008), and Luxembourg (2009). Physician-assisted suicide is also considered legal in the US state of Montana as a result of a court decision that recognised that the consent of a terminally ill patient can constitute a statutory defence to a charge of homicide against an aiding physician. Switzerland does not have a specific law on voluntary assisted dying but, since 1942, under the Swiss Criminal Code it is not a crime to assist someone to take their own life, provided the person assisting does not have selfish motives. Voluntary assisted suicide was legalised in the Northern Territory in Australia in 1995 but this law was overturned by the Federal Parliament in 1997.

The evidence from overseas shows that over the past fifteen years it has been possible to create a safeguarded legislative framework that allows for medical assistance in death, provided that a number of specific criteria and reporting requirements are met.

Through our research into the different models in place overseas we have identified a number of key similarities between the various laws. These are:

- The request for assistance must be voluntary, consistent and persistent.
- The person making the request must be mentally competent and capable of making the decision.
- The doctor's involvement is voluntary.
- More than one doctor must be involved.
- The patient is not offered assisted dying, they must request it.

- There are specific reporting and monitoring requirements that must be adhered to.
- The patient must be a resident of the jurisdiction.

We propose that all these requirements be included in any Tasmanian legislation.

There are also a number of key differences between the various laws on voluntary assisted dying. These are:

- Whether assisted dying is provided through specific legislation designed for that purpose.
- Whether there is a requirement that the patient have a terminal illness or whether the presence of suffering be grounds for assistance.
- The definitions around 'terminal illness' and the prognosis (life expectancy) of the patient.
- Whether the patient can request assisted dying through an advance directive and this could be carried out by a doctor even when the patient is no longer competent to confirm the request.
- Whether the doctor administers the lethal medication or the patient must self-administer.
- The age of the patient who can receive assistance to die.
- The type and number of doctors involved.
- Whether the doctors involved are required to be independent from each other.
- Whether there are waiting periods and for how long.

The way in which a jurisdiction brings about a change in law will influence the outcome of that law. Professor Penney Lewis notes that "Legal

change on assisted dying may be achieved in a variety of ways: challenges to criminal prohibitions using constitutionally entrenched rights; the use of defences available to defendants who are prosecuted for assisting a death; legislative change; or referenda or ballot measures proposed by individual citizens or interest groups.”⁹⁰ Given the variety of circumstances that could lead to a change in the law on voluntary assisted dying, we cannot simply rely “on the experience of one jurisdiction when discussing proposals for regulation of assisted dying in others.”⁹¹ The different approaches identified by Lewis above have created different laws and represent different community expectations with regard to voluntary assisted dying.

Appendix I of this Consultation Paper sets out the key requirements of the laws in place in Oregon, Washington, the Netherlands, Belgium and Switzerland as well as the recommendations put forward in the reports from the Commission on Assisted Dying and the Royal Society of Canada. Table I below also summarises the safeguards and provisions in existing legislation.

Appendixes 5 and 6 set out key data on the operation of the laws in place in Oregon and the Netherlands. One of the most interesting facts evident from this data is that regardless of the differences in the legislation, over 80 per cent of those who choose assisted dying have a form of cancer. This fact also helps to explain why there is increasing pressure for a voluntary assisted dying option here: an increase in the incidence of cancer is a phenomenon in countries such as Australia which is experiencing a rapidly ageing population.

In Oregon data is also collected on end-of-life concerns. The most frequently cited concerns are:

less able to participate in activities making life enjoyable, loss of autonomy and loss of dignity. Other end of life concerns mentioned include losing control of bodily functions; concerns about being burden on family, friends/caregivers; and inadequate pain control.⁹² The data published annually on the operation of the Oregon *Death with Dignity Act 1994* has also shown that “compared with other Oregonians who die, those who choose PAD [physician-assisted dying] are somewhat younger, predominantly white, better education, less likely to be married, and more likely to die of cancer and amyotrophic lateral sclerosis.”⁹³

The data in the annual reports also shows the small rate of voluntary assisted dying, from approximately 0.2 per cent of all deaths in Oregon to 2.9 per cent of deaths in the Netherlands. These statistics reflect the claims that only a small percentage of people struggle to find appropriate relief at the end of their lives. We have every reason to believe that in Tasmania the incidence of assisted dying will be similarly rare. In Tasmania in 2011-12 there were 4,360 deaths.⁹⁴ Considering the small percentage of deaths attributable to voluntary assisted dying in Oregon and the Netherlands, the number of deaths due to specific voluntary assisted dying legislation in Tasmania could be reasonably expected to range from around 8 to approximately 120. It is impossible to know for certain what the number of assisted deaths in Tasmania would be, but we can reasonably assume it would be closer to the lower number, given that our model is more similar to that of Oregon than the Netherlands, which does not have a terminal illness requirement.

TABLE I SAFEGUARDS AND PROVISIONS IN EXISTING LEGISLATION

Provision/Safeguard	Netherlands	Belgium	Oregon	Washington
Specific legislation	<i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001</i>	<i>Act on Euthanasia 2002</i>	<i>Oregon Death with Dignity Act 1994</i>	<i>Washington Death with Dignity Act 2008</i>
Patient administered	Yes	Yes [*]	Yes	Yes
Doctor administered	Yes	Yes	No	No
Terminal illness or condition	No	No	Yes	Yes
Suffering	Yes	Yes	No	No
Mental competence	Yes	Yes	Yes	Yes
Informed decision	Yes	Yes	Yes	Yes
Voluntary request by patient	Yes	Yes	Yes	Yes
Written request	Not specified but generally provided	Yes	Yes	Yes
Request by advance directive	Yes	Yes	No	No
Age – only adults aged over 18	No	No	Yes	Yes
Residency requirement	Not specified but required	Not specified but required	Yes	Yes
Consultation requirement	Yes	Yes	Yes	Yes
Independent consulting doctor	Yes	Yes	No	No
Voluntary participation by doctor	Yes	Yes	Yes	Yes
Specified Waiting period	No	Yes ^β	Yes	Yes
Family notification recommended	No	Yes	Yes	Yes
Opportunity to revoke request	Not specified	Yes	Yes	Yes
Reporting of cases	Yes	Yes	Yes	Yes

^{*} While the Belgian Act only mentions euthanasia, the federal oversight body has acknowledged that some cases of physician-assisted suicide could be covered by the law.

^β For patients who are not expected to die in the near future, the attending physician must “allow at least one month between the patient’s written request and the act of euthanasia” (§3(3)(2)).

5. PROPOSAL FOR A TASMANIAN BILL

5.1 WHAT THE PROPOSED MODEL IS DESIGNED TO ACHIEVE

Legislation to allow for voluntary assisted dying in Tasmania would not give anyone an unfettered right to medical assistance to help them die. What it would provide is the opportunity for a terminally ill patient who makes a voluntary request for assisted dying to have their request considered thoroughly, carefully and compassionately.

Like other laws on voluntary assisted dying, our proposed model is designed to establish safeguards through clear requirements that must be met and processes that must be followed by doctors in dealing with the request and providing assistance. It is also designed to have clear reporting requirements that protect patient and doctor privacy while enabling scrutiny of data and reporting.

There will also be a careful monitoring and review system through the establishment of an independent oversight mechanism. The independent body would be responsible for the collection, analysis and public reporting of data. In addition, we are proposing that a full review of the legislation take place every five years. We have taken into account criticism of other systems that monitor retrospectively, that is after an assisted death has occurred, and therefore propose an additional safeguard of reporting requirements that must be satisfied at different stages of the process before an assisted death is carried out (see Section 5.17).

The model we are proposing will reinforce the right of those who do not want or support voluntary assisted dying to not access this option or provide assistance. This will apply to patients, doctors, pharmacists and others involved in the care of the patient. We believe it is important that accessing an assisted death be a last resort option when all other care and treatment options have been made known and considered by the patient. Only patients in the advanced stages of a diagnosed terminal condition will be able to access an assisted death.

The proposal we are putting forward is patient-centred. It is the patient that must initiate the request and the process we are proposing can only continue when the patient takes the next step. We also note the evidence from overseas that demonstrates that many patients who start the process do not continue to the end. For these patients, the prospect of an assisted death is recognised as providing comfort and peace of mind should their suffering and quality of life become unbearable. We believe that our proposed legislation will provide the same peace of mind to Tasmanians at the end of their lives.

The model we have developed is designed to achieve a number of other positive outcomes including:

- Encouraging frank and open conversations that improve the provision of information and communication between the doctor and the patient around end-of-life expectations. This is likely to improve doctor-patient relationships.
- Helping patients gain a better understanding of the different care and treatment options they have available to them. This will assist the patient to have their fears allayed and help address any misunderstandings.
- Providing a greater understanding and awareness of the role and scope of palliative care and how it can help the patient.
- Increasing awareness and reinforcing of the legal rights of Tasmanians to make important choices about their health and personal care. These choices include the right to refuse medical treatment or to withdraw from medical treatment, to make wills, appoint an Enduring Guardian, give someone they trust Power of Attorney, and make an Advance Care Directive.
- Providing legal and professional guidance and support for doctors who receive requests from their patients for assistance to die and who want to respond legally and responsibly to provide such assistance in line with their ethical and professional judgement.

- Providing legal and medical professional oversight of end-of-life decision-making with careful monitoring and ongoing review.
- Improving respect and acceptance of the law by aligning it more closely with community opinion and expectations.

5.2 ABOUT THE PROPOSED MODEL

The proposed provisions and safeguards for a Tasmanian model of voluntary assisted dying put forward in this Consultation Paper differ in a number of respects from the existing models found overseas. This is because of the need to make sure that any legislation proposed for Tasmania is compatible with the particular characteristics of the Tasmanian legal, medical and social environment and the need to learn from the experience overseas.

As has been explained in Section 4, while there are a number of similarities between overseas models, there are also significant differences and this fact is often ignored in the debate on voluntary assisted dying. The kind of legislation that suits one jurisdiction may not necessarily be wholly suitable for the Tasmanian context. We can certainly learn from overseas experiences, but in putting forward a proposed model for Tasmania we have not simply been able to adopt an existing approach found in any one jurisdiction.

A legal framework that allows for voluntary assisted dying means that transparency of decision-making will be increased. Proper legal processes, particularly around decision-making and reporting increases accountability and can help us to understand with more certainty the reasons why a terminally ill patient might choose an assisted death. This in turn allows us to be satisfied that a patient's motivation is based on a well-informed, voluntary decision that they are competent to make and not because they are unaware of other more suitable options.

Our model is set out in Sections 5.3 to 5.17. Through the literature on voluntary assisted dying frameworks and reviewing the safeguards and

provisions contained in the legislation in place in Oregon, Washington, the Netherlands and Belgium we have identified 15 key provisions that we believe should be included in any responsible legislation for Tasmania on voluntary assisted dying.⁹⁵ These provisions, which provide safeguards against abuse, set out requirements in relation to:

- voluntariness;
- mental competence;
- informed decision;
- the person's condition and/or experience of suffering;
- the type of assistance;
- the age of the patient;
- requirement for a written request;
- residency requirements;
- consultation and referral requirements;
- the identity of the assisting doctor;
- specified waiting (or 'cooling-off') periods;
- family notification;
- due medical care and safe handling of prescription medicines;
- opportunity to rescind the request; and
- the reporting and scrutiny of cases.

A comparison of how these safeguards and provisions operate in Oregon, Washington, the Netherlands and Belgium is set out in the tables contained in Appendix I. The approach taken in Switzerland is also included in the tables and where possible an example from the DIGNITAS guidelines is given. Although there are a number of right-to-die organisations in Switzerland, DIGNITAS was chosen because it allows non-Swiss citizens to become members and access an assisted death. Where the Commission on Assisted Dying or the Royal Society of Canada Expert Panel made recommendations regarding these safeguards and provisions in their reports, these are also included in the tables in Appendix I.

TABLE 2 OVERVIEW OF THE PROPOSED TASMANIAN MODEL

Provision/Safeguard	Proposal
Voluntary request by patient	Yes
Mental competence	Yes
Informed decision	Yes
Advanced stages of a terminal illness or condition	Yes
Treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient’s condition or alleviate his/her suffering adequately to the satisfaction of the patient.	Yes
Patient administered	Yes
Doctor administered	Yes
Age – only adults aged over 18	Yes
Written request	Yes
Request by advance directive	No
Residency requirement	Yes
Consultation requirement – independent assessment	Yes
Voluntary participation by doctor	Yes
Specified waiting period	Yes
Family notification recommended	Yes
Opportunity to rescind request	Yes
Safe handling of prescription medicines	Yes
Reporting and oversight of cases	Yes

5.3 VOLUNTARINESS

PROPOSED MODEL

- We propose that only voluntary requests for assisted dying be considered.
- There will be multiple checks during the process to confirm the persistence and consistency of the voluntary request, in addition to other provisions, that together contribute to confirmation of the voluntary nature of the request.
- Requirements to establish the voluntary nature of the request will include a signed written request by the patient that confirms that their request is voluntary, informed and is not being made as the result of coercion or under duress.
- We propose that to help confirm the voluntary nature of the request the patient identify the reasons for their request. This data will be collected by the independent oversight body.
- The attending doctor, the consulting doctor and the witnesses to the patient’s written request will contribute to the confirmation of the voluntary nature of the request.
- The patient must always voluntarily initiate the conversation about assisted dying. It is not appropriate for the patient’s doctor, a family member or a social care professional to offer the option of an assisted death to a terminally ill patient.
- The patient must always initiate each stage of the process.

RATIONALE

We are proposing that only persistent and consistent voluntary requests for an assisted death can be considered. We are also proposing multiple checks to establish and confirm that this requirement is met throughout the process in order to provide a very high level of assurance that assisted dying will only be available to those who have made a free, informed and voluntary choice.

The patient must firstly state in writing, as part of their signed written request, that their request is voluntary, informed and is not being made as the result of coercion or under duress.

In order to confirm the voluntariness of the patient's request we are recommending that the patient's written request be signed by two witnesses who confirm that to the best of their knowledge the patient is acting voluntarily. Both the attending and consulting doctors would also be required to declare that to the best of their professional judgement the patient has made a voluntary request and to identify the reasons for this judgement.

It is also important that the doctor takes the time to talk to the patient about their request and their reasons for making this choice. In this regard the provision 'Informed Decision' is also important in ensuring the patient is acting of their own accord (see Section 5.5).

The patient themselves would need to state in their request the reasons for wanting an assisted death. This is also an indicator that the request is considered and coherent. This data is collected in other jurisdictions and provides authorities with useful information and a clearer understanding of the factors that motivate terminally ill patients to request assistance to die. For example, in Oregon the primary reasons recorded relate to the concern about losing autonomy, the inability to engage in activities making life enjoyable, the loss of dignity, and losing control of bodily functions. Lesser ranked concerns include the impact of being a burden on family and care givers, inadequate pain control and the financial implications of treatment.⁹⁶

We propose that the request must always be initiated by the patient and it is not appropriate for a patient's doctor, a family member or a social care professional to offer the option of an assisted death to a terminally ill person. The patient must always initiate the process moving to the next stage and they will always have the right to rescind their request at any time and in any manner (see Section 5.16)

OVERVIEW OF OTHER JURISDICTIONS

Ensuring that a patient's request is voluntary is a condition in Oregon and Washington where both the attending and consulting physicians are required by law to confirm that the patient is making a voluntary request.⁹⁷ The witnesses to the patient's written request must also confirm this.⁹⁸ Lewis and Black note in their report on the effectiveness of safeguards that "In Oregon some cases have raised voluntariness concerns due to failures to meet the witnessing requirements designed to ensure voluntariness."⁹⁹ To confirm that the witnessing requirements are met under our model, we are proposing that the original copy of the patient's written request be forwarded to the independent oversight body early in the process and not as a retrospective action (see Section 5.17).

The Dutch and Belgian legislation also specifies that the patient's request must be voluntary.¹⁰⁰ The importance of ensuring that only voluntary requests are progressed was also stressed in the reports from the Royal Society of Canada Expert Panel and the Commission on Assisted Dying.

In Switzerland, in the absence of a specific law on voluntary assisted dying, individual right-to-die organisations have developed their own internal protocols to ensure a member is eligible for assistance and is making a voluntary request. For example, the DIGNITAS guidelines state that:

... throughout the entire process of preparing an AS [assisted suicide], 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.¹⁰¹

The guidelines issued by DIGNTAS also state that 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 a third person or even someone who is present, the conversation will be continued by giving both DIGNTAS escorts the chance to speak with the member alone. If the doubts of both DIGNTAS escorts cannot be completely removed in this way, then the AS will be cancelled.¹⁰²

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 8(1)(h) requires the patient's medical practitioner to be satisfied that the patient has made their decision for an assisted death voluntarily. Section 8(1)(k) requires the second medical practitioner to confirm the voluntary nature of the patient's request. A record that the patient's request was made voluntarily is required to be attached to the patient's medical record under Section 14(3).

5.4 MENTAL COMPETENCE

PROPOSED MODEL

- We propose that only competent patients can access an assisted death. Competent means that the patient is able to communicate health care decisions for themselves and is not suffering from impaired decision-making due to a psychiatric or psychological disorder or depression.

- Both the attending doctor and consulting doctor must confirm that the patient is competent.
- If either doctor is unsure about the patient's competence then they must take all necessary steps to resolve that uncertainty.
- The witnesses to the patient's written request must also confirm that the patient is competent to the best of their knowledge and belief.

RATIONALE

We propose that only competent patients be able to make a request for an assisted death. By this we mean that the patient is able to communicate health care decisions for themselves and is not suffering from impaired decision-making due to a psychiatric or psychological disorder or depression.

Under our proposed model, it will be the responsibility of both the attending doctor and consulting doctor to confirm that the patient is competent. The witnesses to the patient's written request must also confirm that, to the best of their knowledge and belief, the patient is competent.

It will also be a requirement that if either doctor is unsure about the patient's competence then they must take all necessary steps to resolve that uncertainty.

OVERVIEW OF OTHER JURISDICTIONS

The importance of mental competence is specified in the legislation of Oregon, Washington, the Netherlands and Belgium. While the laws in place in Oregon and Washington are largely identical, for this provision the Oregon Act refers to the patient's 'capability' and the Washington Act refers to 'competence'. However, the definitions they offer are the same and, in both Acts it is stated that if either the attending or consulting physician are of the opinion that "a patient may be suffering

from a psychiatric or psychological disorder causing impaired judgement” they must refer the patient for counselling.¹⁰³ If a counselling referral is made the patient’s application for assisted dying can only progress once it is confirmed that the patient is not suffering from a depressive illness causing impaired judgement.

In Belgium the patient must be “legally competent and conscious at the moment of making the request.”¹⁰⁴ In the Netherlands the patient’s request must be carefully considered and the “attending physician must ... ascertain, or obtain confirmation, that the patient is capable of making an informed decision.”¹⁰⁵

In Switzerland the patient must be mentally competent “if their act is to be considered suicide. The physician must personally examine the person seeking assistance and assess their capacity according to the test set out in the [Criminal] Code. Individual right to die associations have also developed their own [capacity] tests.”¹⁰⁶

Both the reports from the Commission on Assisted Dying and the Royal Society of Canada Expert Panel recognised the importance of the patient being competent to make a request for an assisted death. The Commission identified “the mental capacity to make a voluntary and informed choice” as a key requirement with “the person’s decision-making ... not significantly impaired as a result of mental health problems such as depression.”¹⁰⁷ In Canada, the Royal Society Expert Panel recommended that only competent patients be allowed to access an assisted death and that if the physician was uncertain about the patient’s competence then “they must take all necessary steps to resolve that uncertainty.”¹⁰⁸

DEPRESSION

In their report on the safeguards of assisted dying laws, Lewis and Black highlighted that “Considerable disagreement exists over the prevalence of mental disorder in individuals who request physician assisted suicide, and the influence that mental disorder may have on capacity to request assisted dying.”¹⁰⁹ Other research has concluded that “a level of ‘appropriate sadness’ or depression is considered normal in terminally ill

patients approaching the end of their life. Further, the existence of depression does not necessarily mean that a person lacks mental capacity.”¹¹⁰ The research of Lewis and Black confirms this finding noting “In both the Netherlands and Oregon, depression is significantly less prevalent in granted requests than in refused requests, and in the Netherlands, severe depression is not significantly present in requests generally. This evidence would appear to suggest that individuals with depression who receive assisted dying nevertheless retain capacity to make a request.”¹¹¹

A Canadian study highlighted that depression is a feature of terminal illness and it is part of the anxiety patients feel “about the process of dying, particularly if they have illnesses they feel will result in choking, suffocating, or intractable pain.”¹¹² Further, the Regional Euthanasia Review Committees in the Netherlands note that “it is normal for patients to be in low spirits in the circumstances in which they make a request for euthanasia, and that this is therefore not generally a sign of depression.”¹¹³

There are reported cases of patients with a mental illness or disorder accessing an assisted death under the Dutch model. The 2010 annual report of the Regional Euthanasia Review Committees explains that:

*In general, requests for termination of life or assisted suicide because of unbearable suffering with no prospect of improvement that arises from a mental illness or disorder should be treated with great caution. If such a request is made by a psychiatric patient, even greater consideration must be given to the question of whether the request is voluntary and well-considered. A mental illness or disorder may make it impossible for the patient to determine his own wishes freely. The physician must then ascertain, or obtain confirmation, that the patient is decisionally competent.*¹¹⁴

The report goes on to explain that in that reporting year there were two notifications of assistance provided to patients with psychiatric problems. One of those cases is included as a case study. This case study is set out in great detail and explains the circumstances of a female patient who had been suffering from vital depression since the 1980s that was proving to be therapy resistant. Three independent physicians were consulted and

examined the patient and reviewed her case history and medical records. The Regional Euthanasia Review Committees found that the physician had acted with due care in assisting the patient.

The 2008 annual report from the Regional Euthanasia Review Committees also details a case study of a female patient who was suffering from a psychiatric illness. In summary, the Committees made the following findings with regard to this case:

After a period of hospital admissions and outpatient treatment, the patient, a woman between 60 and 70 years of age, was admitted to an institution for psychiatric patients. She was suffering from a serious, chronic, therapy-resistant depressive disorder, and for many years had had recurrent, serious depressive episodes with suicidal tendencies. She had been extensively treated with electroconvulsive therapy (ECT) and a range of medicines. Light therapy and sleep deprivation had also been tried, as well as a number of psychotherapy sessions. According to current professional views on the treatment of depression, there were no alternative treatments left.

... from the end of 2007 onwards the patient repeatedly and specifically asked the physician to terminate her life. ... In early 2008, a neuropsychological examination was also carried out. Like the clinical impression, the examination revealed no evidence that the patient was incapable of understanding the implications of her request.

Her suffering entailed feelings of anxiety and gloom, as a result of which she had ceased to engage in social activities. She was no longer able to enjoy anything.

... The physician was satisfied that there was no prospect of improvement in the patient's suffering. All the stages of the depression treatment protocol had been completed without there being any improvement in her condition. Her depressive mood was so prolonged and persistent that spontaneous recovery was unlikely. Even if this did occur there was a risk of relapse, just as there had been after her first ECT treatment: within six months she had been readmitted to hospital with

new depressive symptoms that had started two months after the treatment.

The available medication could not be used effectively, either as a direct cure or as maintenance treatment, because of side effects which the patient found unbearable, including hypertension, hair loss and increased anxiety. She found these side effects very distressing, and this contributed to her sense of despair and hopelessness.

... The physician was satisfied that her suffering was unbearable. The patient was always consistent and specific in describing her symptoms, and he therefore took them seriously.

The physician called in a psychiatrist for an expert second opinion. ... The psychiatrist concluded that, although the patient was suffering from serious, therapy-resistant depression, she was decisionally competent and her request for assisted suicide had been voluntary and well-considered.

Although unbearable suffering in psychiatric patients is hard to determine objectively, the expert concluded that the patient's suffering was palpably unbearable. Part of what made it unbearable was that there was very little or no prospect of improvement. All attempts to resocialise the patient had failed. Despite her good relations with various members of her family and years of supportive therapy, she had proved quite unable to improve her poor quality of life. The expert concluded that she no longer had any alternatives left.

The physician consulted another expert, also a psychiatrist, on whether a third ECT treatment – something the patient was opposed to – would serve any purpose. The expert stated that little could be expected of this form of therapy.

... The committee concluded from the physician's excellent and very detailed report that the entire procedure had been very meticulous. There had been many preliminary stages before the assisted suicide took place. Two independent physicians, as well as other experts including several psychiatrists, had been involved in the case, and had given their substantiated opinion on whether the due care criteria had been fulfilled.

The committee found that the physician had acted in accordance with the due care criteria.¹¹⁵

Clearly cases such as these are very sensitive and, particularly for observers outside the medical profession, can be more difficult to make sense of than cases that involve a patient suffering from a terminal illness such as cancer. Decisionally competent patients suffering from therapy resistant depression have been able to access an assisted death in the Netherlands as the annual reports from the Regional Euthanasia Review Committees detail. What has been important in these cases is the confirmation by the physician and the independent consultant that “the patient’s suffering was lasting and unbearable,”¹¹⁶ and that together the patient and the physician have come to the conclusion “that there was no other reasonable solution for the situation he was in”¹¹⁷ as required under the Dutch Act.

The issue of expanding the scope of the Oregon Act to allow for mentally ill patients to access an assisted death was recently voted down in the Oregon Legislature.¹¹⁸

DEMENTIA

The question of whether a person with dementia should be able to request an assisted death often comes up in the debates around assisted dying. In the Netherlands a small number of patients with dementia have accessed an assisted death and these cases have been documented in the annual reports of the Regional Euthanasia Review Committees. In 2010 there were 25 notifications involving patients suffering from dementia and in each case the Committees found that the patient’s doctor had acted with due care.¹¹⁹ The Committees noted that:

The patients were in the initial stages of the disorder and still had insight into the condition and its symptoms (loss of bearings and personality changes). They were deemed decisionally competent because they could fully grasp the implications of their request.¹²⁰

The Committees’ highlight in their annual report that additional caution that must be exercised by

physicians when dealing with requests from patients with dementia:

They must take the stage of the disorder and the other specific circumstances of the case into account when reaching a decision. Patients at a more advanced stage of the disorder are less likely to be decisionally competent. If a patient is in the initial stages of dementia, it is advisable to consult one or more experts, preferably including a geriatrician or a psychiatrist, in addition to the independent physician. Apart from whether or not the request is voluntary and well-considered, the question of whether there is no prospect of improvement in the patient’s suffering, and above all whether the suffering is unbearable, should be key elements in the physician’s decision in all such cases.¹²¹

The 2010 annual report included a case study of a female patient in her eighties who was suffering from Alzheimer’s. In summary, the report explained:

Since mid-2009 the patient, a woman in her eighties, had felt she was becoming forgetful. ... In early 2010, at her own request, she was examined by a psychiatrist, who found her to be decisionally competent. She then underwent a neuropsychological examination to determine whether there was cognitive deterioration. Several functional disorders and general cognitive deterioration were found, and it was concluded that she was suffering from incipient dementia, possibly Alzheimer’s disease. This was confirmed by a geriatrician who was consulted by the attending physician. ... [the patient] realised she was already suffering from slight dementia, and was afraid of a further decline which, among other things, would lead her to become dependent and incontinent, and to lose her way.

... The patient had experienced at close hand what Alzheimer’s disease could be like. Her mother, sisters and brother had all had the disease in later life, and had eventually died in nursing homes. ... The loss of dignity that accompanied the disease had made a deep impression on her. ... She did not want to experience undignified deterioration as a result of dementia, and had therefore signed an advance directive back in 1993. Her disease was incurable, and there was

no prospect of improvement in her suffering. This was unbearable to her.

... She did not want to experience the total humiliation and loss of dignity that the disease would eventually lead to.

The independent physician's report confirmed that the patient's suffering was unbearable with no prospect of improvement, and stated that her fear of the future was realistic. There were no alternative ways to alleviate her suffering.

The committee found that the physician could be satisfied that the patient's request was voluntary and well-considered, that her suffering was unbearable with no prospect of improvement, and that the physician had acted in accordance with the statutory due care criteria.¹²²

Although a patient in Belgium can request an assisted death through an advance directive, this would not appear to apply to cases of future incompetence, such as dementia, because the trigger for acting on the advance request, as set out in the Act, is unconsciousness.¹²³

We recognise that dementia is a devastating and challenging illness, both for the patient and their family and carers. We also recognise that for those people who have watched family members suffer with dementia, or are in the early stages of the disease, the thought of being able to access an assisted death through an advance directive could provide a sense of security and peace of mind. However, we do not have the level of evidence about how to ensure sufficient safeguards, nor do we believe that there has been wide community consideration of, or support for, this option. We are therefore proposing that only patients who are mentally competent at the time assistance is to be provided should be able to access an assisted death.

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Schedule 1(2)(d) of the *Dying with Dignity Bill 2009* required that the witnesses to the patient's request (the patient's medical practitioner and the

second medical practitioner) are required to attest that the patient is mentally competent.

Section 3 of the *Dying with Dignity Bill 2009* defined mentally competent as meaning:

- a) an ability of the sufferer after being given relevant information to understand the general nature of the illness or condition; and to understand the benefits and risks of, and to weigh the pros and cons of, presented medical treatment and palliative care options as well as a request for assistance to end his or her life;
- b) a capacity of the sufferer to make a decision freely, voluntarily and after due consideration.

The Joint Standing Committee on Community Development found that:

... the use of two criteria in the definition creates ambiguity. As there is no link between the two criteria, 'mentally competent' may be perceived to be either when a sufferer 'understands the general nature of the illness' or when a sufferer has the capacity to 'make decision freely'. The definition could be made more precise if it stated that both '(a)' and '(b)' had to be demonstrated before a sufferer could be declared to be mentally competent.¹²⁴

Clearly, this kind of drafting issue can be easily overcome. At this stage we propose to use a definition of 'competence' that is similar to the definition found in the legislation in place in Oregon and Washington. These Acts state that capable/competent means:

... that in the opinion of a court or in the opinion of the patient's attending medical practitioner or consulting medical practitioner, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those person are available.¹²⁵

Section 8(1)(c)(ii) of the *Dying with Dignity Bill 2009* required the patient to be examined by a qualified psychiatrist. Section 8(c)(iv) required the qualified psychiatrist to confirm the mental competence of the patient making the request. The report from the Joint Standing Committee made no comment about this requirement, except to note that the

psychiatrist was not required to sign the patient's certificate of request, and that the patient may lose competence in the intervening period between a psychiatric assessment and the issuing of a certificate of request.¹²⁶

5.5 INFORMED DECISION

PROPOSED MODEL

- We propose that to be eligible for an assisted death a patient must make an informed decision.
- To ensure the patient is making an informed decision, we propose that the attending doctor must inform the patient of:
 - their medical diagnosis and 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 such as palliative care, pain control and hospice care.
- In signing the doctors' declaration form both the attending doctor and the consulting doctor will certify that the patient is making an informed decision.

RATIONALE

Under our proposed model the patient's attending doctor would be required to inform the patient of their prognosis and diagnosis, the risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives to an assisted death such as palliative care and pain management strategies.

This approach will allow doctors to explore different treatment options to an assisted death with their patients, while respecting their patient's right to refuse any treatments that they consider burdensome. This conversation could also play an important role in helping to screen for involuntary requests.

We are also proposing that both the attending and consulting doctors must certify that the patient is making an informed decision prior to the patient being issued with a prescription for lethal medication. This certification would be through signing the doctors' declaration form and submitting it to the independent oversight body.

OVERVIEW OF OTHER JURISDICTIONS

Each example of voluntary assisted dying legislation considered in this paper recognises the importance of the patient making an informed decision. The Oregon and Washington Acts state that:

*A person shall not receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision. Immediately before writing a prescription for medication ... the attending physician shall verify that the qualified patient is making an informed decision.*¹²⁷

In order to make an informed decision under the Oregon and Washington Acts the patient's attending physician is required to advise the patient of his or her medical diagnosis; his or her prognosis; the potential risks associated with taking the medication to be prescribed; and the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.¹²⁸ Under both the Oregon and Washington Acts the consulting physician must also confirm that the patient is making an informed decision.¹²⁹

Under the Dutch Act the patient's request must be informed and the physician is required to "inform the patient about the situation he was in and about his prospects,"¹³⁰ and the process in the Netherlands can take many months as "a typical patient will have discussed the request for euthanasia with their doctor many, many times."¹³¹

In Switzerland, individual right-to-die groups have their own guidelines to determine whether certain preconditions set by their organisations have been complied with before an assisted death can proceed.

Section 3.1 of the Belgian Act states that the patient's decision must be "well considered". Under the Belgian Act the physician is required to "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 course of action and their consequences."¹³²

The Royal Society of Canada Expert Panel concluded that in any assisted dying regime the decision of the patient "must be voluntary and informed [and] ... Great care must be taken to ensure that, at the time of the decision, the person is able to understand and appreciate the nature and consequences of the decision."¹³³ In the United Kingdom, one of "the key elements that the Commission on Assisted Dying considered should underpin any future statutory framework for assisted dying [is that the patient] ... who requests an assisted death is fully informed of all the options available to them for treatment, care and support and still wishes to proceed."¹³⁴

A 'PALLIATIVE FILTER'

The debate about whether a law on voluntary assisted dying should have a 'palliative filter' stems from concerns that "the average doctor might have limited knowledge of the palliative care options that are available."¹³⁵ A 'palliative filter' is defined as "A process through which applicants must go in order to see to what extent their needs can be met through good quality palliative care before deciding to have their lives ended."¹³⁶ The evidence of the effectiveness of a palliative filter is not available because it is not a legal requirement in any jurisdiction. However, in Belgium the absence of a legislative requirement has not prevented a number of institutions from developing their own policies, in addition to the statutory requirements, which obliges the patient to undertake a mandatory palliative care consultation after requesting an assisted death.¹³⁷

We believe that providing palliative care that is satisfactory to the patient should be central to medical decisions made at the end-of-life. In discussing the due care criteria of 'no reasonable alternative', the Regional Euthanasia Review Committees in the Netherlands explain that 'satisfactory palliative care':

*... does not mean that the patient has to undergo every possible form of palliative care or other treatment. Even a patient who is suffering unbearably with no prospect of improvement can refuse palliative care or other treatment. One factor that can lead a patient to refuse palliative or other treatment is, for example, that it may have side effects which he finds hard to tolerate and/or unacceptable. In that case, he does not consider that the effect of the treatment outweighs its disadvantages.*¹³⁸

We recognise that palliative care is not able to provide adequate relief to all terminally ill patients, despite the extremely important role it plays in the care of patients and their families at the end-of-life. In the Tasmanian health system, patients already have the right to refuse treatment. We support the right of patients to refuse any treatments they consider burdensome, including palliative treatments. We firmly believe that palliative care options must be explained to terminally ill patients who request an assisted death. However, we do not consider it reasonable for a terminally ill patient to be required under legislation, and potentially against their personal wishes, to experience palliative treatment before they are provided with assistance to die.

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 10 of the *Dying with Dignity Bill 2009* states:

- (1) *A medical practitioner must not assist a sufferer under this Act if, in his or her opinion and after considering the advice of the medical practitioner referred to in subparagraph 8(1)(c)(i), there are palliative care options reasonably available to the sufferer to alleviate the sufferer's pain and suffering to levels acceptable to the sufferer.*

- (2) *If the sufferer has requested assistance under this Act and has subsequently been provided with palliative care that brings about the remission of the sufferer’s pain or suffering, the medical practitioner must not, in pursuance of the sufferer’s original request for assistance, assist the sufferer under this Act. If subsequently the palliative care ceases to alleviate the sufferer’s pain and suffering to levels acceptable to the sufferer, the medical practitioner may continue to assist the sufferer under this Act only if the sufferer indicates in writing to the medical practitioner the sufferer’s wish to proceed with the request.*

The Joint Standing Committee on Community Development made no specific comment or suggestions about this provision in the 2009 Bill. They did, however, note that “the availability of palliative care specialists especially in regional areas of Tasmania [is] ... an important consideration.”¹³⁹

5.6 THE PERSON’S CONDITION AND EXPERIENCE OF SUFFERING

PROPOSED MODEL

- We propose that the person accessing assistance to die must be terminally ill.
- ‘Terminally ill’ means the advanced stages of an incurable and progressive medical condition, due to disease or injury, that can be reasonably expected to cause the death of that person without significant medical intervention.
- ‘Advanced stages’ means as determined in line with accepted medical practice, guidelines or protocols.
- Both the attending and consulting doctors will be required to confirm that the patient is terminally ill.

- We propose that the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient’s condition and to relieve the patient’s suffering adequately and to the satisfaction of the patient.
- We are proposing that no person shall be eligible for an assisted death solely on the basis of disability or age.

RATIONALE

Our aim is to provide a last resort option for patients to access when there are no other reasonable options remaining. For this reason we are proposing that the person accessing assistance to die must be terminally ill. Both the attending and consulting doctors will be required to confirm that the patient is terminally ill.

We propose that ‘terminally ill’ be defined to mean the advanced stages of an incurable and progressive medical condition, due to disease or injury, that can be reasonably expected to cause the death of person without significant medical intervention.¹⁴⁰ ‘Advanced stages’ means as determined in line with accepted medical practice, guidelines or protocols. Both the attending and consulting doctors will be required to confirm that the patient is terminally ill. We believe that this will include the situation where the patient’s condition has advanced to the stage where the medical treatment reasonably available to the person is unacceptable to him/her or is confined to palliation to provide relief from pain and other distressing symptoms.

We also propose that, as in the Netherlands, the doctor and the patient must have together come to the conclusion that there is no reasonable alternative, given the patient’s situation, to improve the patient’s condition or satisfactorily alleviate their suffering.

Our model aims to give priority to the patient’s wishes to not endure prolonged suffering or futile treatments, while also respecting the doctor-patient relationship. We recognise that the best

options for patients are determined through cooperative and respectful relationships with their doctor/s when both parties are well informed.

Our initial intention at the start of this process to develop a model for a Tasmanian Bill was to adopt either the Oregonian definition of ‘terminal illness’ which involves a prognosis of death within 6 months or the definition proposed by the Commission on Assisted Dying, which involves a prognosis of death within 12 months. However, we were convinced by the evidence and findings of other reviews that “There is no precise science to providing a prognosis of a terminal illness in terms of specific length of time.”¹⁴¹

We have also carefully considered the evidence from Oregon where the data shows that a number of patients who receive a prescription under the requirements of Oregon’s *Death with Dignity Act 1994* and have been assessed by two doctors as having less than 6 months to live, survive for longer than this diagnosis. The 2012 Annual Report on the operation of Oregon’s Act states that the median time between the patient’s first request and their death was 47 days, with the range being from 16 to 388 days. This means that while some patients took the medication immediately after receiving a prescription and died, other patients survived for over a year after receiving a prescription.¹⁴²

We accept that restricting eligibility to terminally ill patients with a life expectancy prognosis of 6 to 12 months unfairly excludes those patients with conditions for which it is difficult to provide a clear prognosis and those whose prognosis may be longer than that, although the progressive nature of their illness will be debilitating and is likely to cause great suffering for which there is no effective remedy. As the 2010 annual report from the Regional Euthanasia Review Committees in the Netherlands states:

*It must be clear that there is no realistic alternative way of alleviating the patient’s suffering, and that termination of life on request or assisted suicide is the only way left to end that suffering. The focus is on treating and caring for the patient and on limiting and where possible eliminating the suffering, even if curative therapy is no longer possible or the patient no longer wants it.*¹⁴³

In debates about voluntary assisted dying legislation, closely linked to the criterion around the patient’s condition and experience of suffering is the impact any legislative change would have on the most vulnerable groups in our community. We understand these concerns but there appears to be significant evidence that demonstrates that these concerns have not eventuated in those jurisdictions with assisted dying legislation. This evidence has been discussed in Section 3.2 of this paper.

We are also proposing that legislation for voluntary assisted dying in Tasmania will specify that no person could qualify for an assisted death solely on the basis of age or disability as we do not believe that disability alone (or age) could ever justify approving a request for voluntary assisted dying – the presence of a terminal condition is an important qualifier. Both the Oregon and Washington Acts contain this provision.¹⁴⁴

OVERVIEW OF OTHER JURISDICTIONS

The legislated criteria relating to the patient’s medical condition and/or their experience of suffering as a result of that condition vary significantly across the jurisdictions considered in this paper. Both the Oregon and Washington Acts state that the patient must be suffering from a terminal disease which is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months.”¹⁴⁵ There is no mention of the patient’s suffering in either Act.

Under the Dutch Act the physician must be convinced that the patient’s suffering is “lasting and unbearable,”¹⁴⁶ and both the patient and physician must “hold the conviction that there was no other reasonable solution for the situation he was in.”¹⁴⁷ While the Dutch Act does not require the patient to be terminally ill, the due care criteria require the patient’s doctor to be satisfied of the lasting, unbearable and incurable nature of the patient’s suffering. A criterion based on ‘terminal illness’ was suggested during the original debate on the Bill, however, this suggestion “was ultimately

rejected because of the widely held belief that ‘the source of the suffering doesn’t have to be a terminal illness’.”¹⁴⁸

The Belgian Act states that the patient must be “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.”¹⁴⁹ Like the Dutch Act, there is no requirement under Belgian law that the patient must be suffering from a terminal condition to be eligible for assistance. However, the Belgian Act contains special provisions relating to consultation requirements if the patient “is clearly not expected to die in the near future.”¹⁵⁰

In Switzerland, the absence of a law on voluntary assisted dying means there is no safeguard around the specific condition of the patient: so long as the assistor does not have a selfish motive, the act is not illegal. The federal narcotics law does provide a check and balance in that “the supply of lethal medication is regulated ... [and] physicians may only administer, dispense or prescribe lethal medication within the limits of accepted professional and scientific practice.”¹⁵¹

Further guidance is provided by the Swiss Academy of Medical Sciences which states that:

If he [the doctor] decides to assist a person to commit suicide, it is his responsibility to check the follow preconditions:

- *The patient’s disease justifies the assumption that he is approaching the end of life.*
- *Alternative possibilities for providing assistance have been discussed and, if desired, have been implemented.*
- *The patient is capable of making the decision, his wish has been well thought out, without external pressure, and he persists in this wish. This has been checked by a third person, who is not necessarily a doctor.*¹⁵²

In the course of their work the Commission on Assisted Dying received a significant amount of evidence from interested parties on what the eligibility criteria should be relating to the person’s medical condition. The difficulties that doctors face in defining ‘terminal illness’ and the problems

of diagnosis and prognosis that would be associated with an eligibility based on ‘terminal illness’ were presented to the Commission from a number of sources. Dr Ann McPherson from Healthcare Professionals for Assisted Dying gave evidence to the Commission that “there are many different ways of defining terminal illness and I think that is one of the problems. We know that it is very difficult to predict what is going to happen to people.”¹⁵³ Additional research cited by the Commission demonstrated that “actual survival times [of terminally ill patients] were 30 per cent shorter than predicted survival times.”¹⁵⁴

The report by the Commission on Assisted Dying concluded that “eligibility based on terminal illness would meet the needs of the majority of people who might wish to request assisted dying”¹⁵⁵ and that the definition of terminal illness should include a life-expectancy prognosis of less than 12 months. In contrast, the Royal Society of Canada Expert Panel recommended:

*... against using ‘terminal illness’ as a prerequisite for requesting assistance. The term is too vague ... There is no precise science to providing a prognosis of a terminal illness in terms of specific length of time. Health care providers cannot be accurate enough, and if the statute or policy does not include a time restriction then the condition ‘terminal illness’ become too broad. For example, a person with Guillain-Barré syndrome will die from her disease, but lives in the average three years after diagnosis. Further, if the term ‘terminal illness’ is made a necessary condition in the statute, then it would be under-inclusive; there are many individuals whose lives are no longer worth living to them who have not being diagnosed with a terminal illness. They may be suffering greatly and permanently, but are not imminently dying. There is no principled basis for excluding them from assisted suicide or voluntary euthanasia.*¹⁵⁶

Despite the different approaches to defining the patient’s condition and/or experience of suffering in the different laws on voluntary assisted dying, it remains that “over 80 per cent of all reported cases of euthanasia or physician assisted suicide in the Netherlands, Belgium and Oregon involve cancer patients.”¹⁵⁷

Following their research into the various models of voluntary assisted dying Lewis and Black

concluded that “Both unbearable suffering and terminal illness appear to be well adhered to when they are legally binding.”¹⁵⁸ And while they did not recommend one approach over the other, they do point to the example of Switzerland to argue that “the imposition of one of these criteria [is supported] over a more relaxed regime that potentially fosters legal and medical uncertainty.”¹⁵⁹

SUFFERING

As mentioned above, eligibility criteria based only on suffering, and not on a terminal illness, is included in the Dutch and Belgian Acts. The Commission on Assisted Dying recommended against eligibility criteria that included any reference to ‘unbearable’ or ‘unrelievable’ suffering, arguing that “it is only for the individual concerned to judge the extent of the suffering caused by their illness.”¹⁶⁰ It also expressed concern “that a criterion based on suffering would be too unclear and subjective for doctors to assess.”¹⁶¹

This view is not in keeping with the evidence from the Netherlands and Belgium where doctors are able to reach reasonable, soundly-based professional judgements related to the level of suffering of the patient to determine if the requirements of their duty of care and the law are met. In the annual report of the Regional Euthanasia Review Committees in the Netherlands it is acknowledged that “In all the notifications that were reviewed by the committees, the patient’s unbearable suffering with no prospect of improvement was chiefly due to a recognised disease or disorder.”¹⁶² Primarily the patient’s disease is a form of cancer.

In the Dutch context it is recognised that “the unbearable nature of the patient’s suffering is determined not only by his present situation, but also by his perception of the future, his physical and mental stamina and his own personality. What is still bearable to one patient may be unbearable to another.”¹⁶³ The notifications received by the Dutch Regional Euthanasia Review Committees note that ‘unbearable suffering’ is often described in terms of:

*... physical symptoms such as pain, nausea and shortness of breath and feelings of exhaustion, increasing humiliation and dependence, and loss of dignity – all based on the patient’s own statements. In practice, a combination of aspects of suffering almost always determines whether it is unbearable. The degree of suffering cannot be determined merely by looking at the symptoms themselves; it is ultimately a matter of what they mean to the patient, in the context of his life history and values.*¹⁶⁴

Despite the best efforts of palliative care, we know that this form of treatment is not able to relieve a patient’s suffering in all circumstances, and this is one of the major factors in determining whether voluntary assisted dying legislation is necessary. Both the Tasmanian Parliamentary Committees and other reviews have detailed evidence that “good quality palliative care can alleviate much, but not all, the suffering that the dying process can cause.”¹⁶⁵ The conclusion of the 1998 Committee report was that despite the limits of palliative care “this is not sufficient cause to legalise voluntary euthanasia.”¹⁶⁶

A number of comprehensive reviews since have examined the impact of greatly improved palliative care treatment on the suffering of terminally ill patients and have reached conclusions similar to that of the Commission on Assisted Dying that “palliative care has helped many people ... [but] it will never meet all needs ... without a change in the law we condemn some people to suffer in a way which we would never allow if we were truly empathetic.”¹⁶⁷

Terminally ill patients experience a number of different kinds of suffering during the course of their illness. Chronic and unrelenting pain caused by the patient’s condition is one of the main sources of suffering, with other causes of suffering including fatigue, generalised weakness, anxiety, depression, constipation and breathlessness.¹⁶⁸ Another source of suffering for some terminally ill patients is the gradual loss of control they have over their bodies and the degenerative impact of their condition on their bodies that they can see occurring. One hospice director who gave evidence to the Commission on Assisted Dying anonymously explained that:

... the patient's suffering associated with loss of control was the most problematic: 'I would say that it's also patients who want to have control and they can see that they are deteriorating and then think 'I'm losing control, I want to have some control' [who suffer most]. They almost feel that the only control they've got is control over their death – the control they'd like'.¹⁶⁹

Mental anguish and psychological suffering are also real concerns for terminally ill patients. These forms of suffering can stem from the strong expectation of future suffering caused by the known progression of the illness. Some patients experience significant distress because they have seen another member or members of their family suffer the same or similar condition and they do not want their own loved ones to see them suffer in such a way.

While the requirement in the Netherlands is that the patient be currently suffering as a result of their condition, requests for euthanasia are considered in cases where the person is not terminally ill. However, these requests are "investigated extremely carefully over a period of time and ... it would be essential that the person was experiencing 'actual suffering' rather than anticipating suffering."¹⁷⁰ In rare cases in the Netherlands 'actual suffering' has included mental suffering (see Section 5.4).

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 5 of the *Dying with Dignity Bill 2009* states that only a person who has a terminal illness and experiences intolerable suffering, that is, a profound level of pain and/or distress that the sufferer finds intolerable, may request their medical practitioner to help them end their life. The Joint Standing Committee on Community Development remarked in their final report on the Bill that a number of commentators found the definition of 'intolerable suffering' to be "problematic ... mainly due to the subjective evaluation of the term by the sufferer."¹⁷¹

CONSULTATION POINT

- Under our proposal, the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient's condition and to relieve the patient's suffering adequately and to the satisfaction of the patient. Should 'unbearable' or 'unrelievable' suffering be included as a separate eligibility criteria?

- Should eligibility be linked to an anticipated life-expectancy?

- Should patients with non-terminal yet progressive illnesses be eligible for an assisted death?

5.7 TYPE OF ASSISTANCE

PROPOSED MODEL

- We propose that both self-administered and doctor-administered assisted dying be available.
- In cases of doctor-administered assisted dying we propose that only the patient's doctor can administer the medication.
- In cases of self-administered assisted dying we propose that the patient's attending doctor must be present when the patient self-administers the medication.

RATIONALE

In our model for Tasmania we are proposing that both doctor-administered and self-administered assisted dying be available. Only voluntary requests that satisfy the other safeguards and provisions of the legislation could be acted upon, and we are not proposing that a person would be able to access voluntary assisted dying through an advance directive.

Under our model we are proposing that the patient's attending doctor must be present at the patient's death to either supervise the patient's self-administration of the medication (in cases of self-administered assisted dying) or to administer the medication to the patient (in cases of doctor-administered assisted dying).

In formulating this approach we have noted the comments of Professor Margaret Otlowski who has argued that physician-assisted suicide (self-administered assisted dying):

... may be appropriate and adequate in many cases, [but] it does not represent a complete solution to the existing difficulties in this area. There will always be a proportion of patients who are physically unable to commit suicide. For others, the concept of suicide may be objectionable, yet they may willingly seek active voluntary euthanasia [doctor-administered assisted dying]. If the legal reform response were limited to physician-assisted suicide, these categories of people would not be provided for.¹⁷²

In proposing a model that includes both self-administered assisted dying and doctor-administered assisted dying we want to ensure that the law does not exclude patients who would be eligible for self-administered assisted dying, but due to some disability or incapacity are physically unable to self-administer the medication. We are also aware that in the Netherlands some doctors "who intend to provide assistance with suicide sometimes end up administering a lethal medication themselves because of the patient's inability to take the medication, or because of problems with the completion of physician-assisted suicide [self-administered assisted dying]."¹⁷³

For example, in the 2010 annual report from the Dutch Regional Euthanasia Review Committees it

was reported that there were 3,136 notifications consisting of 2,910 cases of euthanasia (where the doctor administered the lethal medication), 182 cases of assisted suicide (where the patient administered the medication themselves) and 44 cases involving a combination of the two.¹⁷⁴ While the report does not elaborate on the reasons why there were 44 cases involving a combination of both assisted suicide and euthanasia, it is reasonable to assume that in some cases the doctor was required to intervene and perform euthanasia if the patient's attempt at assisted suicide was not successful. This intervention is required because the doctor's participation must satisfy the due care criteria ('exercise due medical care and attention in terminating the patient's life or assisting in his suicide').

Similar problems with the self-administration of the lethal medication have been reported in Oregon. For example, in the Annual Report's on the operation of Oregon's *Death with Dignity Act*, it has been reported that between 1999 and 2011 there were 22 cases of complications involving regurgitation of the medication and 5 cases recorded where a patient ingested the medication before regaining consciousness. In these cases the patient later died of their underlying illness days or months later and their deaths were not recorded as a death under the provisions of the Act.¹⁷⁵ As Otlowski notes, assistance from the attending doctor "to complete the task would not appear to be possible under the Oregon model, and one can imagine nothing more disturbing for a patient than to awaken from a failed attempt."¹⁷⁶

There is no requirement under the Oregon Act for the physician to be present at the time the patient takes the lethal medication. Given the inability of the physician to provide any direct assistance to the patient when they take the prescribed medication, Lewis and Black note that:

... the presence of the prescribing physician or other health care provider may not seem to be of great importance. However, it may be desirable to have a healthcare provider present (or at least in the vicinity) in the event of complications. Moreover, the absence of health care providers, in particular, the prescribing physician, may leave the individual who dies feeling abandoned 'by the very

people who have assumed a fiduciary commitment to them in their terminal phase of life'.¹⁷⁷

OVERVIEW FROM OTHER JURISDICTIONS

The scope of assistance that is available under existing voluntary assisted dying models is either 'physician-assisted suicide' where the patient administers the lethal dose, or the doctor being able to administer the lethal dose under a model of 'voluntary euthanasia', or the provision of both forms of assistance.

In both Oregon and Washington only self-administered assisted dying is permitted. Neither jurisdiction permits doctor-administered assisted dying and any form of assistance to help a person commit suicide, outside of the provisions of the Act, remains a criminal offence. As mentioned already in this paper, this has led to documented examples in Oregon of patients experiencing complications such as vomiting or regaining consciousness and the attending doctor is unable to intervene to bring about the patient's death.

The Dutch Act allows for both doctor-administered and self-administered assisted dying. In Belgium, only doctor-administered assisted dying is specified under the law, although the Belgian federal oversight body, Commission Fédérale de Contrôle et Évaluation (CFCE), does acknowledge that some cases of self-administered assisted dying are covered by the law.¹⁷⁸ In addition, in both Belgium and the Netherlands a patient can request doctor-administered assisted dying through an advance directive.

In Switzerland, assistance is almost exclusively provided by a range of not-for-profit right to die organisations.¹⁷⁹ However, the patient must self-administer the lethal dose. Doctor-administered assisted dying is not permitted in Switzerland.

The Commission on Assisted Dying recommended that only self-administered assisted dying be allowed. They did not recommend any form of direct assistance from the doctor, preferring a model where the patient "would need to be able

to take the action that will cause their death, as a clear expression of voluntariness."¹⁸⁰ Recognising that some patients would find it difficult to self-administer the lethal dose, the Commission recommend that "appropriate support to take the medication should be provided if it is required by a terminally ill person with an impairment, but this could not take the form of another person administering the medication on their behalf."¹⁸¹ What 'appropriate support' would actually mean in practice was not elaborated on.

In contrast to the recommendation from the Commission on Assisted Dying, the Royal Society of Canada Expert Panel recommended that both self-administered assisted dying and doctor-administered assisted dying be available as the Expert Panel found "no morally significant difference" between the two actions.¹⁸² The Expert Panel concluded that "it can be inferred, based on the different surveys described [in the report] ... that the majority of the Canadian public would support legislation permitting voluntary euthanasia and assisted suicide for people suffering from an incurable physical illness."¹⁸³

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

The *Dying with Dignity Bill 2009* provided for both doctor-administered and self-administered assisted dying.

Under the proposed Bill, a doctor would only be able to assist a patient if a number of safeguards and provisions were satisfied.

CONSULTATION POINT

- Opinion polling consistently shows strong support for a doctor being able to provide a lethal dose of medication to a terminally ill patient. Do you think the patient's attending doctor should be able legally to administer the fatal dose?

- Should voluntary assisted dying be limited to the patient self-administering the fatal dose? If only self-administered assisted dying is legal, what assistance should be provided to those who are physically unable to commit the act?

5.8 AGE OF THE PATIENT

PROPOSED MODEL

- We propose that only adults aged 18 years or older be eligible for an assisted death.

RATIONALE

We propose that under our model only eligible patients aged over 18 years would be able to access assisted dying.

While we acknowledge that the Dutch and Belgian Acts contain specific provisions for approving requests from terminally ill patients under the age of 18 we are not proposing that similar provisions be included in a Tasmanian model.

OVERVIEW OF OTHER JURISDICTIONS

The age requirements for patients accessing voluntary assisted dying vary across the jurisdictions we have reviewed in this Consultation Paper. In both Oregon and Washington only an adult aged 18 years or older may access assisted dying.¹⁸⁴ In Switzerland a person must be aged over 18 to become a member of a right-to-die organisation, and these organisations only provide assistance to their members. Outside of the services provided by right-to-die organisations,

Lewis and Black note that children in Switzerland “cannot have the required legal capacity to commit suicide, though the position for adolescents is unclear.”¹⁸⁵

In Belgium, the patient must have “attained the age of majority or is an emancipated minor.”¹⁸⁶ This means that the patient has been emancipated by a judicial decision. Data published between 2003 and 2006 in the annual reports of the Belgian monitoring organisation detail only four instances of euthanasia of a patient under the age of 20 and no cases involving minors.¹⁸⁷

Under Dutch law, a patient aged between sixteen and eighteen years that “may be deemed to have a reasonable understanding of his interests” may request an assisted death. In these cases the parent and/or guardians must be consulted but they cannot overturn the final decision.¹⁸⁸ Patients aged between twelve and sixteen and “may be deemed to have reasonable understanding of his interests” may also request euthanasia or assisted suicide, provided their parent and/or guardian give their consent.¹⁸⁹ The annual reports issued by the Dutch Regional Euthanasia Review Committees detail “only one case of euthanasia involving a minor (a 12-year old suffering from cancer); the committee decided that the physician had acted in accordance with due care.”¹⁹⁰

The report by the Royal Society of Canada concluded that “any age restriction for access to assisted suicide or voluntary euthanasia should flow from the mature minor law in the particular jurisdiction,”¹⁹¹ whereas the Commission on Assisted Dying recommended that the patient must be aged over 18 to receive an assisted death.¹⁹² This recommendation was made despite the Commission being presented with evidence that argued that patients under the age of 18 should have access to voluntary assisted dying. A palliative care nurse told the Commission that her experience of caring for children aged 14 dying from cancer had led her to form the view that they “understood exactly what was happening to them ... [and] as one can refuse medical treatment from the age of 16, this should also apply to making a decision about an assisted death.”¹⁹³

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 8(1)(a) of the *Dying with Dignity Bill 2009* states that only a person who was aged 18 years or older would be eligible for assistance.

- The original copy of the written request is to be forwarded to the independent oversight body by the attending doctor.
- Under our proposed model a person will not be able to request an assisted death through an advance directive.

5.9 WRITTEN REQUEST

PROPOSED MODEL

- We propose that the patient must make a written request for assistance in addition to two oral requests.
- The written request must be witnessed by two people and one of the witnesses must be a person who is not:
 - A relative of the patient by blood, marriage or adoption,
 - A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
 - An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
- The patient's attending doctor at the time the request is signed cannot be a witness.
- In the event the patient is physically unable to sign a request the patient may designate someone to sign on their behalf. This person cannot be a witness to the request.
- A copy of the patient's written request, and a notation of both oral requests, is to be kept on the patient's medical record.

RATIONALE

Our proposal is that, in addition to an oral request, the patient must complete a written request. A written request is an important record of the patient's intent that still remains after the oral requests have been made and discussed. As a safeguard, the written request would need to be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

Consistent with the approach taken in Oregon and Washington, under our proposed model we are recommending that one of the witnesses shall be a person who is not a relative of the patient by blood, marriage or adoption; a person who at the time the request is signed would not be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or is not an owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident. We are also proposing that the patient's attending doctor at the time the request is signed shall not be a witness.

In the event the patient is physically unable to sign a request themselves, they may designate someone to sign the request on their behalf. This person cannot also be a witness to the request.

The witnesses to the written request play an important role in confirming the voluntariness of the patient's request. In their report on safeguards, Lewis and Black observe that "In Oregon some cases have raised voluntariness concerns due to the failures to meet the

witnessing requirements designed to ensure voluntariness. However, it is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness.¹⁹⁴ In order to avoid similar concerns being raised in Tasmania, we are proposing that the original copy of the written request would be forwarded to the independent oversight body by the attending doctor. This will allow the oversight body to ensure the voluntariness of the request has been confirmed before the request proceeds further. In addition, a copy of the written request is to be attached to the patient's medical record and notations of the patient's oral requests are also to be recorded on the patient's medical record.

A written request is a transparent way of ensuring the wishes of the patient are fully understood and we note the research from Lewis and Black which confirmed that the requirement for a written request for assistance "appears to be well observed where it exists."¹⁹⁵

OVERVIEW OF OTHER JURISDICTIONS

Written requests are features of the assisted dying process in the overseas jurisdictions considered in this paper. The Oregon and Washington Acts have specified requirements for the form of the request which must be signed and witnessed by two people. The aim of the written request is to help confirm that the patient is capable, acting voluntarily and is not being coerced into making the request for assistance to die.¹⁹⁶

Under the Belgian Act a patient is also required to put their request in writing and that Act additionally specifies that if a patient is physically unable to sign the written request themselves then a person designated by the patient can sign the request on their behalf. The requirement states that this person must be an adult and not have any material interest in the death of the patient. In these cases the request must be drafted in the presence of the physician.¹⁹⁷

The Dutch Act does not specify the need for a written request, although "it has long been considered good practice to obtain [one]."¹⁹⁸ The Regional Euthanasia Review Committees

encourage doctors to seek a written request from the patient and it is reported that this occurs in the majority of cases.¹⁹⁹

In Switzerland, individual right to die organisations have their own guidelines around the requirement of a written request. For example, DIGNITAS guidelines state that assisted suicide is only available for members and a written application for membership is a compulsory first step.²⁰⁰ Under DIGNITAS rules the actual request for assisted suicide "must take the form of a letter written and signed personally by the member ... which unmistakably expresses to DIGNITAS the member's desire to end his or her own life with the help of the organisation, and also states the main reason or reasons for the decision."²⁰¹ In addition to the written request, DIGNITAS also requires members to provide "an account of the member's life providing details about a person's character as well as their family and work situations."²⁰²

The Commission on Assisted Dying made no recommendation regarding the form the patient's request should take, whereas the Royal Society of Canada Expert Panel found that "Written or otherwise recorded requests are preferable (as they can be more reliable as evidence that a request was made and what the request was for), but verbal requests are sufficient, if properly documented."²⁰³

ADVANCE REQUESTS

A key difference between the approach to voluntary assisted dying taken in the Netherlands and Belgium with that of Oregon and Washington is that the Dutch and Belgium Acts allow for a patient to access voluntary assisted dying through an advance directive. This approach allows the patient to make a written statement requesting an assisted death in the future event that they suffer from an incurable illness and are not conscious to make a request at the time.²⁰⁴ Of the patients that accessed an assisted death by advance request in Belgium between 2002 and 2007, only 2.1 per cent were by an advance request.²⁰⁵

The Commission on Assisted Dying considered the option of whether an advance request should

be recommended as part of an assisted dying regime in the United Kingdom. They concluded that:

*While an advance directive or other record of a patient's consistent wishes over time could play an important role in confirming the settled intention of a mentally competent person to choose an assisted death, we do not consider that such a document could legitimately substitute for a lack of competency at the time of the request or at the moment of death.*²⁰⁶

In contrast, the Royal Society of Canada Expert Panel recommended that a competent patient should be able to put in writing an advance directive outlining their request for assisted dying in the event of incapacity.

We believe that mental competence and the confirmation of the persistent nature of the patient's wishes at the time that assisted dying is provided are important safeguards in our proposed model of voluntary assisted dying. Accordingly, we do not think it is appropriate to allow for a patient to be provided with an assisted death through a written advance directive if they have lost competence and the ability to confirm the persistent nature of their request.

As discussed in Section 2.5, Tasmanian adults can register an 'Enduring Guardian' with the Guardianship and Administration Board. Appointing an Enduring Guardian allows an individual to give "their instructions about decisions that the Enduring Guardian must carry out, so long as those decisions are lawful, clearly expressed and practically possible to carry out."²⁰⁷

As we are not proposing that our model would allow for a person to obtain an assisted death through a written advance request, we strongly encourage adult Tasmanians to register an Enduring Guardian to ensure their end-of-life treatment preferences around palliative care and the withdrawal or withholding of treatment are understood and carried out in the event of incapacity.

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

The *Dying with Dignity Bill 2009* set out the form of the written request for assistance in Schedule I 'Certificate of Request Forms'. The Joint Standing Committee made no comment about the form of the certificate of request, except to note that the psychiatrist was not required to witness the request.²⁰⁸

CONSULTATION POINT

- What provisions should be made for those patients who are physically unable to sign a request? Do you think a video recording of the request would be appropriate? Or should the patient be able to designate someone to sign the request on their behalf as occurs in Belgium?

5.10 RESIDENCY REQUIREMENT

PROPOSED MODEL

- We propose that only Tasmanian residents be eligible for assistance.
- Tasmanian residency would be proven through such means as proof of enrolment to vote in Tasmania, proof of a Tasmanian drivers licence, or proof that the patient owns or leases property in Tasmania.

RATIONALE

We believe that an important provision for voluntary assisted dying in Tasmania is that eligibility for assistance under such a law be available to Tasmanian residents only. We propose that Tasmanian residency would be proven through such means as proof of enrolment to vote in Tasmania, proof of a Tasmanian driver's licence, or proof that the patient owns or leases property in Tasmania. In line with the laws in place in Oregon and Washington, we are proposing that it would be the responsibility of the attending doctor to ensure the patient was a Tasmanian resident.

It is not feasible to stop people from moving to Tasmania who may wish to seek assistance under a law on assisted dying, but the patient would have to be able to prove to their doctor that they were currently a resident in Tasmania at the time of their initial request and throughout the entire process. While the *Dying with Dignity Bill 2009* sought a 12 month residency requirement, we are not proposing that the patient must have been living in Tasmania for any specified length of time. In this regard we note that it is a requirement of the *Commonwealth Electoral Act 1918* that an individual have resided at their address for at least one month before changing their enrolment details on the State and Commonwealth electoral rolls.²⁰⁹ This requirement suggests that an adult can live in any state or territory for a period of one month before being considered a resident of that jurisdiction.

OVERVIEW OF OTHER JURISDICTIONS

The laws in place in Oregon and Washington restrict eligibility to residents of those states.²¹⁰ Similarly, residency is a requirement of the Dutch and Belgian systems, although it is not explicitly referred to in either Act.²¹¹

In Switzerland, in the absence of any law regulating assisted dying, right-to-die organisations such as DIGNITAS have provided assistance to foreign nationals who travel to Switzerland for an assisted

death. Other right-to-die organisations based in Switzerland assist only Swiss or German nationals.

Residency requirements were not mentioned in the reports from the Commission on Assisted Dying or the Royal Society of Canada Expert Panel.

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 9 of the *Dying with Dignity Bill 2009* set out the residency requirement of the Bill. This section stated:

At the request of an adult sufferer, the treating doctor may provide assistance to that sufferer to end his or her life. However, the treating doctor may only do so if the treating doctor is satisfied on reasonable grounds that;

- (1) the sufferer is domiciled or ordinarily resident in the State; or*
- (2) the sufferer has had his or her settled or usual residence in the State for a minimum of 12 months.*

The aim of this clause was to stop people from interstate (or overseas) from moving to Tasmania for the sole purpose of accessing an assisted death. It was noted in the report from the Joint Standing Committee on Community Development that there were no provisions for the doctor to verify that the residency requirement had been satisfied.²¹² The Committee also commented on a lack of clarity around the residency noting,

The inclusion of 'has had' a residence in the State for a minimum of 12 months could be interpreted to mean was a resident for 12 months at some time in the past. In subclause (1) the use of domiciled 'or' ordinary resident again creates ambiguity.²¹³

5.11 CONSULTATION AND REFERRAL REQUIREMENTS

PROPOSED MODEL

- We propose that the patient's attending doctor must refer the patient for an independent assessment by a consulting doctor for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily.
- The consulting doctor must be qualified to make a professional diagnosis and prognosis regarding the patient's disease.

RATIONALE

We propose that the patient's attending doctor must refer the patient for an independent assessment by a consulting doctor who is qualified to make a professional diagnosis regarding the patient's condition. The consulting doctor would be required to make a medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntary.

The purpose of the consultation "is intended to build a control mechanism into the procedure and prevent unwarranted euthanasia cases. It is also intended to monitor and safeguard the quality of the practice of euthanasia."²¹⁴ In forming our proposal we have also noted the recommendation from Lewis and Black that arose out of their review of safeguards. Lewis and Black concluded that the adoption of a requirement for an independent consultation should be preferred as this form of consultation "appears effective at screening out a significant proportion of cases that do not meet the substantive criteria."²¹⁵ The Netherlands and Belgium both require the consulting doctor to be independent of the attending doctor. This is not specified in the Oregon or Washington laws.

Both the attending doctor and the consulting doctor will need to confirm the independence of the assessment. We are not proposing that the legislation require that the doctors be 'independent' of each other in the sense that they are not associated in any way or are not known to each other because in the Tasmanian context, our small population makes that unreasonable and impractical. This is particularly the case in small town and rural areas. However, every effort needs to be made to avoid the perception of influence of one doctor over the other, for example where there is a close family relationship between the attending and consulting doctor or where one doctor is employed by the other.

There are other steps that can be taken to provide assurance of the independence of the assessments, including the thoroughness of the process that each follow to reach their conclusions and that the consulting doctor does not receive the treating doctor's opinion before reaching his/her own conclusions.

This could be an issue for the proposed independent oversight body to maintain a 'watching brief' and respond to any unexpected patterns that lead to concerns, such as two doctors consistently using each other to undertake the independent assessment.

OVERVIEW OF OTHER JURISDICTIONS

A legislated provision for the patient's attending doctor to consult with another doctor on the patient's condition is an important safeguard in the Dutch, Belgian, Washington and Oregon models of voluntary assisted dying.

In Belgium the patient's doctor must also consult with another doctor who is required to review the patient's medical record, examine the patient and confirm the patient's constant and unbearable physical and mental suffering that cannot be alleviated. The Belgian Act further states that 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.

The consultation criteria in the Belgium Act are well adhered to. The report by Lewis and Black cites review of cases in Belgium carried out between 2002 and 2007 that demonstrated “that a second independent physician had been consulted in 99.8 per cent of all reported cases. In those cases in which an additional consultation was required (because the patient was not expected to die in the near future), that additional consultation took place in 100 per cent of such cases.”²¹⁶

In recognition of the role that nurses play in the treatment and care of patients with terminal illnesses, the Belgian Act includes a provision that 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 team. Belgium is the only jurisdiction we have examined that has this specific requirement, however, the evidence suggests that this “requirement is not well adhered to.”²¹⁷

Under the Dutch Act, which does not require that the patient be suffering from a terminal illness, the patient’s physician is required to consult with “at least one other independent physician, who must see the patient and give a written opinion on whether the due care criteria ... have been fulfilled.”²¹⁸ In their study of legislative safeguards, Lewis and Black explain that “The consultation requirements are more stringent if the patient’s suffering is the result of a psychiatric disorder.”²¹⁹

In the Netherlands the requirement for an independent consultation is satisfied in almost every reported case. Between 2007 and 2009 only 11 out of 7,487 reported cases did not meet this criterion.²²⁰ Lewis and Black explain that of the 11 instances, “In eight of these cases the consulting physician was not sufficiently independent of the treating physician. In two cases no consultation had been undertaken, and in one case there was a five-month delay between the consultation and euthanasia.”²²¹

Oregon and Washington have the same requirement that 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.”²²² Under both Acts the consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient’s

disease. The Oregon and Washington Acts also require 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.”²²³ The request for assistance can only proceed once the counsellor determines that the patient is not suffering from a depressive illness.

Under the Oregon Death with Dignity Act there is no requirement that the consulting physician be independent from the attending physician. The only specification relates to their qualifications. There is a very high compliance rate with this criteria in Oregon as well: not one physician has been referred to the Oregon Board of Medical Examiners for failing to consult with a second physician.²²⁴

In Switzerland individual right-to-die organisations have developed their own guidelines around consultation and referral requirements. However, since 2008 they have been guided by a directive from the Zurich cantonal physician which stated that prescriptions for lethal medication “written after only one doctor’s consultation [would] be a violation of the principle of ethical practice of medicine ... [and] disciplinary action [would be taken] against any doctor who wrote such a prescription after only one consultation.”²²⁵ This has meant that physicians in Zurich must meet with the patient at least twice prior to writing a prescription, but there is no legislative requirement or directive that they refer the patient to another doctor for confirmation of the diagnosis and prognosis.

The report from the Royal Society of Canada Expert Panel did not make any recommendations around consultation and referral requirements except in circumstances where “an individual physician is uncertain about the person make a request, she must take all necessary steps to resolve this uncertainty (e.g., consulting with a colleague with greater experience or expertise).”²²⁶

The Commission on Assisted Dying was much more definitive in its recommendations relating to consultation and referral requirements. They considered that “an assessment to determine if the

person meets the eligibility criteria [be] provided by at least two doctors who are wholly independent of each other”²²⁷ and that this approach would be a key element of any legislative approach taken in the UK.

THE RELATIONSHIP BETWEEN THE TWO DOCTORS

Much of the discussion on consultation and referral requirements of assisted dying law centres on the issue of whether the two doctors (generally referred to as the attending medical practitioner/physician and consulting medical practitioner/physician) should be wholly independent of one another or not.

The Commission on Assisted Dying was concerned that collusion between the two doctors could occur if they were not wholly independent. The explained that “the second doctor would need to be an experienced professional who could offer an independent opinion and was prepared to challenge the decisions of the first doctor if necessary.”²²⁸ Consultation with an independent physician is a requirement of the Belgian and Dutch Acts. In the Dutch context ‘independent’ means:

... that there is no family or working relationship between the two physicians. Nor may they be members of the same group practice.

... The physician’s independence may also appear open to question if the same two medical practitioners very often act as independent physicians on each other’s behalf, thus effectively acting in tandem. ... The committees feel that, if a physician always consults the same independent physician, the latter’s independence can easily be jeopardised. It is vital to avoid anything that may suggest the physician is not independent.

The independence of the physician conducting the assessment must be guaranteed. This implies, for example, that a member of the same group practice, a business partner, trainee doctor, relative or doctor who is in some other way in a dependent relationship with the physician who calls in the independent physician is not in principle eligible to act as a formal independent physician. The

*appearance of dependence must be avoided. In the case of the patient there must, among other things, be no family relationship or friendship between them, the physician must not be helping to treat him (and must not have done so in the past) and he must not have come into contact with him in the capacity of locum.*²²⁹

To help ensure independent physicians are available to provide advice and be consulted on requests in both the Netherlands and Belgium consultation services have been set up. In the Netherlands there is the ‘Support and Consultation on Euthanasia’ (SCEN) program which was established by the government. The SCEN program in the Netherlands is supported by the Royal Dutch Medical Association and the Association of General Practitioners. These organisations “wanted to professionalize the consultation process and thus make physicians take responsibility for the quality of the practice.”²³⁰ Like the SCEN program in the Netherlands, in the Flanders region of Belgium the ‘Life End Information Forum’ (LEIF) has been established and provides an independent consultation for physicians treating patients at the end of their lives. In their review of the SCEN and LEIF programs, Van Wesemael et al note that in Belgium “the legalisation progress of euthanasia ... enjoyed less support from associations of health care professionals”²³¹ than was the case with the establishment of SCEN in the Netherlands.

To be an independent consultant with the LEIF or SCEN programs “a physician must have at least five years of experience as a physician, have experience in the field of euthanasia, be skilful in consultations, and must not be a priori opposed to euthanasia as this would preclude objective consultation.”²³² The main difference between the organisations is the wider scope of services provided by LEIF than the SCEN program. This is consistent with the broader legislative approach taken in Belgium where a law on accessing palliative care and patient rights were passed by the Belgian parliament at the same time as the *Act on Euthanasia*.²³³ LEIF physicians accordingly provide a consultation service to attending physicians and patients that covers not only voluntary assisted dying, but all the other aspects

of end-of-life care.²³⁴ Van Wesemael et al concluded in their study of SCEN and LEIF that:

Both organisations were founded to improve (the practice of) consultation in euthanasia requests by specifically training physicians for that purpose. These physicians also support and inform their colleagues on euthanasia.

... The creation of specialized services for a priori consultation in euthanasia cases can play an important role. It helps physicians to relatively easily consult a competent second physician when they are confronted with a euthanasia request. Such a service may also guarantee more compliance with the due care requirements and hence function as an additional control mechanism. ... Both SCEN and LEIF put emphasis on knowledge of the law and of palliative care, and on communication with the patient and the attending physician.

... As both SCEN and LEIF play an important role in the performance of euthanasia in their respective countries, it is possible to conclude that, in countries where legislation on physician-assisted death is being considered, the development of such a service is warranted, parallel to or even incorporated into the relevant laws.²³⁵

We are not proposing at this stage that a body akin to SCEN or LEIF be established as part of our proposed model. However, that does not mean we do not support this form of independent consultation service being established. We would welcome the thoughts of doctors on this issue.

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

The *Dying with Dignity Bill 2009* included a requirement that the patient be examined by a doctor “who holds prescribed qualifications, or has prescribed experience with the treatment of the terminal illness from which the person is suffering.”²³⁶ In addition, Section 8(1)(c)(ii) required that a qualified psychiatrist also examine the patient. Section 8(1)(c) also required that neither the second doctor nor the psychiatrist could be a “relative or employee of, or a member

of the same medical practice as, the first medical practitioner or each other.”

Under the Bill the second doctor is required to confirm “the first medical practitioner’s opinion as to the existence and seriousness of the illness; and that the sufferer is likely to die as a result of the illness; and the first medical practitioner’s prognosis.”²³⁷ Under Section 8(1)(c)(iv) the psychiatrist is required to confirm that the patient is mentally competent.

CONSULTATION POINT

- What are your views on the role of an independent consultation service in a legislated model of voluntary assisted dying?
- Should the consulting doctor have to meet face-to-face with the patient? Is it enough for them to just review the patient’s medical record? Could the utilisation of ‘telehealth’ or ‘e-health’ technology replace a face-to-face consultation?

5.12 IDENTITY OF THE ATTENDING DOCTOR

PROPOSED MODEL

- We propose that the attending doctor be the doctor who has the primary responsibility for the care of the patient and the treatment of the patient’s terminal condition.
- A doctor will always retain the right to refuse to assist a patient that requests an assisted death.

- If the patient has their request for assistance refused they may request that their relevant medical records be forwarded to a new doctor.

RATIONALE

We propose that the attending doctor be the doctor who has primary responsibility for the care of the patient and treatment of the patient's terminal condition. However, we are not proposing a requirement that the patient and doctor must have a longstanding doctor-patient relationship.

We recognise that some doctors will be willing to provide assistance to their patients, and others will not. We propose that a doctor will always be able to decline a patient's request for assistance. However, if the patient wishes to seek assistance from another doctor then they may request that their relevant medical records be forwarded to the new attending doctor.

OVERVIEW OF OTHER JURISDICTIONS

In Oregon and Washington the attending doctor is defined as "the physician who has primary responsibility for the care and treatment of the patient's terminal disease."²³⁸ However, there is no requirement that the patient and their doctor have a pre-existing or longstanding doctor-patient relationship before the patient requests assistance to die.²³⁹ In Belgium, the attending doctor is not defined in the way it is in Oregon or Washington, but the Act does state the doctor 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."²⁴⁰

Under the Dutch law, the doctor that provides assistance 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."²⁴¹ In Switzerland, as there is no law that sets out a model of voluntary assisted dying, any individual may assist another to suicide, provided that the assistor does not have selfish motives. There are five right-to-die organisations in Switzerland that provide assisted suicide to their members in accordance with the provisions set out in the Swiss Criminal Code. These organisations are Exit Deutsche Schweiz (Exit DS), Exit Association for the Right to Die with Dignity (Exit ADMD), DIGNITAS, Ex International and Verein Suizidhilfe.

PARTICIPATION AND REFERRAL REQUIREMENTS

A key feature across all the jurisdictions we have reviewed in this Paper is that no model compels doctors to provide assistance. In each jurisdiction the voluntary participation of doctors remains and a doctor can opt out of providing assistance to an eligible patient if they choose. We believe this is an important principle and this will be the case under any Tasmanian law.

If the patient has their request for assistance refused they may request for their relevant medical records to be forwarded to a new doctor. This provision is specified in Belgium, Oregon and Washington.²⁴² An additional requirement is included in Section 14 of the Belgian *Act on Euthanasia* which states:

Should the physician consulted refuse to perform euthanasia, then he/she must inform the patient and the person taken in confidence, if any, of this fact in a timely manner, and explain his/her reasons for such a refusal. If the refusal is based on medical reasons, then these reasons are noted in the patient's medical record.

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

The *Dying with Dignity Bill 2009* did not specify that the patient and doctor must have a pre-existing or longstanding doctor-patient relationship prior to the commencement of a request for assistance.

5.13 WAITING PERIODS

PROPOSED MODEL

- We are proposing a number of specific waiting periods throughout our model:
 - 48 hours are to elapse between the patient's initial oral request for assistance and the completion of the formal written request.
 - Once both doctors have certified that the patient is eligible for assistance and have signed the doctors' declaration form a 14 day 'cooling off' period commences.
 - The prescription for lethal medication can only be written following the end of the 14 day 'cooling off' period.

RATIONALE

Legislated waiting periods between a patient's request and the provision of assistance are an important safeguard as it allows the patient "to fully consider the immense importance of their decision."²⁴³ We are mindful that, as we propose that eligible patients would need to have an advanced, progressive and incurable condition (see Section 5.6) a lengthy and convoluted approval process would be inappropriate and too great a burden on the patient.

Despite evidence suggesting that "a 'cooling off' period is less important for cases of assisted suicide, as many who receive lethal prescriptions do not immediately take them, but keep them as an 'insurance policy',"²⁴⁴ we believe that legislated waiting periods are important to ensure that the patient is making an informed decision at each stage of the process and is not acting in haste.

We are proposing a number of waiting periods throughout our model:

- 48 hours are to elapse between the patient's initial oral request for assistance and the completion of a formal written request.
- Once both doctors have certified that the patient is eligible for assistance and have signed the doctors' declaration a 14 day 'cooling off' period commences.

OVERVIEW OF OTHER JURISDICTIONS

Legislated waiting periods are a common feature in the voluntary assisted dying models in place in Belgium, Washington and Oregon. In Belgium there is a waiting period of one month if "the patient is clearly not expected to die in the near future."²⁴⁵ For other patients, the law states that the doctor is to have "several conversations with the patient spread out over a reasonable period of time, taking into account the progress of the patient's condition."²⁴⁶ However, there is no definition in the Belgium Act around what constitutes a 'reasonable' period of time.

In Oregon and Washington both Acts state that "no less than fifteen days shall elapse between the patient's initial oral request and the writing of a prescription ... [and] no less than forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription."²⁴⁷

Associate Professor Barbara Glidewell, former Hospital Ombudsman from Oregon explained how the process worked in Oregon in an interview on ABC radio in October 2010:

BARBARA GLIDEWELL: ... There's a day one where there's the first interview. It's a very sensitive, compassionate but probing interview to determine the nature of the suffering that would cause the patient to want to take a medication, how they have considered this and to look for signs of depression or a clinical depression that would need treatment, ...

MARK COLVIN: But then there's another interview much later because you don't want to have caught somebody on a bad day as it were?

BARBARA GLIDEWELL: *Exactly, and that's later; 15 days later is interview number two, day two, and we have to see if it's still the same request, still the same value. During those 15 days, a second opinion physician reviews all the records, determines that indeed the patient does likely have less than six months to live, is acting voluntarily, does not have a depression and is not under duress, and the patient also signs a written request form as witnessed by two individuals, one who may not be related to him or her.*

*Then 48 hours later, after the 15th day, then a prescription may be written, if the patient qualifies on all parts. Most patients ask to leave the prescription with a physician and they may ask for it later, or some choose to have it filled at the time and they keep it at home more or less as an insurance in their mind that if the time comes when they feel they want it, that they would be available to them.*²⁴⁸

There is no specified waiting period in the Dutch Act. Individual right to die organisations in Switzerland have their own guidelines with regard to waiting periods. There is no waiting period that must be adhered to after someone has become a member of DIGNITAS before they are allowed to submit an application for assisted suicide. The only requirement set by DIGNITAS is that the member must consult with a doctor prior to the writing of a prescription and this can be “a very lengthy process.”²⁴⁹

The Royal Society of Canada Expert Panel found that:

*The time required to elapse between the initial request and the granting of assistance will depend on the time required to ensure that the person's request is voluntary and informed and that the individual is competent. ... Depending on the circumstances, this may take a short or quite a long time. Once all the other conditions have been met, there must be a short (for example, twenty-four hours) pause before the assistance is provided to allow confidence that all of the conditions and procedural requirements have been met. Beyond that, the Panel does not recommend any delay requirements.*²⁵⁰

In the United Kingdom, the Commission on Assisted Dying concluded that:

*Given that the person concerned would need to have an advanced, progressive, incurable disease according to the proposed eligibility criteria, ... it would be inappropriate to suggest safeguards that would require a very lengthy approval process at this point. However, it is also important that some time should be built into the process to ensure that the patient's decision cannot be made hastily, and that it is a settled decision to die, as opposed to a fluctuating wish.*²⁵¹

The Commission on Assisted Dying put forward the recommendation the minimum waiting period between a request being made and a patient receiving an assisted death was recommended to be 2 weeks. If the patient's death was judged by the two doctors as likely to occur within a month the waiting period could be reduced to 6 days.²⁵²

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 8(1)(i) states that after the patient's oral request to their doctor (§8(1)(f)) the patient must wait 7 days before the certificate of request can be signed. Under Section 8(1)(n) no less than 48 hours must pass since the signing of the completed certificate of request.

5.14 FAMILY NOTIFICATIONS

PROPOSED MODEL

- We are proposing that the attending doctor should encourage the patient to notify their family of their request for an assisted death, but if the patient declines or is unable to notify next-of-kin they shall not have their request denied for that reason.

RATIONALE

Many of those who request assisted dying will want to involve their families and loved one. They will have the support of their families, both in principle for their right to make decisions about their own lives, and because their family members would be well aware of the suffering that is being endured and would want their loved one to have relief from it. In the debate on this issue, this fact is often forgotten as the focus is on more negative family relationships where the patient is seen to be coerced into making a decision against their will.

We acknowledge that some patients who wish to access an assisted death may have strained and difficult relationships with their next-of-kin or that religious or moral disapproval of voluntary assisted dying may make it difficult for a patient to discuss their wish for an assisted death with their family. We propose that the patient's attending doctor should be required to advise the patient to inform their family or next-of-kin of their request, but as in Oregon and Washington, we do not believe that a patient should have their request refused if they decline to do so.

OVERVIEW OF OTHER JURISDICTIONS

In Oregon and Washington, the attending physician is required under those Acts to advise the patient to notify their next-of-kin of their request for assisted dying. However, the attending physician cannot refuse the patient's request if the patient refuses or is unable to notify their next-of-kin.²⁵³ In Belgium, the Act states that the request can be discussed by the physician with the patient's relatives "if the patient so desires."²⁵⁴ In the Netherlands, there is no requirement for adult patients to notify their next-of-kin of their request for an assisted death. However, patients aged between twelve and eighteen must involve their parents and/or guardians in the decision making process and the parents and/or guardians of patients aged twelve to sixteen must give their permission for an assisted death to take place.²⁵⁵

In all jurisdictions that allow assisted dying, the patient themselves must make the request and

evidence from Oregon is that "most patients have discussed their wishes and values regarding the dying process with their family members long before this specific request occurs."²⁵⁶ In situations where the patient is concerned about a difference in religious or moral views regarding assisted dying they may choose not to inform their family, or to only inform their family of their request after they receive a prescription.²⁵⁷ Data from Oregon has shown that 80 per cent of patients who received a prescription under the *Oregon Death with Dignity Act* had informed their family of their request. In 73 per cent of cases the doctor also spoke with the patient's family about the request, nine per cent of the patients chose not to inform their family of their request and five per cent had no next-of-kin to inform.²⁵⁸

While the Dutch Act came about through a reform process driven by the medical profession who sought to have a doctor's responsibility in relation to assisted dying clarified, in other jurisdictions reform has come about through public campaigns focused on patients' rights. As a consequence, in jurisdictions such as Oregon and Washington there is much more of a focus on the patient and their requirements, and in both the Oregon and Washington Act's the patient's family is mentioned several times. Under both the Oregon and Washington Act's one member of the patient's family can be a witness to the written request,²⁵⁹ and the Acts also provide "family members and others ... [with] legal immunity from prosecution for being present at the time of the patient's ingestion of the lethal dose of medication, if the requirements of the ... Act have been met."²⁶⁰

We recognise that the death of a loved one is an extremely difficult process for many families to deal with, especially if the dying process is prolonged and their loved one is suffering pain and discomfort as a result of their condition. Academic research into the attitudes and reactions of family members to assisted dying has revealed a number of interesting findings. The work of Professor Bregje Onwuteaka-Philipsen, who specialises in end-of-life research in the Netherlands, has demonstrated that "it is common for a patient's family to disagree with a patient's wish to have an assisted death."²⁶¹ Onwuteaka-Philipsen's research has found that "in some

situations, families put pressure on patients to continue with certain treatments, when the patient may not wish to do so, implying that individuals often feel pressurised by family members to stay alive, not to die.”²⁶² This suggests that families are not putting pressure on patients to make a decision to access assisted dying, but instead the “pressures on individuals commonly work in the opposite direction: it is often the patient’s family who does not want the patient to die.”²⁶³

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 8(1)(g) of the *Dying with Dignity Bill 2009* requires the patient’s doctor to be “satisfied that the sufferer has considered the possible implications of the sufferer’s decision to his or her family.” Nowhere in the Bill is the patient required to notify or advise their family of their request. In their evidence to the Joint Standing Committee on Community Development, the Law Society of Tasmania expressed concern that “there is no requirement that any person outside the patient and the care team (eg. advocate, lawyer, family member, spouse or friend) is notified of the signing of the certificate.”²⁶⁴

5.15 DUE CARE: SAFE HANDLING OF PRESCRIPTION MEDICINE

PROPOSED MODEL

- We are proposing that the lethal medication prescribed to an eligible patient must stay under the supervision of the attending doctor.
- For this reason the attending doctor will be required to collect the medication from the pharmacy and deliver it to the patient when it is to be taken.

- The attending doctor must offer the patient the opportunity to rescind their request prior to the patient taking the medication or the medication being administered to the patient. If the patient chooses to rescind their request the attending doctor must return the unused medication to the pharmacy.

RATIONALE

While we recognise that doctors must always act with due care, we are proposing a number of provisions that specifically relate to the safe handling of the medication prescribed for an assisted death.

Firstly, it is important that the lethal medication prescribed to an eligible patient stay under the supervision of the attending doctor and not be given to the patient until they choose to take it.

This will mean that under our model the attending doctor will be required to collect the medication from the pharmacy and deliver it to the patient at the time it is to be taken. As we have already proposed in Section 5.7, the attending doctor is to be present when the patient takes the lethal medication.

In Section 5.16 we propose that the attending doctor must offer the patient the opportunity to rescind their request prior to the patient taking the medication or the medication being administered to the patient. If the patient chooses to rescind their request the attending doctor must return the unused medication to the pharmacy.

OVERVIEW OF OTHER JURISDICTIONS

The criteria of due care are handled differently in each jurisdiction considered in this paper.

In the Dutch context ‘due care’ specifically refers to the provisions set out in Section 2 (a-f) of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*. The requirements of due care mean the physician:

- a) holds the conviction that the request by the patient was voluntary and well-considered;
- b) holds the conviction that the patient's suffering was lasting and unbearable;
- c) has informed the patient about the situation he was in and about his prospects;
- d) and the patient holds the conviction that there was no other reasonable solution for the situation he was in;
- e) has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a-d; and
- f) has terminated a life or assisted in a suicide with due care.

The final criterion of due medical care “also normally requires the physician’s continuous presence during the euthanasia or assisted suicide in case further medical intervention is required. This requirement also ensures that the medication to be used remains under the control of the physician.”²⁶⁵

The laws in Belgium, Oregon and Washington do not have specific due care provisions, although doctors are always expected to exercise due care in their treatment of patients.²⁶⁶ However, it could be argued that the reporting provisions in those Acts play an important role in ensuring that due care is practiced.

In Oregon and Washington, the Acts state that only the prescription of lethal medication for the purpose of self-administration by the patient is permitted. In Washington, an extra section requires that any medication dispensed under the Act which was not self-administered must be lawfully disposed of.²⁶⁷

Lewis and Black explain that “[i]n Switzerland, any form of suicide assistance is permissible in principle. However, in practice almost all cases involve a prescription of the barbiturate sodium pentobarbital. Physicians prescribing lethal medication must act in accordance with accepted medical practice.”²⁶⁸ In 2008 the cantonal physician of Zurich issued a ruling that “any

prescriptions for NaP [sodium pentobarbital or ‘Nembutal’] written after only one doctor’s consultation [would be considered] ... a violation of the principle of the ethical practice of medicine.”²⁶⁹ Disciplinary action would be taken against doctors who did not comply. Accordingly, under DIGNITAS’ guidelines the doctor is required to meet with the patient twice.²⁷⁰

The due care recommendations from the Royal Society of Canada Expert Panel related to reporting requirements and a recommendation “that permission to provide assistance be granted only to those: who have the knowledge and skills necessary to ensure that the condition for access ... (e.g., competence, voluntariness, conveyance of information) have been met.”²⁷¹

The Commission on Assisted Dying also made recommendations relating to reporting requirements (See Section 5.17) and they also recommended “that the suitably qualified professional overseeing the person’s death should be legally required to return the medication to the pharmacy. ... [and] a doctor who prescribes lethal medication for the purpose of an assisted death should have ongoing responsibility for the care of that patient up to and including their death ... the doctor ... must be on hand (... although not necessarily in the same room) when the patient takes the medication.”²⁷²

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Due care requirements in the *Dying with Dignity Bill 2009* predominantly related to reporting requirements which were set out in Section 14 of that Bill.

5.16 OPPORTUNITY TO RESCIND REQUEST

PROPOSED MODEL

- We propose that the patient may rescind their request at any time and in any manner.
- We propose that the attending doctor must offer the patient an opportunity to rescind their request prior to writing a prescription for lethal medication.
- We propose that the attending doctor must offer the patient an opportunity to rescind their request prior to the patient either self-administering the medication, or the doctor administering the medication to the patient.

RATIONALE

A legislated requirement that an eligible patient be offered the opportunity to rescind their request is an extremely important safeguard. We are proposing an approach based on that in place in Oregon and Washington where a patient is able to rescind their request at any point during the process. The attending doctor must also offer the patient the opportunity to rescind their request at a number of specific points during the process. These are:

- When the patient makes the initial oral request the doctor is to note on the patient's medical record that the patient was informed that they have the opportunity to rescind their request at any time and in any manner throughout this process.
- When the patient reiterates their oral request at the end of the 14 day 'cooling off' period the doctor is to remind the patient that they can rescind their request at any time and in any manner before issuing a prescription for lethal medication.

- The doctor must also provide the patient with an opportunity to rescind their request prior to the administration (by the doctor or the patient) of the lethal medication.

OVERVIEW OF OTHER JURISDICTIONS

In Oregon and Washington the law states that "a patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication ... may be written without the attending physician offering the qualified patient an opportunity to rescind the request."²⁷³ It is the attending physician's responsibility under both Acts to ensure this occurs,²⁷⁴ and the attending physician must ensure this offer is documented on the patient's medical record.

Under the Belgian Act "the patient may revoke his/her request at any time, in which case the document [the written request] is removed from the medical record and returned to the patient."²⁷⁵ Advance directives for voluntary euthanasia in the event of incapacity may also be amended or revoked at any time.²⁷⁶

There is no specified reference in the Dutch Act relating to a patient's opportunity to rescind their request. Both the Royal Society of Canada Expert Panel and the Commission on Assisted Dying made no recommendation relating to this provision.

In Switzerland, individual right-to-die organisations have their own guidelines around assisted suicide. DIGNITAS's guidelines state that a meeting is held with the patient prior to the planned assisted suicide. At this time "it is repeatedly and clearly stressed that the fact that the member travelled to Switzerland does not automatically mean that he or she must go through the AS [assisted suicide]. At this point, and indeed right up to the last moment before the medication is taken, the member is completely free to decide against going through with the AS."²⁷⁷

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 12 of the *Dying with Dignity Bill 2009* state that:

- (1) *Notwithstanding anything in this Act, a sufferer may rescind a request for assistance under this Act at any time and in any manner.*
- (2) *If a sufferer rescinds a request, the sufferer's medical practitioner must, as a soon as practicable, destroy the certificate of request and note the fact on the sufferer's medical record.*

In addition, Section 8(1)(o) states that a medical practitioner cannot assist a sufferer if the sufferer gives “the medical practitioner an indication that it was no longer the sufferer’s wish to end his or her life.”

The report from the Joint Standing Committee on Community Development made the observation that “As the sufferer may rescind their request for assistance under the Act at any time and in any manner, they may do so in a way that is not communicated back to the medical practitioner who is assisting them. The medical practitioner may be ignorant of the changed circumstances [and] could not fulfil his or her responsibility under subclause (2) which requires the destruction of the certificate and endorsement of the patient’s medical record.”²⁷⁸

The Committee went on to note that “It was highlighted that there is a need for an extra safeguard by confirming the sufferer’s wishes at the final point in the process.”²⁷⁹ For this reason, under our model we are proposing that the attending doctor must offer the patient an opportunity to rescind their request prior to the patient either self-administering the medication, of the doctor administering the medication to the patient.

5.17 REPORTING AND SCRUTINY OF CASES

PROPOSED MODEL

- We propose that an independent oversight mechanism be established.
- This independent oversight body would be required to prepare an annual report on the operation of the Act to be tabled in Parliament.
- The independent oversight body would be required to check that the eligibility requirements of the legislation have been met **before** assisted dying is provided.
- We are proposing that at key points of the process, the oversight body must be notified by the patient’s attending doctor. The attending doctor must:
 - forward to the oversight body the original of the patient’s written request.
 - forward to the oversight body the original doctors’ declaration form signed by both the attending and consulting doctors certifying the eligibility of the patient.
 - notify the oversight body that a prescription has been written.
 - notify the oversight body of the death of a patient to whom a prescription for lethal medication has been written, but not ingested.
 - notify the oversight body of the death of a patient following administration of the lethal medication.
- The independent oversight body will be responsible for undertaking community education programs about the Act directed to both patients and their families and doctors.

- We propose that a full review of the Act be undertaken after 5 years of operation.

RATIONALE

We are proposing that an independent oversight mechanism would be established in Tasmania to monitor, review and report on the operation of a law that provides for voluntary assisted dying. One of the important responsibilities of this oversight body will be to prepare an annual report to Parliament each year on the operation of the Act including data on requests and presenting anonymous case studies where appropriate.

Under our proposed model the independent oversight body would be engaged at key points in the process and provide a check that requirements of the legislation have been met before assisted dying is provided. This provides a safeguard that is not present in overseas legislation.

This includes the patient's attending doctor first notifying the oversight body by forwarding to them the original copy of the patient's written request. This will allow the oversight body to be aware of how many 'active' requests there are, as well as ensuring that the necessary paperwork is complete. In this respect we have noted the reports from Oregon that an incorrectly completed form is the main reason physicians are referred by the Oregon Department of Human Services to the State Board of Medical Examiners.²⁸⁰ This kind of non-compliance can be easily corrected and we believe that a properly safeguarded law ensures compliance throughout the process as a preference to any kind of retrospective review and investigation.

At other stages of the process we are proposing that the independent oversight body must be notified. These points are:

- Following the completion of the patient declaration form which must be signed by both the attending doctor and consulting doctor.
- When a prescription has been written.

- Following the death of a patient to whom a prescription for lethal medication has been written (but that medication has not been ingested).
- Following the death of a patient after they have ingested the lethal medication.

We are also proposing that the independent oversight body would be responsible for undertaking community education programs about the Act that caters for both patients and their families and doctors.

To ensure the Act is meeting the needs of the community, we are proposing that a full review be undertaken after 5 years of operation.

OVERVIEW OF OTHER JURISDICTIONS

To ensure the safeguards of a voluntary assisted dying regime are adhered to it is important to have a robust reporting system that allows for the scrutiny and review of cases.

In Oregon and Washington the responsibility to report on and scrutinise cases lies with the state Health Department and the attending medical practitioner also has a responsibility to provide information relating to a request for assistance to the Health Department, and to ensure that specified documentation is filed on the patient's medical file.

The following reporting requirements are specified under the Oregon Act:

- All oral requests by a patient for medication must be documented on the patient's medical record (§3.09(1)).
- All written requests by a patient for medication must be documented on the patient's medical record (§3.09(2)).
- The attending physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision must be documented on the patient's medical record (§3.09(3)).

- The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision must be documented on the patient's medical record (§3.09(4)).
- If counselling has been undertaken, a report on the outcome and determinations made during counselling must be filed with the patient's medical record (§3.09(5)).
- The attending physician's offer to the patient to rescind their request and the time the second oral request is made must be noted on the patient's medical record (§3.09(6)).
- The attending physician must note on the patient's medical record that all requirements under the Act have been met, including the steps taken to carry out the request and a notation of the medication prescribed (§3.09(7)).
- Any health care provider that dispenses medication under the Act must file a copy of the dispensing record with the Department of Human Services (§3.11(1)(b)).

From the evidence available, the reporting requirements in Oregon appear well adhered to. As mentioned above, the main cause of a referral to the State Board of Medical Examiners relates to incorrectly completed paperwork.

In comparison to Oregon and Washington, the approach taken in Belgium and the Netherlands has seen the establishment of independent committees that review all cases of assisted dying to ensure they were undertaken in accordance with the legislation. The laws in both jurisdictions require that all cases must be reported, and if the review committees find that the physician did not provide assistance in accordance with the law, the case is referred to prosecutors.²⁸¹

In the Netherlands the review committees are organised on a regional basis. The Act specifies that the committee comprise "an uneven number of members, include at any rate one legal specialist, also chairman, one physician and one expert on ethical or philosophical issues."²⁸² Lewis and Black note in their report on safeguards that the notification rate in the Netherlands is 80%.²⁸³

Section 6 of the Belgian Act on Euthanasia 2002 establishes the Federal Control and Evaluation Commission. The Act states that

*... the commission is to be composed of sixteen members, appointed on the basis of their knowledge and experience in the issues belonging to the commission's jurisdiction. Eight members are doctors of medicine, of whom at least four are professors at university in Belgium. Four members are professors of law at a university in Belgium, or practising lawyers. Four members are drawn from groups that deal with the problem of incurably ill patients.*²⁸⁴

In Belgium the reporting rate is lower at 53%.²⁸⁵ Lewis and Black note that the main reasons cases are not reported is because "Physicians only report those cases they perceive to be euthanasia, while many more cases are labelled as euthanasia by researchers."²⁸⁶ There is also evidence from Belgium that indicates that some physicians are not notifying the oversight committee "because they are unaware of the reporting obligation, indicating a need for an education programme when rolling out a new reporting regime."²⁸⁷ We agree with the importance of providing an education and awareness program. We are suggesting that the independent oversight body be responsible for reporting on and monitoring the Act and providing community education programs about the Act that caters for both patients and their families and doctors.

The departments of Health in Oregon and Washington and the independent review bodies in the Netherlands and Belgium are all required to produce annual reports on their activities under the legislation.

The absence of any national law on voluntary assisted dying in Switzerland has meant that there is no organised and transparent data on the number or requests and deaths under this provision of the Criminal Code. However, this has not meant that there is no oversight or control. On the contrary, all assisted suicides must be reported to the local authorities as unnatural deaths which results in the police investigating all cases to determine if the suicide was in compliance with the law. Lewis and Black note that there is no evidence to suggest that right-to-die

organisations are not reporting the deaths that they assist.²⁸⁸

The report by the Royal Society of Canada Expert Panel recommended that “a national oversight commission be established to monitor and report annually and publicly on assisted suicide and voluntary euthanasia in Canada.”²⁸⁹ The Commission on Assisted Dying also recommended an independent statutory monitoring commission should be established to report on whether individual cases have complied with the law and to produce an annual report on the operation of the law each year.²⁹⁰ The Commission’s report recommended that a monitoring commission would be a “national body with legal, medical and ethical input.”²⁹¹ The Commission proposed that such a body would have four main functions:

- To monitor and review every individual case for compliance with the law, taking further investigatory action in cases of potential non-compliance and referring instances of malpractice to the professional bodies or prosecutorial authorities where appropriate.
- To encourage (and potentially fund) prospective independent academic research on the process and the consequences of the introduction of an assisted dying framework.
- To publish anonymised information on ‘difficult cases’ to inform and develop doctors’ professional practice in cases of assisted dying that might be regarded as particularly problematic.
- To collect and publish national data on reported cases of assisted dying and publish an annual report to Parliament each year; findings from these reports could be used to inform ongoing policy development and at the end of the first five years, the monitoring commission could assist Parliament in conducting a full review of the law’s implementation.²⁹²

APPROACH TAKEN IN THE DYING WITH DIGNITY BILL 2009

Section 14 of the *Dying with Dignity Bill 2009* details the medical records that are to be kept. These include:

- (1) a note of any oral request of the sufferer for such assistance;
- (2) the certificate of request;
- (3) a record of the opinion of the sufferer’s medical practitioner as to the sufferer’s state of mind at the time of signing the certificate of request and certification of the medical practitioner’s opinion that the sufferer’s decision to end his or her life was made freely, voluntarily and after due consideration;
- (4) the reports of the medical practitioner and qualified psychiatrist referred to in paragraph 8(1)(c);
- (5) a note by the sufferer’s medical practitioner;
 - a. certifying the independence of the medical practitioner and qualified psychiatrist referred to in paragraph 8(1)(c) and the residential and period of practice qualifications of the sufferer’s medical practitioner; and
 - b. indicating that all requirements under this Act have been met; and
 - c. indicating the steps taken to carry out the request for assistance; and
 - d. including a notation of the substance prescribed;and other such information, if any, as prescribed.

The Joint Standing Committee on Community Development made a couple of comments in their report relating to terminology used in this Section of the Bill, but these related to issues of drafting and definition and not the specific provision of the section. Section 16 of the Bill requires the medical practitioner to provide the patient’s medical record to the Coroner. The Coroner is required to advise the Attorney-General of the number of

patients who died under the provisions of the Act. The Attorney-General is then required to report that number to both Houses of Parliament. The Committee noted concerns about the provisions of Section 16 which requires the patient's medical record to be provided to the Coroner, whereas Section 15(2) suggests that deaths resulting from assistance provided under the Act would not be reportable deaths in accordance with the *Coroner's Act 1995*.

Section 17 provides an additional reporting mechanism whereby the:

Coroner may, at any time and in his or her absolute discretion, report to the Attorney-General on the operation, or any matter affecting the operation, of this Act and the Attorney-General must, within 3 sitting days of the Parliament after receiving the report, table a copy of the report in both Houses of the Parliament.

CONSULTATION POINT

- We are proposing that an independent oversight mechanism be established to monitor and report on the operation of voluntary assisted dying legislation. Do you think this body should take the form of an independent 'committee' (as occurs in Belgium and the Netherlands) or could this monitoring be undertaken by a government department (as occurs in Oregon and Washington)?

APPENDIX I TABLES OF COMPARISON: SAFEGUARDS AND PROVISIONS OF EXISTING VOLUNTARY ASSISTED DYING LEGISLATION AND PROPOSALS

TABLE 3 VOLUNTARINESS

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>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).</p>	<p>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 (§4(1) and §5).</p>	<p>The patient's request must be voluntary (§2(1)(a)).</p>	<p>The patient's request must be "voluntary, well considered and repeated and is not the result of any external pressure" (§3(1)).</p>	<p>Individual right to die organisations in Switzerland have their own internal protocols for determining whether assistance will be provided.</p> <p>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."²⁹³</p>	<p>The Panel concluded that "the decision must be voluntary and informed" and "great care must be taken to ensure that these conditions are met."²⁹⁴</p>	<p>The Commission concluded that if "the person is making a voluntary choice that is an expression of his or her own wishes and is not unduly influenced by others" they should be able to request an assisted death.²⁹⁵</p>

TABLE 4 MENTAL COMPETENCE

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>The patient must be capable of making and communicating health care decisions to their doctors (§1.01(3)).</p> <p>If either the attending or consulting physician are of the opinion that “the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement” they must refer the patient for counselling (§3.03).</p>	<p>The patient must be competent of making and communicating health care decisions to their doctors (§1(3)).</p> <p>If either the attending or consulting physician are of the opinion that “the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement” they must refer the patient for counselling (§6).</p>	<p>The patient’s request must be “voluntary and carefully considered” (§2(1)(a)).</p> <p>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.”²⁹⁶</p>	<p>The patient must be “legally competent and conscious at the moment of making the request” (§3.1).</p>	<p>Lewis and Black explain that “the person assisted with suicide must have capacity if their act is to be considered suicide. The physician must personally examine the person seeking assistance and assess their capacity according to the test set out in the Civil [Criminal] Code. Individual right to die associations have also developed their own tests.”²⁹⁷</p> <p>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.”²⁹⁸</p>	<p>The Panel recommend that “[t]he person making the request for assisted suicide or voluntary euthanasia must be competent or, while competent, must have expressed the wish for voluntary euthanasia through a valid advance directive.”²⁹⁹</p> <p>The Panel also recommended that if the physician is un-certain about the competence of their patient they “must take all necessary steps to resolve this uncertainty.”³⁰⁰</p>	<p>A key safeguard identified by the Commission is that the patient should have “the mental capacity to make a voluntary and informed choice, and the person’s decision-making is not significantly impaired as a result of mental health problems such as depression.”³⁰¹</p>

TABLE 5 INFORMED DECISION

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>The patient must be making an informed decision and the attending physician is required to inform the patient of “his or her medical diagnosis, ... prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and palliative care” (§3.01(c)).</p>	<p>The 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” (§4(c)).</p>	<p>The request must be informed and the physician is required to “inform the patient about the situation he was in and about his prospects” (§2(1)(c)).</p>	<p>Section 3.1 states that the patient’s decision must be “well considered.”</p> <p>The physician must “inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences” (§3.2.1).</p>	<p>Individual right to die organisations have their own guidelines.</p> <p>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.”³⁰²</p>	<p>The Panel concluded that “the decision must be voluntary and informed” and “Great care must be taken to ensure that, at the time of the decision, the person is able to understand and appreciate the nature and consequences of the decision.”³⁰³</p>	<p>One of “the key elements that the Commission considers should underpin any future statutory framework for assisted dying ... [is that the patient] who requests an assisted death is fully informed of all the options available to them for treatment, care and support and still wishes to proceed.”³⁰⁴</p>

TABLE 6 THE PERSON'S CONDITION AND/OR EXPERIENCE OF SUFFERING

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>The patient must be suffering from a terminal disease which is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months” (§1.01(12)).</p>	<p>The patient must be suffering from a terminal disease which is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months” (§1(13)).</p>	<p>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)).</p> <p>There is no requirement that the patient be diagnosed with a terminal illness.</p>	<p>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.”</p> <p>There is no requirement that the cause of the patient’s suffering be a terminal illness.</p>	<p>There is no requirement that the patient be terminally ill or suffering from a specified medical condition.</p> <p>However, lethal medication must be supplied and dispensed in accordance with federal laws and doctors must operate “within the limits of accepted professional practice.”³⁰⁵</p>	<p>The Panel recommended “against using ‘terminal illness’ as a prerequisite for requesting assistance. The term is too vague... There is no precise science to providing a prognosis of a terminal illness in terms of specific length of time. Health care providers cannot be accurate enough, and if the statute or policy does not include a time restriction then the condition ‘terminal illness’ becomes too broad. ... Further, if the term ‘terminal illness’ is made a necessary condition in the statute, then it would be under-inclusive; there are many individuals whose lives are no longer worth living to them who have not been diagnosed with a terminal illness. They may be suffering greatly and permanently, but are not imminently dying. There is no principled basis for excluding them from assisted suicide or voluntary euthanasia.”³⁰⁶</p>	<p>The Commission concluded that “eligibility based on terminal illness would meet the needs of the majority of people who might wish to request assisted dying.”³⁰⁷</p> <p>With regards to suffering, the Commission did not recommend “that any criterion based on ‘unbearable’ or ‘unrelievable’ suffering should be included in potential assisted dying legislation as we are concerned that a criterion based on suffering would be too unclear and subjective for doctors to assess.”³⁰⁸</p>

TABLE 7 TYPE OF ASSISTANCE

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>Physician assisted suicide (patient must self-administer the lethal dose).</p> <p>Voluntary euthanasia is not permitted.</p>	<p>Physician assisted suicide (patient must self-administer the lethal dose).</p> <p>Voluntary euthanasia is not permitted.</p> <p>Unlike the Oregon Act, the Washington law explicitly states that the patient must self-administer the medication (§2(1)).</p>	<p>Voluntary euthanasia and assisted suicide.</p>	<p>Voluntary euthanasia which is defined as “intentionally terminating life by someone other than the person concerned, at the latter’s request” (§2).</p>	<p>It is not a crime to assist another person’s suicide if the assistor does not have a selfish motive.</p> <p>Voluntary euthanasia is not permitted.</p>	<p>The Expert Panel recommended that both assisted suicide and voluntary euthanasia be available: “The Panel found no morally significant difference” between the two acts.³⁰⁹</p> <p>The Panel concluded that “it can be inferred, based on the different surveys described ... [in the report] that the majority of the Canadian public would support legislation permitting voluntary euthanasia and assisted suicide for people suffering from an incurable physical illness.”³¹⁰</p>	<p>The Commission only recommended the legalisation of physician assisted suicide where the patient self-administers the lethal dose.</p> <p>No form of euthanasia was recommended and the Commission explained that “the patient ... would need to be able to take the action that will cause their death, as a clear expression of voluntariness. Appropriate support to take the medication should be provided if it is required by a terminally ill person with an impairment, but this could not take the form of another person administering the medication on their behalf.”³¹¹</p>

TABLE 8 AGE OF THE PATIENT

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
The patient must be an adult aged 18 years or older (§2.01(1)).	The patient must be an adult aged 18 years or older (§2(1)).	Under Dutch law, a patient aged between sixteen and eighteen years that “may be deemed to have a reasonable understanding of his interests” may request euthanasia or assisted suicide. In these cases the parent and/or guardians must be consulted but do not have a veto on the final decision (§2(3)). Patients aged between twelve and sixteen and “may be deemed to have a reasonable understanding of his interests” may also request euthanasia or assisted suicide, provided the parents and/or guardian give their consent (§2(3)).	The patient must have “attained the age of majority or is an emancipated minor” (§3(1)).	Lewis and Black explain that “in Switzerland, children cannot have the required legal capacity to commit suicide, though the position for adolescents is unclear.” ³¹² Membership the right-to-die organisation DIGNITAS is only available for people “of legal age and full capacity of discernment.” ³¹³	The Panel concluded that “any age restrictions for access to assisted suicide or voluntary euthanasia should flow from the mature minor law in the particular jurisdiction.” ³¹⁴	The Commission recommended that the patient be aged 18 or over in order to request an assisted death. ³¹⁵

TABLE 9 WRITTEN REQUEST

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>The request must be in writing in a form prescribed in the Act and signed by two witnesses (§2.02).</p>	<p>The request must be in writing in a form prescribed in the Act and signed by two witnesses (§3).</p>	<p>The request does not need to be in writing but “it has long been considered good practice to obtain a written request.”³¹⁶</p> <p>The Act does allow for termination of life on advance request and this must be in writing. Section 2(2) states that “If the patient aged sixteen years or older is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request.”</p>	<p>Section 3.4 states that “The patient’s request must be in writing. The document is drawn up, dated and signed by the patient.” Special provisions apply to those patients who are physically unable to sign the written request.</p> <p>Section 4 also allows for advance directives to be used by stating “In cases where one is no longer able to express one’s will, every legally competent person of age, or emancipated minor, can draw up an advance directive instructing a physician to perform euthanasia if the physician ensures that the patient suffers from a serious and incurable disorder, caused by illness or accident; the patient is no longer conscious; this condition is irreversible given the current state of medical science.”</p>	<p>Individual right to die organisations have their own guidelines.</p> <p>DIGNITAS’ guidelines state that assisted suicide is only available for members and a written application for membership is a compulsory first step.³¹⁷</p> <p>Under DIGNITAS’ rules the actual request for assisted suicide “must take the form of a letter written and signed personally by the member ... which unmistakably expresses to DIGNITAS the member’s desire to end his or her own life with the help of the organisation, and also states the main reason or reasons for the decision.”³¹⁸ In addition to the written request, DIGNITAS also requires members to provide “an account of the member’s life providing details about a person’s character as well as their family and work situations.”³¹⁹</p>	<p>The Panel found that “written or otherwise recorded requests are preferable (as they can be more reliable as evidence that a request was made and what the request was for), but verbal request are sufficient, if properly documented.”³²⁰</p>	<p>The UK report did not make any recommendations about the form a patient’s request should take.</p>

TABLE 10 RESIDENCY REQUIREMENT

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
The patient must be a resident of Oregon (§2.01).	The patient must be a resident of Washington State (§2).	Residency is not mentioned in the Act but is required. The Dutch Ministry of Foreign Affairs advises that it is impossible for people to travel to the Netherlands to seek an assisted death “given the need for a close doctor-patient relationship. The legal procedure for the notification and assessment of each individual case of euthanasia requires the patient to have made a voluntary, well-considered request and to be suffering unbearably without any prospect of improvement. In order to be able to assess whether this is indeed the case, the doctor must know the patient well. This implies that the doctor has treated the patient for some time.” ³²¹	Residency is not mentioned in the Act but is required. ³²²	There is no requirement for residency. Individual right-to-die organisations have their own rules around membership and residency with some groups only accepting members from Switzerland or Germany and others accepting members from abroad. However, assistance can only be provided in Switzerland.	Residency is not mentioned as an eligibility criterion in the recommendations from the Royal Society of Canada.	Residency is not mentioned as an eligibility criterion in the recommendations from the Commission.

TABLE II CONSULTATION AND REFERRAL REQUIREMENTS

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>The attending physician must “refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily” (§3.01(d)). The consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient’s disease.</p> <p>Section 3.03 states that “if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counselling.” The request for assistance can only proceed once the counsellor determines that the patient is not suffering from depression.</p> <p>The patient must be informed about palliative care options in accordance with Section §3.01(c)(E).</p>	<p>The attending physician must “refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily” (§4(d)). The consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient’s disease.</p> <p>Section 6 states that “if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counselling.” The request for assistance can only proceed once the counsellor determines that the patient is not suffering from depression.</p> <p>The patient must be informed about palliative care options in accordance with Section 4(c)(v).</p>	<p>The patient’s physician must consult another “independent physician who has seen the patient and has given his written opinion on the requirements of due care” (§2(1)(e)).</p> <p>Lewis and Black explain that “[t]he consultation requirements are more stringent if the patient’s suffering is the result of a psychiatric disorder.”³²³</p>	<p>The patient’s physician must consult another physician who is required to review the medical record, examine the patient, confirm the patient’s constant and unbearable physical and mental suffering that cannot be alleviated (§3.2.3).</p> <p>The consulting physician must be independent of both the patient and the attending physician and be competent to give an opinion about the disorder in question (§3.2).</p> <p>If there is a nursing team that forms part of the patient’s regular care, the attending physician must discuss the patient’s request with the nursing team (§3.2.4).</p> <p>An additional requirement exists for patients who are “not expected to die in the near future” (§3.3).</p>	<p>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.”³²⁴</p>	<p>There is no recommendation that two doctors examine and confirm that the patient meets the eligibility criteria as occurs in Oregon, Washington, the Netherlands and Belgium. However, the Panel did recommend that “if an individual physician is uncertain about the competence of the person making a request, she must take all necessary steps to resolve this uncertainty (e.g., consulting with a colleague with greater experience or expertise).”³²⁵</p>	<p>The Commission considers that “an assessment to determine if the person meets the eligibility criteria ... [be] provided by at least two doctors who are wholly independent of each other” is one of a number of “key elements ... [that] should underpin any future statutory framework for assisted dying.”³²⁶</p>

TABLE 12 IDENTITY OF THE ATTENDING DOCTOR

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>The attending physician is defined as “the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease” (§1.01(2)).</p>	<p>The attending physician is defined as “the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease” (§1(2)).</p>	<p>Under Dutch law only physicians can provide assistance with assisted suicide or voluntary euthanasia. The physician does not need to be the patient’s primary physician but it is required “that the physician must know the patient sufficiently well to assess whether the due care criteria are met.”³²⁷</p>	<p>The role of the attending physician is not defined as occurs in the Oregon or Washington Acts. However, the Act does state that the physician must have “several conversations with the patient spread out over a reasonable period of time” in order “to be certain of the patient’s constant physical or mental suffering and of the durable nature of his/her request” (§3(2)(2)).</p>	<p>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.”³²⁸</p> <p>There are five right-to-die organisations in Switzerland. They are: Exit Deutsche Schweiz (Exit DS), Exit Association for the Right to Die with Dignity (Exit ADMD), Ex International, Verein Suizidhilfe and DIGNITAS.</p>	<p>The Panel concluded that “permission to provide assistance be granted only to those: who have the knowledge and skills necessary to ensure that the conditions for access ... (e.g., competence, voluntariness, conveyance of information) have been met.”³²⁹</p>	<p>The Commission recommended that “the first doctor would be one with usual responsibility for the patient’s care, who knows the patient well. This might be a specialist in the patient’s medical condition or the patient’s GP. The first doctor would take responsibility for overseeing the developing conversation with the patient about their medical condition, the treatment and care they wished to receive and, should they request it, their motivation for wanting an assisted death. This doctor would be responsible for the patient’s welfare and should continue to explore throughout the process the issues of whether their request for an assisted death is wholly voluntary and whether they have the capacity to make this request.”³³⁰</p>

TABLE 13 WAITING PERIODS

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
Section 3.08 states that “no less than fifteen (15) days shall elapse between the patient’s initial oral request and the writing of the prescription. ... no less than 48 hours shall elapse between the patient’s written request and the writing of a prescription.”	Section 11(1) states that “at least fifteen days shall elapse between the patient’s initial oral request and the writing of a prescription” and Section 11(2) states that “at least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription.”	There are no specified waiting periods in the Dutch Act.	There are no specified waiting periods in the Act, however, the attending physician must have “several conversations with the patient spread out over a reasonable period of time” (§3(2)(2)). For patients who are not expected to die in the near future, the attending physician must “allow at least one month between the patient’s written request and the act of euthanasia” (§3(3)(2)).	Individual right to die organisations have their own guidelines. There are no waiting periods that must be adhered to after someone has become a member of DIGNITAS before they are allowed to submit an application for assisted suicide. ³³¹ The requirements of DIGNITAS are that the member must consult with a doctor prior to the writing of a prescription, and this can be “a very lengthy process.” ³³²	The Panel found that “[t]he time required to elapse between the initial request and the granting of the assistance will depend on the time required to ensure that the person’s request is voluntary and informed and that the individual is competent. ... Depending on the circumstances, this may take a short or quite a long time. Once all of the other conditions have been met, there must be a short (for example, twenty-four hours) pause before the assistance is provided to allow confidence that all of the conditions and procedural requirements have been met. Beyond that, the Panel does not recommend any delay requirements.” ³³³	The Commission concluded that “given that the person concerned would need to have an advanced, progressive, incurable disease according to the proposed eligibility criteria, ... it would be inappropriate to suggest safeguards that would require a very lengthy approval process at this point. However, it is also important that some time should be built into the process to ensure that the patient’s decision cannot be made hastily, and that it is a settled decision to die, as opposed to a fluctuating wish.” ³³⁴ The minimum waiting period between a request being made and a patient receiving an assisted death was recommended to be 2 weeks. If the patient’s death was judged by the two doctors to likely occur within a month the waiting period could be reduced to 6 days. ³³⁵

TABLE 14 FAMILY NOTIFICATIONS

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>In accordance with Section 3.05, the attending physician is to advise the patient to notify their next of kin of their request. However, a patient who declines or is unable to notify next of kin cannot have their request refused for that reason.</p>	<p>In accordance with Section 8, the attending physician is to advise the patient to notify their next of kin of their request. However, a patient who declines or is unable to notify next of kin cannot have their request refused for that reason.</p>	<p>There is no requirement for adult patients to notify their next of kin of their request for euthanasia or assisted suicide.</p> <p>Patients aged between twelve and eighteen must involve their parents and/or guardians in the decision making process and the parents of patients aged 12-16 must give their permission for euthanasia or assisted suicide to take place (§2(3) and §2(4)).</p>	<p>The request can be discussed with the patient's relatives "if the patient so desires" (§3(2)(5)).</p>	<p>There is no requirement for family notifications, although individual right-to-die organisations have their own guidelines.</p> <p>DIGNITAS' guidelines state "whenever possible, it is extremely important to inform family and friends about the [assisted suicide]."³³⁶</p>	<p>The Royal Society of Canada Expert Panel made no recommendation relating to this criterion.</p>	<p>The Commission on Assisted Dying made no recommendation relating to this criterion.</p>

TABLE 15 DUE MEDICAL CARE

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>There are no specified due care provisions in the Oregon Act, but the attending physician must fulfil a number of reporting and medical record documentation requirements.</p> <p>The Act only permits the prescription of lethal medication for the purpose of self-administration by the patient.</p>	<p>There are no specified due care provisions in the Washington Act, but the attending physician must fulfil a number of reporting and medical record documentation requirements.</p> <p>The Act only permits the prescription of lethal medication for the purpose of self-administration by the patient.</p> <p>Section 14 requires any medication dispensed under the Act which was not self-administered to be disposed of lawfully.</p>	<p>Section 2(1)(f) of the Dutch Act requires the physician to have “terminated [the patient’s] life or assisted in a suicide with due care.”</p> <p>Lewis and Black explain that “The criterion of due medical care and attention also normally requires the physician’s continuous presence during the euthanasia or assisted suicide in case further medical intervention is required. This requirement also ensures that the medication to be used remains under the control of the physician.”³³⁷</p> <p>Information regarding appropriate medications for physicians to use is provided by the Royal Dutch Pharmacological Association.</p>	<p>Lewis and Black explain that while there is no specific provision that the physician exercise due medical care when carrying out euthanasia, all Belgian doctors must exercise due care regardless of the procedure being performed.³³⁸</p>	<p>Lewis and Black explain that “In Switzerland, any form of suicide assistance is permissible in principle. However, in practice almost all cases involve a prescription of the barbiturate sodium pentobarbital. Physicians prescribing lethal medication must act in accordance with accepted medical practice.”³³⁹</p> <p>In 2008 the cantonal physician of Zurich issued a ruling that “any prescriptions for NaP [sodium pentobarbital or ‘Nembutal’] written after only one doctor’s consultation [would be considered] ... a violation of the principle of the ethical practice of medicine.”³⁴⁰ Disciplinary action would be taken against doctors who did not comply. Accordingly, under DIGNITAS’ guidelines the doctor is required to meet with the patient twice.³⁴¹</p>	<p>The Panel recommends “that permission to provide assistance be granted only to those: who have the knowledge and skills necessary to ensure that the condition for access ... (e.g., competence, voluntariness, conveyance of information) have been met.”³⁴²</p>	<p>The Commission recommends “that the suitably qualified professional overseeing the person’s death should be legally required to return the medication to the pharmacy.”³⁴³</p> <p>The Commission also recommended that “a doctor who prescribes lethal medication for the purpose of an assisted death should have ongoing responsibility for the care of that patient up to and including their death. ... the doctor ... must be on hand (... although not necessarily in the same room) when the patient takes the medication.”³⁴⁴</p>

TABLE 16 OPPORTUNITY TO RESCIND REQUEST

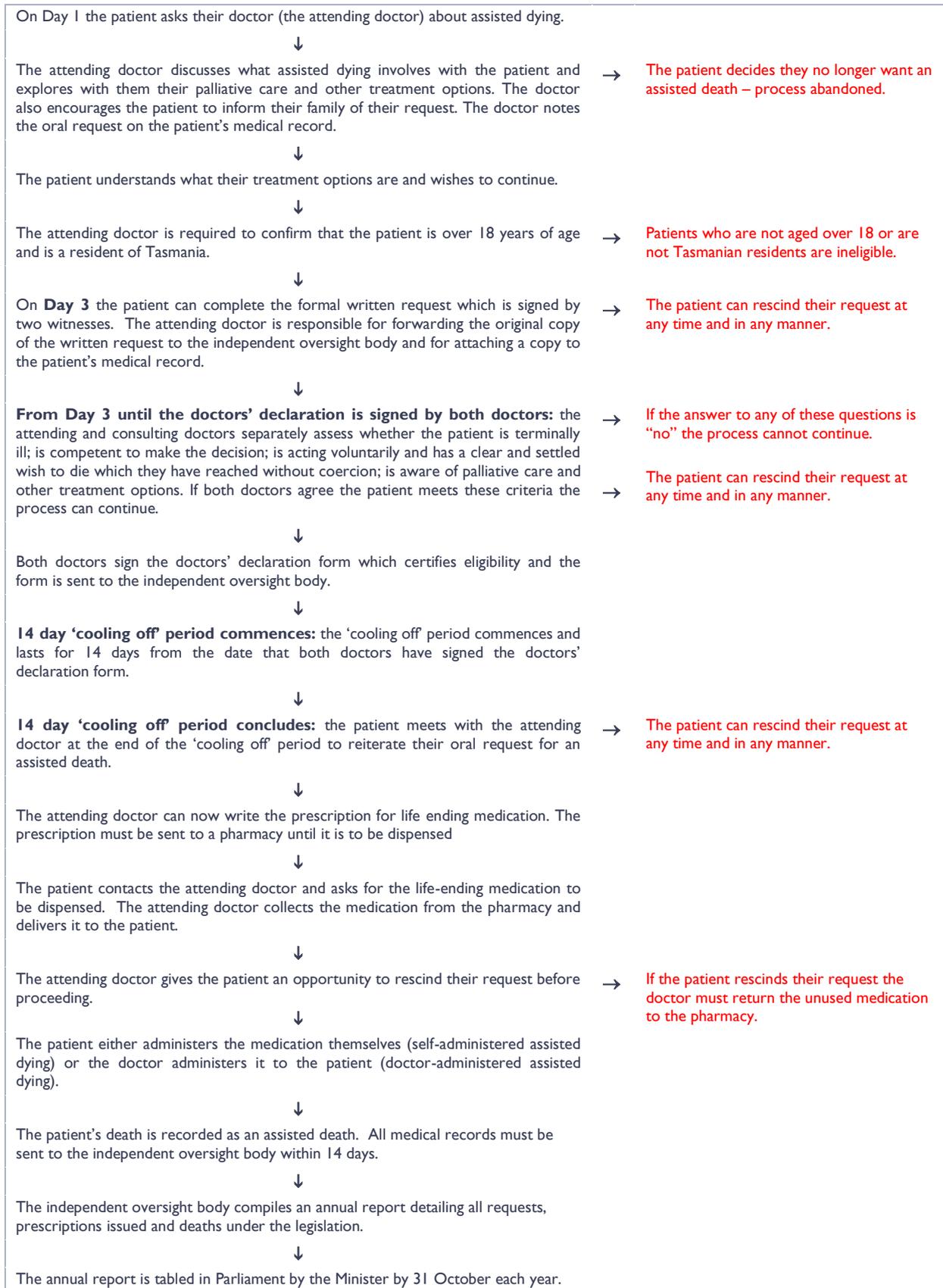
Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
Section 3.07 states that “a patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication ... may be written without the attending physician offering the qualified patient an opportunity to rescind the request.”	Section 9 states that “a patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication ... may be written without the attending physician offering the qualified patient an opportunity to rescind the request.”	There is no specified section in the Act relating to a patient’s opportunity to rescind their request.	Section 3(4) states that “the patient may revoke his/her request at any time, in which case the document is removed from the medical record and returned to the patient.” Advance directives may be amended or revoked at any time (§4(1)).	Individual right-to-die guidelines have their own guidelines. DIGNITAS’ guidelines state that a meeting is held with the patient prior to the planned assisted suicide. At this time “it is repeatedly and clearly stressed that the fact that the member travelled to Switzerland does not automatically mean that he or she must go through with the AS. At this point, and indeed right up to the last moment before the medication is taken, the member is completely free to decide against going through with the AS.” ³⁴⁵	The Royal Society of Canada Expert Panel made no recommendation relating to this provision.	The Commission on Assisted Dying made no recommendation relating to this provision.

TABLE 17 REPORTING AND SCRUTINY OF CASES

Oregon	Washington	The Netherlands	Belgium	Switzerland	Canada	UK
<p>Section 3.11 sets out the reporting requirements to be undertaken by the Department of Human Services.</p> <p>Section 3.11 also requires “any health care provider upon dispensing medication ... to file a copy of the dispensing record with the department [of Human Services].”</p> <p>The Department of Human Services is required to prepare an annual report on the operation of the Act (§3.11(3)).</p>	<p>Section 15 sets out the reporting requirements to be undertaken by the Department of Health.</p> <p>Section 15 also requires “any health care provider ... to file a copy of the dispensing record and other such administrative required documentation with the department.”</p> <p>The documentation is to be provided to the department within thirty calendar days after the writing of a prescription and dispensing of medication (§15(1)(b)).</p> <p>The prescribing physician must file all documents required after the death of the patient with the department no later than 30 days after the patient has died (§15(1)(b)).</p> <p>The Department of Health is required to prepare an annual report on the Act (§15(3)).</p>	<p>Regional review committees are established under Section 3 of the Act.</p> <p>For the physician to be protected by the legal defence provided by the 2001 Act, he or she must report the case to the municipal pathologist (§20(2)). The municipal pathologist is responsible for forwarding the file to the relevant review committee: “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.”³⁴⁶</p> <p>The review committees are required to provide an annual report on their activities (§17).</p>	<p>The Belgian Act establishes a Federal Control and Evaluation Commission (§6).</p> <p>Section 5 states that “any physician who has performed euthanasia is required to fill in a registration form ... and to deliver the document to the Commission within four working days. Section 7 details the information the physician is required to provide about the patient.</p> <p>The Commission is responsible for reviewing all cases of euthanasia to ensure they were undertaken in accordance with the Act (§8).</p> <p>If the Commission believes that the statutory criteria have not been met they will refer the case to the public prosecutor (§8).</p>	<p>Individual right-to-die organisations produce their own reports on their activities.</p> <p>The only reporting requirement is that “assisted suicides must be reported to the local authorities as unnatural deaths.”³⁴⁷</p> <p>Concerns have been raised about a lack of reporting of assisted suicide in Switzerland, particularly as there is no national body to which assisted suicide must be reported. This means that there is no national reporting data available for review.³⁴⁸</p>	<p>The Panel recommended that “a national oversight commission be established to monitor and report annually and publicly on assisted suicide and voluntary euthanasia in Canada.”³⁴⁹</p>	<p>The Commission recommended that should assisted dying be legalised, an independent statutory national monitoring commission should be established to report to the Department of Health on whether individual cases have complied with the law. One of the functions of the national monitoring commission would be to publish an annual report to Parliament on the operation of the law each year.³⁵⁰</p>

APPENDIX 2

FLOW CHART: PROPOSED MODEL OF VOLUNTARY ASSISTED DYING



<p>Voluntariness</p>	<ul style="list-style-type: none"> • We propose that only voluntary requests for assisted dying be considered. • There will be multiple checks during the process to confirm the persistence and consistency of the voluntary request, in addition to other provisions, that together contribute to confirmation of the voluntary nature of the request. • Requirements to establish the voluntary nature of the request will include a signed written request by the patient that confirms that their request is voluntary, informed and is not being made as the result of coercion or under duress. • We propose that to help confirm the voluntary nature of the request the patient identify the reasons for their request. This data will be collected by the independent oversight body. • The attending doctor, the consulting doctor and the witnesses to the patient’s written request will contribute to the confirmation of the voluntary nature of the request. • The patient must always voluntarily initiate the conversation about assisted dying. It is not appropriate for the patient’s doctor, a family member or a social care professional to offer the option of an assisted death to a terminally ill patient. • The patient must always initiate each stage of the process.
<p>Mental competence</p>	<ul style="list-style-type: none"> • We propose that only competent patients can access an assisted death. Competent means that the patient is able to communicate health care decisions for themselves and is not suffering from impaired decision-making due to a psychiatric or psychological disorder or depression. • Both the attending doctor and consulting doctor must confirm that the patient is competent. • If either doctor is unsure about the patient’s competence then they must take all necessary steps to resolve that uncertainty. • The witnesses to the patient’s written request must also confirm that the patient is competent to the best of their knowledge and belief.
<p>Informed decision</p>	<ul style="list-style-type: none"> • We propose that to be eligible for an assisted death a patient must make an informed decision. • To ensure the patient is making an informed decision, we propose that the attending doctor must inform the patient of: <ul style="list-style-type: none"> ○ their medical diagnosis and 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 such as palliative care, pain control and hospice care. • In signing the doctors’ declaration form both the attending doctor and the consulting doctor will certify that the patient is making an informed decision.

<p>The person's condition and experience of suffering</p>	<ul style="list-style-type: none"> • We propose that the person accessing assistance to die must be terminally ill. • 'Terminally ill' means the advanced stages of an incurable and progressive medical condition, due to disease or injury, that can be reasonably expected to cause the death of that person without significant medical intervention. • 'Advanced stages' means as determined in line with accepted medical practice, guidelines or protocols. • Both the attending and consulting doctors will be required to confirm that the patient is terminally ill. • We propose that the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient's condition and to relieve the patient's suffering adequately and to the satisfaction of the patient. • We are proposing that no person shall be eligible for an assisted death solely on the basis of disability or age.
<p>Type of assistance</p>	<ul style="list-style-type: none"> • We propose that both self-administered and doctor-administered assisted dying be available. • In cases of doctor-administered assisted dying we propose that only the patient's doctor can administer the medication. • In cases of self-administered assisted dying we propose that the patient's attending doctor must be present when the patient self-administers the medication.
<p>Age of the patient</p>	<ul style="list-style-type: none"> • We propose that only adults aged 18 years or older be eligible for an assisted death.
<p>Written request</p>	<ul style="list-style-type: none"> • We propose that the patient must make a written request for assistance in addition to two oral requests. • The written request must be witnessed by two people and one of the witnesses must be a person who is not: <ul style="list-style-type: none"> ○ A relative of the patient by blood, marriage or adoption, ○ A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or ○ An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident. • The patient's attending doctor at the time the request is signed cannot be a witness. • In the event the patient is physically unable to sign a request the patient may designate someone to sign on their behalf. This person cannot be a witness to the request. • A copy of the patient's written request, and a notation of both oral requests, is to be kept on the patient's medical record. • The original copy of the written request is to be forwarded to the independent oversight body by the attending doctor. • Under our proposed model a person will not be able to request an assisted death through an advance directive.

Residency requirement	<ul style="list-style-type: none"> • We propose that only Tasmanian residents be eligible for assistance. • Tasmanian residency would be proven through such means as proof of enrolment to vote in Tasmania, proof of a Tasmanian drivers licence, or proof that the patient owns or leases property in Tasmania.
Consultation and referral requirements	<ul style="list-style-type: none"> • We propose that the patient’s attending doctor must refer the patient for an independent assessment by a consulting doctor for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily. • The consulting doctor must be qualified to make a professional diagnosis and prognosis regarding the patient’s disease.
Identity of the attending doctor	<ul style="list-style-type: none"> • We propose that the attending doctor be the doctor who has the primary responsibility for the care of the patient and the treatment of the patient’s terminal condition. • A doctor will always retain the right to refuse to assist a patient that requests an assisted death. • If the patient has their request for assistance refused they may request that their relevant medical records be forwarded to a new doctor.
Waiting periods	<ul style="list-style-type: none"> • We are proposing a number of specific waiting periods throughout our model: <ul style="list-style-type: none"> ○ 48 hours are to elapse between the patient’s initial oral request for assistance and the completion of the formal written request. ○ Once both doctors have certified that the patient is eligible for assistance and have signed the doctors’ declaration form a 14 day ‘cooling off’ period commences. ○ The prescription for lethal medication can only be written following the end of the 14 day ‘cooling off’ period.
Family notifications	<ul style="list-style-type: none"> • We are proposing that the attending doctor should encourage the patient to notify their family of their request for an assisted death, but if the patient declines or is unable to notify next-of-kin they shall not have their request denied for that reason.
Due care: safe handling of prescription medicine	<ul style="list-style-type: none"> • We are proposing that the lethal medication prescribed to an eligible patient must stay under the supervision of the attending doctor. • For this reason the attending doctor will be required to collect the medication from the pharmacy and deliver it to the patient when it is to be taken. • The attending doctor must offer the patient the opportunity to rescind their request prior to the patient taking the medication or the medication being administered to the patient. If the patient chooses to rescind their request the attending doctor must return the unused medication to the pharmacy.

<p>Opportunity to rescind request</p>	<ul style="list-style-type: none"> • We propose that the patient may rescind their request at any time and in any manner. • We propose that the attending doctor must offer the patient an opportunity to rescind their request prior to writing a prescription for lethal medication. • We propose that the attending doctor must offer the patient an opportunity to rescind their request prior to the patient either self-administering the medication, or the doctor administering the medication to the patient.
<p>Reporting and scrutiny of cases</p>	<ul style="list-style-type: none"> • We propose that an independent oversight mechanism be established. • This independent oversight body would be required to prepare an annual report on the operation of the Act to be tabled in Parliament. • The independent oversight body would be required to check that the eligibility requirements of the legislation have been met before assisted dying is provided. • We are proposing that at key points of the process, the oversight body must be notified by the patient's attending doctor. The attending doctor must: <ul style="list-style-type: none"> ○ forward to the oversight body the original of the patient's written request. ○ forward to the oversight body the original doctors' declaration form signed by both the attending and consulting doctors certifying the eligibility of the patient. ○ notify the oversight body that a prescription has been written. ○ notify the oversight body of the death of a patient to whom a prescription for lethal medication has been written, but not ingested. ○ notify the oversight body of the death of a patient following administration of the lethal medication. • The independent oversight body will be responsible for undertaking community education programs about the Act directed to both patients and their families and doctors. • We propose that a full review of the Act be undertaken after 5 years of operation.

These questions do not represent an exhaustive list, but are questions that we are specifically interested in seeking feedback on. We also welcome your feedback on any other aspect of our proposed model.

- Under our proposal, the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient's condition and to relieve the patient's suffering adequately and to the satisfaction of the patient. Should 'unbearable' or 'unrelievable' suffering be included as a separate eligibility criteria?

- Should eligibility be linked to an anticipated life-expectancy?

- Should patients with non-terminal yet progressive illnesses be eligible for an assisted death?

- Opinion polling consistently shows strong support for a doctor being able to provide a lethal dose of medication to a terminally ill patient. Do you think the patient's attending doctor should be able legally to administer the fatal dose?

- Should voluntary assisted dying be limited to the patient self-administering the fatal dose? If only self-administered assisted dying is legal, what assistance should be provided to those who are physically unable to commit the act?

- What provisions should be made for those patients who are physically unable to sign a request? Do you think a video recording of the request would be appropriate? Or should the patient be able to designate someone to sign the request on their behalf as occurs in Belgium?

- What are your views on the role of an independent consultation service in a legislated model of voluntary assisted dying?

- Should the consulting doctor have to meet face-to-face with the patient? Is it enough for them to just review the patient's medical record? Could the utilisation of 'telehealth' or 'e-health' technology replace a face-to-face consultation?

- We are proposing that an independent oversight mechanism be established to monitor and report on the operation of voluntary assisted dying legislation. Do you think this body should take the form of an independent 'committee' (as occurs in Belgium and the Netherlands) or could this monitoring be undertaken by a government department (as occurs in Oregon and Washington)?

APPENDIX 5 KEY DATA ON THE OPERATION OF THE OREGON DEATH WITH DIGNITY ACT 1994

TABLE 18 KEY DATA ON THE OPERATION OF THE OREGON DEATH WITH DIGNITY ACT 1994

Note: The ‘-’ symbol indicates that no data was recorded against that characteristic in the corresponding annual report.

Characteristics	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Oregon – total deaths	29,346	29,356	29,541	30,128	31,082	30,813	30,201	30,854	31,304	31,433	32,020	31,547	31,899	32,728	30,777
No. of patients receiving prescriptions	24	33	39	44	58	67	60	64	65	85	88	95	96	114	115
No. of patients taking the prescription	16	27 ^a	27 ^b	21 ^c	38 ^d	42 ^e	37 ^f	38 ^g	46 ^h	49 ⁱ	60 ^j	50 ^k	65 ^l	71 ⁿ	77
No. of patients who died of their underlying condition	6	5	8	14	16	18	13	15	19	26	22	30	22 ^m	27 ^o	23
No. of patients still alive at the end of the reporting period	2	2	5	11	6	10	12	17	11	13	12	12	15	25	
No. of prescribing physicians	14	22	22	33	33	42	40	39	40	45	59	55	59	62	61
Sex															
Male	8	16	12	8	27	19	18	23	26	26	30	31	38	26	39
Female	7	11	15	13	11	23	19	15	20	23	30	28	27	45	38

^a includes one patient who received a prescription in 1998; ^b includes one patient who received a prescription in 1999; ^c includes two patients who received a prescription in 2000; ^d includes two patients who received a prescription in 2001; ^e includes one patient who received a prescription in 2001 and two who received prescriptions in 2002; ^f includes two patients who received prescriptions in 2003; ^g includes six patients who received prescriptions in 2004; ^h includes eleven patients who received earlier prescriptions; ⁱ includes three patients who received earlier prescriptions; ^j includes six patients who received earlier prescriptions; ^k includes six patients who received earlier prescriptions; ^l includes six patients who received earlier prescriptions; ^m this figure includes 2 patients who took the medication but did not die after ingestion and later died of their underlying illness; ⁿ includes nine patients who received earlier prescriptions; ^o this figure includes 2 patients who took the medication but did not die after ingestion and later died of their underlying illness;

(Table 18 continued)

Characteristics	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Age															
Median age (years)	69	71	69	68	69	73	64	70	74	65	72	76	72	70	69
Race															
White	15	26	26	20	37	41	37	36	45	48	59	58	65	65	75
Other ^o	0	1	1	1	1	1	0	2	1	1	1	1	0	6	2
Marital status															
Married	2	12	18	8	20	15	15	20	23	21	31	27	33	26	33
Widowed	5	6	6	5	7	12	6	8	8	10	12	16	14	19	23
Never married	4	8	0	1	2	5	2	2	5	6	7	3	4	7	6
Divorced	4	1	3	7	9	10	14	8	10	12	10	13	14	16	15
Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Education															
Less than High School	3	2	2	3	4	2	2	3	4	2	3	3	4	3	2
High School graduate/some College	12	12	11	10	24	20	16	21	23	28	21	27	33	32	42
Baccalaureate or higher	4	13	13	8	10	20	19	14	19	19	36	28	27	33	29
Unknown	-	0	1	0	0	0	0	0	0	0	0	1	1	3	0

^o Includes African American, American Indian, Asian, Pacific Islander, Hispanic and other.

(Table 18 continued)

Characteristics	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Underlying illness															
Cancer	13	17	21	18	32	35	29	32	40	42	48	47	51	56	58
Amyotrophic lateral sclerosis	-	4	2	-	3	3	3	4	3	3	4	5	7	2	5
Chronic lower respiratory disease	-	-	-	-	1	1	1	1	0	3	4	3	2	5	2
HIV/AIDs	-	1	-	-	-	2	2	0	1	1	1	0	0	0	1
Other illness ^b	2	5	4	3	2	1	2	1	2	0	3	4	5	5	11
End of life concerns															
Losing autonomy	12	21	25	16	32	39	32	30	44	49	57	57	61	63	72
Less able to engage in activities making life enjoyable	10	22	21	13	32	39	34	34	44	42	55	51	61	64	71
Loss of dignity	-	-	-	-	-	31	29	34	35	42	55	54	51	53	60
Losing control of bodily functions	8	16	21	9	18	24	24	17	27	31	37	31	30	24	27
Burden on family, friends, care givers	2	7	17	4	14	16	14	16	20	22	20	15	17	30	44
Inadequate pain control or concern about it	1	7	8	1	10	9	8	9	22	16	3	6	10	23	23
Financial implications of treatment	0	0	1	1	1	1	2	1	0	2	2	1	1	2	3

^b Other illness includes: heart disease, deaths due to benign and uncertain neoplasms, other respiratory disease, disease of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease) musculoskeletal and connective tissue disease, viral hepatitis, diabetes mellitus, cerebrovascular disease and alcohol liver disease.

(Table 18 continued)

Characteristics	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Location of death															
Home	12	25	25	19	38	39	36	36	43	44	58	58	63	64	75
Long term care facility	-	-	2	-	0	2	1	2	2	4	2	0	2	4	2
Hospital	-	-	0	1	0	0	0	0	0	0	0	0	0	0	0
Other	-	2	0	1	0	1	0	0	1	1	0	1	0	3	0
Complications															
Regurgitation	0	0	1	1	2	3	3	2	4	3	0	1	1	1	0
Regaining consciousness after ingesting medicine	0	0	0	0	0	0	0	1	0	0	0	0	2	2	1
Timings															
Median time between 1 st request and death (days)	20	83	30	54	49	36	33	40	54	14	42	46	64	47	47
Time range between 1 st request and death (days)	15 – 75	15 – 289	1 – 851	15 – 466	16 – 329	16 – 737	15 – 593	15 – 1009	15 – 747	0 – 1,440	15 – 436	15 – 527	16 – 338	15 – 872	16 – 388
Median time between ingestion and unconsciousness (mins)	-	10	9	3	5	4	5	5	5	5	5	5	5	5	5
Time range between ingestion and unconsciousness (mins)	-	1 – 30	1 – 38	1 – 30	1 – 30	1 – 20	1 – 30	2 – 15	1 – 29	1 – 20	1 – 20	1 – 30	1 – 20	2 – 10	3 – 15
Median time between ingestion and death (mins)	-	30	30	25	20	20	25	26	29	25	15	45	35	27	20
Median time between ingestion and death (mins)	-	4 – 1,560	5 – 75	5 – 2,200	5 – 840	5 – 2,880	5 – 1,860	5 – 570	1 – 990	6 – 4,980	2 – 1,500	2 – 6,240	5 – 3,180	15 – 90	10 – 210

ABOUT TABLES 19 AND 20

The data in this section is only a sample of the data available on the operation of the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. It is important not to reach conclusions solely on this limited information. This issue has been subjected to intense scrutiny in the Netherlands and much more detailed data and discussion are included to the reports on the Netherlands referred to in this paper.

In the Netherlands, annual reports are produced by the Regional Euthanasia Review Committees detailing information about the notifications they have received from doctors. Table 19 includes data from the 2008, 2009 and 2010 annual reports.

In addition to the annual data collected from doctors, five yearly reviews are done by a team of respected researchers from government agencies

and academic institutions. The reviews are also highly regarded as reliable, rigorously designed studies, as demonstrated by their publication in *The Lancet*.

Table 20 includes data from the reviews that have been conducted since 1990 and include three sets of data collected before legislation was passed in 2002 and two sets of data collected since the Dutch Act came into force. These reviews are based on samples of death certificates and are not dependent on doctors' reports. They explore euthanasia and assisted suicide in the context of end-of-life decision making. They provide important indications of changes over time in end-of-life practices. Some of the same practices occur in Australia and in other countries without voluntary assisted dying legislation but without this level of study and analysis to enable effective comparisons, such as around the level of continuous deep sedation (otherwise referred to terminal or palliative sedation).

TABLE 19 DATA FROM THE NETHERLANDS

Characteristics	2008	2009	2010
Notifications	2,331	2,636	3,136 [‡]
Euthanasia and assisted suicide			
Cases of euthanasia	2,146	2,443	2,910
Cases of assisted suicide	152	156	182
Cases involving a combination of assisted suicide and euthanasia	33	37	44
Attending physician			
General practitioner	2,083	2,356	2,819
Medical specialist	152	184	193
Geriatrician	91	87	115
Registrar	5	10	9

(Table 19 continued overleaf)

[‡] Total number of deaths in the Netherlands in 2010 was 136,056. Notifications comprised 2.3 per cent of total deaths.

Characteristics	2008	2009	2010
Underlying illness			
Cancer	1,893	2,153	2,548
Cardiovascular disease	62	54	158
Neurological disorders	117	131	75
Other conditions	145	168	237
Combination of conditions	114	130	118
Location			
Patient died at home	1,851	2,117	2,499
Patient died in hospital	145	170	182
Patient died in a nursing home	87	77	109
Patient died in a care home	111	111	127
Patient died elsewhere (eg. hospice)	137	161	219
Findings			
Number of cases in which physician found to not to have acted in accordance with the due care criteria [§]	10	9	9

TABLE 20 DATA FROM THE NETHERLANDS**

Characteristics	1990	1995	2001	2005	2010
Deaths					
Annual number of deaths in the Netherlands	128,824	135,675	140,377	136,402	136,056
Number of cases studied	5,197	5,146	5,617	9,965	6,861
Cause of death					
Voluntary euthanasia	1.7%	2.4%	2.6%	1.7%	2.8%
Assisted suicide	0.2%	0.2%	0.2%	0.1%	0.1%
Life-terminating acts without explicit request of the patient ^{††}	0.8%	0.7%	0.7%	0.4%	0.2%
Intensified alleviation of symptoms	18.8%	19.1%	20.1%	24.7%	36.4%
Forgoing of life-prolonging treatment	17.9%	20.2%	20.2%	15.6%	18.2%
Total	39.4%	42.6%	43.8%	42.5%	57.8%
Continuous deep sedation ^{‡‡}	n/a	n/a	-	8.2%	12.3%
Patient deciding to end life by stopping eating and drinking	n/a	n/a	n/a	n/a	0.4%

[§] A finding that the physician did not act with due care does not mean that the patient was not eligible for assistance.

** The source of the data in this table is Bregje Onwuteaka-Philipsen, Arianne Brinkman-Stoppelenburg, Corine Penning, Gwen de Jong-Krul, Johannes van Delden, and Agnes van der Heide, 'Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey', *The Lancet*, volume 380, issue 9845, (8 September 2012).

†† The report by Onwuteaka-Philipsen et al includes an important discussion about this aspect.

‡‡ The report notes, "Continuous deep sedation might have been provided in conjunction with practices that possibly hastened death. In 2001, continuous deep sedation was only studied when it occurred in conjunction with end-of-life decisions; the frequency was 5.6%; corresponding numbers are 7.1% in 2005 and 11% in 2010." (Onwuteaka-Philipsen et al, 'Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey').

ENDNOTES

¹ Joint Standing Committee on Community Development, 'Report on the *Dying with Dignity Bill 2009*', (Hobart: Parliament of Tasmania, 2009), p. 10.

² See for example, Newspoll survey prepared for Dying with Dignity Victoria, (February 2007), available online at: <http://www.dwdv.org.au/surveys.html>, (accessed 29 February 2012); Newspoll survey prepared for Dying with Dignity New South Wales, (October 2009), available online at: <http://www.dwdv.org.au/surveys.html>, (accessed 29 February 2012); Brenden Hills, 'Australians Back Right To Die Legislation', *The Sunday Telegraph* (26 September 2010), available online at: <http://www.dwdv.org.au/News/News0621.html>, (accessed 29 February 2012).

³ Margaret Otlowski, 'Active Voluntary Euthanasia: A Timely Reappraisal', University of Tasmania Law School Occasional Paper 1, (1992), p. 33.

⁴ Ibid.

⁵ The Commission on Assisted Dying, "*The current legal status of assisted dying is inadequate and incoherent ...*", (London: Demos, 2011), p. 140.

⁶ Professor Sam H Ahmedzai, 'Assisted Dying: Re Assisted Dying', *British Medical Journal*, (19 June 2012), available online at: <http://www.bmj.com/content/344/bmj.e4075/rr/590548>, (29 January 2013).

⁷ Ibid.

⁸ Judicial decision in the case of *Carter v Canada*, paragraph 409, available online at: <http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm>, (accessed 16 June 2012).

⁹ House of Assembly Community Development Committee, 'Report on the need for legislation on voluntary euthanasia', (Hobart: Parliament of Tasmania, 1998), p.15.

¹⁰ Lorena Bartels and Margaret Otlowski, 'A right to die? Euthanasia and the law in Australia', *Journal of Law and Medicine*, volume 17, part 4, (2010), p. 550.

¹¹ Elizabeth Clery, Sheila McLean and Miranda Phillips, 'Quickening Death: the euthanasia debate', in A. Park, J. Curtice, K. Thomson, M. Phillips and M. Johnson (eds), *British Social Attitudes: the 23rd report – Perspectives on a changing society*, (London: Sage, 2007), p. 37.

¹² The Commission on Assisted Dying, "*The current legal status of assisted dying is inadequate and incoherent ...*", p. 70.

¹³ Ibid, p. 71.

¹⁴ Ibid, p. 78.

¹⁵ Greg Callaghan, '10 questions - Simon Longstaff', *The Weekend Australian Magazine*, (7 May 2011), available online at: <http://www.theaustralian.com.au/news/features/questions-simon-longstaff/story-e6frg8h6-1226049959062>, (accessed 19 March 2012).

¹⁶ Judicial decision in the case of *Carter v Canada*, paragraph 409.

¹⁷ The Commission on Assisted Dying, "*The current legal status of assisted dying is inadequate and incoherent ...*", p. 149.

¹⁸ Ibid.

¹⁹ House of Assembly Community Development Committee, 'Report on the need for legislation on voluntary euthanasia', p. 6.

²⁰ Joint Standing Committee on Community Development, 'Report on the *Dying with Dignity Bill 2009*', p. 6.

²¹ Bartels and Otlowski, 'A right to die? Euthanasia and the law in Australia', p. 535.

²² Ibid, p. 540.

²³ Margaret Otlowski, 'Getting the law right on physician-assisted death', *Amsterdam Law Forum*, volume 3, number 1, (2011), p. 128.

²⁴ House of Assembly Community Development Committee, 'Report on the need for voluntary euthanasia legislation', p. 6; Joint Standing Committee on Community Development, 'Report on the *Dying with Dignity Bill 2009*', p. 7.

²⁵ See 'Brother responds to sentence handed down in assisted suicide case', *ABC Tasmania*, (26 May 2004), available online at: <http://www.abc.net.au/tasmania/stories/s1116265.htm>, (accessed 19 March 2012); 'Son freed after helping mother suicide', *Sydney Morning Herald*, (26 May 2004), available online at: <http://www.smh.com.au/articles/2004/05/1085461811471.html>, (accessed 19 March 2012).

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- ²⁶ Justice Peter Underwood, 'Comments on Passing Sentence: *Tasmania v John Stuart Godfrey*', (26 May 2004).
- ²⁷ *Ibid.*
- ²⁸ Otlowski, 'Getting the law right on physician-assisted death', p. 130.
- ²⁹ Russell Korobkin, 'Physician-Assisted Death Legislation: Issues and Preliminary Responses', Working Paper 60, (January 1998), edited by James H. Kuklinski, The Institute of Government and Public Affairs, University of Illinois, p. 1.
- ³⁰ The Commission on Assisted Dying, "*The current legal status of assisted dying is inadequate and incoherent ...*", p. 51.
- ³¹ Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care*, (2007), available online at: <http://ama.com.au/node/2803>, (accessed 30 January 2012).
- ³² Bartels and Otlowski, 'A right to die? Euthanasia and the law in Australia', p. 532.
- ³³ Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, 'End-of-life decisions in Australian medical practice', *The Medical Journal of Australia*, volume 166, number 4, (1997), pp. 191-196.
- ³⁴ *Ibid.*
- ³⁵ *Ibid.*
- ³⁶ *Ibid.*
- ³⁷ *Ibid.*
- ³⁸ The Commission on Assisted Dying, "*The current legal status of assisted dying is inadequate and incoherent...*", p. 51.
- ³⁹ House of Assembly Community Development Committee, 'Report on the need for voluntary euthanasia legislation', p. 6.
- ⁴⁰ *Ibid.*, p. 33.
- ⁴¹ *Ibid.*, p. 25.
- ⁴² *Ibid.*, p. 32.
- ⁴³ Otlowski, 'Getting the law right on physician-assisted death', pp. 127-28.
- ⁴⁴ Joint Select Committee on Community Development, 'Inquiry into the *Dying with Dignity Bill 2009*', transcript of evidence given at Henty House, Launceston, on Monday 10 August 2009, p. 23.
- ⁴⁵ Otlowski, 'Getting the law right on physician-assisted death', p. 128.
- ⁴⁶ *Ibid.*, pp. 129-31.
- ⁴⁷ Tasmanian Association for Hospice and Palliative Care, 'About Palliative Care', (2010), available online at: <http://www.tas.palliativecare.org.au/AboutPalliativeCare.aspx>, (accessed 29 January 2013).
- ⁴⁸ *Ibid.*
- ⁴⁹ Elizabeth Davies and Irene J. Higginson (eds), *Palliative Care: The Solid Facts*, (World Health Organisation: The Regional Office for Europe of the World Health Organisation, 2004), p. 7.
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⁹⁶ The annual reports on the operation Oregon's *Death with Dignity Act 1994* are published by the Oregon Public Health Division. The reports can be found online at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>.

⁹⁷ *Oregon Death with Dignity Act 1994* (§3.01(1)(a)) and (§3.02); *Washington Death with Dignity Act 2008* (§4(1)) and (§5).

⁹⁸ *Oregon Death with Dignity Act 1994* (§2.02(1)); *Washington Death with Dignity Act 2008* (§3(1)).

⁹⁹ Penney Lewis and Isra Black, 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', report commissioned by The Commission on Assisted Dying (London: Demos, January 2012), p. 11.

¹⁰⁰ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* (§2(1)(a)); *Belgian Act on Euthanasia 2002* (§3(1)).

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¹⁰⁷ The Commission on Assisted Dying, "*The current legal status of assisted dying in inadequate and incoherent ...*", p. 21.

¹⁰⁸ The Royal Society of Canada Expert Panel, 'End-of-Life Decision Making', p. 100.

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¹¹¹ Lewis and Black, 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', p. 64.

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